



January 1 – December 31, 2023

Evidence of Coverage:

Your Medicare Health Benefits and Services as a Member of Security Blue HMO-POS Basic HMO-POS

This document gives you the details about your Medicare health care coverage from January 1 – December 31, 2023. **This is an important legal document. Please keep it in a safe place.**

For questions about this document, please contact Member Service at 1-800-935-2583. (TTY users should call 711 National Relay Service). Hours are Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time.

This plan, Security Blue HMO-POS Basic, is offered by Highmark Choice Company. (When this *Evidence of Coverage* says “we,” “us,” or “our,” it means Highmark Choice Company. When it says “plan” or “our plan,” it means Security Blue HMO-POS Basic.)

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

Benefits, premiums and/or copayments/coinsurance may change on January 1, 2024.

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

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

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

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

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CHAPTER 1:

Getting started as a member

CHAPTER 1. Getting started as a member**SECTION 1 Introduction****Section 1.1 You are enrolled in Security Blue HMO-POS Basic, which is a Medicare HMO Point-of-Service Plan**

You are covered by Medicare, and you have chosen to get your Medicare health care through our plan, Security Blue HMO-POS Basic. We are required to cover all Part A and Part B services. However, cost sharing and provider access in this plan differ from Original Medicare.

Security Blue HMO-POS Basic is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) with a Point-of-Service (POS) option approved by Medicare and run by a private company. “Point-of-Service” means you can use providers outside the plan’s network for an additional cost. (See Chapter 3, Section 2.4 for information about using the Point-of-Service option.) Security Blue HMO-POS Basic does not include Part D prescription drug coverage.

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

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

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

The words “coverage” and “covered services” refer to the medical care and services available to you as a member of Security Blue HMO-POS Basic.

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

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

Section 1.3 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how Security Blue HMO-POS Basic covers your care. Other parts of this contract include your enrollment form 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 Security Blue HMO-POS Basic between January 1, 2023 and December 31, 2023.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of Security Blue HMO-POS Basic after December 31, 2023. We

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can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2023.

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

SECTION 2 What makes you eligible to be a plan member?**Section 2.1 Your eligibility requirements**

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

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

Section 2.2 Here is the plan service area for Security Blue HMO-POS Basic

Security Blue HMO-POS Basic is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes these counties in Pennsylvania: Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Huntingdon, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, Somerset, Venango, Warren, Washington and Westmoreland counties.

If you plan to move out of the service area, you cannot remain a member of this plan. Please contact Member Service to see if we have a plan in your new area. When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

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

Section 2.3 U.S. Citizen or Lawful Presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify Security Blue HMO-POS



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Basic if you are not eligible to remain a member on this basis. Security Blue HMO-POS Basic must disenroll you if you do not meet this requirement.

SECTION 3 Important membership materials you will receive

Section 3.1 Your plan membership card

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

			
MEMBER NAME FIRSTNAME M LASTNAME MEMBER ID SDRXXXXXXXXXXXX PLAN (80840) 915101/60		PCP INFORMATION PCP NAME XXXXX XXXX	
Group XXXXXX BC/BS Plan 3XX RxGrp KHP001	Hear/Vision/Dental Office Visit \$XX \$XX \$XX Specialist Visit \$XX \$XX \$XX Emergency Room \$XX \$XX \$XX CMS HXXXX XXX	www.highmarkblueshield.com/medicare Member Service 1-8XX-XXX-XXXX Blues on Call 1-888-258-3428 TTY/TDD Service Dial 711 HMS 1-800-547-3627	
MEDICARE ADVANTAGE HMO		Blues on Call: 24-hour access to nurses who provide health education and support services. All health care services must be provided by Medicare HMO providers. The only exceptions are emergency care, urgently needed care and out-of-area renal dialysis services. Medicare HMO is a Medicare Advantage managed care program. Original Medicare will not pay for services for Medicare HMO Members. Medicare limiting charges apply. Call Healthcare Management Services (HMS) for authorizations and eligibility.	

Do NOT use your red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your Security Blue HMO-POS Basic membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare approved clinical research studies also called clinical trials.

If your plan membership card is damaged, lost, or stolen, call Member Service right away and we will send you a new card.

Section 3.2 Provider Directory

The *Provider Directory* lists our network providers and durable medical equipment suppliers.

Network providers are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full.

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization you will have to pay in full. The only exceptions are emergencies, urgently needed services when the network is not available (that is, in situations when it is unreasonable or

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not possible to obtain services in-network), out-of-area dialysis services, and cases in which Security Blue HMO-POS Basic authorizes use of out-of-network providers.

The Point-of-Service (POS) benefit provides some “out-of-network” coverage. You may see out-of-network providers as long as the services are covered benefits and medically necessary. You may pay more for services than when you would if you used a “network provider.”

If you don’t have your copy of the *Provider Directory*, you can request a copy from Member Service. You can also find this information on our website at [medicare.highmark.com](https://www.medicare.highmark.com).

SECTION 4 Your monthly costs for Security Blue HMO-POS Basic

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums review your copy of *Medicare & You 2023* handbook, the section called “2023 Medicare Costs.” If you need a copy you can download it from the Medicare website (www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.1 Plan premium

As a member of our plan, you pay a monthly plan premium. The monthly premium amount for Security Blue HMO-POS Basic is listed below.

County	Monthly Premium
Allegheny, Armstrong, Beaver, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Washington and Westmoreland counties.	\$50.00
Bedford, Blair, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Forest, Huntingdon, Jefferson, McKean, Mercer, Potter, Somerset, Venango and Warren counties.	\$49.00

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, **you must continue paying your Medicare premiums to remain a member of the plan.** This includes your premium for Part B. It may also include a premium for Part A which affects members who aren’t eligible for premium free Part A.

CHAPTER 1. Getting started as a member**SECTION 5 More information about your monthly premium****Section 5.1 There are several ways you can pay your plan premium**

There are four ways you can pay your plan premium. When you first enroll in our plan you will be billed monthly. Other billing frequencies, such as quarterly or semi-annually, are available.

Option 1: Paying by check

Invoices for your plan premium will be mailed on or about the 4th day of the month. Payment must be received by the last day of the month for the following month. For example, your bill for February coverage will be mailed on or about January 4 and is due by January 31.

Make your check payable to “Highmark Choice Company” or “Security Blue HMO-POS”. **(Do not make it payable to CMS or HHS)**. Please include your billing ID number on your check or money order and mail it to us at:

Highmark Choice Company or Security Blue HMO-POS
P.O. Box 640529
Pittsburgh, PA 15264-0529

If you prefer, you can drop off your payment in person at either of our Member Service Centers. Hours are Monday through Friday, 8:30 a.m. to 4:30 p.m.

Highmark - Johnstown Service Center
One Pasquerilla Plaza
Johnstown, PA 15901

Highmark - Erie Service Center
717 State Street
Erie, PA 16501

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

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

Option 3: You can pay your plan premium online

Our *e-Bill* option is available through our secure website at medicare.highmark.com. Switching to online *e-Bill* payment allows you to have your premium automatically deducted from your checking account. Online *e-Bill* payment gives you freedom and flexibility to make a one-time payment while you are temporarily away from home; make recurring payments over several months; view and print your current or past bills; or easily change your checking account information online.

Option 4: Having your premium taken out of your monthly Social Security check

Changing the way you pay your premium. 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. To change your payment method, please contact Member Service.

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

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

If you are 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 costs.

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. In the future, if you want to enroll again in our plan (or another plan that we offer), you will need to pay the late premiums before you can enroll.

If you think we have wrongfully ended your membership, you can make a complaint (also called a grievance); see Chapter 7 for how to file 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 plan premium within our grace period, you can make a complaint. For complaints, we will review our decision again. Chapter 7, Section 9 of this document tells how to make a complaint, or you can call us at 1-800-935-2583 between Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time. TTY users should call 711 National Relay Service. You must make your request no later than 60 days after the date your membership ends.

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

SECTION 6 Keeping your plan membership record up to date

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.

The doctors, hospitals, 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 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

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- If you have been admitted to a nursing home
- If you receive care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study (**Note:** You are not required to tell your plan about the clinical research studies you intend to participate in but we encourage you to do so)

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).

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

SECTION 7 How other insurance works with our plan

Other insurance

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

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

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

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

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
 - If you're under 65 and disabled and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
 - If you're over 65 and you or your spouse is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.

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- 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.

CHAPTER 2:

*Important phone numbers and
resources*

CHAPTER 2. Important phone numbers and resources

SECTION 1 Security Blue HMO-POS Basic contacts
 (how to contact us, including how to reach Member Service)

How to contact our plan's Member Service

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

Method	Member Service – Contact Information
CALL	1-800-935-2583 Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time. Member Service also has free language interpreter services available for non-English speakers.
TTY	711 National Relay Service This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time.
FAX	1-717-635-4235
WRITE	P.O. Box 1068 Pittsburgh, PA 15230-1068
WEBSITE	medicare.highmark.com

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

A "coverage decision" is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on asking for coverage decisions or appeals about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

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

CHAPTER 2. Important phone numbers and resources

Method	Coverage Decisions for Medical Care – Contact Information
TTY	<p>711 National Relay Service</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free. Monday through Friday, 8:30 a.m. to 7:00 p.m.; Saturday and Sunday, 8:30 a.m. to 4:30 p.m. Eastern Time.</p>
FAX	1-800-894-7947
WRITE	<p>P.O. Box 1068 Pittsburgh, PA 15230-1068</p> <p>To file an expedited organization determination, send your request to: Appeals and Grievance Department P.O. Box 535047 Pittsburgh, PA 15253-5047</p>
WEBSITE	medicare.highmark.com

Method	Appeals for Medical Care – Contact Information
CALL	<p>1-800-935-2583</p> <p>Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time. To file an expedited appeal, call 1-800-485-9610, option 2.</p>
TTY	<p>711 National Relay Service</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time.</p>
FAX	<p>1-717-635-4209</p> <p>To file an expedited appeal, fax your request to 1-800-894-7947.</p>
WRITE	<p>Appeals and Grievance Department P.O. Box 535047 Pittsburgh, PA 15253-5047</p>
WEBSITE	medicare.highmark.com

CHAPTER 2. Important phone numbers and resources**How to contact us when you are making a complaint about your medical care**

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. For more information on making a complaint about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Complaints About Medical Care – Contact Information
CALL	1-800-935-2583 Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time.
TTY	711 National Relay Service This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time.
FAX	1-717-635-4209
WRITE	Appeals and Grievance Department P.O. Box 535047 Pittsburgh, PA 15253-5047
MEDICARE WEBSITE	You can submit a complaint about Security Blue HMO-POS Basic 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 you have received

If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill, see Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) for more information.

Method	Payment Requests – Contact Information
CALL	1-800-935-2583 Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time.

CHAPTER 2. Important phone numbers and resources

Method	Payment Requests – Contact Information
TTY	<p>711 National Relay Service</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time.</p>
FAX	1-717-635-4235
WRITE	<p>P.O. Box 1068</p> <p>Pittsburgh, PA 15230-1068</p>
WEBSITE	medicare.highmark.com

SECTION 2 Medicare

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

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

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

Method	Medicare – Contact Information
CALL	<p>1-800-MEDICARE, or 1-800-633-4227</p> <p>Calls to this number are free.</p> <p>24 hours a day, 7 days a week.</p>
TTY	<p>1-877-486-2048</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p>
WEBSITE	<p>www.medicare.gov</p> <p>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</p>

CHAPTER 2. Important phone numbers and resources

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

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

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Pennsylvania, the SHIP is called PA MEDI - Pennsylvania Medicare Education and Decision Insight.

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

CHAPTER 2. Important phone numbers and resources

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

METHOD TO ACCESS SHIP and OTHER RESOURCES:

- Visit www.medicare.gov
- Click on “**Talk to Someone**” in the middle of the homepage
- You now have the following options
 - Option #1: You can have a **live chat with a 1-800-MEDICARE representative**
 - Option #2: You can select your **STATE** from the dropdown menu and click GO. This will take you to a page with phone numbers and resources specific to your state.

Method	PA MEDI - Pennsylvania Medicare Education and Decision Insight (Pennsylvania SHIP) - Contact Information
CALL	1-800-783-7067
TTY	711 National Relay Service This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	555 Walnut Street, 5 th Floor Harrisburg, PA 17101
WEBSITE	www.aging.pa.gov

SECTION 4 Quality Improvement Organization

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For Pennsylvania, the Quality Improvement Organization is called Livanta BFCC-QIO Program.

Livanta BFCC-QIO Program has a group of doctors and other health care professionals who are paid by Medicare to check on and help improve the quality of care for people with Medicare. Livanta BFCC-QIO Program is an independent organization. It is not connected with our plan.

You should contact Livanta BFCC-QIO Program 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.

CHAPTER 2. Important phone numbers and resources

Method	Livanta BFCC-QIO Program (Pennsylvania's Quality Improvement Organization) - Contact Information
CALL	1-888-396-4646 Monday through Friday, 8:30 a.m. to 5:00 p.m. Eastern Time. Saturday, Sunday and Holidays, 11:00 a.m. to 3:00 p.m., Eastern Time.
TTY	1-888-985-2660 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

SECTION 5 Social Security

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

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

Method	Social Security– Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 8:00 a.m. to 7:00 p.m., 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 8:00 a.m. to 7:00 p.m., Monday through Friday.

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Method	Social Security– Contact Information
WEBSITE	www.ssa.gov

SECTION 6 Medicaid

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. The programs offered through Medicaid help people with Medicare pay their Medicare costs, such as their Medicare premiums. These “Medicare Savings Programs” include:

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

To find out more about Medicaid and its programs, contact Pennsylvania Department of Human Services:

Method	Pennsylvania Department of Human Services– Contact Information
CALL	1-800-537-8862 Monday through Friday, 8:00 a.m. to 6:00 p.m., Eastern Time.
TTY	711 National Relay Service This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Health and Welfare Bldg., Room 515 P.O. Box 2675 Harrisburg, PA 17105
WEBSITE	www.dhs.pa.gov

SECTION 7 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation’s railroad workers and their families. If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or

CHAPTER 2. Important phone numbers and resources

change your mailing address. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

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

SECTION 8 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 as part of this plan, you may call the employer/union benefits administrator or Customer 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 document.) You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

CHAPTER 3:

*Using the plan for your medical
services*

CHAPTER 3. Using the plan for your medical services

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

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

For the details on what medical care is covered by our plan and how much you pay when you get this care, 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”?

