2026

Evidence of Coverage

CareFirst BlueCross BlueShield Group Advantage (PPO)

Frederick County Government

January 1, 2026 - December 31, 2026

CareFirst BlueCross BlueShield Medicare Advantage is a PPO plan with a Medicare contract. Enrollment in CareFirst BlueCross BlueShield Medicare Advantage depends upon contract renewal.

Y0154_H7379_MA03651GRP_C

January 1 – December 31, 2026

Evidence of Coverage for 2026:

Your Medicare Health Benefits and Services and Drug Coverage as a Member of CareFirst BlueCross BlueShield Group Advantage PPO

This document gives the details of your Medicare health and drug coverage from January 1 – December 31, 2026. **This is an important legal document. Keep it in a safe place.**

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

- Our plan premium and cost sharing
- Our medical and drug benefits
- How to file a complaint if you're not satisfied with a service or treatment
- How to contact us
- Other protections required by Medicare law

For questions about this document, call Member Services at 833-939-4103 (TTY users call 711). Hours are Monday - Friday 8am-6pm EST. This call is free.

This plan, CareFirst BlueCross BlueShield Group Advantage, is offered by CareFirst Advantage PPO, Inc. (d/b/a *CareFirst BlueCross BlueShield Medicare Advantage*). (When this *Evidence of Coverage* says "we," "us," or "our," it means CareFirst Advantage PPO, Inc. (d/b/a CareFirst BlueCross BlueShield Medicare Advantage). When it says "plan" or "our plan," it means CareFirst BlueCross BlueShield Group Advantage.)

This document is available for free in Spanish.

To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back cover of this document). We can give you information in braille, large print, or other alternate formats if you need it.

Per the final rule CMS-4205-F released on April 4, 2024, §§ 422.2267(e)(31)(ii) and 423.2267(e)(33)(ii), plans must provide a Notice of Availability of language assistance services and auxiliary aids and services that at a minimum states that our plan provides language assistance services and appropriate auxiliary aids and services free of charge. Our plan must provide the notice in English and at least the 15 languages most commonly spoken by people with limited English proficiency in the relevant state or states in our plan's service area and must provide the notice in alternate formats for people with disabilities who require auxiliary aids and services to ensure effective communication.

Benefits, premiums, deductibles, and/or copayment/coinsurance may change on January 1, 2027.

Our formulary, pharmacy network, and/or provider network can change at any time. You'll get notice about any changes that can affect you at least 30 days in advance.

Y0154_H7379_MA03651GRP_C

OMB Approval 0938-1051 (Expires: August 31, 2026)

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CHAPTER 1: Get started as a member

SECTION 1 You're a member of CareFirst BlueCross BlueShield Group Advantage

Section 1.1 You're enrolled in CareFirst BlueCross BlueShield Group Advantage, which is a Medicare PPO

You’re covered by Medicare, and you chose to get your Medicare health and drug coverage through our plan, CareFirst BlueCross BlueShield Group Advantage. Our plan covers all Part A and Part B services. However, cost sharing and provider access in this plan are different from Original Medicare.

CareFirst BlueCross BlueShield Group Advantage is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company.

Section 1.2 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how CareFirst BlueCross BlueShield Group Advantage covers your care. Other parts of this contract include your *List of Covered Drugs* (formulary), and any notices you get 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 the months in which you're enrolled in CareFirst BlueCross BlueShield Group Advantage between January 1, 2026, and December 31, 2026.

Medicare allows us to make changes to our plans we offer each calendar year. This means we can change the costs and benefits of CareFirst BlueCross BlueShield Group Advantage after December 31, 2026. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2026.

Medicare (the Centers for Medicare & Medicaid Services) must approve CareFirst BlueCross BlueShield Group Advantage each year. Your employer can continue each year to offer you Medicare coverage as a member of our plan as long as we choose to continue offering our plan and Medicare renews its approval of our plan.

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

You're eligible for membership in our plan as long as you meet all these conditions:

- You meet the eligibility requirements of your employer group.
- You have both Medicare Part A and Medicare Part B.
- You live in our geographic service area (described in Section 2.2) People who are incarcerated aren't considered to be living in the geographic service area, even if they're physically located in it.
- You're a United States citizen or are lawfully present in the United States.

Section 2.2 Plan service area for CareFirst BlueCross BlueShield Group Advantage

CareFirst BlueCross BlueShield Group Advantage is only available to people who live in our plan service area. To stay a member of our plan, you must continue to live in our service area. The service area is described below.

Our service area includes all 50 states, the District of Columbia, and all U.S. territories.

If you move out of our plan's service area, you can't stay a member of this plan. Call Member Services at 833-939-4103 (TTY users call 711) to see if we have a plan in your new area. When you move, you'll have a Special Enrollment Period. Please contact your employer plan administrator to see what other plan options are available to you if you move out of the service area.

If you move or change your mailing address, it's also important to call Social Security. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

Section 2.3 U.S. citizen or lawful presence

You must be a U.S. citizen or lawfully present in the United States to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify CareFirst BlueCross BlueShield Group Advantage if you're not eligible to stay a member of our plan on this basis. CareFirst BlueCross BlueShield Group Advantage must disenroll you if you don't meet this requirement.

SECTION 3 Important membership materials

Section 3.1 Our plan membership card

Use your membership card whenever you get services covered by our plan and for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card, if you have one. Sample plan membership card:

DON'T use your red, white, and blue Medicare card for covered medical services while you're a member of this plan. If you use your Medicare card instead of your CareFirst BlueCross BlueShield Group Advantage 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 our plan membership card is damaged, lost, or stolen, call Member Services at 833-939-4103 (TTY users call 711) right away and we'll send you a new card.

Section 3.2 Provider Directory

The *Provider Directory* available at *www.carefirst.com/myaccount* lists our current 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.

As a member of our plan, you can choose to receive care from out-of-network providers. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and medically necessary. Your cost sharing is the same for out-of-network providers as it is for in-network providers as long as the provider accepts Medicare, is willing to bill CareFirst or their local Blues plan, and is willing to treat the member. Go to Chapter 3 for more specific information.

The most recent list of providers and suppliers is available on our website at www.carefirst.com/myaccount.

If you don't have a *Provider Directory*, you can ask for a copy (electronically or in paper form) from Member Services at 833-939-4103 (TTY users call 711). Requested paper *Provider Directories* will be mailed to you within 3 business days.

Section 3.3 Pharmacy Directory

The *Pharmacy Directory* available at www.carefirst.com/myaccount lists our network pharmacies. **Network pharmacies** are pharmacies that agree to fill covered prescriptions for our plan members. Use the *Pharmacy Directory* to find the network pharmacy you want to use. Go to Chapter 5, Section 2.5 for information on when you can use pharmacies that aren't in our plan's network.

If you don't have a *Pharmacy Directory*, you can ask for a copy from Member Services at 833-939-4103 (TTY users call 711). You can also find this information on our website at www.carefirst.com/myaccount.

Section 3.4 Drug List (formulary)

Our plan has a *List of Covered Drugs* (also called the Drug List or formulary). It tells which prescription drugs are covered under the Part D benefit included in CareFirst BlueCross BlueShield Group Advantage. The drugs on this list are selected by our plan, with the help of doctors and pharmacists. The Drug List must meet Medicare's requirements. Drugs with negotiated prices under the Medicare Drug Price Negotiation Program will be included on your Drug List unless they have been removed and replaced as described in Chapter 5, Section 6. Medicare approved the CareFirst BlueCross BlueShield Group Advantage Drug List.

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

We'll give you a copy of the Drug List. To get the most complete and current information about which drugs are covered, visit www.carefirst.com/myaccount or call Member Services at 833-939-4103 (TTY users call 711).

SECTION 4 Summary of Important Costs

	Your Costs in 2026
Monthly plan premium Go to Section 4.1 for details.	**Contact your former employer or union for premium information.**
Maximum out-of-pocket amount This is the most you'll pay out-of-pocket for covered Part A and Part B services.	**$0 from in-network and out-of-network providers combined**

	Your Costs in 2026
(Go to Chapter 4 Section 1 for details.)	
Primary care office visits	**$0 per visit**
Specialist office visits	**$0 per visit**
Inpatient hospital stays	**$0**
Part D drug coverage deductible (Go to Chapter 6 Section 4 Section for details.)	**$0**
Part D drug coverage (Go to Chapter 6 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.)	***Copayment* during the Initial Coverage Stage:** **Drug Tier 1: $10** **Drug Tier 2: $30** **Drug Tier 3: $50** **You pay $35 per month supply of each covered insulin product on this tier.** **Drug Tier 4: $75** **You pay $35 per month supply of each covered insulin product on this tier.** **Catastrophic Coverage Stage:** **During this payment stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.**

Your costs can include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Part D Late Enrollment Penalty (Section 4.3)
- Income Related Monthly Adjusted Amount (Section 4.4)
- Medicare Prescription Payment Plan Amount (Section 4.5)

Section 4.1 Plan premium

As a member of your plan, you pay a monthly plan premium. Your coverage is provided through a contract with your current employer or former employer or union. Please contact the employer's or union's benefits administrator for information about your plan premium.

In some situations, your plan premium could be less

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

If you already get help from one of these programs, we sent you a separate insert, called the Evidence of Coverage Rider for People Who Get "Extra Help" Paying for Prescription Drugs (also known as the Low-Income Subsidy Rider or the LIS Rider), which tells you about your drug coverage. If you don't have this insert, please call Member Services at 833-939-4103 (TTY users call 711) and ask for the LIS Rider.

Medicare Part B and Part D premiums differ for people with different incomes. If you have questions about these premiums, check your copy of the *Medicare & You* 2026 handbook in the section called 2026 *Medicare Costs*. Download a copy from the Medicare website at (www.Medicare.gov/medicare-and-you) or order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

You must continue paying your Medicare premiums to stay a member of our plan. This includes your premium for Part B. You may also pay a premium for Part A if you aren't eligible for premium-free Part A.

Section 4.3 Part D Late Enrollment Penalty

Some members are required to pay a Part D **late enrollment penalty**. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there was a period of 63 days or more in a row when you didn't have Part D or other creditable prescription drug coverage. Creditable prescription drug coverage is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You'll have to pay this penalty for as long as you have Part D coverage.

The Part D late enrollment penalty is added to your monthly premium. When you first enroll in CareFirst BlueCross BlueShield Group Advantage, we let you know the amount of the penalty. If you don't pay your Part D late enrollment penalty, you could lose your prescription drug benefits.

You **don't** have to pay the Part D late enrollment penalty if:

- You get Extra Help from Medicare to help pay your drug costs.
- You went less than 63 days in a row without creditable coverage.

- You had creditable drug coverage through another source (like a former employer, union, TRICARE, or Veterans Health Administration (VA)). Your insurer or human resources department will tell you each year if your drug coverage is creditable coverage. You may get this information in a letter or in a newsletter from our plan. Keep this information because you may need it if you join a Medicare drug plan later.
  - **Note:** Any letter or notice must state that you had creditable prescription drug coverage that is expected to pay as much as Medicare's standard drug plan pays.
  - **Note:** Prescription drug discount cards, free clinics, and drug discount websites aren't creditable prescription drug coverage.

Medicare determines the amount of the Part D late enrollment penalty. Here's how it works:

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, our plan will count the number of full months you didn't have coverage. The penalty is 1% for every month you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty percentage will be 14%.
- Then Medicare determines the amount of the average monthly plan premium for Medicare drug plans in the nation from the previous year (national base beneficiary premium). For 2026, this average premium amount is $38.99.
- To calculate your monthly penalty, multiply the penalty percentage by the national base beneficiary premium and round to the nearest 10 cents. In the example here, it would be 14% times $38.99, which equals $5.4586. This rounds to $5.50. This amount would be added **to the monthly plan premium for someone with a Part D late enrollment penalty.**

Three important things to know about the monthly Part D late enrollment penalty:

- **The penalty may change each year,** because the national base beneficiary premium can change each year.
- **You'll continue to pay a penalty** every month for as long as you're enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- If you're *under* 65 and enrolled in Medicare, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months you don't have coverage after your initial enrollment period for aging into Medicare.

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review. Generally, you must ask for this review **within 60 days** from the date on the first letter you get stating you have to pay a late enrollment penalty. However, if you were paying a penalty before you joined our plan, you may not have another chance to ask for a review of that late enrollment penalty.

Important: Don't stop paying your Part D late enrollment penalty while you're waiting for a review of the decision about your late enrollment penalty. If you do, you could be disenrolled for failure to pay our plan premiums.

Section 4.4 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount (IRMAA). The extra charge is calculated using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit www.Medicare.gov/health-drug-plans/part-d/basics/costs.

If you have to pay an extra IRMAA, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay our plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you'll get a bill from Medicare. **You must pay the extra IRMAA to the government. It can't be paid with your monthly plan premium. If you don't pay the extra IRMAA, you'll be disenrolled from our plan and lose prescription drug coverage.**

If you disagree about paying an extra IRMAA, you can ask Social Security to review the decision. To find out how to do this, call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

Section 4.5 Medicare Prescription Payment Plan Amount

If you're participating in the Medicare Prescription Payment Plan, each month you'll pay our plan premium (if you have one) and you'll get a bill from your health or drug plan for your prescription drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Chapter 2, Section 7 tells more about the Medicare Prescription Payment Plan. If you disagree with the amount billed as part of this payment option, you can follow the steps in Chapter 9 to make a complaint or appeal.

SECTION 5 More information about your monthly plan premium

Section 5.1 Our monthly plan premium won't change during the year

Changes to premiums and benefits are subject to yearly contractual agreements between your group and us. In general, monthly plan premiums will not change during the plan year. Your group is responsible for notifying you, prior to the date when any changes would become effective, if there are changes to any portion of your monthly premium you are required to pay.

However, in some cases, you (or the group, on your behalf) may need to start paying or may be able to stop paying a late enrollment penalty. This could happen if you become eligible for the "Extra Help" program or if you lose your eligibility for the "Extra Help" program during the year.

- If you (or the group, on your behalf) currently pay the Part D late enrollment penalty and you become eligible for "Extra Help" during the year, you (or the group, on your behalf) would be able to stop paying your penalty.
- If you lose Extra Help, you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.

Find out more about the "Extra Help" program in Chapter 2, Section 7.

SECTION 6 Keep our plan membership record up to date

Your membership record has information including your address and phone number. It shows your specific plan coverage.

The doctors, hospitals, pharmacists, and other providers in our plan's network **use your membership record to know what services and drugs are covered and your cost-sharing amounts.** Because of this, it's very important to help us keep your information up to date.

If you have any of these changes, let us know:

- Changes to your name, your address, or your phone number.
- Changes in any other health coverage you have (such as from your employer, your spouse or domestic partner's employer, Workers' Compensation, or Medicaid).
- Any liability claims, such as claims from an automobile accident.
- If you're admitted to a nursing home.
- If you get 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 participate in a clinical research study. (**Note:** You're not required to tell our plan about clinical research studies you intend to participate in, but we encourage you to do so.)

If any of this information changes, let us know by calling Member Services at 833-939-4103 (TTY users call 711).

It's also important to contact Social Security if you move or change your mailing address. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

SECTION 7 How other insurance works with our plan

Medicare requires us to collect information about any other medical or drug coverage you have so we can coordinate any other coverage with your benefits under our plan. This is called **Coordination of Benefits**.

Once a year, we'll send you a letter that lists any other medical or drug coverage we know about. Read this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that's not listed, call Member Services at 833-939-4103

(TTY users call 711). You may need to give our plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

When you have other insurance (like employer group health coverage through active employment), Medicare rules decide whether our plan or your other insurance pays first. The insurance that pays first (the "primary payer"), pays up to the limits of its coverage. The insurance that pays second (the "secondary payer"), only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all 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, your Medicare Advantage plan 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) are 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 has more than 100 employees.
  - If you're over 65 and you (or your spouse or domestic partner) are 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 has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' Compensation

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

CHAPTER 2:
Phone numbers and resources

SECTION 1 CareFirst BlueCross BlueShield Group Advantage contacts

For help with claims, billing, or member card questions, call or write to CareFirst BlueCross BlueShield Group Advantage Member Services at 833-939-4103 (TTY users call 711). We'll be happy to help you.

Member Services – Contact Information	
Call	833-939-4103 Calls to this number are free. 8am-6pm EST, Monday - Friday. Member Services 833-939-4103 (TTY users call 711) also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. 8am-6pm EST, Monday - Friday.
Fax	844-961-0696
Write	CareFirst BlueCross BlueShield Medicare Advantage Attention: Member Services Department P.O. Box 915 Owings Mills, MD 21117
Website	www.carefirst.com/myaccount

Member Services for Part D Prescription Drugs – Contact Information	
Call	888-970-0917 Calls to this number are free. 24 hours a day, 7 days a week, 365 days a year. Member Services 888-970-0917 (TTY users call 711) also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. 24 hours a day, 7 days a week, 365 days a year.

Member Services for Part D Prescription Drugs – Contact Information	
Fax	855-633-7673
Website	www.carefirst.com/myaccount

How to ask 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 pay for your medical services or Part D drugs. An appeal is a formal way of asking us to review and change a coverage decision. For more information on how to ask for coverage decisions or appeals about your medical care or Part D drugs, go to Chapter 9.

Coverage Decisions for Medical Care – Contact Information	
Call	833-939-4103 Calls to this number are free. 8am-6pm EST, Monday-Friday.
TTY	711 Calls to this number are free. 8am-6pm EST, Monday-Friday.
Fax	Inpatient Services: 443-753-2341 Outpatient Services: 443-753-2342 Home Care Services and Durable Medical Equipment: 443-753-2343 Outpatient Therapies--Physical Therapy, Occupational Therapy, and Speech Therapy: 443-753-2346 Behavioral Health and Substance Use: 443-753-2347
Write	CareFirst BlueCross BlueShield Preservice Review Department P.O. Box 915 Owings Mills, MD 21117 Email: Inpatient Services: MAInpatient@carefirst.com Outpatient Services: MAOutpatient@carefirst.com Home Care Services and Durable Medical Equipment: MAHC-DME@carefirst.com Outpatient Therapies (Physical Therapy, Occupational Therapy, and Speech Therapy): MAOPAP@carefirst.com Behavioral Health and Substance Use: MABH@carefirst.com

Appeals for Medical Care – Contact Information	
Call	833-939-4103 Calls to this number are free. 8am-6pm EST, Monday-Friday.
TTY	711

Appeals for Medical Care – Contact Information	
	Calls to this number are free. 8am-6pm EST, Monday-Friday.
Fax	Medical Payment Appeals: 443-753-2298 Clinical Expedited Appeals: 410-605-2566
Write	CareFirst BlueCross BlueShield Medicare Advantage Clinical Appeals and Analysis P.O. Box 915 Owings Mills, MD 21117

Coverage Decisions for Part D Prescription Drugs – Contact Information	
Call	888-970-0917 Calls to this number are free. 24 hours a day, 7 days a week, 365 days a year.
TTY	711 Calls to this number are free. 24 hours a day, 7 days a week, 365 days a year.
Fax	Standard and Expedited Coverage Decisions: 855-633-7673
Write	CVS Caremark Coverage Determinations/Exceptions P.O. Box 52000 Phoenix, AZ 85072-2000
Website	https://www.carefirst.com/learngroupma/prescription-drug-coverage/drug-management-programs.html

Appeals for Part D Prescription Drugs – Contact Information	
Call	888-970-0917 Calls to this number are free. 24 hours a day, 7 days a week, 365 days a year.
TTY	711 Calls to this number are free. 24 hours a day, 7 days a week, 365 days a year.
Fax	855-633-7673
Write	CVS Caremark Coverage Determinations/Exceptions P.O. Box 52000 Phoenix, AZ 85072-2000

Appeals for Part D Prescription Drugs – Contact Information	
Website	https://www.carefirst.com/learngroupma/prescription-drug-coverage/drug-management-programs.html

How to make a complaint about your medical care

You can make a complaint about us or one of our network providers or pharmacies, including a complaint about the quality of your care. This type of complaint doesn't involve coverage or payment disputes. For more information on how to make a complaint about your medical care, go to Chapter 9.

Complaints about Medical Care – Contact Information	
Call	833-939-4103 Calls to this number are free. 8am-6pm EST, Monday-Friday.
TTY	711 Calls to this number are free. 8am-6pm EST, Monday-Friday.
Fax	443-753-2298
Write	CareFirst BlueCross BlueShield Medicare Advantage Attention: Appeals & Grievances Department P.O. Box 915 Owings Mills, MD 21117
Medicare Website	To submit a complaint about CareFirst BlueCross BlueShield Group Advantage directly to Medicare, go to www.Medicare.gov/my/medicare-complaint.

Complaints about Part D Prescription Drugs – Contact Information	
Call	888-970-0917 Calls to this number are free. 24 hours a day, 7 days a week, 365 days a year.
TTY	711 Calls to this number are free. 24 hours a day, 7 days a week, 365 days a year.
Fax	855-633-7673
Write	Grievance Department P.O. Box 30016 Pittsburgh, PA 15222-0330

Complaints about Part D Prescription Drugs – Contact Information	
Medicare Website	To submit a complaint about CareFirst BlueCross BlueShield Group Advantage directly to Medicare, go to www.Medicare.gov/my/medicare-complaint.

How to ask us to pay our share of the cost for medical care or a drug you got

If you got a bill or paid for services (like a provider bill) you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. Go to Chapter 7 for more information.

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to Chapter 9 for more information.

Payment Requests for Medical Care – Contact Information	
Call	833-939-4103 8am-6pm EST, Monday-Friday. Calls to this number are free.
TTY	711 Calls to this number are free. 8am-6pm EST, Monday-Friday.
Fax	855-215-6947
Write	CareFirst BlueCross BlueShield Medicare Advantage Attention: Member Claims Reimbursement P.O. Box 915 Owings Mills, MD 21117
Website	www.carefirst.com/myaccount

Payment Requests for Part D Prescription Drugs – Contact Information	
Call	888-970-0917 24 hours a day, 7 days a week, 365 days a year. Calls to this number are free.
TTY	711 Calls to this number are free. 24 hours a day, 7 days a week, 365 days a year.
Fax	855-633-7673
Write	CVS Caremark Medicare Part D Claims Processing P.O. Box 52066 Phoenix, AZ 85072-2066

Payment Requests for Part D Prescription Drugs – Contact Information	
Website	www.carefirst.com/myaccount

SECTION 2 Get help from Medicare

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 (CMS). This agency contracts with Medicare Advantage organizations, including our plan.

Medicare – Contact Information	
Call	1-800-MEDICARE (1-800-633-4227) Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
Chat Live	Chat live at www.Medicare.gov/talk-to-someone.
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044
Website	www.Medicare.gov • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly “Wellness” visits). • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers. You can also visit www.Medicare.gov to tell Medicare about any complaints you have about CareFirst BlueCross BlueShield Group Advantage:

Medicare – Contact Information	
	To submit a complaint to Medicare, go to www.Medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

SECTION 3 State Health Insurance Assistance Program (SHIP)

State Health Insurance Assistance Programs (SHIP) are government programs with trained counselors in every state that offers free help, information, and answers to your Medicare questions. A list of State Health Insurance Assistance Programs can be found in Exhibit A located at the end of this Evidence of Coverage.

State Health Insurance Assistance Programs are independent state programs (not connected with any insurance company or health plan) that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

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

SECTION 4 Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state. Here is a list of Quality Improvement Organizations in each state we serve.

The Quality Improvement Organization has a group of doctors and other health care professionals paid by Medicare to check on and help improve the quality of care for people with Medicare. The Quality Improvement Organization is an independent organization. It's not connected with our plan.

Contact the Quality Improvement Organization in any of these situations:

- You have a complaint about the quality of care you got. Examples of quality-of-care concerns include getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis.
- 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 is ending too soon.

For the following states and territories, the Quality Improvement Organization is called Commence Health:

Region 2: New Jersey, New York, Puerto Rico, U.S. Virgin Islands
Region 3: Delaware, Maryland, Pennsylvania, Virginia, Washington, D.C., West Virginia

Region 5: Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin
Region 7: Iowa, Kansas, Missouri, Nebraska
Region 9: American Samoa, Arizona, California, Guam, Nevada, Northern Mariana Islands

Commence Health – Contact Information (Quality Improvement for Regions 2, 3, 5, 7 and 9)	
Call	**Region 2:** 866-815-5440 **Region 3:** 888-396-4646 **Region 5:** 888-524-9900 **Region 7:** 888-755-5580 **Region 9:** 877-588-1123 Monday-Friday, 9am-5pm, and Saturday-Sunday, 10am-4pm. 24-hour voicemail is available.
TTY	711
Write	Commence Health BFCC-QIO 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701
Website	www.livantaqio.com

For the following states, the Quality Improvement Organization is called Acentra Health:

Region 1: Connecticut, Massachusetts, Maine, New Hampshire, Rhode Island, Vermont
Region 4: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee
Region 6: Arkansas, Louisiana, New Mexico, Oklahoma, Texas
Region 8: Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming
Region 10: Alaska, Idaho, Oregon, Washington

Acentra Health - Contact Information **(Quality Improvement Organization for Regions 1, 4, 6, 8 and 10)**	
Call	**Region 1:** 888-319-8452 **Region 4:** 888-317-0751 **Region 6:** 888-315-0636 **Region 8:** 888-317-0891 **Region 10:** 888-305-6759 Monday-Friday, 9am-5pm, and Saturday-Sunday, 10am-4pm. 24-hour voicemail is available.
TTY	711
Write	Acentra Health BFCC-QIO 1650 Summit Lake Dr. Suite 102 Tallahassee, FL 32317
Website	www.acentraqio.com

SECTION 5 Social Security

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

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

Social Security – Contact Information	
Call	1-800-772-1213 Calls to this number are free. Available 8 am to 7 pm, Monday through Friday. 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.

Social Security – Contact Information	
	Available 8 am to 7 pm, Monday through Friday.
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. Medicaid offers programs to 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 Medicare Savings Programs, contact the Medicaid agency for your state or territory. Contact information is available in Exhibit A at the end of this Evidence of Coverage.

SECTION 7 Programs to help people pay for prescription drugs

The Medicare website (www.Medicare.gov/basics/costs/help/drug-costs) has information on ways to lower your prescription drug costs. The programs below can help people with limited incomes.

Extra Help from Medicare

Medicare and Social Security have a program called Extra Help that can help pay drug costs for people with limited income and resources. If you qualify, you get help paying for your Medicare drug plan's monthly plan premium, yearly deductible, and copayments. Extra Help also counts toward your out-of-pocket costs.

If you automatically qualify for Extra Help, Medicare will mail you a purple letter to let you know. If you don't automatically qualify, you can apply any time. To see if you qualify for getting Extra Help:

- Visit https://secure.ssa.gov/i1020/start to apply online.
- Call Social Security at 1-800-772-1213. TTY users call 1-800-325-0778.

When you apply for Extra Help, you can also start the application process for a Medicare Savings Program (MSP). These state programs provide help with other Medicare costs. Social Security will send information to your state to initiate an MSP application, unless you tell them not to on the Extra Help application.

If you qualify for Extra Help and you think that you're paying an incorrect amount for your prescription at a pharmacy, our plan has a process to help you get evidence of the right copayment amount. If you already have evidence of the right amount, we can help you share this evidence with us.

- Contact Member Services if you're not sure what evidence you need to provide to us. Often, this evidence is a notice from your state Medicaid office or from Social Security that confirms you qualify for "Extra Help." Depending on your situation, it may be other kinds of documentation. Please send us this evidence in one of two ways; we will then forward the updated information to Medicare.

  Fax: 855-215-6946

  Write: CareFirst BlueCross BlueShield Medicare Advantage
  Attention: Member Services Department
  P.O. Box 915
  Owings Mills, MD 21117

- **Note:** Until Medicare updates its records, you or your representative may need to provide a copy of the evidence at the pharmacy when obtaining covered Part D prescriptions so that you will be charged the appropriate cost sharing amount.
- When we get the evidence showing the right copayment level, we'll update our system so you can pay the right amount when you get your next prescription. If you overpay your copayment, we'll pay you back, either by check or a future copayment credit. If the pharmacy didn't collect your copayment and you owe them a debt, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Call Pharmacy Member Services at 888-970-0917 (TTY users call 711) if you have questions.