- **“Providers”** are doctors and other health care professionals licensed by the state to provide medical services and care. The term “providers” also includes hospitals and other health care facilities.
- **“Network providers”** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- **“Covered services”** include all the medical care, health care services, supplies, 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, Security Blue HMO-POS Basic must cover all services covered by Original Medicare and must follow Original Medicare’s coverage rules.

Security Blue HMO-POS Basic 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 document).
- **The care you receive is considered medically necessary.** “Medically necessary” means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You 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).
- **You must receive your care from a provider who is eligible to provide services under Original Medicare.** As a member of our plan, you can receive your care for most medically

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necessary services from either a network provider or an out-of-network provider (for more about this, see Section 2 in this chapter).

- The providers in our network are listed in the *Provider Directory*.
- If you use an out-of-network provider, your share of the costs for your covered services may be higher.
- **Please note:** While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you go to a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

SECTION 2 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 Security Blue HMO-POS Basic you must choose a plan provider to be your PCP. Your PCP is a family physician, general practitioner or internal medicine physician who meets state requirements and is trained to give you basic medical care. A PCP can also be a physician assistant or nurse practitioner. Your PCP is much like the “old-fashioned family doctor” – one who knows your current health as well as your medical history; a provider with whom you feel comfortable discussing all of your health care needs. You will get your routine or basic care from this doctor. Your PCP can also help coordinate the rest of the covered services you get as a member of Security Blue HMO-POS Basic. Coordinating your services includes checking or consulting with other plan providers about your care and how it is going. You are encouraged, but not required to see your PCP whenever you need care. This helps ensure that you receive the right care for your needs, when you need it. For your convenience and security, network primary care physicians or their covering doctors are on call 24 hours a day, seven days a week.

How do you choose your PCP?

PCPs and their group practices, if applicable, are listed in the *Provider Directory*. You can also find PCPs on our website at [medicare.highmark.com](https://www.medicare.highmark.com). Click on the “Find a Provider” link to access our online Provider Directory. The name of the PCP’s practice and the PCP number for that practice must be included on your Enrollment Application. Because your PCP plays a central role in your health care, please select one with careful consideration to hospital affiliation and office location.

To view board certification information and the hospital affiliation of your PCP or Network specialist, visit our website at [medicare.highmark.com](https://www.medicare.highmark.com). Click on the “Find a Provider” link to access our online Provider Directory. Search for the physician, then click on the provider’s name to view this

CHAPTER 3. Using the plan for your medical services

information. In addition to this information, to obtain the full professional qualifications of network providers, including medical schools attended and residencies completed, call Member Service at the numbers printed on the back cover of this booklet.

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, contact Member Service. They will check to be sure the PCP you want is accepting new patients. Member Service will also request the change to your membership record to show the name of the new PCP.

- If your request for change is received between the 1st and the 15th day of the month, your PCP change will become effective the first day of the following month.
- If your request for change is received between the 16th and the last day of the month, your PCP change will become effective the first day of the second month after it is received.

Section 2.2 How to get care from specialists and other network providers

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

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

We list the specialists and other network providers that participate with Security Blue HMO-POS Basic in the *Provider Directory*. You can also locate participating network providers on our website, [medicare.highmark.com](https://www.medicare.highmark.com). While you are not required to get a referral from your PCP prior to receiving covered specialty care, you are encouraged to coordinate and record your treatment with your PCP at each stage of your care. This way, you can be sure that your need for specialty care is based on an informed diagnosis. Your PCP can direct you to the right specialist promptly, so you don't waste time tracking down the best doctor for your case. You also can be confident that your specialty care will complement other care you may be receiving. Certain services, such as non-emergency inpatient hospital care, require prior-authorization from Highmark Choice Company for the service to be covered. Network providers are responsible for obtaining this prior-authorization (for more information on which services require prior authorization, see Chapter 4, Section 2.1).

If you believe you need **treatment for mental health or substance abuse**, contact the network behavioral health provider of your choice or call Member Service at the toll-free / TTY number on the back of your member ID card and select the *mental health, drug or alcohol treatment services* option from the menu. You will be connected to Highmark Behavioral Health Department, which is available Monday through Friday, 8:30 a.m. through 7:00 p.m., Eastern Time. The Highmark Behavioral Health Department is a valuable resource for accessing information about mental health and substance abuse providers, facilities and related information.

CHAPTER 3. Using the plan for your medical services

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

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. If your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If our network does not have a qualified specialist for a plan-covered service, we must cover that service at in-network cost sharing (prior authorization is required).
- If you find out your doctor or specialist is leaving your plan please contact us so we can assist you in finding a new provider to manage your care.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file quality of care complaint to the QIO, a quality of care grievance to the plan, or both. Please see Chapter 7.

Section 2.3 How to get care from out-of-network providers

As a member of our plan, you can choose to receive care from out-of-network providers, including those in our service area, for most services. However, please note providers that do not contract with us are under no obligation to treat you, except in emergency situations. Our plan will cover services from either network or out-of-network providers, as long as the services are covered benefits and are medically necessary. However, **if you use an out-of-network provider, your share of the costs for your covered services may be higher.** Here are other important things to know about using out-of-network providers:

- You can get your care from an out-of-network provider; however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you receive care from a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.
- Prior authorization is still required for applicable services when you get care from out-of-network providers. This is important because:

CHAPTER 3. Using the plan for your medical services

- Without a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 7 (*What to do if you have a problem or complaint*) to learn how to make an appeal.
- It is best to ask an out-of-network provider to bill the plan first. But, if you have already paid for the covered services, we will reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill that you think we should pay, you can send it to us for payment. See Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*) for information about what to do if you receive a bill or if you need to ask for reimbursement.
- If you are using an out-of-network provider for emergency care, urgently needed services, or out-of-area dialysis, you may not have to pay a higher cost sharing amount. See Section 3 for more information about these situations.

See the Medical Benefits Chart in Chapter 4 for specific Point-of-Service benefits.

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

Section 3.1 Getting care if you have a medical emergency

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

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

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP. You do not need to use a network doctor. You may get covered emergency medical care whenever you need it, anywhere in the United States, its territories or worldwide, and from any provider with an appropriate state license even if they are not part of our network.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. You can reach Member Service at the number included on the back of this book. You can also locate the phone number on the back of your ID card.

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What is covered if you have a medical emergency?

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency.

The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. Your follow-up care will be covered by our plan.

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 services” 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 services
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What are “urgently needed services”?

An “urgently needed service” is a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. For example, an unforeseen flare-up of a known condition that you have or a severe sore throat that occurs over the weekend. Urgently needed services may be furnished by out-of-network providers when it is unreasonable, given your circumstances, to obtain immediate care from network providers.

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

You should always try to obtain urgently needed services from network providers. However, if providers are temporarily unavailable or inaccessible and it is not reasonable to wait to obtain care from your network provider when the network becomes available, we will cover urgently needed services that you get from an out-of-network provider.

If you believe you have an urgent need for care, go to the nearest emergency room or urgent care facility. Note – If you go to the emergency room, your cost sharing could be higher. See the Medical Benefits Chart in Chapter 4 of this booklet for more information.

CHAPTER 3. Using the plan for your medical services

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 services that you get from any provider.

Our plan covers worldwide emergency and urgent care services outside the United States under the following circumstances:

- injury
- sudden illness
- medical condition that is quickly getting worse

Section 3.3 Getting care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from your plan.

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

If you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost sharing.

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

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

If you have paid more than your plan cost sharing for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services*) for information about what to do.

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

Security Blue HMO-POS Basic covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4 of this document. If you receive services not covered by our plan or services obtained out-of-network and were not authorized, you are responsible for paying the full cost of services.

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. These payments will not count

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toward your out-of-pocket maximum. You can call Member Service when you want to know how much of your benefit limit you have already used.

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

Section 5.1 What is a “clinical research study”?

A clinical research study (also called a “clinical trial”) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically request volunteers to participate in the study.

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

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. If you tell us that you are in a qualified clinical trial, then you are only responsible for the in-network cost sharing for the services in that trial. If you paid more, for example, if you already paid the Original Medicare cost sharing amount, we will reimburse the difference between what you paid and the in-network cost sharing. However, you will need to provide documentation to show us how much you paid. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

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

Although you do not need to get our plan’s permission to be in a clinical research study, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

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

Section 5.2 When you participate in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you receive as part of the study, including:

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

After Medicare has paid its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan. However, you are required to submit documentation showing how much cost sharing you paid. Please see Chapter 5 for more information for submitting requests for payments.

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

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

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

Do you want to know more?

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

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

CHAPTER 3. Using the plan for your medical services**SECTION 6 Rules for getting care in a “religious non-medical health care institution”****Section 6.1 What is a religious non-medical health care institution?**

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member’s religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

Section 6.2 Receiving Care From a Religious Non-Medical Health Care Institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is “non-excepted.”

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

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

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

All Medicare Inpatient Hospital coverage limits apply. See the Medical Benefits Chart in Chapter 4 for details.

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?**

Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating

CHAPTER 3. Using the plan for your medical services

devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of Security Blue HMO-POS Basic, however, you usually will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan, even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under certain limited circumstances we will transfer ownership of the DME item to you. Call Member Service for more information.

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

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

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare do not count. You will have to make 13 payments to our plan before owning the item.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You were in our plan but did not obtain ownership while in our plan. You then go back to Original Medicare. You will have to make 13 consecutive new payments to own the item once you join Original Medicare again. All previous payments (whether to our plan or to Original Medicare) do not count.

Section 7.2	Rules for oxygen equipment, supplies, and maintenance
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What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage, Security Blue HMO-POS Basic will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

If you leave Security Blue HMO-POS Basic or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

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

Original Medicare requires an oxygen supplier to provide you services for five years. During the first 36 months you rent the equipment. The remaining 24 months the supplier provides the equipment and maintenance (you are still responsible for the copayment for oxygen). After five years, you may choose to stay with the same company or go to another company. At this point, the five-year

CHAPTER 3. Using the plan for your medical services

cycle begins again, even if you remain with the same company, requiring you to pay copayments for the first 36 months. If you join or leave our plan, the five-year cycle starts over.

CHAPTER 4:

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

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

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

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

Section 1.1 Types of out-of-pocket costs you may pay for your covered services

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

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

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

Section 1.2 What is the most you will pay for Medicare Part A and Part B covered medical services?

Under our plan, there are two different limits on what you have to pay out-of-pocket for covered medical services:

- Your **in-network maximum out-of-pocket amount** is \$5,900. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from network providers. The amounts you pay for copayments and coinsurance for covered services from network providers count toward this in-network maximum out-of-pocket amount. (The amounts you pay for plan premiums and services from out-of-network providers do not count toward your in-network maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your in-network maximum out-of-pocket amount. These services are noted as such in the Medical Benefits Chart.) If you have paid \$5,900 for covered Part A and Part B services from network providers, you will not have any out-of-pocket costs for the rest of the year when you see our network providers. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

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

- Your **combined maximum out-of-pocket amount** is \$8,950. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from both in-network and out-of-network providers. The amounts you pay for copayments and coinsurance for covered services count toward this combined maximum out-of-pocket amount. (The amounts you pay for your plan premiums do not count toward your combined maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your combined maximum out-of-pocket amount. These services are noted as such in the Medical Benefits Chart.) If you have paid \$8,950 for covered services, you will have 100% coverage and will not have any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay your plan premium 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 Security Blue HMO-POS Basic, an important protection for you is that you only have to pay your cost sharing amount when you get services covered by our plan. Providers may not add additional separate charges, called “balance billing.” This protection applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don’t pay certain provider charges.

Here is how this protection works:

- If your cost sharing is a copayment (a set amount of dollars, for example, \$15.00), then you pay only that amount for any covered services from a network provider.
- 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 or for emergencies or urgently needed services.)
 - 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, or for emergencies or urgently needed services.)
- If you believe a provider has “balance billed” you, call Member Service.

CHAPTER 4. Medical Benefits Chart (what is covered and what you pay)**SECTION 2 Use the *Medical Benefits Chart* to find out what is covered and how much you will pay****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 Security Blue HMO-POS Basic 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, equipment, and Part B prescription drugs) *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.
- Some of the services listed in the Medical Benefits Chart are covered as in-network services *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 by an asterisk (*).

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2023* handbook. View it online at www.medicare.gov or ask for a copy 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.)
- 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.
- If Medicare adds coverage for any new services during 2023, either Medicare or our plan will cover those services.
- If you are diagnosed with the following chronic condition(s) identified below and meet certain criteria, you may be eligible for special supplemental benefits for the chronically ill.
 - Congestive Heart Failure, COPD, Diabetes and/or Hypertension
 - Members must have a diagnosis code on file for one of the above conditions

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

- Please go to the “Special Supplemental Benefits for the Chronically Ill” row in the below Medical Benefits Chart for further detail.



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

- ✓ You will see this symbol next to a service that does not apply to the Out-of-Pocket Maximum.