There are programs in Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa to help people with limited income and resources pay their Medicare costs. Programs vary in these areas. Call your local Medical Assistance (Medicaid) office to find out more about its rules (phone numbers are in Exhibit A at the end of this Evidence of Coverage). Or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week and say "Medicaid" for more information. TTY users should call 1-877-486-2048. You can also visit www.medicare.gov for more information.

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

Many states offer help paying for prescriptions, drug plan premiums and/or other drug costs. If you're enrolled in a State Pharmaceutical Assistance Program (SPAP), Medicare's Extra Help

pays first. A list of State Pharmaceutical Assistance Programs can be found in Exhibit A located at the end of this Evidence of Coverage.

What if you have Extra Help and coverage from an AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps people living with HIV/AIDS access life-saving HIV medications. Medicare Part D drugs that are also on the ADAP formulary qualify for prescription cost-sharing help through the ADAP in your state.

Note: To be eligible for the ADAP in your state, people must meet certain criteria, including proof of state residence and HIV status, low income (as defined by the state), and uninsured/ under-insured status. If you change plans, notify your local ADAP enrollment worker so you can continue to get help. For information on eligibility criteria, covered drugs, or how to enroll in the program, a list of AIDS Drug Assistance Programs can be found in Exhibit A located at the end of this Evidence of Coverage.

State Pharmaceutical Assistance Programs

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

A list of State Pharmaceutical Assistance Programs can be found in Exhibit A located at the end of this Evidence of Coverage.

The Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage, and it can help you manage your costs for drugs covered by our plan by spreading them across **the calendar year** (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026.** To learn more about this payment option, call Pharmacy Member Services at 888-970-0917 (TTY users call 711) or visit www.Medicare.gov.

Medicare Prescription Payment Plan – Contact Information	
Call	888-970-0917 Calls to this number are free. 24 hours a day, 7 days a week, 365 days a year Pharmacy Member Services 888-970-0917 (TTY users call 711) has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. 24 hours a day, 7 days a week, 365 days a year

Medicare Prescription Payment Plan – Contact Information	
Write	P.O. Box 7 Pittsburgh, PA 15230
Website	www.carefirst.com/myaccount

SECTION 8 Railroad Retirement Board (RRB)

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 get Medicare through the Railroad Retirement Board, let them know if you move or change your mailing address. For questions about your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board (RRB) – Contact Information	
Call	1-877-772-5772 Calls to this number are free. Press "0" to speak with an RRB representative from 9 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9 am to 12 pm on Wednesday. Press "1" to access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number aren't free.
Website	https://RRB.gov

SECTION 9 If you have group insurance or other health insurance from an employer

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner's) employer or retiree group as part of this plan, call the employer/union benefits administrator or Member Services at 833-939-4103 (TTY users call 711) with any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Member Services are printed on the back cover of this document.) You can call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2048.

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

CHAPTER 3:
Using our plan for your medical services

SECTION 1 How to get medical care as a member of our plan

This chapter explains what you need to know about using our plan to get your medical care covered. For details on what medical care our plan covers and how much you pay when you get care, go to the Medical Benefits Chart in Chapter 4.

Section 1.1 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 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 equipment, and prescription drugs that are covered by our plan. Your covered services for medical care are listed in the Medical Benefits Chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

Section 1.2 Basic rules for your medical care to be covered by our plan

As a Medicare health plan, CareFirst BlueCross BlueShield Group Advantage must cover all services covered by Original Medicare and follow Original Medicare's coverage rules.

CareFirst BlueCross BlueShield Group Advantage will generally cover your medical care as long as:

- **The care you get is included in our plan's Medical Benefits Chart** in Chapter 4.
- **The care you get 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 get your care from a provider who's eligible to provide services under Original Medicare.** As a member of our plan, you can get care from either a network provider or an out-of-network provider (go to Section 2 for more information).

- The providers in our network are listed in the *Provider Directory* at www.carefirst.com/myaccount.
- 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 can't pay a provider who isn't eligible to participate in Medicare. If you go to a provider who isn't eligible to participate in Medicare, you'll be responsible for the full cost of the services you get. Check with your provider before getting services to confirm that they're eligible to participate in Medicare.

SECTION 2 Use network and out-of-network providers to get your medical care

Section 2.1 You may 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?

A "PCP" is a Primary Care Provider. A PCP can help manage your overall health care and can assist with coordinating services with other healthcare providers. A PCP is not responsible for obtaining authorization for the services provided by a specialist when authorization is required. Authorization is the responsibility of the specialist or other provider. Your PCP can either be a network provider or an out-of-network provider.

Is a PCP required?

You are not required to select a PCP to obtain benefits from this plan.

How to change your PCP

If you do select a PCP, you can change your PCP for any reason, at any time.

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. For example:

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

Prior authorization may be needed for certain services (please see Chapter 4 for information on which services require prior authorization). Authorization can be obtained from the plan. You or your provider, including a non-contracted provider, can ask the plan before a service is furnished whether the plan will cover it. You or your provider can request that this determination be in writing. This process is called an advanced determination. If we say we will not cover your services, you, or your provider, have the right to appeal our decision not to cover your care.

Chapter 9 (If you have a problem or complaint (coverage decisions, appeals, complaints)) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made.

Note: It is important to know in advance what Medicare will or will not cover. Be sure to ask your provider if a service is covered. Providers should let you know when something is not covered and give you a written notice, or tell you verbally, when Medicare does not cover the service.

When a specialist or another network provider leaves our plan

We may make changes to the hospitals, doctors, and specialists (providers) in our plan's network during the year. If your doctor or specialist leaves our plan, you can contact CareFirst BlueCross BlueShield Group Advantage (phone numbers are printed on the back cover of this document) and we can help you find another provider in our network. In addition, you can continue to obtain covered services from that provider as an out-of-network provider if that provider continues to accept Medicare. See Chapter 3, Section 2.3 - *How to get care from out-of-network providers – Medicare participating, Medicare non-participating, and Medicare opt-out providers* for more information.

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

As a member of our plan, you can choose to get care from out-of-network providers. However, providers that don't 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 medically necessary. Here are more 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 can't pay a provider who isn't eligible to participate in Medicare. If you get care from a provider who isn't eligible to participate in Medicare, you'll be responsible for the full cost of the services you get. Check with your provider before getting services to confirm that they're eligible to participate in Medicare.
- You don't need a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers, ask for a pre-visit coverage decision to confirm that the services you get are covered and medically necessary (go to Chapter 9, Section 4). This is important because:
  - Without a pre-visit coverage decision, and if our plan later determines that the services aren't covered or weren't medically necessary, our plan may deny coverage and you'll be responsible for the entire cost. If we say we won't cover the services you got, you have the right to appeal our decision not to cover your care (go to Chapter 9).

It Is Important to Understand the Types of Out-of-Network Providers
When you use out-of-network providers, it is your responsibility to understand whether the out-of-network provider participates with Medicare (a "Medicare participating provider"), is a

provider that does not participate with Medicare (a “Medicare non-participating provider”) or is a provider who has opted out of Medicare (a “Medicare opt-out provider”). As explained below, CareFirst BlueCross BlueShield Group Advantage will not cover any non-emergency services you obtain from an opt-out provider.

Medicare Participating Providers

Medicare participating providers have signed an agreement to accept assignment for all Medicare-covered services. Assignment means that your provider agrees to accept the Medicare-approved amount as full payment for covered services.

When you see Medicare participating providers, be sure to provide them with your CareFirst BlueCross BlueShield Group Advantage member ID card. Here's what happens if you obtain covered services from Medicare participating providers:

- They agree to charge you only the CareFirst BlueCross BlueShield Group Advantage copayment or coinsurance amount.
- They must submit your claim directly to CareFirst BlueCross BlueShield Group Advantage and can't charge you for submitting the claim.
- CareFirst BlueCross BlueShield Group Advantage will pay the provider, and you will owe any copayment or coinsurance due under the terms of this plan.

Medicare Non-Participating Providers

Medicare non-participating providers haven't signed an agreement to accept assignment for all Medicare-covered services, but they can still choose to accept assignment for individual services.

When you see a Medicare non-participating provider, be sure to provide them with your CareFirst BlueCross BlueShield Group Advantage member ID card. This way, these Medicare non-participating providers will know that you are enrolled in CareFirst BlueCross BlueShield Group Advantage.

Here's what happens if you obtain covered services from a non-participating provider:

- Medicare non-participating providers can bill more than the Medicare-approved amount for a covered service, but they cannot charge more than an amount called "the limiting charge.” The limiting charge applies only to certain Medicare-covered services and doesn't apply to some supplies and durable medical equipment.
- For covered services, CareFirst BlueCross BlueShield Group Advantage will pay the Medicare non-participating provider an amount up to the Medicare-approved amount plus the limiting charge for a covered service you receive, less any copayment or coinsurance owed by you for that covered service under the terms of this plan. For covered supplies and durable medical equipment that are not subject to the limiting charge, CareFirst BlueCross BlueShield Group Advantage will pay the amount billed by the Medicare non-participating supplier. You will pay any copayment or coinsurance applicable to the covered service.

- **You might have to pay the entire charge at the time of service** and then be reimbursed (less any copayment or coinsurance owed) by the plan. Your Medicare non-participating provider should submit a claim to CareFirst BlueCross BlueShield Group Advantage for any Medicare-covered services they provide to you. If your Medicare non-participating provider does not submit a Medicare claim to us, call Member Services (phone numbers are printed on the back cover of this document).
- In some cases, you might have to submit your own claim to CareFirst BlueCross BlueShield Group Advantage to get reimbursed. (See Chapter 3, Section 4, *"What if you are billed directly for the full cost of your services?"*)
- Medicare non-participating providers cannot "balance bill" you for any amount above the amount CareFirst BlueCross BlueShield Group Advantage will pay (except for any copayment or coinsurance you must pay under the terms of this plan). Non-participating providers also can't charge you for submitting a claim on your behalf.

Medicare Opt-Out Providers

Certain doctors and other health care providers who don't want to work with the Medicare program may "opt out" of Medicare. Medicare doesn't pay for any covered items or services you get from an opt-out doctor or other provider, except in the case of an emergency or urgently-needed services. If you still want to see a Medicare opt-out provider, you and your provider can set up payment terms that you both agree to through a private contract.

A doctor or other provider who chooses to opt out of Medicare must do so for two (2) years, a term that automatically renews every two (2) years unless the provider requests not to renew opt-out status.

You can find providers that have opted out of Medicare at the following link: https://data.cms.gov/tools/provider-opt-out-affidavits-look-up-tool. You can search by their first and last name, National Provider Identifier (NPI), specialty, or ZIP code.

CareFirst BlueCross BlueShield Group Advantage will not pay any amount for the services you get from Medicare opt-out providers, even for a Medicare-covered service. The only exception to this is when you obtain emergency or urgently-needed services from such a provider.

You don't have to sign a private contract or get non-emergency services from a Medicare opt-out provider. You can always go to another provider who provides services through CareFirst BlueCross BlueShield Group Advantage.

Here's what happens if you sign a private contract with a Medicare opt-out provider or otherwise obtain non-emergency or non-urgent care services from a Medicare opt-out provider:

- You'll have to pay the full amount the provider charges you for services. You and your Medicare opt-out provider will set up your own payment terms.
- CareFirst BlueCross BlueShield Group Advantage does not cover any non-emergency services you receive from a Medicare opt-out provider. CareFirst BlueCross BlueShield Group Advantage will not reimburse you for any amount that you owe a Medicare opt-out provider for these services.

- Amounts that you pay a Medicare opt-out provider will not apply toward your Maximum Out-of-Pocket (MOOP) amount under this plan.
- Your provider must tell you if Medicare would pay for the service if you received it from a provider who accepts Medicare.
- Your provider must tell you if he or she has been excluded from Medicare.
- You can't be asked to sign a private contract for emergency or urgent care.
- You're always free to get services not covered by Medicare if you choose to pay for a service yourself.

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.
- It’s best to ask an out-of-network provider to bill our plan first. But, if you’ve already paid for the covered services, we’ll reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill you think we should pay, you can send it to us for payment (go to Chapter 7).
- If you’re 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 (go to Section 3).

SECTION 3 How to get services in an emergency, disaster, or urgent need for care

Section 3.1 Get care if you have a medical 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 (and, if you’re 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’s 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 don't need to get approval or a referral first from your PCP. You don't need to use a network doctor. You can get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they're not part of our network. Your plan also provides coverage for emergency medical care outside the United States and its territories.
- **As soon as possible, make sure 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. Please call 833-939-4103, 8am-6pm EST, Monday - Friday.

Covered services in 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 giving you emergency care will decide when your condition is stable and when the medical emergency is over.

After the emergency is over, you're 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 wasn't an emergency, as long as you reasonably thought your health was in serious danger, we'll cover your care.

Section 3.2 Get care when you have an urgent need for services

A service that requires immediate medical attention (but isn't an emergency) is an urgently needed service if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

You can receive urgent care through urgent care centers or through telehealth and online options. The Provider Directory includes a list of urgent care centers that are within the network. You can also take advantage of remote options such as our 24-Hour Nurse Advice Line and Additional Telehealth Services (see the Medical Benefits Chart in Chapter 4 for more information).

Urgently needed services are covered worldwide.

Only benefits rendered in an urgent care setting are covered. If you are admitted, inpatient benefits related to your urgent care visit are not covered by the plan.

If you have an emergency service outside the U.S. and its territories, you will be responsible for payment at the time services are rendered. You may then submit your claims and proof of payment for reimbursement consideration (minus any applicable member cost sharing). Transportation and repatriation are not covered.

For more information please see Chapter 7 (Section 1).

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

- The care is needed to treat, evaluate, or stabilize an emergency medical condition within an emergency room setting; or
- Services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care within an urgent care setting

Only benefits rendered in an emergency room setting are covered. If you are admitted, inpatient benefits related to your emergency are not covered by the plan.

If you have an emergency service outside the U.S. and its territories, you will be responsible for payment at the time services are rendered. You may then submit your claims and proof of payment for reimbursement consideration (minus any applicable member cost sharing). Transportation and repatriation are not covered.

For more information please see Chapter 7 (Section 1).

Section 3.3 Get 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're still entitled to care from our plan.

Visit www.carefirst.com/learngroupma for information on how to get needed care during a disaster.

If you can't use a network pharmacy during a disaster, you may be able to fill your prescriptions at an out-of-network pharmacy. Go to Chapter 5, Section 2.5.

SECTION 4 What if you're billed directly for the full cost of covered services?

If you paid more than our plan cost sharing for covered services, or if you get a bill for the full cost of covered medical services, you can ask us to pay our share of the cost of covered services. Go to Chapter 7 for information about what to do.

Section 4.1 If services aren't covered by our plan, you must pay the full cost

CareFirst BlueCross BlueShield Group Advantage covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4. If you get services that aren't covered by our plan, you're responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you use up your benefit for that type of covered service. Any amounts you pay after the benefit has been exhausted will not count toward the Maximum Out-of-Pocket Amount.

SECTION 5 Medical services 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 ask for volunteers to participate in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that's not related to the study) through our plan.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for covered services you get as part of the study. If you tell us you're in a qualified clinical trial, you're 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'll reimburse the difference between what you paid and the in-network cost sharing. You'll need to provide documentation to show us how much you paid.

If you want to participate in any Medicare-approved clinical research study, you don't need to tell us or get approval from us. The providers that deliver your care as part of the clinical research study don't need to be part of our plan's network. (This doesn't apply to covered benefits that require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.)

While you don't need 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 not approved by Medicare, you'll be responsible for paying all costs for your participation in the study.

Section 5.2 Who pays for services in a clinical research study

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

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

After Medicare pays 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'll pay the same amount for services you get as part of the study as you would if you got these services from our plan. However, you must submit documentation showing how much cost sharing you paid. Go to Chapter 7 for more information on submitting requests for payments.

Example of cost sharing in a clinical trial: Let's say you have a lab test that costs $100 as part of the research study. Your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan. In this case, Original Medicare would pay $80 for the test, and you would pay the $20 copay required under Original Medicare. You would notify our plan that you got a qualified clinical trial service and submit documentation (like a provider bill) to our plan. Our plan would then directly pay you $10. This makes your net payment for the test $10, the same amount you'd pay under our plan's benefits.

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

- Generally, Medicare won't pay for the new item or service the study is testing unless Medicare would cover the item or service even if you weren't in a study.
- Items or services provided only to collect data and not used in your direct health care. For example, Medicare won't pay for monthly CT scans done as part of a study if your medical condition would normally require only one CT scan.
- Items and services provided by the research sponsors free of charge for people in the trial.

Get more information about joining a clinical research study

Get more information about joining a clinical research study in the Medicare publication *Medicare and Clinical Research Studies,* available at https://www.medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

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

Section 6.1 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'll instead cover 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 How to get 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're conscientiously opposed to getting medical treatment that is **non-excepted**.

- **Non-excepted** medical care or treatment is any medical care or treatment that's *voluntary* and *not required* by any federal, state, or local law.
- **Excepted** medical treatment is medical care or treatment that you get that's *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 only covers non-religious aspects of care.
- If you get services from this institution provided to you in a facility, the following conditions apply:
  - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
  - – *and* – you must get approval in advance from our plan before you're admitted to the facility, or your stay won't be covered.

Medicare Psychiatric Inpatient Hospital and Skilled Nursing Facility Care coverage limits apply. Please refer to the Medical Benefits Chart in Chapter 4 for more details.

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 You won't own some durable medical equipment after making a certain number of payments under our plan

Durable medical equipment (DME) includes items like oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for members to use in the home. The member always owns some DME items, like prosthetics. Other types of DME 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 CareFirst BlueCross BlueShield Group Advantage, you won't get ownership of rented DME items no matter how many copayments you make for the item while a member of our plan.** You won't get ownership even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan.

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

If you didn't get ownership of the DME item while in our plan, you'll have to make 13 new consecutive payments after you switch to Original Medicare to own the DME item. The payments you made while enrolled in our plan don't count towards these 13 payments.

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 don't count.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You didn't get ownership of the item while in our plan. You then go back to Original Medicare. You'll have to make 13 consecutive new payments to own the item once you rejoin Original Medicare. Any payments you already made (whether to our plan or to Original Medicare) don't count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

If you qualify for Medicare oxygen equipment coverage, CareFirst BlueCross BlueShield Group Advantage 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 CareFirst BlueCross BlueShield Group Advantage or no longer medically require oxygen equipment, the oxygen equipment must be returned.

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

Original Medicare requires an oxygen supplier to provide you services for 5 years. During the first 36 months, you rent the equipment. For the remaining 24 months, the supplier provides the equipment and maintenance (you're still responsible for the copayment for oxygen). After 5 years, you can choose to stay with the same company or go to another company. At this point, the 5-year cycle starts over again, even if you stay with the same company, and you're again required to pay copayments for the first 36 months. If you join or leave our plan, the 5-year cycle starts over.

CHAPTER 4:
Medical Benefits Chart (what's covered and what you pay)

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

The Medical Benefits Chart lists your covered services and shows how much you pay for each covered service as a member of CareFirst BlueCross BlueShield Group Advantage. This section also gives information about medical services that aren’t covered and explains limits on certain services.

Section 1.1 Out-of-pocket costs you may pay for covered services

Types of out-of-pocket costs you may pay for covered services include.

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

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program don't pay copayments or coinsurance. If you’re in one of these programs, be sure to show your proof of Medicaid or QMB eligibility to your provider.

Section 1.2 What's the most you'll pay for Medicare Part A and Part B covered medical services?

- Your **combined maximum out-of-pocket amount** is $0. This is the most you pay during the calendar year for covered Medicare Part A and Part B services got 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 plan premiums and for your Part D drugs don't count toward your combined maximum out-of-pocket amount.) In addition, amounts you pay for some covered services don't count toward your maximum out-of-pocket amount. These services are marked in the Medical Benefits Chart. If you pay $0 for covered services, you'll have 100% coverage and won't 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).

Please note: The following amounts **don't** count toward your combined maximum out-of-pocket amount:

- The amounts you pay for your plan premiums and for your Part D prescription drugs.
- The amounts you pay for some covered services. These services are marked in the Medical Benefits Chart.
- Any amounts you pay for services that are not covered by this plan. This includes services CareFirst BlueCross BlueShield Group Advantage does not cover because you did not obtain prior authorization for that service as required.
- Any amounts that you pay to a Medicare opt-out provider.

Section 1.3 Providers aren't allowed to balance bill you

As a member of CareFirst BlueCross BlueShield Group Advantage, you have an important protection because you only have to pay your cost-sharing amount when you get services covered by our plan from network providers or out-of-network providers who participate with Medicare. Providers can't bill you for 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's a dispute and we don't pay certain provider charges.

Here's how protection from balance billing works:

- If your cost sharing is a copayment (a set amount of dollars, for example, $15.00), you pay only that amount for any covered services from a network provider. You'll generally have higher copayments when you get care from out-of-network providers.
- If your cost sharing is a coinsurance (a percentage of the total charges), you never pay more than that percentage. However, your cost depends on which type of provider you see:

  - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (this is set in the contract between the provider and our plan).
  - If you get 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.
  - If you get covered services from an out-of-network provider who doesn't participate with Medicare, then you pay the coinsurance amount multiplied by the Medicare payment rate for non-participating providers.
- If you think a provider has balance billed you, call Member Services at 833-939-4103 (TTY users call 711).

Please note that this "balance bill" protection does not apply if you obtain services from a Medicare opt-out provider.

SECTION 2 The Medical Benefits Chart shows your medical benefits and costs

The Medical Benefits Chart on the next pages lists the services CareFirst BlueCross BlueShield Group Advantage covers and what you pay out of pocket for each service (Part D drug coverage is covered in Chapter 5). The services listed in the Medical Benefits Chart are covered only when these requirements are met:

- Your Medicare-covered services must be provided according to Medicare coverage guidelines.
- Your services (including medical care, services, supplies, equipment, and Part B 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.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan can't require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- Some of the services listed in the Medical Benefits Chart are covered *only* if your doctor or other provider gets approval in advance (sometimes called "prior authorization") from CareFirst BlueCross BlueShield Group Advantage.
  - Covered services that need approval in advance are marked in italics in the Medical Benefits Chart.
  - You never need approval in advance for covered services from out-of-network providers.
  - While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.

- If your coordinated care plan provides approval of a prior authorization request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, your medical history, and the treating provider's recommendation.

Other important things to know about our coverage:

- For benefits where your cost sharing is a coinsurance percentage, the amount you pay depends on what type of provider you get the services from:
  - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (as determined in the contract between the provider and our plan).
  - If you get 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.
  - If you get covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- 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*. (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You 2026* handbook. View it online at www.Medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.)
- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you're also treated or monitored for an existing medical condition during the visit when you get the preventive service, a copayment will apply for the care you got for the existing medical condition.
- If Medicare adds coverage for any new services during 2026, either Medicare or our plan will cover those services.

 **This apple shows preventive services in the Medical Benefits Chart.**

Medical Benefits Chart

Covered Service	What you pay
 **Abdominal aortic aneurysm screening** A one-time screening ultrasound for people at risk. Our 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.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for chronic low back pain	$0 copay at a PCP office or $0 copay at a Specialist office for

Covered Service	What you pay
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: • lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy. An additional 8 sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. **Provider Requirements:** Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. 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: • a master's 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. 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.	each Medicare-covered acupuncture visit.

Covered Service	What you pay
Ambulance services *Prior authorization may be required for non-emergent services.* Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be 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.	$0 copay for each Medicare-covered one-way ambulance ground trip. $0 copay for each Medicare-covered air ambulance trip. This copay is not waived if you are admitted to a hospital.
Annual physical exam The plan covers a routine physical exam, in addition to the annual wellness visit, once a year. This exam includes a detailed medical/family history and the performance of a detailed head to toe assessment with hands-on examination of all the body systems. Additional services include, as appropriate, follow-up orders or referrals to other practitioners, lab tests, clinical screenings, EKG, recommendations for preventive screenings, vaccination(s), and counseling about healthy behaviors.	$0 copay for an annual physical exam (1 per calendar year).
 **Annual wellness visit** If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note**: Your first annual wellness visit can't take place within 12 months of your *Welcome to Medicare* preventive visit. However, you don't need to have had a *Welcome to Medicare* visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.
 **Bone mass measurement** For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.

Covered Service	What you pay
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.	
 **Breast cancer screening (mammograms)** Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women aged 40 and older • Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for covered screening mammograms.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	$0 copay for each Medicare-covered cardiac or intensive cardiac rehabilitation visit.
 **Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)** 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.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
 **Cardiovascular disease screening tests** Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.
 **Cervical and vaginal cancer screening** Covered services include:	There is no coinsurance, copayment, or deductible for

Covered Service	What you pay
• For all women: Pap tests and pelvic exams are covered once every 24 months • If you're at high risk of cervical or vaginal cancer or you're of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months	Medicare-covered preventive Pap and pelvic exams.
Chiropractic services *Prior authorization may be required for Medicare-covered chiropractic services only.* Covered services include: • Manual manipulation of the spine to correct subluxation	$0 copay for each Medicare-covered chiropractic visit.
Chronic pain management and treatment services Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning.	Cost sharing for this service will vary depending on individual services provided under the course of treatment. Please consult the Medical Benefits Chart for cost-sharing amounts. These services will most likely be provided through a PCP or Specialist and your cost sharing would be: $0 copay for each Medicare-covered Primary Care Provider visit or each telehealth visit. $0 copay for each Medicare-covered Specialist visit or each telehealth visit.
 **Colorectal cancer screening** The following screening tests are covered:	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. If your

Covered Service	What you pay
• Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 year and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare-covered non-invasive stool-based colorectal cancer screening test returns a positive result.	doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam. You pay the cost-sharing of your provider office visit and services or outpatient hospital services. $0 copay for each Medicare-covered barium enema.

Covered Service	What you pay
• Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.	
Dental services *Clinical review may be required for non-preventive dental services.* In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation.	$0 copay for Medicare-covered comprehensive dental services.
 **Depression screening** We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.
 **Diabetes screening** We cover this screening (includes fasting glucose tests) if you have any of these 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. You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.

Covered Service	What you pay
Diabetes self-management training, diabetic services, and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • For people with diabetes who have severe diabetic foot disease: one pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts, or one pair of depth shoes and 3 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. CareFirst BlueCross BlueShield Group Advantage covers True Metrix and Accu-Chek products such as blood glucose monitors and blood glucose test strips that are available at network pharmacies with a valid prescription. Dexcom and FreeStyle Libre continuous glucose monitors and supplies are available at participating pharmacies with a valid prescription. We may apply quantity limits for certain diabetic supplies. If the request exceeds the quantity limits, a review may be required. Please note, other test strip and blood glucose monitor brands may be available at a contracted DME provider with a valid provider order.	$0 copay for Medicare-covered diabetic supplies. $0 copay for Medicare-covered therapeutic shoes and inserts. $0 copay for each Medicare-covered diabetes self-management training.
Durable medical equipment (DME) and related supplies *Prior authorization may be required and is the responsibility of the provider or supplier.* (For a definition of durable medical equipment, go to Chapter 12 and Chapter 3)	$0 copay for Medicare-covered items. Your cost sharing for Medicare oxygen equipment coverage is $0 copay for Medicare-covered items every month.

Covered Service	What you pay
Covered items include, but aren't 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. 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 can ask them if they can special order it for you. The most recent list of suppliers is available on our website at www.carefirst.com/myaccount.	Your cost sharing won't change after you're enrolled for 36 months. If you made 36 months of rental payment for oxygen equipment coverage before you enrolled in CareFirst BlueCross BlueShield Group Advantage, your cost sharing in CareFirst BlueCross BlueShield Group Advantage is $0.
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. 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're 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's quickly getting worse. Cost sharing for necessary emergency services you get out-of-network is the same as when you get these services furnished in-network. Emergency care is covered worldwide. Only benefits rendered in an emergency room setting are covered. If you are admitted, inpatient benefits related to your emergency are not covered by the plan. If you have an emergency service outside the U.S. and its territories, you will be responsible for payment at the time services are rendered. You may then submit your claims and proof of payment for reimbursement consideration (minus	$0 copay for each Medicare-covered emergency room visit. Copay is waived if you are admitted to the hospital within 24 hours for the same condition. **Worldwide Emergency Coverage:** **Worldwide Emergency benefits do NOT count toward your maximum out-of-pocket (MOOP).** $0 copay for each worldwide emergency room visit. $50,000 combined annual limit for emergency and urgent care services provided outside the U.S. and its territories. Copay is waived if you are admitted to the hospital for the worldwide emergency or urgent care coverage.