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 have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	Network: There is no coinsurance, copayment, or deductible for members eligible for this preventive screening. <hr/> Point-of-Service Out-of-Network: There is no coinsurance, copayment, or deductible for members eligible for this preventive screening. <i>A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.</i> <i>Additional medically necessary diagnostic services will be charged the cost sharing that applies to the type of service received.</i>
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: <ul style="list-style-type: none"> • lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, disease, etc.); 	Network: \$30 copay per Medicare-covered visit <hr/> Point-of-Service Out-of-Network: \$45 copay per Medicare-covered visit


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

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • not associated with surgery; and • not associated with pregnancy. <p>An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually.</p> <p>Treatment must be discontinued if the patient is not improving or is regressing.</p> <p>Provider Requirements:</p> <p>Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act) may furnish acupuncture in accordance with applicable state requirements.</p> <p>Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:</p> <ul style="list-style-type: none"> • a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. <p>Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.</p>	



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

Services that are covered for you	What you must pay when you get these services
<p>Ambulance services*</p> <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 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 could endanger the person's health and that transportation by ambulance is medically required. To meet this definition, the member's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. Non-emergency transportation by ambulance is appropriate if either: the member is bed-confined, and it is documented that the member's condition is such that other methods of transportation are contraindicated; or, if the member's medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required. 	<p>\$125 copay per one way trip for emergency and non-emergency ambulance services</p> <p>Non-emergency ambulance or other transportation services outside the United States back to the plan service area are not covered. Non-emergency ambulance services require a Physician Certification Statement (PCS).</p> <p>Point-of-Service Out-of-Network for non-emergent ambulance is <u>not available</u>.</p> <p><i>Advanced life support services (ALS) delivered by paramedics that operate separately from the agency that provides the ambulance transport are not covered.</i></p>
<p><u>Prior Authorization Requirements</u></p> <p>All non-emergency transportation by ambulance must be prior authorized (approved in advance) by a plan or a delegate of the plan. The member's non-emergent ambulance provider is responsible for obtaining prior authorization.</p>	


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

Services that are covered for you	What you must pay when you get these services
Any non-emergency transportation services not prior authorized will not be covered.	
<p>Annual routine physical exam</p> <p>We cover one visit per calendar year. The exam services include:</p> <ul style="list-style-type: none"> • Visual inspection of the body • Tapping specific areas of the body and listening to sounds • Checking vital signs and measuring height/weight 	<p>Network:</p> <p>There is no coinsurance, copayment, or deductible for the annual physical exam.</p> <hr/> <p>Point-of-Service Out-of-Network:</p> <p>There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.</p> <p><i>A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.</i></p> <p><i>Additional medically necessary diagnostic services will be charged the cost sharing that applies to the type of service received.</i></p>
<p> Annual wellness visit</p> <p>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 calendar year.</p> <p>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.</p>	<p>Network:</p> <p>There is no coinsurance, copayment, or deductible for the annual wellness visit.</p> <hr/> <p>Point-of-Service Out-of-Network:</p> <p>There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.</p> <p><i>A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.</i></p> <p><i>Additional medically necessary diagnostic services will be charged the cost sharing that applies to the type of service received.</i></p>



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

Services that are covered for you	What you must pay when you get these services
<p>Bathroom safety devices*</p> <p>This benefit is part of your Durable Medicare Equipment benefit. (For a definition of “durable medical equipment,” see Chapter 10 of this document.)</p> <p>Covered services are limited to:</p> <ul style="list-style-type: none"> • Shower chairs/seats - 1 every 3 years • Grab bars - 1 every 3 years 	<p>Network:</p> <p>20% coinsurance</p> <p>Point-of-Service Out-of-Network for Bathroom Safety Devices is <u>not available</u>.</p>
<p> Bone mass measurement</p> <p>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.</p>	<p>Network:</p> <p>There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.</p> <hr/> <p>Point-of-Service Out-of-Network:</p> <p>There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.</p> <p><i>A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.</i></p> <p><i>Additional medically necessary diagnostic services will be charged the cost sharing that applies to the type of service received.</i></p>
<p> Breast cancer screening (mammograms)</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • One baseline mammogram between the ages of 35 and 39 (includes 3D mammogram) • One screening mammogram every calendar year for women aged 40 and older (includes 3D mammogram) 	<p>Network:</p> <p>There is no coinsurance, copayment, or deductible for covered screening mammograms.</p> <p>A screening mammogram may convert to a diagnostic mammogram at the time services are rendered. Diagnostic testing will be subject to diagnostic cost sharing.</p>


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

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> Clinical breast exams once every calendar year 	<hr/> <p>Point-of-Service Out-of-Network:</p> <p>There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.</p> <p><i>A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.</i></p> <p><i>Additional medically necessary diagnostic services will be charged the cost sharing that applies to the type of service received.</i></p>
<p>Cardiac rehabilitation services</p> <p>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>	<p>Network:</p> <p>\$0 copay</p> <hr/> <p>Point-of-Service Out-of-Network:</p> <p>30% coinsurance</p>
<p> Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)</p> <p>We cover one 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 healthy.</p>	<p>Network:</p> <p>There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.</p> <hr/> <p>Point-of-Service Out-of-Network:</p> <p>There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.</p>


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

Services that are covered for you	What you must pay when you get these services
	<p><i>A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.</i></p> <p><i>Additional medically necessary diagnostic services will be charged the cost sharing that applies to the type of service received.</i></p>
 Cardiovascular disease testing <p>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>	<p>Network:</p> <p>There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.</p> <hr/> <p>Point-of-Service Out-of-Network:</p> <p>There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.</p> <p><i>A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.</i></p> <p><i>Additional medically necessary diagnostic services will be charged the cost sharing that applies to the type of service received.</i></p>
 Cervical and vaginal cancer screening <p>Covered services include:</p> <ul style="list-style-type: none"> For all women: Pap tests and pelvic exams are covered once every calendar year 	<p>Network:</p> <p>There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.</p> <hr/> <p>Point-of-Service Out-of-Network:</p> <p>There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.</p>



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

Services that are covered for you	What you must pay when you get these services
	<p><i>A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.</i></p> <p><i>Additional medically necessary diagnostic services will be charged the cost sharing that applies to the type of service received.</i></p>
<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 • Routine coverage provides maintenance manual manipulation of the spine • Frequency limits apply <p>✓ <i>Routine chiropractic visits do not count towards the maximum out-of-pocket.</i></p>	<p>Network:</p> <p>\$20 copay per Medicare-covered visit</p> <p>✓ \$20 copay for each of 6 routine visits per calendar year</p> <hr/> <p>Point-of-Service Out-of-Network:</p> <p>\$30 copay per Medicare-covered visit</p> <p>Point-of-Service Out-of-Network for routine chiropractic is <u>not available</u>.</p>
<p> Colorectal cancer screening</p> <p>For people 45 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 • Screening CT Colonography for people ages 45-75 years old once every five years <p>One of the following every calendar year:</p> <ul style="list-style-type: none"> • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) <p>DNA based colorectal screening every 3 years</p> <p>For people at high risk of colorectal cancer, we cover:</p>	<p>Network:</p> <p>There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.</p> <hr/> <p>Point-of-Service Out-of-Network:</p> <p>There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.</p> <p>If the screening test results in a biopsy or removal of a lesion or growth, the procedure is considered diagnostic and outpatient surgery cost sharing may apply.</p>

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

Services that are covered for you	What you must pay when you get these services
<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><i>A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.</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"> 1 oral exam and cleaning every 6 months 1 set of bitewing x-rays every calendar year; full mouth x-rays every 5 years <p>Routine dental services are covered through the United Concordia network for all plan members.</p> <p>For Medicare covered Dental services see the Physician/Practitioner services section of this Medical Benefits chart.</p> <p>✓ <i>Routine dental services are not subject to the maximum out-of-pocket.</i></p>	<p>Network:</p> <p>\$30 copay for Medicare-covered dental office visit services</p> <p>✓ \$15 copay for oral exam and cleaning</p> <p>✓ \$15 copay for x-rays</p> <p>Point-of-Service Out-of-Network for routine dental is <u>not available</u>.</p>
<p> Depression screening</p> <p>We cover one screening for depression per calendar year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.</p>	<p>Network:</p> <p>There is no coinsurance, copayment, or deductible for an annual depression screening visit.</p> <hr/> <p>Point-of-Service Out-of-Network:</p> <p>There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.</p>

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

Services that are covered for you	What you must pay when you get these services
	<p><i>A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.</i></p> <p><i>Additional medically necessary diagnostic services will be charged the cost sharing that applies to the type of service received.</i></p>
<p> Diabetes screening</p> <p>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.</p> <p>Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.</p>	<p>Network:</p> <p>There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.</p> <hr/> <p>Point-of-Service Out-of-Network:</p> <p>There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.</p> <p><i>A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.</i></p> <p><i>Additional medically necessary diagnostic services will be charged the cost sharing that applies to the type of service received.</i></p>
<p> Diabetes self-management training, diabetic services and supplies*</p> <p>For all people who have diabetes (insulin and non-insulin users). Covered services include:</p> <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. 	<p>Network:</p> <p>There is no coinsurance, copayment, or deductible for diabetic self-management training</p> <p>\$0 copay for glucometers, test strips, lancets, control solution, replacement batteries, platforms, lens shield, a continuous glucose monitoring device and non-invasive vagus nerve stimulator</p>


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

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> 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 person at risk of diabetes: Fasting plasma glucose tests are covered 2 times per calendar year Certain DME providers in the Security Blue HMO-POS Basic network have agreed to provide blood glucose monitors free of charge. Call Member Service for details. 	<p>20% coinsurance for all other diabetic supplies and therapeutic shoes</p> <p>Abbott and Lifescan glucometers, diabetic test strips, lancets, control solutions and a continuous glucose monitoring device are available for dispense via a retail or mail order pharmacy.</p> <p>All other desired brands will need to be obtained from a Durable Medical Equipment (DME) supplier (or via an exception process).</p> <hr/> <p>Point-of-Service Out-of-Network:</p> <p>There is no coinsurance, copayment, or deductible for members eligible for diabetic self-management training.</p>
<p>*Prior authorization is required for certain items</p>	<p>Point-of-Service Out-of-Network for diabetic supplies and therapeutic shoes is <u>not available</u>.</p> <p><i>A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.</i></p>
<p>Durable medical equipment (DME) and related supplies*</p> <p>(For a definition of “durable medical equipment,” see Chapter 10 as well as Chapter 3, Section 7 of this document.)</p> <p>Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers.</p>	<p>Network:</p> <p>20% coinsurance</p> <p>Your cost sharing for Medicare oxygen equipment coverage is 20% coinsurance, every month.</p> <p>After 36 months you no longer will pay the cost of the oxygen equipment but you will continue to pay 20% for the oxygen contents.</p> <p>Point-of-Service Out-of-Network for DME is <u>not available</u>.</p>

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

Services that are covered for you	What you must pay when you get these services
<p>We cover all medically necessary DME 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. The most recent list of suppliers is available on our website at medicare.highmark.com.</p> <p>Reimbursement for oxygen services includes payment for equipment rental, oxygen contents, and all accessories and supplies as necessary.</p> <p>Payment for deluxe or special features for durable medical equipment may be made only when such features are prescribed by the attending physician and when medical necessity is established.</p>	
<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 (and, if you are a pregnant woman, loss of an unborn child), 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>Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.</p> <p>Emergency care is covered worldwide.</p>	<p>\$95 copay</p> <p>If you are admitted to the hospital within 3-days for the same condition, you pay \$0 for the emergency room visit. The emergency room copayment applies if you are in the hospital for observation or rapid treatment as these are not considered hospital admissions.</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 return to a network hospital in order for your care to continue to be covered at the network level <i>or</i> you must have your inpatient care at the out-of-network hospital authorized by the plan which would then be covered at the Point-of-Service level.</p> <p>The copayment applies to emergency care out of the country.</p>


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<p>Enhanced disease management</p> <p>Onduo Diabetes Management is a virtual care program that helps individuals manage their Type 2 diabetes. The program helps guide individuals to eat healthier, be more active, and create other lifestyle changes.</p> <p>It includes a smart blood glucose meter, the Onduo app, and support from personal coaches, clinicians and care specialists, including access to physicians through telemedicine when needed.</p>	<p>There is no charge for this program.</p> <p>To be eligible, you must have Type 2 diabetes, be 18 years of age or older and own a smartphone (to use the app).</p> <p>Point-of-Service Out-of-Network is <u>not available</u>.</p>
<p> Health and wellness education programs</p> <p>Highmark's health and wellness education program provides access to network gyms and fitness classes designed to improve muscular strength and endurance, mobility, flexibility, range of motion, balance, agility and coordination through the Tivity, Inc. SilverSneakers® Fitness program. Eligible members receive a membership at network fitness facilities with access to all basic amenities plus SilverSneakers® fitness classes.</p> <p>SilverSneakers FLEX™ classes (which include tai chi, yoga and dance) are in neighborhood locations such as medical campuses, older-adult living communities and parks. SilverSneakers Steps®, which includes various kits for members to use at home or when they travel, is an available alternative for members who can't get to a network fitness location.</p> <p>For more information, to find SilverSneakers fitness locations and FLEX™ classes, or to get started with SilverSneakers Steps®, eligible members should visit silversneakers.com or call 1-888-423-4632 (TTY: 711 National Relay</p>	<p>There is no charge for the fitness program.</p> <p>Point-of-Service Out-of-Network is <u>not available</u>.</p>

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Service), Monday through Friday, 8:00 a.m. to 8:00 p.m., Eastern Time.	
<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 include:</p> <ul style="list-style-type: none"> • 1 routine hearing exam per calendar year <p>Hearing Aids:</p> <ul style="list-style-type: none"> • Up to two TruHearing-branded hearing aids every year (one per ear per year). Benefit is limited to TruHearing's Advanced and Premium hearing aids, which come in various styles and colors. You must see a TruHearing provider to use this benefit. <p>Call 1-855-544-7171 (TTY, dial 711) Monday through Friday, 9:00 a.m. to 9:00 p.m., Eastern Time to schedule an appointment.</p> <p>Hearing aid purchases includes:</p> <ul style="list-style-type: none"> • first year of hearing aid purchase provider visits • 60-day trial period • 3 year extended warranty • 80 batteries per aid for non-rechargeable models <p>Benefit <u>does not</u> include or cover any of the following:</p> <ul style="list-style-type: none"> • Additional cost for optional hearing aid rechargeability • Ear molds • Hearing aid accessories 	<p>Network:</p> <p>\$30 copay per Medicare-covered hearing exam</p> <p>✓\$0 copay per annual routine hearing exam</p> <p>✓\$699 copay per aid for TruHearing Advanced Aids</p> <p>✓\$999 copay per aid for TruHearing Premium Aids</p> <p>✓ \$50 additional cost per aid for optional hearing aid rechargeability</p> <hr/> <p>Point-of-Service Out-of-Network:</p> <p>\$30 copay per Medicare-covered visit.</p> <p>Point-of-Service Out-of-Network for routine hearing is <u>not available</u>.</p>