Covered Service	What you pay
any applicable member cost sharing). Transportation and repatriation are not covered. For more information please see Chapter 7 (Section 1).	
Health and wellness education programs Our health and wellness programs are designed to enrich the health and quality of life of members. These programs are focused on improving health outcomes, including chronic conditions. Our plan covers: - **24-Hour Nurse Advice Line -** Registered nurses are available 24/7 (24 hours, 7 days a week) to discuss your symptoms with you and recommend the most appropriate care. Call 833-968-1773 anytime day or night to speak with a nurse. - **Access to CareFirst's Health Library (https://www.carefirst.com/wellness)** with helpful information about health management and wellness, as well as links to exclusive CareFirst resources. - **In-Home Assessment -** A targeted annual assessment to complete a comprehensive evaluation of your health status in the convenience of your home with an advanced clinician. This evaluation will be shared with your PCP to help initiate proactive care services to help manage your health throughout the year. Receive assistance to review and support any immediate health needs you may have, research and help take full advantage of navigating Health Plan Benefits. For more information please contact 1-800-558-9922 (TTY: 711). **Fitness benefit (SilverSneakers)** **SilverSneakers® Membership** SilverSneakers can help you live a healthier, more active life through fitness and social connection. You are covered for a fitness benefit through SilverSneakers at participating locations, where you can take classes[1] and use exercise equipment and other amenities[2], at no additional cost to you. Enroll in as many locations as you like, at any time. You also	$0 copay for all listed services. Benefit is covered through plan contracted vendor only.

Covered Service	What you pay
have access to instructors who lead specially designed group exercise online classes, seven days a week with SilverSneakers LIVE. Additionally, SilverSneakers Community gives you options to get active outside of traditional gyms at recreation centers, parks and other neighborhood locations. SilverSneakers also connects you to a support network and online resources through SilverSneakers On-Demand videos and the SilverSneakers GO mobile app. Activate your free online account at SilverSneakers.com to view your SilverSneakers Member ID number and explore everything SilverSneakers has to offer. For additional questions, go to SilverSneakers.com or call 1-888-423-4632 (TTY: 711) Monday through Friday, 8 a.m. to 8 p.m. ET. **Always talk with your doctor before starting an exercise program.** [1]Participating locations ("PL") are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL. Inclusion of specific PLs is not guaranteed and PL participation may differ by health plan. [2]Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location. SilverSneakers is a registered trademark of Tivity Health, Inc. © 2025 Tivity Health, Inc. All rights reserved.	
Hearing services Diagnostic hearing and balance evaluations performed by your PCP or provider to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. In addition to Medicare-covered benefits, we also cover the following through NationsHearing: • Routine hearing exams: one exam every year • Hearing aids • Hearing aid fitting evaluations: one hearing aid fitting/ evaluation every year Hearing aid purchases include:	$0 copay for each Medicare-covered exam to diagnose and treat hearing and balance issues. $0 copay for a routine hearing exam (once per calendar year). $0 copay for a fitting and evaluation for a hearing aid visit (once per calendar year). Hearing Aids: $0 per entry level hearing aid

Covered Service	What you pay
• 3 follow-up visits within first year of initial fitting date • 60-day trial period from date of fitting • 60 batteries per hearing aid (3-year supply) • 3-year manufacturer repair warranty • 1-time replacement coverage for lost, stolen or damaged hearing aid (deductible may apply per aid) • First set of ear molds (when needed) Our plan has contracted with NationsHearing to provide your non-Medicare-coverage hearing services. You must obtain your hearing aids from a NationsHearing provider. Please contact NationsHearing by phone at (877) 246-1666 (TTY: 711) for more information or to schedule an appointment.	$0 per basic level hearing aid $0 per prime level hearing aid $0 per preferred level hearing aid $150 per advanced level hearing aid $950 per premium level hearing aid Non-Medicare covered/ routine services do not count towards your maximum-out-of-pocket (MOOP).
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months If you are pregnant, we cover: • Up to 3 screening exams during a pregnancy	There's no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home health agency care *Prior authorization may be required and is the responsibility of the provider.* Before you get 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. Covered services include, but aren't limited to: • 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)	$0 copay for Medicare-covered home health visits.

Covered Service	What you pay
• Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	
Home infusion therapy *Prior authorization may be required and is the responsibility of the provider or supplier.* Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person 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). Covered services include, but aren't limited to: • Professional services, including nursing services, furnished in accordance with our plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	$0 copay for each Medicare-covered visit.
Hospice care You're 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 can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care	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 CareFirst BlueCross BlueShield Group Advantage.

Covered Service	What you pay
When you're admitted to a hospice, you have the right to stay in our plan; if you stay in our plan you must continue to pay plan premiums. **For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis:** 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're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost sharing. **For services covered by Medicare Part A or B not related to your terminal prognosis**: If you need non-emergency, non-urgently needed services covered under Medicare Part A or B that aren't related to your terminal prognosis, your cost for these services depends on whether you follow plan rules (like if there's a requirement to get prior authorization). • If you follow plan rules for obtaining service, you only pay the plan cost-sharing amount for in-network services. **For services covered by CareFirst BlueCross BlueShield Group Advantage but not covered by Medicare Part A or B:** CareFirst BlueCross BlueShield Group Advantage will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our plan cost-sharing amount for these services. **For drugs that may be covered by our plan's Part D benefit:** If these drugs are unrelated to your terminal hospice condition, you pay cost sharing. If they're related to your terminal hospice condition, you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, go to Chapter 5, Section 9.4). **Note:** If you need non-hospice care (care that's not related to your terminal prognosis), contact us to arrange the services.	

Covered Service	What you pay
Immunizations Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you're at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover most other adult vaccines under our Part D drug benefit. Go to Chapter 6, Section 8 for more information.	There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines.
Inpatient hospital care *Prior authorization may be required and is the responsibility of the provider.* Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. There is no limit to the number of days covered by our plan. Covered services include but aren't limited to: • 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	For each Medicare-covered inpatient hospital stay: $0 copay per admission/stay.

Covered Service	What you pay
• Inpatient substance abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're 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 CareFirst BlueCross BlueShield Group Advantage 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'll arrange or pay for appropriate lodging and transportation costs for you and a companion. All CareFirst Medicare Advantage plans provide coverage for travel and lodging related organ transplant for eligible members with an approved prior authorization for a covered Medicare organ transplant provided at a distant location. Members need to contact the plan to discuss their options locally before a distant location, travel, and lodging may be approved. The benefit period for a covered transplant begins five days prior to the transplant and extends through the patient's transplant episode of care (not to exceed one year from the date of the transplant). Travel and lodging expenses are covered for the recipient (exclusive of inpatient hospital admission) and companion, subject to eligibility of the recipient and an approved prior authorization. The combined total maximum reimbursement allowed for travel and lodging per transplant episode of care is $5,000 a year. Lodging expenses are limited up to $150 per day, which applies to the combined $5,000 annual maximum. Please refer to the Reimbursement Policy for Transplant Services for more information.	

Covered Service	What you pay
• Blood - including storage and administration. Coverage of whole blood and packed red cells starts with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you're not sure if you're an inpatient or an outpatient, ask the hospital staff. Get more information in the Medicare fact sheet *Medicare Hospital Benefits*. This fact sheet is available at www.Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	
Inpatient services in a psychiatric hospital *Prior authorization may be required and is the responsibility of the provider.* Covered services include mental health care services that require a hospital stay. • Medicare limits covered inpatient mental health services provided in a psychiatric hospital to a maximum of 190 days. These 190 days are referred to as a "lifetime limit." • The 190-day lifetime limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital. • Our plan covers 90 days of inpatient mental health care services per admission. We also cover 60 extra days over your lifetime. These are called "lifetime reserve days." If you need more than 90 days of inpatient mental health care, you may use your lifetime reserve days. Once these lifetime reserve days have all been used, your coverage for inpatient mental health care will be limited to 90 days per admission.	For each Medicare-covered inpatient psychiatric hospital stay: $0 per admission/stay.
Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay *Prior authorization may be required and is the responsibility of the provider.*	You pay the applicable cost sharing for services as though they were provided on an outpatient basis. Please refer

Covered Service	What you pay
If you've used up your inpatient benefits or if the inpatient stay isn't reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you get while you're in the hospital or the skilled nursing facility (SNF). Covered services include, but aren't limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses; and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	to the applicable benefit in the Medical Benefits Chart of this Evidence of Coverage.
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during the first year you get 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 get 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.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.

Covered Service	What you pay
Medicare Diabetes Prevention Program (MDPP) **MDPP services are covered for eligible people 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 drugs *Prior authorization may be required and is the responsibility of the provider.* **These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include:** • Drugs that usually aren't self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical center services. • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump). • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan. • The Alzheimer's drug, Leqembi®, (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment. • Clotting factors you give yourself by injection if you have hemophilia. • Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D drug coverage covers immunosuppressive drugs if Part B doesn't cover them.	$0 copay for Medicare-covered chemotherapy drugs. $0 copay for Medicare-covered Part B insulin or other Part B drugs. Medicare Part B drugs may be subject to step therapy requirements.

Covered Service	What you pay
• Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug. • Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision. • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does. • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug. • Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B. • Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv® and the oral medication Sensipar®. • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary and topical anesthetics. • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa, Mircera®, or Methoxy polyethylene glycol-epoetin beta). • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases. • Parenteral and enteral nutrition (intravenous and tube feeding).	

Covered Service	What you pay
This link will take you to a list of Part B Drugs that may be subject to Step Therapy: www.carefirst.com/medicare-options/compare-medicare-plans/medicare-part-b-prescription-drugs.html. We also cover some vaccines under our Part B and most adult vaccines under our Part D drug benefit. Chapter 5 explains our Part D drug benefit, including rules you must follow to have prescriptions covered. What you pay for Part D drugs through our plan is explained in Chapter 6.	
Obesity screening and therapy to promote sustained weight loss 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.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • 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	$0 copay for each opioid treatment program service.
Outpatient diagnostic tests and therapeutic services and supplies *Prior authorization may be required for non-routine tests and services.*	$0 copay for each Medicare-covered diagnostic procedure or test.

Covered Service	What you pay
Covered services include, but aren't limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem. • Other outpatient diagnostic tests	$0 copay for each Medicare-covered lab service (per day per facility). $0 copay for each Medicare-covered diagnostic radiological service. $0 copay for each Medicare-covered nuclear medicine service. $0 copay for each Medicare-covered therapeutic radiological service. $0 copay for each Medicare-covered X-ray service. $0 copay for Medicare-covered blood services. $0 copay of the total cost for Medicare-covered prosthetic devices and medical supplies related to prosthetics, splints, and other devices.
Outpatient hospital observation *Prior authorization may be required and is the responsibility of the provider.* Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.	$0 copay for each Medicare-covered outpatient hospital observation.

Covered Service	What you pay
Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you're 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 aren't sure if you're an outpatient, ask the hospital staff. Get more information in the Medicare fact sheet *Medicare Hospital Benefits*. This fact sheet is available at www.Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	
Outpatient hospital services *Prior authorization may be required and is the responsibility of the provider.* 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 aren't limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're 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 aren't sure if you're an outpatient, you should ask the hospital staff.	$0 copay for select outpatient hospital services. $0 copay for select services received at an Ambulatory Surgical Center. To see the cost-sharing amounts you will pay, refer to other sections of the Medical Benefits Chart for services that could apply in an outpatient hospital setting, such as: • Partial hospitalization • Emergency care • Medicare Part B prescription drugs • Durable Medical Equipment • Outpatient diagnostic tests and therapeutic services and supplies, including lab and x-ray • Outpatient surgery
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social	$0 copay for each Medicare-covered individual therapy visit with any type of

Covered Service	What you pay
worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.	mental health professional or each telehealth visit. $0 copay for each Medicare-covered group therapy visit with any type of mental health professional or each telehealth visit.
Outpatient rehabilitation services *Prior authorization may be required and is the responsibility of the provider.* Covered services include physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	$0 copay for each Medicare-covered occupational therapy, physical therapy, or speech language therapy visit.
Outpatient substance use disorder services Outpatient substance use disorder services include various levels of care, to include: • Office-based outpatient treatment • Intensive outpatient programs (IOP) • Partial hospitalization programs (PHP) • Residential treatment • Inpatient care, including detoxification. All levels of care may include individual and/or group counseling and medication-assisted treatments.	$0 copay for each Medicare-covered individual outpatient substance abuse treatment visit. $0 copay for each Medicare-covered group outpatient substance abuse treatment visit.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers *Prior authorization may be required and is the responsibility of the provider.* **Note:** If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if	$0 copay for each Medicare-covered outpatient hospital facility visit. $0 copay for each Medicare-covered Ambulatory Surgical Center visit.

Covered Service	What you pay
you stay in the hospital overnight, you might still be considered an outpatient.	
Partial hospitalization services and Intensive outpatient services *Prior authorization may be required and is the responsibility of the provider.* *Partial hospitalization* is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. *Intensive outpatient service* is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a federally qualified health center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.	$0 copay for each Medicare-covered partial hospitalization or intensive outpatient services.
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically necessary medical care or surgery services you get in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment • Certain telehealth services, including: Primary Care Provider, Specialist, Mental Health Care (individual or group), and Mental Health Care with a Psychologist (individual or group), and urgently needed services. Services will only be provided via telehealth when	$0 copay for each Medicare-covered Primary Care Provider visit or each telehealth visit. $0 copay for each Medicare-covered Specialist visit or each telehealth visit. $0 copay for each Medicare-covered individual therapy visit with any type of mental health professional or each telehealth visit. $0 copay for each Medicare-covered group therapy visit with any type of mental health professional or each telehealth visit.

Covered Service	What you pay
deemed clinically appropriate by the network provider rendering the service. ◦ 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 may use an in or out-of-network provider who offers the service by telehealth. ◦ We offer the following means of telehealth: ▪ Interactive video visits for professional services when care can be provided in this format as determined by an in-network or out-of-network provider • 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 • 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: ◦ 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 getting 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:**	$0 copay for each Medicare-covered urgent care visit in-person or via telehealth.

Covered Service	What you pay
◦ 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 sent to your doctor, and interpretation and follow-up by your doctor within 24 hours **if:** ◦ 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 • Second opinion by another network provider prior to surgery	
Podiatry services Covered services include: • 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 In addition to Medicare-covered podiatry services above, we also offer: • Non-Medicare routine podiatry care for members with any medical condition affecting the lower limbs	$0 copay for each Medicare-covered podiatry visit.
Pre-exposure prophylaxis (PrEP) for HIV prevention If you don’t have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include:	There is no coinsurance, copayment, or deductible for the PrEP benefit.

Covered Service	What you pay
• FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug. • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to 8 HIV screenings every 12 months. • A one-time hepatitis B virus screening.	
 **Prostate cancer screening exams** For men, age 50 and older, covered services include the following once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for an annual PSA test. $0 copay for each Medicare-covered digital rectal exam.
Prosthetic and orthotic devices and related supplies *Prior authorization may be required and is the responsibility of the provider or supplier.* Devices (other than dental) that replace all or part of a body part or function. These include but aren't limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as 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 and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to *Vision Care later* in this table for more detail. Includes wigs following chemotherapy or radiation therapy (up to $350 benefit annually).	$0 copayment of the total cost for Medicare-covered prosthetic devices and medical supplies related to prosthetics, splints, and other devices.
Pulmonary rehabilitation services 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.	$0 copay for each Medicare-covered pulmonary rehabilitation service.

Covered Service	What you pay
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults (including pregnant women) who misuse alcohol, but aren't alcohol dependent. 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.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified people, a LDCT is covered every 12 months. **Eligible members are** people age 50 – 77 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 get an 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. *For LDCT lung cancer screenings after the initial LDCT screening:* the members must get an 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 later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision-making visit or for the LDCT.
Screening for Hepatitis C Virus infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus.

Covered Service	What you pay
• You had a blood transfusion before 1992. • You were born between 1945-1965. If you were born between 1945-1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. 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.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
Services to treat kidney disease Covered services include: • 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 6 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're 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.	$0 copay for Medicare-covered kidney disease education services. $0 copay for each Medicare-covered renal dialysis visit.

Covered Service	What you pay
• 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). Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, go to **Medicare Part B drugs** in this table.	
Skilled nursing facility (SNF) care *Prior authorization may be required and is the responsibility of the provider.* (For a definition of skilled nursing facility care, go to Chapter 12. Skilled nursing facilities are sometimes called SNFs.) We cover up to 100 days per benefit period of skilled nursing inpatient services in a skilled nursing facility in accord with Medicare guidelines. A prior hospital stay is not required. Covered services include but aren't limited to: • 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 our 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. All other components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you get SNF care from network facilities. Under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn’t a network	For each Medicare-covered Skilled Nursing Facility stay: $0 copay per day for days 1 to 100

Covered Service	What you pay
provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital	
 **Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)** Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: • Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • Are competent and alert during counseling • A qualified physician or other Medicare-recognized practitioner provides counseling We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.)	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD). Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • 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	$0 copay for each Medicare-covered supervised exercise therapy visit.

Covered Service	What you pay
• 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 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.	
Urgently needed services A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or, even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable. Urgently needed services are covered worldwide. Only benefits rendered in an urgent care setting are covered. If you are admitted, inpatient benefits related to your urgent care visit are not covered by the plan. If you have an emergency service outside the U.S. and its territories, you will be responsible for payment at the time services are rendered. You may then submit your claims and proof of payment for reimbursement consideration (minus any applicable member cost sharing). Transportation and repatriation are not covered. For more information please see Chapter 7 (Section 1).	$0 copay for each Medicare-covered urgent care visit in-person or via telehealth. Copay is waived if you are admitted to the hospital within 48 hours for the same condition. **Worldwide Urgently Needed Services:** **Worldwide Urgently needed services do NOT count toward your maximum out-of-pocket (MOOP).** $0 copay for each worldwide urgent care visit. $50,000 combined annual limit for emergency and urgent care services provided outside the U.S. and its territories. Copay is waived if you are admitted to the hospital for the worldwide emergency or urgent care coverage.
Vision care Covered services include:	$0 copay for each Medicare-covered eye exam to diagnose and treat diseases and conditions of the eye.

Covered Service	What you pay
• 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 for glaucoma, we 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. • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. If you have 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery. We also provide routine vision coverage through Davis Vision: • Diabetic eye exam • Routine eye exam • Additional eyewear that includes prescription lenses and one pair of eyeglass frames or contact lenses. For more details about the routine vision coverage and allowances, please contact Davis Vision at 888-573-2990 (TTY: 711).	$0 copay for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery. $0 copay for each Medicare-covered glaucoma screening visit. $0 copay for each diabetic eye exam (one per calendar year). $0 copay for each routine eye exam (includes dilation & refraction) from a Davis Vision provider (one per calendar year). $40 reimbursement out-of-network. Additional Eyewear Coverage In-network: Eyewear (Frames and Lenses): - $0, $15, or $40 for select frames purchased from Davis Vision's exclusive collection. - $200 or $250 at Visionworks plus a 20% discount on any overage for any other frames annually. - $0 copay for Single Vision, Bifocal, Trifocal, and Lenticular lenses annually. Contacts (Medical and Elective): - $0 for contact lenses that are medically necessary covered through Davis Vision.

Covered Service	What you pay
	- $200 plus 15% off balance for elective contact lenses annually. - 15% discount for contact lens evaluation and fitting for standard contacts. - 15% discount for contact lens evaluation and fitting for specialty contacts. Out-of-network: Eyewear (Frames and Lenses): - $88 for any other frames annually. - $40, $60, $80 or $100 copay depending on the type of lenses selected for Single Vision, Bifocal, Trifocal, and Lenticular lenses annually. Contacts (Medical and Elective): - If contact lenses are medically necessary they will be covered via a $240 reimbursement. - $136 for elective contact lenses annually. - Contact lens evaluation and fitting for standard and specialty contacts not covered. Non-Medicare covered / routine services do not count toward your maximum-out-of-pocket (MOOP). The vision benefit

Covered Service	What you pay
	cannot be combined with any provider offered discounts or promotions. Insurance must be used at time of sale for benefits to apply.
Welcome to Medicare preventive visit Our 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 preventive services you need (including certain screenings and shots (or vaccines)), and referrals for other care if needed. **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 want to schedule your *Welcome to Medicare* preventive visit.	There is no coinsurance, copayment, or deductible for the *Welcome to Medicare* preventive visit.

SECTION 3 Services that aren't covered by our plan (exclusions)

This section tells you what services are *excluded* from Medicare coverage, and therefore, aren't covered by this plan.

The chart below lists services and items that either aren't 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 get the excluded services at an emergency facility, the excluded services are still not covered, and our plan won't 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 made to not cover a medical service, go to Chapter 9, Section 5.3.)

Services not covered by Medicare	Covered only under specific conditions
Acupuncture	Available for people with chronic low back pain under certain circumstances.
Cosmetic surgery or procedures	Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member.

Services not covered by Medicare	Covered only under specific conditions
	Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Custodial care Custodial care is personal care that doesn't 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	Not covered under any condition
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.	May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
Fees charged for care by your immediate relatives or members of your household.	Not covered under any condition
Full-time nursing care in your home.	Not covered under any condition
Home-delivered meals	Not covered under any condition
Homemaker services including basic household help, such as light housekeeping or light meal preparation.	Not covered under any condition
Naturopath services (uses natural or alternative treatments).	Not covered under any condition
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.

Services not covered by Medicare	Covered only under specific conditions
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	Not covered under any condition
Private room in a hospital.	Covered only when medically necessary.
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	Not covered under any condition
Routine chiropractic care	Manual manipulation of the spine to correct a subluxation is covered.
Routine dental care, such as cleanings, fillings or dentures.	Not covered under any condition
Routine foot care	Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes).
Services considered not reasonable and necessary, according to Original Medicare standards	Not covered under any condition

CHAPTER 5:
Using plan coverage for Part D drugs

SECTION 1 Basic rules for our plan's Part D drug coverage

Go to the Medical Benefits Chart in Chapter 4 for Medicare Part B drug benefits and hospice drug benefits.

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

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription, that's valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription. (Go to Section 2 or you can fill your prescription through the plan's mail-order service.)
- Your drug must be on our plan's Drug List (go to Section 3).
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that's either approved by the FDA or supported by certain references. (Go to Section 3 for more information about a medically accepted indication.)
- Your drug may require approval from our plan based on certain criteria before we agree to cover it. (Go to Section 4 for more information.)

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

In most cases, your prescriptions are covered *only* if they're filled at our plan's network pharmacies. (Go to Section 2.5 for information about when we cover prescriptions filled at out-of-network pharmacies.)

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

Section 2.1 Network pharmacies

Find a network pharmacy in your area

To find a network pharmacy, go to your *Pharmacy Directory*, visit our website (www.carefirst.com/myaccount), and/or call Pharmacy Member Services at 888-970-0917 (TTY users call 711).

You may go to any of our network pharmacies.

If your pharmacy leaves the network

If the pharmacy you use leaves our plan's network, you'll have to find a new pharmacy in the network. To find another pharmacy in your area, call Pharmacy Member Services at 888-970-0917 (TTY users call 711) or use the *Pharmacy Directory*. You can also find information on our website at www.carefirst.com/myaccount.

Specialized pharmacies

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you have difficulty getting Part D drugs in an LTC facility, call Pharmacy Member Services at 888-970-0917 (TTY users call 711).
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs restricted by the FDA to certain locations or that require special handling, provider coordination, or education on its use. To locate a specialized pharmacy, go to your *Pharmacy Directory* at www.carefirst.com/myaccount or call Pharmacy Member Services at 888-970-0917 (TTY users call 711).

Section 2.2 Our plan's mail-order service

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

Our plan's mail-order service allows you to order **up to a 100-day supply for Tier 1 drugs and up to a 90-day supply for Tiers 2-3 drugs.**

To get order forms and information about filling your prescriptions by mail, contact Pharmacy Member Services at 888-970-0917 (TTY users call 711).

Usually, a mail-order pharmacy order will be delivered to you in no more than 10 days. If the mail-order pharmacy expects the order to be delayed, they will notify you of the delay. If you need to request a rush order because of a mail-order delay, you may contact Pharmacy Member Services to discuss options which may include filling at a local retail pharmacy or expediting the shipping method. Provide the representative with your ID number and prescription number(s). If you want second day or next day delivery of your medications, you may request this from the Pharmacy Member Services representative for an additional charge.

New prescriptions the pharmacy gets directly from your doctor's office.
The pharmacy will automatically fill and deliver new prescriptions it gets from healthcare providers, without checking with you first, if either:

- You used mail-order services with this plan in the past, or
- You sign up for automatic delivery of all new prescriptions received directly from healthcare providers. You may request automatic delivery of all new prescriptions at any time by contacting Pharmacy Member Services (phone numbers are printed on the back cover of this document).

If you get a prescription automatically by mail that you don't want, and you were not contacted to see if you wanted it before it shipped, you may be eligible for a refund.

If you used mail order in the past and don't want the pharmacy to automatically fill and ship each new prescription, contact us by calling Pharmacy Member Services at 888-970-0917 (TTY users call 711).

If you have never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a healthcare provider to see if you want the medication filled and shipped immediately. It is important that you respond each time you are contacted by the pharmacy to let them know whether to ship, delay, or cancel the new prescription.

To opt out of automatic deliveries of new prescriptions received directly from your health care provider's office, contact us by calling Pharmacy Member Services at 888-970-0917 (TTY users call 711).

Refills on mail order prescriptions. For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program, we will start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you prior to shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed.

If you choose not to use our auto- refill program but still want the mail-order pharmacy to send you your prescription, please contact your pharmacy 15 days before your current prescription will run out. This will ensure your order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, please contact us by calling Pharmacy Member Services at 888-970-0917 (TTY users call 711).

If you receive a refill automatically by mail that you do not want, you may be eligible for a refund.

Section 2.3 How to get a long-term supply of drugs

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

1. **Some retail pharmacies** in our network allow you to get a long-term supply of maintenance drugs. Your *Pharmacy Directory* available at *www.carefirst.com/myaccount* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Pharmacy Member Services at 888-970-0917 (TTY users call 711) for more information.
2. You may also get maintenance drugs through our mail-order program. Please see Section 2.2 for more information.

Section 2.4 Using a pharmacy that's not in our plan's network

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you aren't able to use a network pharmacy. **Check first with Pharmacy Member Services 888-970-0917 (TTY users call 711)** to see if there's a network pharmacy nearby.

We cover prescriptions filled at an out-of-network pharmacy only in these circumstances:

- The prescription is for a medical emergency or urgent care.
- You are unable to get a covered drug in a time of need because there are no 24-hour network pharmacies within a reasonable driving distance.
- The prescription is for a drug that is out of stock at an accessible network retail or mail service pharmacy (including high-cost and unique drugs).
- If you are evacuated or otherwise displaced from your home because of a Federal disaster or other public health emergency declaration.
- A vaccine or drug is administered in your doctor's office.

Even if we do cover the drugs you get at an out-of-network pharmacy, you may still pay more than you would have paid if you had gone to an in-network pharmacy.

If you do need to go to an out-of-network pharmacy for any of the reasons listed above, the plan will cover up to a 30-day supply of drugs.

If you must use an out-of-network pharmacy, you'll generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Go to Chapter 7, Section 2 for information on how to ask our plan to pay you back.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost we would cover at an in-network pharmacy.

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

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

Our plan has a *List of Covered Drugs* (formulary). In this *Evidence of Coverage*, **we call it the Drug List.**

The drugs on this list are selected by our plan with the help of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare. The Drug List only shows drugs covered under Medicare Part D.