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Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Extra batteries • Hearing aids that are not TruHearing-branded hearing aids • Costs associated with loss & damage warranty claims <p>Costs associated with excluded items are the responsibility of the member and not covered by the plan.</p> <p>✓ <i>Routine hearing exams and hearing aid copays do not count towards the maximum out-of-pocket.</i></p>	
 HIV screening <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 calendar year <p>For women who are pregnant, we cover:</p> <ul style="list-style-type: none"> • Up to three screening exams during a pregnancy 	<p>Network:</p> <p>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.</p> <hr/> <p>Point-of-Service Out-of-Network:</p> <p>There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.</p> <p><i>A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.</i></p> <p><i>Additional medically necessary diagnostic services will be charged the cost sharing that applies to the type of service received.</i></p>
<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>Network:</p> <p>\$0 copay</p> <p>Point-of-Service Out-of-Network for home health is <u>not available</u>.</p>


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Services that are covered for you	What you must pay when you get these services
<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>Please reference “Durable medical equipment (DME) and related supplies” section above for medical equipment and supplies.</p>
<p>Home infusion therapy</p> <p>Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters).</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring <p>Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier</p> <p>*Prior authorization is required for certain drugs.</p>	<p>Network:</p> <p>\$0 copay</p> <p>Point-of-Service Out-of-Network for home infusion is <u>not available</u>.</p> <p>Medicare Part B drugs that are billed separately may be billed under the <i>Medicare Part B prescription drug</i> benefit (see below).</p>

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Services that are covered for you	What you must pay when you get these services
<p>Hospice care</p> <p>You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider.</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>When you are admitted to a hospice you have the right to remain in your plan; if you chose to remain in your plan you must continue to pay plan premiums.</p> <p><u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis:</u> Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost sharing.</p> <p><u>For services that are covered by Medicare Part A or B and are not related to your terminal prognosis:</u> If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not</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 prognosis are paid for by Original Medicare, not Security Blue HMO-POS Basic.</p> <p>\$0 copay for a one time only hospice consultation with a primary care physician</p>

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Services that are covered for you	What you must pay when you get these services
<p>related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization).</p> <ul style="list-style-type: none"> • If you obtain the covered services from a network provider and follow plan rules for obtaining service, 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 Security Blue HMO-POS Basic but are not covered by Medicare Part A or B:</u> Security Blue HMO-POS Basic 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 prognosis. 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 prognosis), you should contact us to arrange 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>	
 Immunizations <p>Covered Medicare Part B services include:</p> <ul style="list-style-type: none"> • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccine 	<p>Network:</p> <p>There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B and COVID-19 vaccines.</p> <hr/> <p>Point-of-Service Out-of-Network:</p> <p>There is no coinsurance, copayment, or deductible for members eligible for this preventive service.</p>

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Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> Other vaccines if you are at risk and they meet Medicare Part B coverage rules 	<p>See Immunizations section above for vaccines covered under Part B.</p> <p><i>A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.</i></p>
<p>Inpatient hospital care*</p> <p>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.</p> <p>Covered services include but are not limited to:</p> <ul style="list-style-type: none"> COVID-19 related services and stay requirements 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 	<p>If a patient is admitted for an Inpatient Acute Hospital Care stay due to COVID-19, the cost share for this service will be waived both in and out-of-network. Inpatient rehabilitation is not included.</p> <p>Network:</p> <p>\$340 copay per admit</p> <hr/> <p>Point-of-Service Out-of-Network:</p> <p>\$390 copay per admit</p> <p>If you get inpatient care at an out-of-network hospital after your emergency condition is stabilized, your service is covered at the Point-of-Service Out-of-Network level.</p>


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Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Security Blue HMO-POS Basic provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion up to a \$10,000 allowance (restrictions apply). Items not directly related to travel and lodging expenses are not payable. Please contact Member Service for more information. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. • Physician services <p>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.</p>	


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Services that are covered for you	What you must pay when you get these services
<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 https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.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>Inpatient services in a psychiatric hospital*</p> <p>Covered services include mental health care services that require a hospital stay.</p> <p>There is a 190-day lifetime limit for inpatient services in a psychiatric hospital.</p> <p>The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital.</p>	<p>Network:</p> <p>\$340 copay per admit</p> <hr/> <p>Point-of-Service Out-of-Network:</p> <p>\$390 copay per admit</p>
<p>Inpatient stay: Covered services received in a hospital or SNF 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 	<p>Network:</p> <p>\$0 copay per primary care visit</p> <p>\$30 copay per specialist visit</p> <p>\$25 copay for each x-ray service</p> <p>\$100 copay for each advanced imaging services (MRI, MRA, CT and PET scan)</p> <p>\$60 copay for radiation therapy</p> <p>\$20 copay for lab services and diagnostic procedures/tests</p> <p>20% coinsurance for DME, Prosthetics, and Orthotics</p> <p>\$30 copay per therapy type, per provider, per day for physical and speech services</p> <p>\$30 copay per provider, per day for occupational services</p>


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Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • 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>Point-of-Service Out-of-Network:</p> <p>\$0 copay per primary care visit</p> <p>\$30 copay per specialist visit</p> <p>\$40 copay for each x-ray service</p> <p>\$175 copay for each advanced imaging services (MRI, MRA, CT and PET scan)</p> <p>\$75 copay for each radiation therapy</p> <p>\$30 copay for lab services and diagnostic procedures/tests</p> <p>\$45 copay per therapy type, per provider, per day for physical and speech services</p> <p>\$45 copay per provider, per day for occupational services</p> <p>Point-of-Service Out-of-Network for DME is <u>not available</u>.</p>
 Medical nutrition therapy <p>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered 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 order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.</p>	<p>Network:</p> <p>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.</p> <hr/> <p>Point-of-Service Out-of-Network:</p> <p>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.</p> <p><i>A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.</i></p>

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 Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
Medicare Part B prescription drugs* 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: <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 	Network: Certain categories of Medicare Part B drugs are covered in full. These categories include certain vaccines, toxoids, pathology drugs, laboratory drugs, contrast materials, and miscellaneous drugs and solutions. 20% coinsurance for Medicare Part B Chemotherapy Drugs, associated administration services and all other Medicare Part B drugs <hr/> Point-of-Service Out-of-Network: 30% coinsurance

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Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • 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®, or Aranesp®) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases <p>The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: HighmarkStepBTargets.com.</p> <ul style="list-style-type: none"> • We also cover some vaccines under our Part B prescription drug benefit (see Immunizations section above). <p>*Prior authorization is required for certain drugs.</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><i>Please note: Commercial weight loss programs (such as, but not limited to, Weight Watchers, Jenny Craig, and Nutri-System) are not eligible.</i></p>	<p>Network:</p> <p>There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.</p> <hr/> <p>Point-of-Service Out-of-Network:</p> <p>There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.</p> <p><i>A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.</i></p> <p><i>Additional medically necessary diagnostic services will be charged the cost sharing that applies to the type of service received.</i></p>

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<p>Opioid treatment program services*</p> <p>Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:</p> <ul style="list-style-type: none"> • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications. • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments 	<p>Network:</p> <p>\$30 copay per individual or group therapy visit</p> <hr/> <p>Point-of-Service Out-of-Network:</p> <p>\$45 copay per individual or group therapy visit</p>
<p>Outpatient diagnostic tests and therapeutic services and supplies*</p> <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 • Advanced imaging services • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. • Other outpatient diagnostic tests <p>Either the freestanding or outpatient facility lab copay may apply in a physician's office setting. Discuss with your physician about the</p>	<p>Network:</p> <p>\$25 copay for each x-ray service</p> <p>\$60 copay for radiation therapy</p> <p>\$0 copay for lab services and diagnostic procedures/tests performed in a physician's office or freestanding lab</p> <p>\$20 copay for lab services and diagnostic procedures/tests performed in an outpatient hospital facility</p> <p>\$100 copay for advanced imaging services (MRI, MRA, CT and PET scan)</p> <p>There is no coinsurance, copayment, or deductible for outpatient blood</p> <hr/> <p>Point-of-Service Out-of-Network:</p> <p>\$40 copay for each x-ray service</p> <p>\$75 copay for radiation therapy</p>

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<p>designated site of service to identify the appropriate copay.</p>	<p>\$30 copay for lab services and diagnostic procedures/tests performed in a physician's office or freestanding lab</p> <p>\$30 copay for lab services and diagnostic procedures/tests performed in an outpatient hospital facility</p> <p>\$175 copay for advanced imaging services (MRI, MRA, CT and PET scan)</p> <p>30% coinsurance for outpatient blood</p> <p><i>If your physician sends your lab or diagnostic test to another facility for analysis, you may be billed separately by the performing provider.</i></p>
<p>Outpatient hospital observation*</p> <p>Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged.</p> <p>For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.</p> <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</p>	<p>Network:</p> <p>\$200 copay</p> <hr/> <p>Point-of-Service Out-of-Network:</p> <p>\$250 copay</p> <p>Self-administered drugs provided in an outpatient setting may not be covered under medical coverage.</p> <p>Diagnostic testing will be subject to diagnostic cost sharing. Some visits you may only be charged the <i>Emergency Care</i> cost sharing.</p>

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<p>– Ask!” This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.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>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. 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 • Advanced imaging services • Medical supplies such as splints and casts • 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>Network:</p> <ul style="list-style-type: none"> \$95 copay for emergency services \$200 copay per visit, per provider, per day for surgery performed in an outpatient hospital setting \$100 copay per visit, per provider, per day for surgery performed in an ambulatory surgical center \$30 copay per specialist visit \$0 copay for partial hospitalization \$30 copay per individual or group therapy visit for outpatient mental health \$30 copay per individual or group therapy visit for outpatient substance abuse \$20 copay for lab services and diagnostic procedures/tests performed in an outpatient hospital facility \$25 copay for each x-ray service \$100 copay for advanced imaging services (MRI, MRA, CT and PET scan) 20% coinsurance for Part B drugs <hr/> <p>Point-of-Service Out-of-Network:</p> <ul style="list-style-type: none"> \$95 copay for emergency services \$250 copay per visit, per provider, per day for surgery performed in an outpatient hospital setting

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Services that are covered for you	What you must pay when you get these services
<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 https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.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>\$250 copay per visit, per provider, per day for surgery performed in an ambulatory surgical center</p> <p>\$30 copay per specialist visit</p> <p>30% coinsurance for partial hospitalization</p> <p>\$45 copay per individual or group therapy visit for mental health or substance abuse services</p> <p>\$30 copay for lab services and diagnostic procedures performed in an outpatient facility</p> <p>\$40 copay for each x-ray service</p> <p>\$175 copay for advanced imaging services (MRI, MRA, CT and PET scan)</p> <p>30% coinsurance for Part B drugs</p>
<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>Network:</p> <p>\$30 copay per individual or group therapy visit</p> <hr/> <p>Point-of-Service Out-of-Network:</p> <p>\$45 copay per individual or group therapy visit</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>Network:</p> <p>\$30 copay per therapy type, per provider, per day for physical and speech services</p> <p>\$30 copay per provider, per day for occupational services</p> <hr/> <p>Point-of-Service Out-of-Network:</p> <p>\$45 copay per therapy type, per provider, per day for physical and speech services</p> <p>\$45 copay per provider, per day for occupational services</p>

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Services that are covered for you	What you must pay when you get these services
<p>Outpatient substance abuse services*</p> <p>Individual and group therapy visits on an outpatient basis for diagnosis and treatment of alcoholism, substance use and dependency. This includes treatment by any licensed substance abuse therapist or counselor in their office or in a clinic setting.</p>	<p>Network:</p> <p>\$30 copay per individual or group therapy visit</p> <hr/> <p>Point-of-Service Out-of-Network:</p> <p>\$45 copay per individual or group therapy visit</p>
<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>Network:</p> <p>\$100 copay per visit, per provider, per day for surgery performed in an ambulatory surgical center</p> <p>\$200 copay per visit, per provider, per day for surgery performed in an outpatient hospital setting</p> <hr/> <p>Point-of-Service Out-of-Network:</p> <p>\$250 copay per visit, per provider, per day for surgery performed in an ambulatory surgical center</p> <p>\$250 copay per visit, per provider, per day for surgery performed in an outpatient hospital setting</p>
<p>Partial hospitalization services*</p> <p>“Partial hospitalization” is a structured program of active psychiatric treatment provided as a hospital outpatient service 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>Network:</p> <p>There is no coinsurance, copayment, or deductible for partial hospitalization.</p> <hr/> <p>Point-of-Service Out-of-Network:</p> <p>30% coinsurance</p>
<p>Physician/Practitioner services, including doctor’s office visits</p> <p>Covered services include:</p>	<p>Services that are available via telehealth are listed in the description of this benefit. The cost sharing for an in-person or telehealth visit will be the same for the type of service.</p>


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

Services that are covered for you	What you must pay when you get these services
<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 specialist, if your doctor orders it to see if you need medical treatment • Certain telehealth services, including: acute care home health, mental health, psychiatric, opioid treatment, substance abuse, occupational, physical and speech therapies <ul style="list-style-type: none"> ◦ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. ◦ Telehealth services are available using interactive audio and video telecommunications on your computer, tablet or mobile device. • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location 	<p>Network:</p> <p>\$0 copay per primary care in-person or telehealth visit</p> <p>\$30 copay per specialist in-person or telehealth visit</p> <p>\$30 copay for Medicare-covered hearing in-person visit</p> <p>\$30 copay for Medicare-covered dental in-person visit</p> <p>\$100 copay per visit, per provider, per day for surgery performed in an ambulatory surgical center</p> <p>\$200 copay per visit, per provider, per day for surgery performed in an outpatient hospital setting</p> <hr/> <p>Point-of-Service Out-of-Network:</p> <p>\$0 copay per primary care in-person or telehealth visit</p> <p>\$30 copay per specialist in-person or telehealth visit</p> <p>\$30 copay per Medicare-covered hearing in-person visit</p> <p>\$250 copay per visit, per provider, per day for surgery performed in an ambulatory surgical center</p> <p>\$250 copay per visit, per provider, per day for surgery performed in an outpatient hospital setting</p> <p>Point-of-Service Out-of-Network for non-routine (Medicare-covered) dental visits are <u>not available</u>.</p>


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

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: <ul style="list-style-type: none"> ◦ You have an in-person visit within 6 months prior to your first telehealth visit ◦ You have an in-person visit every 12 months while receiving these telehealth services ◦ Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: <ul style="list-style-type: none"> ◦ You're not a new patient and ◦ The check-in isn't related to an office visit in the past 7 days and ◦ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours if: <ul style="list-style-type: none"> ◦ You're not a new patient and ◦ The evaluation isn't related to an office visit in the past 7 days and ◦ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record 	



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

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Second opinion 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>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>✓ <i>Routine podiatry visits do not count towards the maximum out-of-pocket.</i></p>	<p>Network:</p> <p>\$30 copay per Medicare-covered service</p> <p>✓ \$30 copay for each of 8 routine visits per calendar year</p> <hr/> <p>Point-of-Service Out-of-Network:</p> <p>\$30 copay per Medicare-covered visit</p> <p>Point-of-Service Out-of-Network for routine podiatry is <u>not available</u>.</p>
<p> Prostate cancer screening exams</p> <p>For men aged 50 and older, covered services include the following - once every calendar year:</p> <ul style="list-style-type: none"> • Digital rectal exam • Prostate Specific Antigen (PSA) test 	<p>Network:</p> <p>There is no coinsurance, copayment, or deductible for an annual PSA test.</p> <hr/> <p>Point-of-Service Out-of-Network:</p> <p>There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.</p> <p><i>A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.</i></p> <p><i>Additional medically necessary diagnostic services will be charged the cost sharing that applies to the type of service received.</i></p>

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

Services that are covered for you	What you must pay when you get these services
<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>Network:</p> <p>20% coinsurance</p> <p>Point-of-Service Out-of-Network for prosthetic devices and related supplies is <u>not available</u>.</p>
<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>Network:</p> <p>\$0 copay</p> <hr/> <p>Point-of-Service Out-of-Network:</p> <p>30% coinsurance</p>
<p> Screening and counseling to reduce alcohol misuse</p> <p>We cover one alcohol misuse screening every calendar year 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>Network:</p> <p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.</p> <hr/> <p>Point-of-Service Out-of-Network:</p> <p>There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.</p> <p><i>A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.</i></p>

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

Services that are covered for you	What you must pay when you get these services
 Screening for lung cancer with low dose computed tomography (LDCT) <p>For qualified individuals, a LDCT is covered every calendar year.</p> <p>Eligible members are: people aged 50 – 80 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner.</p> <p><i>For LDCT lung cancer screenings after the initial LDCT screening:</i> the members must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.</p>	<p>Network:</p> <p>There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision-making visit or for the LDCT.</p> <hr/> <p>Point-of-Service Out-of-Network:</p> <p>There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.</p> <p><i>A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.</i></p> <p><i>Additional medically necessary diagnostic services will be charged the cost sharing that applies to the type of service received.</i></p>
 Screening for sexually transmitted infections (STIs) and counseling to prevent STIs <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</p>	<p>Network:</p> <p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.</p> <hr/> <p>Point-of-Service Out-of-Network:</p>


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

Services that are covered for you	What you must pay when you get these services
<p>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>There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.</p> <p><i>A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.</i></p> <p><i>Additional medically necessary diagnostic services will be charged the cost sharing that applies to the type of service received.</i></p>
<p>Services to treat kidney disease</p> <p>Covered services include:</p> <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, or when your provider for this service is temporarily unavailable or inaccessible) • 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>Network:</p> <p>20% coinsurance</p> <hr/> <p>Point-of-Service Out-of-Network:</p> <p>30% coinsurance</p> <p>Renal dialysis when temporarily out of the service area is covered according to Medicare guidelines at the network cost share. Maximum coinsurance applies when enrollees choose to go to a non-network provider while in the service area.</p>

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

Services that are covered for you	What you must pay when you get these services
<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, “Medicare Part B prescription drugs.”</p> <p>✓ Dialysis services obtained inside the plan service area by a non-participating (out-of-network) provider do not count towards the maximum out-of-pocket.</p>	
<p>Skilled nursing facility (SNF) care*</p> <p>(For a definition of “skilled nursing facility care,” see Chapter 10 of this document. Skilled nursing facilities are sometimes called “SNFs.”)</p> <p>100 days covered for each benefit period.</p> <p>Covered services include but are not limited to:</p> <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 therapy • Drugs administered to you as part of your plan of care (this includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells 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 	<p>A benefit period starts the day you are admitted at a Medicare-certified hospital or skilled nursing facility. It ends when you haven’t been an inpatient at any hospital or SNF for 60 days in a row. If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.</p> <p>Network:</p> <p>Days 1 - 20: \$0 copay per day per admission</p> <p>Days 21 - 100: \$196 copay per day per admission</p> <p>Point-of-Service Out-of-Network for skilled nursing is <u>not available</u>.</p>

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

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • 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 	
 Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) <p>If you use tobacco, but do not have signs or symptoms of tobacco-related disease: 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>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: 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>Network:</p> <p>There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.</p> <hr/> <p>Point-of-Service Out-of-Network:</p> <p>There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.</p> <p><i>A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.</i></p>
<p>Special Supplemental Benefits for the Chronically Ill</p> <p>Members who have Congestive Heart Failure, COPD, Diabetes and/or Hypertension are eligible for a healthcare kit to help manage your condition once per calendar year.</p>	<p>Network:</p> <p>There is no coinsurance, copayment, or deductible for the healthcare kit.</p>


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

Services that are covered for you	What you must pay when you get these services
Eligible members with a diagnosis code on file will be contacted to receive a kit.	Point-of-Service Out-of-Network for this benefit is <u>not</u> available.
<p>Supervised Exercise Therapy (SET)</p> <p>SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment.</p> <p>Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.</p> <p>The SET program must:</p> <ul style="list-style-type: none"> • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques <p>SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.</p>	<p>Network:</p> <p>\$0 copay</p> <hr/> <p>Point-of-Service Out-of-Network:</p> <p>30% coinsurance</p>
<p>Telehealth - Remote Access</p> <p>Provides access to in-network visits using interactive audio and video telecommunications on your computer, tablet or mobile device if offered by your PCP or Specialist. Coverage is limited to the following conditions:</p>	<p>Network:</p> <p>\$0 copay per primary care visit</p> <p>\$30 copay per specialist visit</p>


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

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • medication reconciliation post-discharge • nutritional counseling • pharmacy clinic counseling (chronic disease and medication management) <p>Any other conditions or services would not be covered.</p>	<p>Point-of-Service Out-of-Network for telehealth is <u>not available</u>.</p>
<p>Transportation*</p> <p>Plan provides a benefit for up-to 24 one-way routine trips for non-emergency, medical-related purposes such as doctor visits; appointments for dental, vision, hearing, and behavioral health services; and visits to pharmacies to pick up prescription drugs within a 50 mile limit. Destination must always be plan-approved.</p> <p>Mode of transportation could include van, medical transport, wheelchair van, or car at the discretion of the plan. If you pay out of pocket for these modes of transportation, reimbursement may be provided in special circumstances at the discretion of the plan; however, personal vehicle expenses will not be considered for reimbursement.</p> <p>Plan authorization and scheduling rules apply. Any routine transportation services not scheduled through the plan or prior-authorized will not be covered.</p> <p>To obtain prior authorization and schedule a pickup, please call us at least 48 hours in advance at 1-800-935-2583, Monday through Friday, 8:00 a.m. to 5:00 p.m. Eastern Time, excluding holidays. TTY users should call 711 National Relay Service.</p> <p>✓ <i>Transportation services are not subject to the maximum out-of-pocket.</i></p>	<p>Network:</p> <p>\$0 copay per one-way trip</p> <p>Transportation services that are arranged for you for continued acute care after discharge from an emergency room does not apply towards the trip limit. This is limited to a one way trip to the home and any round-trip to a physician's office related to the emergency condition.</p> <p>Point-of-Service Out-of-Network for transportation is <u>not available</u>.</p>

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

Services that are covered for you	What you must pay when you get these services
<p>Urgently needed services</p> <p>Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. Examples of urgently needed services that the plan must cover out of network are i) you need immediate care during the weekend, or ii) you are temporarily outside the service area of the plan. Services must be immediately needed and medically necessary. If it is unreasonable given your circumstances to immediately obtain the medical care from a network provider, then your plan will cover the urgently needed services from a provider out-of-network.</p> <p>Urgently needed services are covered worldwide.</p>	<p>\$50 copay per in-person or telehealth visit</p> <p>The copay is not waived if admitted.</p> <p>The copay applies to medically necessary urgent services out of the country.</p> <p><i>Diagnostic testing will be subject to diagnostic cost sharing.</i></p>
<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, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year 	<p>Network:</p> <p>\$30 copay per Medicare-covered eye exam</p> <p>✓\$0 copay for an annual routine eye exam</p> <p>✓\$0 copay for an annual contact lens examination and fitting</p> <p>Davis Vision Collection eyeglass frames and standard plastic eyeglass lenses are covered in full.</p> <p>✓ A \$150 allowance is available towards the purchase of any other frame/lenses or contacts at the participating Davis Vision provider location.</p> <hr/> <p>Point-of-Service Out-of-Network:</p>

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

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> 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.) \$200 benefit maximum applies to upgrades to post cataract surgery eyewear that are not medically necessary. Benefit maximum is available following cataract surgery once per operated eye. <p>One routine eye exam every calendar year, inclusive of dilation (when professionally indicated), performed in a specialist physician setting at any participating network provider location.</p> <ul style="list-style-type: none"> One routine eye examination, including refraction, every calendar year One pair of standard eyeglass frames and standard plastic eyeglasses lenses per calendar year, or contact lenses per calendar year This benefit cannot be combined with other special offers <p>Routine vision benefits are offered through Davis Vision. Please contact Member Service for a list of participating providers.</p> <p>✓ <i>Routine eye exams, fitting/evaluations, and eyewear are not subject to the maximum out-of-pocket.</i></p>	<p>\$30 copay per Medicare-covered visit</p> <p>Point-of-Service Out-of-Network for routine vision is <u>not available</u>.</p>
 “Welcome to Medicare” preventive visit <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</p>	<p>Network:</p> <p>There is no coinsurance, copayment, or deductible for the “Welcome to Medicare” preventive visit.</p>

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Services that are covered for you	What you must pay when you get these services
<p>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>Point-of-Service Out-of-Network:</p> <p>There is no coinsurance, copayment, or deductible for members eligible for this preventive benefit.</p> <p><i>A physician or specialist copay may apply for any non-preventive services also rendered at time of visit.</i></p> <p><i>Additional medically necessary diagnostic services will be charged the cost sharing that applies to the type of service received.</i></p>

SECTION 3 What services are not covered by the plan?**Section 3.1 Services we do *not* cover (exclusions)**

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

The chart below lists services and items that either are not covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them. The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 7, Section 5.3 in this document.)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Acupuncture		Available for people with chronic low back pain under certain circumstances.

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

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Cosmetic surgery or procedures		<ul style="list-style-type: none"> • Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
<p>Custodial care</p> <p>Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.</p>	✓	
<p>Experimental medical and surgical procedures, equipment, and medications.</p> <p>Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.</p>		<p>May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan.</p> <p>(See Chapter 3, Section 5 for more information on clinical research studies.)</p>
Fees charged for care by your immediate relatives or members of your household.	✓	
Full-time nursing care in your home.	✓	
Home-delivered meals		Some limited coverage provided - See Medical Benefit Chart above.
Homemaker services including basic household assistance, such	✓	

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

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
as light housekeeping or light meal preparation.		
Naturopath services (uses natural or alternative treatments).	✓	
Non-routine dental care		Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Orthopedic shoes or supportive devices for the feet		Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	✓	
Private room in a hospital.		Covered only when medically necessary.
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	✓	
Services considered not reasonable and necessary, according to Original Medicare standards	✓	
Telehealth services other than those listed in the <i>Medical Benefits Chart</i> .	✓	
Vision - Radial keratotomy, LASIK surgery, vision therapy and other low vision aids.	✓	

CHAPTER 5:

*Asking us to pay our share of a bill
you have received for covered
medical services*

CHAPTER 5. Asking us to pay our share of a bill you have received for covered medical services

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

Sometimes when you get medical care, you may need to pay the full cost. Other times, you may find that you have paid more than you expected under the coverage rules of the plan or you may receive a bill from a provider. In these cases, you can ask our plan to pay you back (paying you back is often called “reimbursing” you). It is your right to be paid back by our plan whenever you’ve paid more than your share of the cost for medical services that are covered by our plan. There may be deadlines that you must meet to get paid back. Please see Section 2 of this chapter.

There may also be times when you get a bill from a provider for the full cost of medical care you have received or possibly for more than your share of cost sharing as discussed in the document. First try to resolve the bill with the provider. If that does not work, send the bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly. If we decide not to pay it, we will notify the provider. You should never pay more than plan-allowed cost-sharing. If this provider is contracted you still have the right to treatment.