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

- Approved by the FDA for the diagnosis or condition for which it's prescribed, or
- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System.

The Drug List includes brand name drugs, generic drugs, and biological products (which may include biosimilars).

A brand name drug is a prescription drug sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. On the Drug List, when we refer to drugs, this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Biological products have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as the brand name drug or original biological product and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

Go to Chapter 12 for definitions of the types of drugs that may be on the Drug List.

Drugs that aren't on the Drug List

Our plan doesn't cover all prescription drugs.

- In some cases, the law doesn't allow any Medicare plan to cover certain types of drugs. (For more information, go to Section 7.)
- In other cases, we decided not to include a particular drug on the Drug List.
- In some cases, you may be able to get a drug that's not on the Drug List. (For more information, go to Chapter 9.)

Section 3.2 Four cost-sharing tiers for drugs on the Drug List

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

- **Tier 1 – Generic:** is the lowest tier and includes most generic drugs and may include some brand drugs.
- **Tier 2 – Preferred Brand:** includes preferred brand drugs and non-preferred generic drugs.

- **Tier 3 – Non-Preferred Drug:** includes non-preferred brand and generic drugs.
- **Tier 4 – Specialty:** is the highest tier and includes high-cost brand and generic drugs.

To find out which cost-sharing tier your drug is in, look it up in our plan's Drug List. The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6.

Section 3.3 How to find out if a specific drug is on the Drug List

To find out if a drug is on our Drug List, you have these options:

- Check the most recent Drug List we provided electronically.
- Visit our plan's website (www.carefirst.com/myaccount). The Drug List on the website is always the most current.
- Call Pharmacy Member Services at 888-970-0917 (TTY users call 711) to find out if a particular drug is on our plan's Drug List or to ask for a copy of the list.
- Use our plan's "Real-Time Benefit Tool" (www.carefirst.com/myaccount) to search for drugs on the Drug List to get an estimate of what you'll pay and see if there are alternative drugs on the Drug List that could treat the same condition. You can also call Pharmacy Member Services at 888-970-0917 (TTY users call 711).

SECTION 4 Drugs with restrictions on coverage

Section 4.1 Why some drugs have restrictions

For certain prescription drugs, special rules restrict how and when our plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective ways. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List.

If a safe, lower-cost drug will work just as well medically as a higher-cost drug, our plan's rules are designed to encourage you and your provider to use that lower-cost option.

Note that sometimes a drug may appear more than once in our Drug List. This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your health care provider, and different restrictions or cost sharing may apply to the different versions of the drug (for example, 10 mg versus 100 mg; one per day versus 2 per day; tablet versus liquid).

Section 4.2 Types of restrictions

If there's a restriction for your drug, it usually means that you or your provider have to take extra steps for us to cover the drug. Call Pharmacy Member Services at 888-970-0917 (TTY users call 711) to learn what you or your provider can do to get coverage for the drug. **If you want us to waive the restriction for you, you need to use the coverage decision process**

and ask us to make an exception. We may or may not agree to waive the restriction for you (go to Chapter 9).

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from our plan based on specific criteria before we agree to cover the drug for you. This is called **prior authorization**. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you don't get this approval, your drug might not be covered by our plan. Our plan's prior authorization criteria can be obtained by calling Pharmacy Member Services at 888-970-0917 (TTY users call 711) or on our website www.carefirst.com/learngroupma.

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before our plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, our plan may require you to try Drug A first. If Drug A doesn't work for you, our plan will then cover Drug B. This requirement to try a different drug first is called **step therapy**. Our plan's step therapy criteria can be obtained by calling Pharmacy Member Services at 888-970-0917 (TTY users call 711) or on our website www.carefirst.com/myaccount.

Quantity limits

For certain drugs, we limit how much of a drug you can get each time you fill your prescription. For example, if it's normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

SECTION 5 What you can do if one of your drugs isn't covered the way you'd like

There are situations where a prescription drug you take, or that you and your provider think you should take, isn't on our Drug List or has restrictions. For example:

- The drug might not be covered at all. Or a generic version of the drug may be covered but the brand name version you want to take isn't covered.
- The drug is covered, but there are extra rules or restrictions on coverage.
- The drug is covered, but it is in a cost-sharing tier that makes your cost sharing more expensive than you think it should be.

If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.1 to learn what you can do.

If your drug isn't on the Drug List or is restricted, here are options for what you can do:

- You may be able to get a temporary supply of the drug.
- You can change to another drug.

- You can ask for an **exception** and ask our plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, our plan must provide a temporary supply of a drug you're already taking. This temporary supply gives you time to talk with your provider about the change.

To be eligible for a temporary supply, the drug you take **must no longer be on our plan's Drug List OR is now restricted in some way.**

- **If you're a new member,** we'll cover a temporary supply of your drug during the first 90 days of your membership in our plan.
- **If you were in our plan last year,** we'll cover a temporary supply of your drug during the first 90 days of the calendar year.
- This temporary supply will be for a maximum of a 30 day supply. If your prescription is written for fewer days, we'll allow multiple fills to provide up to a maximum of a 30 day supply of medication. The prescription must be filled at a network pharmacy. (Note that a long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For members who've been in our plan for more than 90 days and live in a long-term care facility and need a supply right away:** We'll cover one 31 day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.
- If you experience a change in your setting of care (such as being discharged or admitted to a long-term care facility), your physician or pharmacy can request a temporary supply of the drug. This temporary supply (up to 31 days) will allow you time to talk with your doctor about the change in coverage.

For questions about a temporary supply, call Pharmacy Member Services at 888-970-0917 (TTY users call 711).

During the time when you're using a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You have 2 options:

Option 1. You can change to another drug

Talk with your provider about whether a different drug covered by our plan may work just as well for you. Call Pharmacy Member Services at 888-970-0917 (TTY users call 711) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

Option 2. You can ask for an exception

You and your provider can ask our plan to make an exception and cover the drug in the way you'd like it covered. If your provider says you have medical reasons that justify asking us for an exception, your provider can help you ask for an exception. For example, you can ask

our plan to cover a drug even though it is not on our plan's Drug List. Or you can ask our plan to make an exception and cover the drug without restrictions.

If you're a current member and a drug you take will be removed from the formulary or restricted in some way for next year, we'll tell you about any change before the new year. You can ask for an exception before next year and we'll give you an answer within 72 hours after we get your request (or your prescriber's supporting statement). If we approve your request, we'll authorize coverage for the drug before the change takes effect.

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

Section 5.1 What to do if your drug is in a cost-sharing tier you think is too high

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

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, talk to your provider. There may be a different drug in a lower cost-sharing tier that might work just as well for you. Call Pharmacy Member Services at 888-970-0917 (TTY users call 711) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can ask for an exception

You and your provider can ask our plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says you have medical reasons that justify asking us for an exception, your provider can help you ask for an exception to the rule.

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

Drugs in our Specialty Tier 4 aren't eligible for this type of exception. We don't lower the cost-sharing amount for drugs in this tier. Prescription drugs covered under our enhanced drug coverage (see Section 7) are also not eligible for this type of tiering exception.

SECTION 6 Our Drug List can change during the year

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

- **Add or remove drugs from the Drug List.**
- **Move a drug to a higher or lower cost-sharing tier.**
- **Add or remove a restriction on coverage for a drug**.
- **Replace a brand name drug with a generic version of the drug.**

- **Replace an original biological product with an interchangeable biosimilar version of the biological product.**

We must follow Medicare requirements before we change our plan's Drug List.

Information on changes to drug coverage

When changes to the Drug List occur, we post information on our website about those changes. We also update our online Drug List regularly. Sometimes you'll get direct notice if changes are made to a drug you take.

Changes to drug coverage that affect you during this plan year

- **Adding new drugs to the Drug List and immediately removing or making changes to a like drug on the Drug List.**
  - When adding a new version of a drug to the Drug List, we may immediately remove a like drug from the Drug List, move the like drug to a different cost-sharing tier, add new restrictions, or both. The new version of the drug will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
  - We'll make these immediate changes only if we add a new generic version of a brand name or add certain new biosimilar versions of an original biological product that was already on the Drug List.
  - We may make these changes immediately and tell you later, even if you take the drug that we remove or make changes to. If you take the like drug at the time we make the change, we'll tell you about any specific change we made.
- **Adding drugs to the Drug List and removing or making changes to a like drug on the Drug List.**
  - When adding another version of a drug to the Drug List, we may remove a like drug from the Drug List, move it to a different cost-sharing tier, add new restrictions, or both. The version of the drug that we add will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
  - We'll make these changes only if we add a new generic version of a brand name drug or add certain new biosimilar versions of an original biological product that was already on the Drug List.
  - We'll tell you at least 30 days before we make the change, or tell you about the change and cover a 30-day fill of the version of the drug you're taking.
- **Removing unsafe drugs and other drugs on the Drug List that are withdrawn from the market.**
  - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug List. If you take that drug, we'll tell you after we make the change.
- **Making other changes to drugs on the Drug List.**
  - We may make other changes once the year has started that affect drugs you are taking. For example, we based on FDA boxed warnings or new clinical guidelines recognized by Medicare.

- We'll tell you at least 30 days before we make these changes or tell you about the change and cover an additional 30-day fill of the drug you're taking.

If we make any of these changes to any of the drugs you take, talk with your prescriber about the options that would work best for you, including changing to a different drug to treat your condition, or asking for a coverage decision to satisfy any new restrictions on the drug you're taking. You or your prescriber can ask us for an exception to continue covering the drug or version of the drug you've been taking. For more information on how to ask for a coverage decision, including an exception, go to Chapter 9.

Changes to your drug coverage that don't affect you during this plan year

We may make certain changes to the Drug List that aren't described above. In these cases, the change won't apply to you if you're taking the drug when the change is made; however, these changes will likely affect you starting January 1 of the next plan year if you stay in the same plan.

In general, changes that won't affect you during the current plan year are:

- We move your drug into a higher cost-sharing tier.
- We put a new restriction on the use of your drug.
- We remove your drug from the Drug List.

If any of these changes happen for a drug you take (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), the change won't affect your use or what you pay as your share of the cost until January 1 of the next year.

We won't tell you about these types of changes directly during the current plan year. You'll need to check the Drug List for the next plan year (when the list is available during the open enrollment period) to see if there are any changes to drugs you take that will impact you during the next plan year.

SECTION 7 Types of drugs we don't cover

Some kinds of prescription drugs are *excluded*. This means Medicare doesn't pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself (except for certain excluded drugs covered under our enhanced drug coverage). If you appeal and the requested drug is found not to be excluded under Part D, we will pay for or cover it. (For information about appealing a decision, go to Chapter 9.)

Here are 3 general rules about drugs that Medicare drug plans won't cover under Part D:

- Our plan's Part D drug coverage can't cover a drug that would be covered under Medicare Part A or Part B.
- Our plan can't cover a drug purchased outside the United States or its territories.

- Our plan can't cover *off-label* use of a drug when the use isn't supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System. *Off-label* use is any use of the drug other than those indicated on a drug's label as approved by the FDA.

In addition, by law, the following categories of drugs aren't covered by Medicare drug plans: (Our plan covers certain drugs listed below through our enhanced drug coverage. More information is provided below the list.)

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction
- Drugs used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer requires associated tests or monitoring services be purchased only from the manufacturer as a condition of sale

We offer additional coverage of some prescription drugs (enhanced drug coverage) not normally covered in a Medicare prescription drug plan. For certain drugs, special rules restrict how and when the plan covers them. There may be prior authorizations, coverage limits and step therapy for the enhanced drugs.

For the following prescription drugs, you pay Tier 1 cost sharing for generic drugs and Tier 3 cost sharing for brand-name drugs (please refer to Chapter 6 for more details on cost-sharing amounts):

- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.
- Drugs when used for the treatment of sexual or erectile dysfunction.
- Drugs when used for treatment of anorexia or weight loss.
- Drugs when used to relieve the symptoms of cough and colds.

The amount you pay for these drugs doesn't count toward qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 6, Section 6.)

If you get Extra Help from Medicare to pay for your prescriptions, Extra Help won't pay for drugs that aren't normally covered. (Go to our plan's Drug List or call Pharmacy Member Services at 888-970-0917 (TTY users call 711) for more information. If you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Contact your state Medicaid program to determine what drug coverage may be available to you. (Find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8 How to fill a prescription

To fill your prescription, provide our plan membership information (which can be found on your membership card) at the network pharmacy you choose. The network pharmacy will automatically bill our plan for *our* share of your drug cost. You need to pay the pharmacy *your* share of the cost when you pick up your prescription.

If you don't have our plan membership information with you, you or the pharmacy can call our plan to get the information, or you can ask the pharmacy to look up our plan enrollment information.

If the pharmacy can't get the necessary information, **you may have to pay the full cost of the prescription when you pick it up**. You can then **ask us to reimburse you** for our share. Go to Chapter 7, Section 2 for information about how to ask our plan for reimbursement.

SECTION 9 Part D drug coverage in special situations

Section 9.1 In a hospital or a skilled nursing facility for a stay covered by our plan

If you're admitted to a hospital or to a skilled nursing facility for a stay covered by our plan, we'll generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, our plan will cover your prescription drugs as long as the drugs meet all our rules for coverage described in this chapter.

Section 9.2 As a resident in a long-term care (LTC) facility

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

Check your *Pharmacy Directory* at www.carefirst.com/myaccount to find out if your LTC facility's pharmacy or the one it uses is part of our network. If it isn't, or if you need more information or help, call Pharmacy Member Services at 888-970-0917 (TTY users call 711). If you're in an LTC facility, we must ensure that you're able to routinely get your Part D benefits through our network of LTC pharmacies.

If you're a resident in an LTC facility and need a drug that's not on our Drug List or restricted in some way, go to Section 5 for information about getting a temporary or emergency supply.

Section 9.3 If you're in Medicare-certified hospice

Hospice and our plan don't cover the same drug at the same time. If you're enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea drugs, laxatives, pain medication or anti-anxiety drugs) that aren't covered by your hospice because it is unrelated to your terminal

illness and related conditions, our plan must get notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in getting these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover your drugs as explained in this document. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, bring documentation to the pharmacy to verify your revocation or discharge.