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

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

You can receive emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases, you are only responsible for paying your share of the cost. Ask the provider to bill the plan for our share of the cost.

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

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

CHAPTER 5. Asking us to pay our share of a bill you have received for covered medical services

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

3. If you are retroactively enrolled in our plan

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

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

4. If you've paid for a flu shot.

- Flu shots can be given in a provider's office or in another setting such as a community flu shot clinic. Flu shots given in a provider's office and billed directly to Security Blue HMO-POS Basic are covered in full. If you receive a flu shot in another setting, you may be required to pay the full cost of the shot up front. If you are required to pay for the full cost of the flu shot, obtain a receipt and send a copy to us asking us to pay you back for our share of the cost. We will reimburse you the Medicare-approved amount. You will be responsible for paying the difference between the provider's charge and the Medicare-approved amount. For more information on your coverage for immunizations, see the Medical Benefits Chart in Chapter 4.

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 7 of this document has information about how to make an appeal.

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

You may request us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records. You must submit your claim to us within 12 months of the date you received the service, item, or drug.

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

- You don't have to use the form, but it will help us process the information faster. Please include your name, member number from your identification card, address, phone number and a copy of an itemized receipt.

CHAPTER 5. Asking us to pay our share of a bill you have received for covered medical services

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

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

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

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 and how much we owe
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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 is covered and you followed all the rules, we will pay for our share of the cost. If you have already paid for the service, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service yet, we will mail the payment directly to the provider.
- If we decide that the medical care is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. We will send you a letter explaining the reasons why we are not sending the payment and your 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, you can make an appeal
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If you think we have made a mistake in turning down your request for payment or the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 7 of this document.

CHAPTER 6:

Your rights and responsibilities

CHAPTER 6. Your rights and responsibilities

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

Section 1.1	We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, in large print or other alternate formats, etc.)
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Your plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how a plan may meet these accessibility requirements include, but are not limited to provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Service.

Our plan is required to give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

If providers in the plan's network for a specialty are not available, it is the plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you will only pay in-network cost sharing. If you find yourself in a situation where there are no specialists in the plan's network that cover a service you need, call the plan for information on where to go to obtain this service at in-network cost sharing.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Member Service at 1-800-935-2583. You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

Section 1.2	We must ensure that you get timely access to your covered services
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You have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services. We do not require you to get referrals to go to network providers.

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.

If you think that you are not getting your medical care within a reasonable amount of time, Chapter 7 tells what you can do.

CHAPTER 6. Your rights and responsibilities**Section 1.3 We must protect the privacy of your personal health information**

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

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

How do we protect the privacy of your health information?

- We make sure that unauthorized people don’t see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn’t providing your care or paying for your care, *we are required to get written permission from you or someone you have given legal power to make decisions for you first.*
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
 - We are required to release health information to government agencies that are checking on quality of care.
 - Because you are a member of our plan through Medicare, we are required to give Medicare your health information. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

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

You have the right to look at your medical records held 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.

We are committed to protecting your privacy and personal health information (PHI). This includes PHI discussed verbally. Some of the ways we protect your privacy includes not discussing PHI outside of our offices, as well as verifying your identity before we discuss PHI with you over the phone. You can also read our Notice of Privacy Practices (NPP) on our website. Log onto [medicare.highmark.com](https://www.medicare.highmark.com) and click on “Privacy Policy and Notice of Privacy Practices” at the bottom of the

CHAPTER 6. Your rights and responsibilities

page. To download a copy, click on “Highmark Inc. NPP”. You can also call Member Service at the number listed on your ID card to request a copy of our NPP.

Section 1.4 We must give you information about the plan, its network of providers, and your covered services

As a member of Security Blue HMO-POS Basic, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call Member Service.

- **Information about our plan.** This includes, for example, information about the plan’s financial condition.
- **Information about our network providers.** You have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services.
- **Information about why something is not covered and what you can do about it.** Chapter 7 provides information on asking for a written explanation on why a medical service is not covered or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 We must support your right to make decisions about your care**You have the right to know your treatment options and participate in decisions about your health care**

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

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

- **To know about all of your choices.** You have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan.
- **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. Of course, if you refuse treatment, you accept full responsibility for what happens to your body as a result.

CHAPTER 6. Your rights and responsibilities

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.** You can get an advance directive form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can’t. You may want to give copies to close friends or family members. Keep a copy at home.

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

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

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

What if your instructions are not followed?

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

For Complaints about Doctors in Pennsylvania:

CHAPTER 6. Your rights and responsibilities

Department of State
Bureau of Professional and Occupational Affairs Compliance Office
P.O. Box 2649
Harrisburg, PA 17105
717-787-8503
www.dos.pa.gov/Pages/File-a-Complaint.aspx

For Complaints about Hospitals in Pennsylvania:

Pennsylvania Department of Health
Division of Acute and Ambulatory Care
H&W Building, Room 532
625 Forster Street
Harrisburg, PA 17120
1-800-254-5164
apps.health.pa.gov/dohforms/FacilityComplaint.aspx

Section 1.6	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, concerns, or complaints and need to request coverage, or make an appeal, Chapter 7 of this document tells what you can do. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

Section 1.7	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, sexual orientation, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

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

- You can **call Member Service**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

CHAPTER 6. Your rights and responsibilities**Section 1.8 How to get more information about your rights**

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

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

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

Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Service.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* document 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.
- **If you have any other health insurance coverage in addition to our plan, or separate prescription drug coverage, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
 - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
 - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
 - If you have any questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor’s office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
 - You must pay your plan premiums.
 - You must continue to pay a premium for your Medicare Part B to remain a member of the plan.

CHAPTER 6. Your rights and responsibilities

- For some of your medical services covered by the plan, you must pay your share of the cost when you get the service.
- **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.
- **If you move *outside* of our plan service area, you cannot remain a member of our plan.**
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

CHAPTER 7:

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

CHAPTER 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 Introduction

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

This chapter explains two types of processes for handling problems and concerns:

- For some problems, you need to use the **process for coverage decisions and appeals**.
- For other problems, you need to use the **process for making complaints**; also called grievances.

Both of these processes have been approved by Medicare. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

The guide in Section 3 will help you identify the right process to use and what you should do.

Section 1.2 What about the legal terms?

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand. To make things easier, this chapter:

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

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

SECTION 2 Where to get more information and personalized assistance

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

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

CHAPTER 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

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

Medicare

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

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

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

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

Is your problem or concern about your benefits or coverage?

This includes problems about whether medical care or prescription drugs are covered or not, the way they are covered, and problems related to payment for medical care or prescription drugs.

Yes.

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

No.

Skip ahead to **Section 9** at the end of this chapter: **“How to make a complaint about quality of care, waiting times, customer service or other concerns.”**

COVERAGE DECISIONS AND APPEALS

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

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

Coverage decisions and appeals deal with problems related to your benefits and coverage for medical services, including 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.

CHAPTER 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**Asking for coverage decisions prior to receiving services**

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 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. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

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

Making an appeal

If we make a coverage decision, whether before or after a service is received, and you are not satisfied, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request an expedited or "fast appeal" of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we were properly following the rules. When we have completed the review, we give you our decision. In limited circumstances a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we do not dismiss your case but 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 review organization that is not connected to us. (Appeals for medical services and Part B drugs will be automatically sent to the independent review organization for a Level 2 appeal – you do not need to do anything. If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 8 in this chapter explains the Level 3, 4, and 5 appeals processes).

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

CHAPTER 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

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

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

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

- **Section 5** of this chapter: “Your medical care: How to ask for a coverage decision or make an appeal”
- **Section 6** of this chapter: “How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon”
- **Section 7** of this chapter: “How to ask us to keep covering certain medical services if you think your coverage is ending too soon” (*Applies to only these services*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

CHAPTER 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

If you're not sure which section you should be using, please call Member Service. You can also get help or information from government organizations such as your SHIP.

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

Section 5.1	This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care
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This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this document: *Medical Benefits Chart (what is covered and what you pay)*. To keep things simple, we generally refer to “medical care coverage” or “medical care” which includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

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

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

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read Sections 6 and 7 of this Chapter. Special rules apply to these types of care.

CHAPTER 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**Section 5.2 Step-by-step: How to ask for a coverage decision****Legal Terms**

When a coverage decision involves your medical care, it is called an **“organization determination.”**
 A “fast coverage decision” is called an **“expedited determination.”**

Step 1: Decide if you need a “standard coverage decision” or a “fast coverage decision.”

A **“standard coverage decision”** is usually made within 14 days or 72 hours for Part B drugs. A **“fast coverage decision”** is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. In order to get a fast coverage decision, you must meet two requirements:

- You may *only ask* for coverage for medical care *you have not yet received*.
- You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor’s support, we will decide whether your health requires that we give you a fast coverage decision.**
 If we do not approve a fast coverage decision, we will send you a letter that:
 - Explains that we will use the standard deadlines.
 - Explains if your doctor asks for the fast coverage decision, we will automatically give you a fast coverage decision.
 - Explains that you can file a “fast complaint” about our decision to give you a standard coverage decision instead of the fast coverage decision you requested.

Step 2: Ask our plan to make a coverage decision or fast coverage decision.

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this. Chapter 2 has contact information.

Step 3: We consider your request for medical care coverage and give you our answer.

For standard coverage decisions, we use the standard deadlines

This means we will give you an answer within 14 calendar days after we receive your request for a medical item or service. If your request is for a **Medicare Part B prescription drug**, we will give you an answer **within 72 hours** after we receive your request.

- **However**, if you ask for more time, or if we need more information that may benefit you **we can take up to 14 more days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.

CHAPTER 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- If you believe we should *not* take extra days, you can file a “fast complaint”. We will give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. See Section 9 of this chapter for information on complaints.)

For Fast Coverage decisions we use an expedited timeframe

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

- **However**, if you ask for more time, or if we need more that may benefit you **we can take up to 14 more days**. If we take extra days, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a “fast complaint”. (See Section 9 of this chapter for information on complaints.) We will call you as soon as we make the decision.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Step 4: If we say no to your request for coverage for medical care, you can appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the medical care coverage you want. If you make an appeal, it means you are going on to Level 1 of the appeals process.

Section 5.3 Step-by-step: How to make a Level 1 appeal

Legal Terms

An appeal to the plan about a medical care coverage decision is called a plan “**reconsideration.**”
A “fast appeal” is also called an “**expedited reconsideration.**”

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

A “standard appeal” is usually made within 30 days. A “fast appeal” is generally made within 72 hours.

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a “fast appeal.” If your doctor tells us that your health requires a “fast appeal,” we will give you a fast appeal.
- The requirements for getting a “fast appeal” are the same as those for getting a “fast coverage decision” in Section 5.2 of this chapter.

Step 2: Ask our plan for an Appeal or a Fast Appeal

CHAPTER 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- **If you are asking for a standard appeal, submit your standard appeal in writing.** You may also ask for an appeal by calling us. Chapter 2 has contact information.
- **If you are asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.**

Step 3: We consider your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take a careful look at all of the information. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if needed, possibly contacting you or your doctor.

Deadlines for a “fast appeal”

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to.
 - However, if you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can’t take extra time if your request is for a Medicare Part B prescription drug.
 - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it receives your appeal.

Deadlines for a “standard appeal”

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet

CHAPTER 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.

- However, if you ask for more time, or if we need more information that may benefit you, we can take **up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a "fast complaint." When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (See Section 9 of this chapter for information on complaints.)
- If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage within **30 calendar days** if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug.
- **If our plan says no to part or all of your appeal**, we will automatically send your appeal to the independent review organization for a Level 2 appeal.

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

Legal Terms

The formal name for the "Independent Review Organization" is the "**Independent Review Entity.**" It is sometimes called the "**IRE.**"

The **independent review organization is an independent organization hired by Medicare**. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: The independent review organization reviews your appeal.

- We will send the information about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file.**
- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

If you had a "fast appeal" at Level 1, you will also have a "fast appeal" at Level 2

- For the "fast appeal" the review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it receives your appeal.

CHAPTER 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- However, if your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

If you had a "standard appeal" at Level 1, you will also have a "standard appeal" at Level 2

- For the "standard appeal" if your request is for a medical item or service, the review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it receives your appeal. If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it receives your appeal.
- However, if your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

Step 2: The independent review organization gives you their answer.

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

- **If the review organization says yes to part or all of a request for a medical item or service**, we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization for standard requests. For expedited requests, we have 72 hours from the date we receive the decision from the review organization.
- **If the review organization says yes to part or all of a request for a Medicare Part B prescription drug**, we must authorize or provide the Part B prescription drug within **72 hours** after we receive the decision from the review organization for **standard requests**. For **expedited requests**, we have **24 hours** from the date we receive the decision from the review organization.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision" or "turning down your appeal"). In this case, the independent review organization will send you a letter:
 - Explaining its decision.
 - Notifying you of the right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
 - Telling you how to file a Level 3 appeal.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

CHAPTER 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter explains the Level 3, 4, and 5 appeals processes.

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

Chapter 5 describes when you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you are asking for a coverage decision. To make this decision, we will check to see if the medical care you paid for is a covered service. We will also check to see if you followed all the rules for using your coverage for medical care.

- **If we say yes to your request:** If the medical care is covered and you followed all the rules, we will send you the payment for our share of the cost within 60 calendar days after we receive your request. If you haven't paid for the services, we will send the payment directly to the provider.
- **If we say no to your request:** If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why.

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in Section 5.3. For appeals concerning reimbursement, please note:

- We must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for, you are not allowed to ask for a fast appeal.)
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

CHAPTER 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 6 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.

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will help arrange for care you may need after you leave.

- The day you leave the hospital is called your “**discharge date**.”
- When your discharge date is decided, your doctor or the hospital staff will tell you.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered.

Section 6.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights
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Within two days of being admitted to the hospital, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice. If you do not get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, please call Member Service or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

1. Read this notice carefully and ask questions if you don’t understand it. It tells you:

- Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be involved in any decisions about your hospital stay.
- Where to report any concerns you have about the quality of your hospital care.
- Your right to **request an immediate review** of the decision to discharge you if you think you are being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time.

2. You will be asked to sign the written notice to show that you received it and understand your rights.

- You or someone who is acting on your behalf will be asked to sign the notice.
- Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does not mean** you are agreeing on a discharge date.

3. Keep your copy of the notice handy so you will have the information about making an appeal (or reporting a concern about quality of care) if you need it.

CHAPTER 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- If you sign the notice more than two days before your discharge date, you will get another copy before you are scheduled to be discharged.
- To look at a copy of this notice in advance, you can call Member Service or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

Section 6.2 Step-by-step: How to make a Level 1 appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are:

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Service. Or call your SHIP, a government organization that provides personalized assistance.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

- The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts are not part of our plan.

Step 1: Contact the Quality Improvement Organization for your state and ask for an "immediate" review of your hospital discharge. You must act quickly.

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. Or, find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge**.
 - **If you meet this deadline**, you may stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
 - **If you do *not* meet this deadline**, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.

CHAPTER 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see Section 6.4.
- Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted, we will give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling Member Service or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

- Health professionals at the Quality Improvement Organization (“the reviewers”) will ask you (or your representative) why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers told us of your appeal, you will get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.***What happens if the answer is yes?***

- If the review organization says *yes*, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary**.
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

- If the review organization says *no*, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says *no* to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

CHAPTER 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- If the Quality Improvement Organization has said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to "Level 2" of the appeals process.

Section 6.3 Step-by-step: How to make a Level 2 appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at their decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you stay in the hospital after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you their decision.***If the review organization says yes:***

- **We must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made on your Level 1 appeal. 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.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

CHAPTER 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**Section 6.4 What if you miss the deadline for making your Level 1 appeal?****Legal Terms**

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

You can appeal to us instead

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

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

Step-by-Step: How to make a Level 1 Alternate appeal**Step 1: Contact us and ask for a “fast review.”**

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

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

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

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

- **If we say yes to your appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date. We will keep providing your covered inpatient hospital services for as long as they are medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
 - If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

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

CHAPTER 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

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

Legal Terms

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

The **independent review organization is an independent organization hired by Medicare**. It is not connected with our plan and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: We will automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 9 of this chapter tells how to make a complaint.)

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

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

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 appeal, you decide whether to accept their decision or go on to Level 3 appeal.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

CHAPTER 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 7 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 7.1 *This section is only about three services: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services*

When you are getting **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, 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.

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

Legal Terms

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

1. **You receive a notice in writing** at least two days before our plan is going to stop covering your care. The notice tells you:
 - The date when we will stop covering the care for you.
 - How to request a “fast track appeal” to request us to keep covering your care for a longer period of time.
2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you received it.** Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan’s decision to stop care.

CHAPTER 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**Section 7.3 Step-by-step: How to make a Level 1 appeal to have our plan cover your care for a longer time**

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Service. Or call your SHIP, a government organization that provides personalized assistance.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate.

- The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts are not part of our plan.

Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a *fast-track appeal*. You must act quickly.

How can you contact this organization?

- The written notice you received (*Notice of Medicare Non-Coverage*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the Notice of Medicare Non-Coverage.

Your deadline for contacting this organization.

- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see Section 7.5.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

Legal Terms

“Detailed Explanation of Non-Coverage.” Notice that provides details on reasons for ending coverage.

What happens during this review?

CHAPTER 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- Health professionals at the Quality Improvement Organization (“the reviewers”) will ask you, or your representative, why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers tell us of your appeal, you will get the **Detailed Explanation of Non-Coverage** from us that explains in detail our reasons for ending our coverage for your services.

Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.

What happens if the reviewers say yes?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say *no*, then **your coverage will end on the date we have told you.**
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If reviewers say *no* to your Level 1 appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make a Level 2 appeal.

Section 7.4 Step-by-step: How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

CHAPTER 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes?

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7.5 What if you miss the deadline for making your Level 1 appeal?

You can appeal to us instead

As explained above, you must act quickly to start your Level 1 appeal (within a day or two, at the most). If you miss the deadline for contacting the Quality Improvement Organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

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

Legal Terms

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

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

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

CHAPTER 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

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

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

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

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

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

Legal Terms

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

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

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

Step 1: We automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 9 of this chapter tells how to make a complaint.)

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

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

CHAPTER 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

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

Step 3: If the independent review organization says no to your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- A Level 3 appeal is reviewed by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 Taking your appeal to Level 3 and beyond

Section 8.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

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

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain how to make a Level 3 appeal.

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

Level 3 appeal An Administrative Law Judge or an attorney adjudicator who works for the Federal government will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that is favorable to you. If we decide to appeal, it will go to a Level 4 appeal.
 - If we decide *not* to appeal, we must authorize or provide you with the service within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.

CHAPTER 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- 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 or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may* or *may not* be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We will decide whether to appeal this decision to Level 5.
 - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Council's decision.
 - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 appeal and how to continue with Level 5 appeal.

Level 5 appeal A judge at the **Federal District Court** will review your appeal.

- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

CHAPTER 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**MAKING COMPLAINTS****SECTION 9 How to make a complaint about quality of care, waiting times, customer service, or other concerns****Section 9.1 What kinds of problems are handled by the complaint process?**

The complaint process is *only* used for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	<ul style="list-style-type: none"> • Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	<ul style="list-style-type: none"> • Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	<ul style="list-style-type: none"> • Has someone been rude or disrespectful to you? • Are you unhappy with our Member Service? • Do you feel you are being encouraged to leave the plan?
Waiting times	<ul style="list-style-type: none"> • Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors or other health professionals? Or by our Member Service or other staff at the plan? <ul style="list-style-type: none"> ◦ Examples include waiting too long on the phone, in the waiting or exam room
Cleanliness	<ul style="list-style-type: none"> • Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	<ul style="list-style-type: none"> • Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)	<p>If you have asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples:</p> <ul style="list-style-type: none"> • You asked us for a “fast coverage decision” or a “fast appeal,” and we have said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint.

CHAPTER 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Complaint	Example
	<ul style="list-style-type: none"> You believe we are not meeting deadlines for covering or reimbursing you for certain medical services that were approved; you can make a complaint. You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 9.2 How to make a complaint**Legal Terms**

- A “**Complaint**” is also called a “**grievance.**”
- “**Making a complaint**” is also called “**filing a grievance.**”
- “**Using the process for complaints**” is also called “**using the process for filing a grievance.**”
- A “**fast complaint**” is also called an “**expedited grievance.**”

Section 9.3 Step-by-step: Making a complaint**Step 1: Contact us promptly – either by phone or in writing.**

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

Your initial inquiry should be directed to the Member Service department. If you are dissatisfied with the response to your inquiry, you can ask for a Complaint Review. Your request for a Complaint Review can be made orally or in writing and may include written information from you or any other party of interest. Send your written complaint to:

Appeals and Grievance Department
 P.O. Box 535047
 Pittsburgh, PA 15253-5047
 Fax: 1-717-635-4209

We will review your written complaint. For complaints regarding such issues as waiting times, physician or pharmacy staff behavior and demeanor, quality of care, adequacy of or access to facilities, fraud or abuse concerns, and other similar member concerns, we will take the appropriate steps to investigate your complaint. These steps may include, but are not

CHAPTER 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

limited to, investigating with the provider, a review of the medical records or ongoing provider monitoring. We will respond in writing within 30 days or as expeditiously as the case requires. Decisions made during the Complaint Review Process are final and binding.

The Expedited or “Fast Grievance” Procedure is as follows:

The expedited grievance procedure is used in the following instances:

- If you disagree with Highmark Choice Company invoking a 14-day extension on either an initial determination or a reconsideration.
- If you disagree with the decision not to grant you an expedited initial determination or reconsideration.

Your initial inquiry should be directed to the Member Service department. You may call the number on your member ID card, Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time. Outside these hours, please call 1-800-935-2583 (TTY users, call 711).

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

- The **deadline** for making a complaint is **60 calendar days** from the time you had the problem you want to complain about.

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If you are making a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we will automatically give you a “fast complaint.”** If you have a “fast complaint,” it means we will give you **an answer within 24 hours**.
- **If we do not agree** with some or all of your complaint or don’t take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

Section 9.4	You can also make complaints about quality of care to the Quality Improvement Organization
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When your complaint is about *quality of care*, you also have two extra options:

CHAPTER 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- **You can make your complaint directly to the Quality Improvement Organization.** The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

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

Section 9.5 You can also tell Medicare about your complaint

You can submit a complaint about Security Blue HMO-POS Basic directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 8:

*Ending your membership in the
plan*

CHAPTER 8. Ending your membership in the plan**SECTION 1 Introduction to ending your membership in our plan**

Ending your membership in Security Blue HMO-POS Basic may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you want to leave. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, our plan must continue to provide your medical care and you will continue to pay your cost share until your membership ends.

SECTION 2 When can you end your membership in our plan?**Section 2.1 You can end your membership during the Annual Enrollment Period**

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

- **The Annual Enrollment Period** is from **October 15 to December 7**.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans:
 - Another Medicare health plan, with or without prescription drug coverage.
 - Original Medicare *with* a separate Medicare prescription drug plan.

OR

- Original Medicare *without* a separate Medicare prescription drug plan.
- **Your membership will end in our plan** when your new plan’s coverage begins on January 1.

Section 2.2 You can end your membership during the Medicare Advantage Open Enrollment Period

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

- **The annual Medicare Advantage Open Enrollment Period** is from January 1 to March 31.
- **During the annual Medicare Advantage Open Enrollment Period** you can:
 - Switch to another Medicare Advantage Plan with or without prescription drug coverage.

CHAPTER 8. Ending your membership in the plan

- Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of Security Blue HMO-POS Basic may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply to you. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (www.medicare.gov):

- Usually, when you have moved.
- If you have Medicaid.
- If we violate our contract with you.
- If you get care in an institution, such as a nursing home or long-term care (LTC) hospital.
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE).

The enrollment time periods vary depending on your situation.

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

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

OR

- Original Medicare *without* a separate Medicare prescription drug plan.

Your membership will usually end on the first day of the month after your request to change your plan is received.

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

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

- **Call Member Service.**

CHAPTER 8. Ending your membership in the plan

- Find the information in the *Medicare & You 2023* handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

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

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

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

Note: If you also have creditable prescription drug coverage (e.g., standalone PDP) and disenroll from that coverage, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later after going without creditable prescription drug coverage for 63 days or more in a row.

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

Until your membership ends, and your new Medicare coverage begins, you must continue to get your medical care through our plan.

CHAPTER 8. Ending your membership in the plan

- **Continue to use our network providers to receive medical care.**
- **If you are hospitalized on the day that your membership ends, your hospital stay will be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 Security Blue HMO-POS Basic must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?
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Security Blue HMO-POS Basic must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.
- If you are away from our service area for more than six months.
 - If you move or take a long trip, call Member Service to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you are no longer a United States citizen or lawfully present in the United States.
- If you 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 three months.
 - We must notify you in writing that you have three months to pay the plan premium before we end your membership.

Where can you get more information?

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

CHAPTER 8. Ending your membership in the plan

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

Security Blue HMO-POS Basic is not allowed to ask you to leave our plan for any health related reason.

What should you do if this happens?

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

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

CHAPTER 9:

Legal notices

CHAPTER 9. Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws are not included or explained in this document.

SECTION 2 Notice about non-discrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at <https://www.hhs.gov/ocr/index>.

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

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Security Blue HMO-POS Basic, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

NOTICE OF MEDICARE SECONDARY PAYER SUBROGATION RIGHTS

As a Medicare Advantage Plan that provides your federal Medicare benefits, this Plan has the right and responsibility to recover for covered Medicare services for which Medicare is not the primary payer. This means that the benefits provided under this Plan are secondary to any other sources of payment including but not limited to uninsured and underinsured motorist coverage, any no-fault

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insurance, medical payments coverage (auto, homeowners or otherwise), individual or group health insurance, workers compensation, any other insurance or any individual or other liable party(including companies, corporations or other entities).

This Medicare Advantage Plan conditionally provides payments until another source is identified, available and determined to be responsible for payment, whether through settlement, judgment, arbitration award or verdict. A Medicare Advantage Plan, pursuant to 42 C.F.R §422.108 and 423.462, has the same rights of recovery exercised by traditional Medicare through Federal Law and supersedes any State law. In addition to the rights granted under Federal law, this Plan asserts contractual rights of recovery through subrogation and reimbursement.

Reimbursement

This section applies when a Covered Person, or the legal representative, estate or heirs of the Covered Person (sometimes collectively referred to as the “Covered Person”) recovers damages, by settlement, verdict or otherwise (including wrongful death and/or survivorship cases) for an injury, sickness or other condition. If the Covered Person has made, or in the future may make, such a recovery, including a recovery from any insurance carrier, the Plan will not cover either the reasonable value of the services to treat such an injury or illness or the treatment of such an injury or illness. These benefits are specifically excluded.

However, if the Plan does advance moneys or provide care for such an injury, sickness or other condition, the Covered Person shall promptly convey moneys or other property from any settlement, arbitration award, verdict or any insurance proceeds or monetary recovery from any party received by the Covered Person (or by the legal representatives, estate or heirs of the Covered Person), to the Plan for the reasonable value of the medical benefits advanced or provided by the Plan to the Covered Person, regardless of whether or not (1) the Covered Person has been fully compensated, or “made-whole” for his/her loss; (2) liability for payment is admitted by the Covered Person or any other party; or (3) the recovery by the Covered Person is itemized or called anything other than a recovery for medical expenses incurred.

If a recovery is made, the Plan shall have first priority in payment over the Covered Person, or any other party, to receive reimbursement of the benefits advanced on the Covered Person’s behalf. This reimbursement shall be from any recovery made by the Covered Person, and includes, but is not limited to, uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers’ compensation settlement, compromises or awards, other group insurance (including student plans), and direct recoveries from liable parties. Likewise, the reimbursement provision specifically applies to recoveries obtained from wrongful death and/or survivorship cases. The Plan’s first priority right shall apply to all recoveries whether or not the amount constitutes a full or partial recovery of the Covered Person’s damages.

In order to secure the rights of the Plan under this section, and because of the Plan’s advancement of benefits, the Covered Person hereby (1) acknowledges that the Plan shall have a first priority lien against the proceeds of any such settlement, arbitration award, verdict, or any other amounts received by the Covered Person; and (2) assigns to the Plan any benefits the Covered Person may have under any automobile policy or other coverage, to the extent of the Plan's claim for

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reimbursement. The Covered Person shall sign and deliver, at the request of the Plan or its agents, any documents needed to protect such priority or reimbursement right, or to effect such assignment of benefits. By accepting any benefits advanced by the Plan under this section, the Covered Person acknowledges that any proceeds of settlement or judgment, including a Covered Person's claim to such proceeds held by another person, held by the Covered Person or by another, are being held for the benefit of the Plan under these provisions. The Covered Person agrees that the proceeds subject to the plan's lien are Plan assets and that the Covered Person will hold such assets as a trustee for the Plan's benefit and shall remit to the Plan, or its representative, such assets upon request. If represented by counsel, the Covered Person agrees to direct such counsel to hold the proceeds subject to the Plan's lien in trust and to remit such funds to the Plan, or its representative, upon request. Should the Covered Person violate any portion of this section, the Plan shall have a right to offset future benefits otherwise payable under this plan to the extent of the value of the benefits advanced under this section to the extent not recovered by the plan. The Plan may also seek double damages in a private action.

The Covered Person shall cooperate with the Plan and its agents, and shall sign and deliver such documents as the Plan or its agents reasonably request to protect the Plan's right of reimbursement, provide any relevant information, and take such actions as the Plan or its agents reasonably request to assist the Plan making a full recovery of the reasonable value of the benefits provided. The Covered Person shall not take any action that prejudices the Plan's rights of reimbursement and consents to the right of the Plan, by and through its agent, to impress an equitable lien or constructive trust on the proceeds of any settlement to enforce the Plan's rights under this section, and/or to set off from any future benefits otherwise payable under the Plan the value of benefits advanced under this section to the extent not recovered by the Plan.

The Plan shall be responsible only for those legal fees and expenses to which it agrees in writing. No Covered Person hereunder shall incur any expenses on behalf of the Plan in pursuit of the Plan's rights hereunder. Specifically, no court costs or attorney's fees may be deducted from the Plan's recovery without the express written consent of the Plan. Any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right.

In cases of occupational illness or injury, the Plan's recovery rights shall apply to all sums recovered, regardless of whether the illness or injury is deemed compensable under any workers' compensation or other coverage. Any award or compromise settlement, including any lump-sum settlement, shall be deemed to include the Plan's interest and the Plan shall be reimbursed in first priority from any such award or settlement.

The Plan shall recover the full amount of benefits advanced and paid hereunder, without regard to any claim or fault on the part of any beneficiary of Covered Person, whether under comparative negligence or otherwise.

Subrogation

This section applies when another party is, or may be considered, liable for a Covered Person's injury, sickness or other condition (including insurance carriers who are so financially liable) and the Plan has advanced benefits.

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In consideration for the advancement of benefits, the Plan is subrogated to all of the rights of the Covered Person against any party liable for the Covered Person's injury or illness, or is or may be liable for the payment for the medical treatment of such injury or occupational illness (including any insurance carrier), to the extent of the value of the medical benefits advanced to the Covered Person under the Plan. The Plan may assert this right independently of the Covered Person. This right includes, but is not limited to, the Covered Person's rights under uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, or other insurance, as well as the Covered Person's rights under the Plan to bring an action to clarify his or her rights under the Plan. The Plan is not obligated in any way to pursue this right independently or on behalf of the Covered Person, but may choose to pursue its rights to reimbursement under the Plan, at its sole discretion.

The Covered Person is obligated to cooperate with the Plan and its agents in order to protect the Plan's subrogation rights. Cooperation means providing the Plan or its agents with any relevant information requested by them, signing and delivering such documents as the Plan or its agents reasonably request to secure the Plan's subrogation claim, and obtaining the consent of the Plan or its agents before releasing any party from liability for payment of medical expenses.

If the Covered Person enters into litigation or settlement negotiations regarding the obligations of other parties, the Covered Person must not prejudice, in any way, the subrogation rights of the Plan under this section. In the event that the Covered Person fails to cooperate with this provision, including executing any documents required herein, the Plan may, in addition to remedies provided elsewhere in the Plan and/or under the law, set off from any future benefits otherwise payable under the Plan the value of benefits advanced under this section to the extent not recovered by the Plan.

The Plan's subrogation right is a first priority right and must be satisfied in full prior to any other claim of the Covered Person or his/her representative(s), regardless of whether the Covered Person is fully compensated for his/her damages. The costs of legal representation of the Plan in matters related to subrogation shall be borne solely by the Plan. The costs of legal representation of the Covered Person shall be borne solely by the Covered Person.

SECTION 4 Notice about how we determine if a technology is experimental

Medical experts are constantly searching for and testing new equipment and methods for treating health conditions. In turn, health care plans like Highmark Choice Company must evaluate these technologies to determine if they are covered by your Security Blue HMO-POS Basic plan.

Highmark Choice Company believes that decisions for evaluating new technologies, new applications of existing technologies and devices should be made by medical professionals. But Highmark Choice Company also honors decisions made by regulatory bodies, such as the Centers for Medicare & Medicaid Services (CMS). For Medicare Advantage plans like Freedom Blue PPO, CMS requires health plans to follow National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). Sometimes NCDs or LCDs disagree with the health plan's decision. If the

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service is being provided to a Medicare Advantage member, the health plan must abide by the regulations and guidance of the NCDs or LCDs.

To stay current and patient-responsive, these reviews are ongoing and all encompassing. They consider factors such as product efficiency, safety and effectiveness. If the technology passes the review process, the Medical Affairs Committee recommends that it be considered an acceptable medical practice and a covered benefit. Technology that does not pass the review is usually considered "experimental/investigative" and not covered by the health plan. However, it may be re-evaluated in the future.

We recognize that situations may occur when you choose to pursue experimental or investigative treatment. If you are concerned that a service you will receive may be considered experimental or investigational, you, the hospital and/or the professional provider may contact Highmark Choice Company to determine if the service will be covered.

SECTION 5 Notice about how we determine if a drug is experimental

A process similar to the one outlined above is followed for evaluating new drugs. The Pharmacy and Therapeutics (P & T) Committee assesses new drugs based on national and international data, research that is currently underway and expert opinion from leading clinicians. The P & T Committee consists of at least one Highmark Choice Company employed pharmacist and/or medical director, five board-certified, actively practicing network physicians and two licensed, registered pharmacists currently providing clinical pharmacy services within the Highmark Choice Company service area. At the committee's discretion, advice, support and consultation may also be sought from physician subcommittees in the following specialties: cardiology, dermatology, endocrinology, hematology/oncology, obstetrics/gynecology, ophthalmology, psychiatry, infectious disease, neurology, gastroenterology and urology. Issues that are addressed during the review process include clinical efficacy, unique value, safety, patient compliance, local physician and specialist input, and pharmacoeconomic impact. After the review is complete, the P & T Committee makes recommendations.

SECTION 6 Notice about what you need to know about your coverage

Have you ever wondered why your health care benefits pay for certain medical services but may not cover other care? Highmark Choice Company looks at two important things:

- **Your specific benefit plan and what it covers.** You can find out more about what's covered under your benefits by referring to this *Evidence of Coverage*.

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- **Whether the specific procedure, therapy, medication or equipment is “medically necessary.”**Highmark Choice Company and the companies that work with us determine if something is “medically necessary” by using nationally recognized guidelines, our own medical policy, Medicare guidelines and specific government guidelines that may apply. The outside companies we work with specialize in certain areas, such as radiology or prescription drugs. All of these companies must meet certain standards, follow Highmark Choice Company policy, and agree to allow us to review their work every year.

By using this approach to provide coverage, we ensure that all members receive medically appropriate health care and are treated consistently.

No Rewards For Denying Coverage

Highmark Choice Company does not reward employees, doctors, other health care providers or anyone for denying coverage. We also don’t give rewards to anyone who is reviewing care—or making decisions about what’s covered—to encourage them to deny coverage.

Who Reviews Requests?

If you or your doctor requests a service that needs to be approved, this request goes to a nurse in our Medical Management & Policy Department. If the nurse cannot approve the request, it is forwarded to a Highmark Choice Company physician for review. The physician may contact your physician to discuss the request and get more information. After all the medical information has been reviewed, a decision is made.

Need More Information?

Both you and your physician have the right to know the source of the criteria that we use to make decisions about what is covered and what isn’t.

- Your physician may request this information by calling 1-800-452-8507 for medical or surgical decisions, and 1-800-258-9808 for a behavioral health decision.
- You may also request information about your coverage or benefits by calling Member Service.

SECTION 7 Notice about coordination of benefits

If you are covered under another insurance carrier’s program in addition to Security Blue HMO-POS Basic, duplicate coverage exists. If you have duplicate coverage, it must be determined which insurance company has primary liability – that is, which coverage will pay first for your eligible health care services. The process of determining this is called “coordination of benefits.”

If you are age 65 and older and you have coverage under an employer group plan, based on your current employment or that of your spouse, you must use the benefits of that plan first. Similarly, if you have Medicare based on disability and are covered under an employer plan, either through your own current employment or that of a family member, you must use the benefits of that plan first. In both cases, you will receive only those Security Blue HMO-POS Basic benefits that are not covered by the employer group plan.

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Definitions of important words

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Allowed Amount – For services provided in-network, it is the contracted rate between the plan and the provider. For services performed by an out-of-network provider, the charge is the Medicare Fee Schedule.

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 drug 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 payment for services 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 an item or service you think you should be able to receive. Chapter 7 explains appeals, including the process involved in making an appeal.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost sharing amount. As a member of Security Blue HMO-POS Basic, you only have to pay our plan's cost sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" or otherwise charge you more than the amount of cost sharing your plan says you must pay.

Benefit Period – The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you 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.

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. Coinsurance is usually a percentage (for example, 20%).

Complaint – The formal name for "making a complaint" is "filing a grievance." 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. See also "Grievance," in this list of definitions.

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 (or "copay") – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription. A copayment is a set amount, rather than a percentage. For example, you might pay \$10 or \$20 for a doctor's visit or prescription.

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Cost Sharing – Cost sharing refers to amounts that a member has to pay when services 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 are covered; (2) any fixed “copayment” amount that a plan requires when a specific service is received; or (3) any “coinsurance” amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is received.

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.

Customer 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 Customer Service.

Deductible – The amount you must pay for health care 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).

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, 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 treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

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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.

Grievance - A type of complaint you make about us, 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.

Hospice - A member who has 6 months or less to live has the right to elect hospice. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer. The hospice will provide special treatment for your state.

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 Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. For example, if you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins three months before the month you turn 65, includes the month you turn 65, and ends three months after the month you turn 65.

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 and Medicare Part A and Part B premiums do not count toward the maximum out-of-pocket amount. See Chapter 4, Section 1.3 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 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 PACE plan, or a Medicare Advantage Plan.

Medicare Advantage Open Enrollment Period – A set time each year when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan, or obtain coverage through Original Medicare. If you choose to switch to Original Medicare

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during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is from January 1 until March 31, and is also available for a 3-month period after an individual is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an 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 Advantage health plan that is offered in their area. Security Blue HMO-POS Basic does not offer Medicare prescription drug coverage.

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).

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 plan 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. Organization determinations are called “coverage decisions” in this booklet. Chapter 7 explains how to ask us for a coverage decision.

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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 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 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 (LTC) 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.)

Point-of-Service (POS) – A benefit that allows you to get some Medicare covered services from a provider that does not participate in the plan’s network, including providers that are within the service area.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Primary Care Provider (PCP) – 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

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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. 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.

Prosthetics and Orthotics – These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

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 permanently move out of the plan’s service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of 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 drug 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 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.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Services – Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.

Health benefits or health benefit administration may be provided by or through Highmark Senior Health Company. Highmark Blue Cross Blue Shield provides certain administrative communications for this company. Highmark Blue Cross Blue Shield and Highmark Senior Health Company are independent licensees of the Blue Cross Blue Shield Association. All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration.

Dental coverage is provided by United Concordia Companies, Inc. United Concordia Companies, Inc. is a separate company that administers Highmark dental services. Vision coverage is provided by Davis Vision, Inc. Davis Vision, Inc. is a separate company that administers Highmark vision benefits. The Onduo Diabetes Management program is made available with support from Onduo. Onduo is a separate company that provides a virtual diabetes care program for Highmark members. SilverSneakers is a registered mark of Tivity Health Inc. Tivity Health Inc., is a separate company that administers the SilverSneakers program. TruHearing is a registered trademark of TruHearing, Inc.

Security Blue HMO-POS Basic Member Service

Method	Member Service – Contact Information
CALL	1-800-935-2583 Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time. Member Service also has free language interpreter services available for non-English speakers.
TTY	711 National Relay Service This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time.
FAX	1-717-635-4235
WRITE	P.O. Box 1068 Pittsburgh, PA 15230-1068
WEBSITE	medicare.highmark.com

PA MEDI - Pennsylvania Medicare Education and Decision Insight (Pennsylvania SHIP)

PA MEDI is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	Contact Information
CALL	1-800-783-7067
TTY	711 National Relay Service This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	555 Walnut Street, 5 th Floor Harrisburg, PA 17101
WEBSITE	www.aging.pa.gov

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