SECTION 10 Programs on drug safety and managing medications

We conduct drug use reviews for our members to help make sure our members get safe and appropriate care.

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

- Possible medication errors
- Drugs that may not be necessary because you take another similar drug to treat the same condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions for drugs that have ingredients you're allergic to
- Possible errors in the amount (dosage) of a drug you take
- Unsafe amounts of opioid pain medications

If we see a possible problem in your use of medications, we will work with your provider to correct the problem. Please note, our prescription system reviews for excess accumulation of medication to decrease medication waste and ensure medication safety. We may delay when you can refill your medications if you have extra medication on-hand.

Section 10.1 Drug Management Program (DMP) to help members safely use their opioid medications

We have a program that helps make sure members safely use prescription, opioids, and other frequently abused medications. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several prescribers or pharmacies, or if you had a recent opioid overdose, we may talk to your prescribers to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescribers, if we decide your use of prescription opioid or benzodiazepine medications may not be safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain doctor(s)
- Limiting the amount of opioid or benzodiazepine medications we'll cover for you

If we plan on limiting how you get these medications or how much you can get, we'll send you a letter in advance. The letter will tell you if we'll limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific prescriber or pharmacy. You'll have an opportunity to tell us which prescribers or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we'll send you another letter confirming the limitation. If you think we made a mistake or you disagree with our decision or with the limitation, you and your prescriber have the right to appeal. If you appeal, we'll review your case and give you a new decision. If we continue to deny any part of your request about the limitations that apply to your access to medications, we'll automatically send your case to an independent reviewer outside of our plan. Go to Chapter 9 for information about how to ask for an appeal.

You won't be placed in our DMP if you have certain medical conditions, such as cancer-related pain or sickle cell disease, you're getting hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.2 Medication Therapy Management (MTM) program to help members manage medications

We have a program that can help our members with complex health needs. Our program is called a Medication Therapy Management (MTM) program. This program is voluntary and free. A team of pharmacists and doctors developed the program for us to help make sure that our members get the most benefit from the drugs they take.

Some members who have certain chronic diseases and take medications that exceed a specific amount of drug costs or are in a DMP to help them use opioids safely, may be able to get services through an MTM program. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will get information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Keep your medication list up to date and with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we'll automatically enroll you in the program and send you information. If you decide not to participate, notify us and we'll withdraw you. For questions about this program, call Pharmacy Member Services at 888-970-0917 (TTY users call 711).

CHAPTER 6:
What you pay for Part D drugs

SECTION 1 What you pay for Part D drugs

If you're in a program that helps pay for your drugs, **some information in this** *Evidence of Coverage* **about the costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug coverage. If you don't have this insert, call Member Services at 833-939-4103 (TTY users call 711) and ask for the *LIS Rider.*

We use "drug" in this chapter to mean a Part D prescription drug. Not all drugs are Part D drugs. Some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5 explains these rules. When you use our plan's "Real-Time Benefit Tool" to look up drug coverage, the cost you see shows an estimate of the out-of-pocket costs you're expected to pay. You can also get information provided by the "Real-Time Benefit Tool" by calling Member Services at 833-939-4103 (TTY users call 711).

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

There are 2 different types of out-of-pocket costs for covered Part D drugs that you may be asked to pay:

- **Copayment** is a fixed amount you pay each time you fill a prescription.
- **Coinsurance** is a percentage of the total cost you pay each time you fill a prescription.

Section 1.2 How Medicare calculates your out-of-pocket costs

Medicare has rules about what counts and what doesn't count as your out-of-pocket costs. Here are the rules we must follow to keep track of your out-of-pocket costs.

These payments <u>are included</u> in your out-of-pocket costs

Your out-of-pocket costs **include** the payments listed below (as long as they are for Part D drugs, and you followed the rules for drug coverage that are explained in Chapter 5):

- The amount you pay for drugs when you're in any of the following drug payment stages:
  - The Initial Coverage Stage
- Any payments you made during this calendar year as a member of a different Medicare drug plan before you joined our plan
- Any payments for your drugs made by family or friends
- Any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, State Pharmaceutical Assistance Programs (SPAPs), and most charities

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $2,100 in out-of-pocket costs within the calendar year, you will move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

These payments aren't included in your out-of-pocket costs

Your out-of-pocket costs **don't include** any of these types of payments:

- Your monthly plan premium
- Drugs you buy outside the United States and its territories
- Drugs that aren't covered by our plan
- Drugs you get at an out-of-network pharmacy that don't meet our plan's requirements for out-of-network coverage
- Prescription drugs covered by Part A or Part B.
- Payments you make toward drugs covered under our additional coverage but not normally covered in a Medicare Drug Plan
- Payments you make toward drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Health Administration (VA)
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation)
- Payments made by drug manufacturers under the Manufacturer Discount Program

Reminder: If any other organization like the ones listed above pays part or all of your out-of-pocket costs for drugs, you're required to tell our plan by calling Member Services at 833-939-4103 (TTY users call 711).

Tracking your out-of-pocket total costs

- The *Part D Explanation of Benefits* (EOB) you get includes the current total of your out-of-pocket costs. When this amount reaches $2,100, the *Part D EOB* will tell you that you left the Initial Coverage Stage and moved to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Go to Section 3.1 to learn what you can do to help make sure that our records of what you have spent are complete and up to date.

SECTION 2 Drug payment stages for CareFirst BlueCross BlueShield Group Advantage members

There are **2 drug payment stages** for your drug coverage under CareFirst BlueCross BlueShield Group Advantage. How much you pay for each prescription depends on what stage you're in when you get a prescription filled or refilled. Details of each stage are explained in this chapter. The stages are:

- **Stage 1: Initial Coverage Stage**
- **Stage 2: Catastrophic Coverage Stage**

SECTION 3 Your *Part D Explanation of Benefits (EOB)* explains which payment stage you're in

Our plan keeps track of your prescription drug costs and the payments you make when you get prescriptions at the pharmacy. This way, we can tell you when you move from one drug payment stage to the next. We track 2 types of costs:

- **Out-of-Pocket Costs:** this is how much you paid. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, and any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- **Total Drug Costs:** this is the total of all payments made for your covered Part D drugs. It includes what our plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

If you filled one or more prescriptions through our plan during the previous month, we'll send you a *Part D EOB*. The *Part D EOB* includes:

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

- **Drug price information.** This displays the total drug price, and information about changes in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This shows information about other available drugs with lower cost sharing for each prescription claim, if applicable.

Section 3.1 Help us keep our information about your drug payments up to date

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

- **Show your membership card every time you get a prescription filled.** This helps make sure we know about the prescriptions you fill and what you pay.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we won't automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. **Examples of when you should give us copies of your drug receipts:**
  - When you purchase a covered drug at a network pharmacy at a special price or use a discount card that's not part of our plan's benefit.
  - When you pay a copayment for drugs provided under a drug manufacturer patient assistance program.
  - Any time you buy covered drugs at out-of-network pharmacies or pay the full price for a covered drug under special circumstances.
  - If you're billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.
- **Send us information about the payments others make for you.** Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you get a *Part D EOB*, look it over to be sure the information is complete and correct. If you think something is missing or you have questions, call Member Services at 833-939-4103 (TTY users call 711). Be sure to keep these reports.

SECTION 4 There is no deductible for CareFirst BlueCross BlueShield Group Advantage

There is no deductible for CareFirst BlueCross BlueShield Group Advantage. You begin in the Initial Coverage Stage when you fill your first prescription of the year. Go to Section 5 for information about your coverage in the Initial Coverage Stage.

SECTION 5 The Initial Coverage Stage

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage Stage, our plan pays its share of the cost of your covered drugs, and you pay your share (your copayment). Your share of the cost will vary depending on the drug and where you fill your prescription.

Our plan has four cost-sharing tiers

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

- **Tier 1 - Generic:** is the lowest tier and includes most generic drugs and may include some brand drugs.
- **Tier 2 – Preferred Brand:** includes preferred brand drugs and non-preferred generic drugs.
- **Tier 3 – Non-Preferred Drug:** includes non-preferred brand and generic drugs.
- **Tier 4 – Specialty:** is the highest tier and includes high-cost brand and generic drugs.

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

Your pharmacy choices

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

- A network retail pharmacy
- A pharmacy that isn't in our plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Go to Chapter 5, Section 2.5 to find out when we'll cover a prescription filled at an out-of-network pharmacy
- Our plan's mail-order pharmacy

For more information about these pharmacy choices and filling your prescriptions, go to Chapter 5 in this document and our plan's *Pharmacy Directory* at *www.carefirst.com/myaccount.*

Section 5.2 Your costs for a *one-month* supply of a covered drug

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

The amount of the copayment depends on the cost-sharing tier.

Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

Your costs for a *one-month* supply of a covered Part D drug

Tier	**Standard retail cost sharing (in-network)** (up to a 30-day supply)	**Mail-order cost sharing** (up to a 30-day supply)	**Long-term care (LTC) cost sharing** (up to a 31-day supply)	**Out-of-network cost sharing** (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 30-day supply)
Cost-Sharing Tier 1 (Generic)	$10	$10	$10	$10
Cost-Sharing Tier 2 (Preferred Brand)	$30	$30	$30	$30
Cost-Sharing Tier 3 (Non-Preferred Drug)	$50	$50	$50	$50
Cost-Sharing Tier 4 (Specialty)	$75	$75	$75	$75

You won't pay more than $35 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.

Go to Section 8 of this chapter for more information on cost sharing for Part D vaccines.

Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a drug covers a full month's supply. There may be times when you or your doctor would like you to have less than a month's supply of a drug (for example,

when you're trying a medication for the first time). You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply if this will help you better plan refill dates.

If you get less than a full month's supply of certain drugs, you won't have to pay for the full month's supply.

- If you're responsible for coinsurance, you pay a *percentage* of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower.
- If you're responsible for a copayment for the drug, you only pay for the number of days of the drug that you get instead of a whole month. We calculate the amount you pay per day for your drug (the daily cost-sharing rate) and multiply it by the number of days of the drug you get.

Section 5.4 Your costs for a *long-term* (up to a 100-day) supply of a covered Part D drug

For some drugs, you can get a long-term supply (also called an extended supply). A long-term supply is up to a 90-day or 100-day supply.

Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

Your costs for a *long-term* (up to a 90-day or 100-day) supply of a covered Part D drug

Tier	Standard retail cost sharing (in-network) (up to a 90-day supply for Tiers 2-3 or 100-day supply for Tier 1 drugs)	Mail-order cost sharing (up to a 90-day supply for Tiers 2-3 or 100-day supply for Tier 1 drugs)
Cost-Sharing Tier 1 (Generic)	$20	$20
Cost-Sharing Tier 2 (Preferred Brand)	$60	$60
Cost-Sharing Tier 3 (Non-Preferred Drug)	$100	$100
Cost-Sharing Tier 4 (Specialty)	Not Covered	Not Covered

You won't pay more than $70 for up to a 2-month supply or $105 for up to a 3-month supply of each covered insulin product regardless of the cost-sharing tier.

Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach $2,100

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach $2,100. You then move on to the Catastrophic Coverage Stage.

We offer additional coverage on some prescription drugs that aren't normally covered in a Medicare Prescription Drug Plan. Payments made for these drugs won't count toward your total out-of-pocket costs.

The *Part D EOB* you get will help you keep track of how much you, our plan, and any third parties, have spent on your behalf for your drugs during the year. Not all members will reach the $2,100 out-of-pocket limit in a year.

We'll let you know if you reach this amount. Go to Section 1.3 for more information on how Medicare calculates your out-of-pocket costs.

SECTION 6 The Catastrophic Coverage Stage

In the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs. You enter the Catastrophic Coverage Stage when your out-of-pocket costs reach the $2,100 limit for the calendar year. Once you're in the Catastrophic Coverage Stage, you'll stay in this payment stage until the end of the calendar year.

- During this payment stage, you pay nothing for your covered Part D drugs and for excluded drugs covered under our enhanced benefit.

SECTION 7 What you pay for Part D Vaccines

Important message about what you pay for vaccines – Some vaccines are considered medical benefits and are covered under Part B. Other vaccines are considered Part D drugs. You can find these vaccines listed in our plan's Drug List. Our plan covers most adult Part D vaccines at no cost to you. Refer to our plan's Drug List or call Member Services at 833-939-4103 (TTY users call 711) for coverage and cost-sharing details about specific vaccines.

There are 2 parts to our coverage of Part D vaccines:

- The first part is the cost of **the vaccine itself**.
- The second part is for the cost of **giving you the vaccine**. (This is sometimes called the administration of the vaccine.)

Your costs for a Part D vaccine depend on 3 things:

1. **Whether the vaccine is recommended for adults by an organization called the Advisory Committee on Immunization Practices (ACIP).**
   - Most adult Part D vaccines are recommended by ACIP and cost you nothing.
2. **Where you get the vaccine.**
   - The vaccine itself may be dispensed by a pharmacy or provided by the doctor's office.
3. **Who gives you the vaccine.**
   - A pharmacist or another provider may give the vaccine in the pharmacy. Or a provider may give it in the doctor's office.

What you pay at the time you get the Part D vaccine can vary depending on the circumstances and what **drug payment stage** you're in.

- When you get a vaccine, you may have to pay the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask our plan to pay you back for our share of the cost. For most adult Part D vaccines, this means you'll be reimbursed the entire cost you paid.
- Other times when you get a vaccine, you pay only your share of the cost under your Part D benefit. For most adult Part D vaccines, you pay nothing.

Below are 3 examples of ways you might get a Part D vaccine.

Situation 1: You get the Part D vaccine at the network pharmacy. (Whether you have this choice depends on where you live. Some states don't allow pharmacies to give certain vaccines.)
- For most adult Part D vaccines, you pay nothing.
- For other Part D vaccines, you will pay the pharmacy your copayment for the vaccine itself, which includes the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

Situation 2: You get the Part D vaccine at your doctor's office.
- When you get the vaccine, you may have to pay for the entire cost of the vaccine itself and the cost for the provider to give it to you.
- You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.
- For most adult Part D vaccines, you'll be reimbursed the full amount you paid. For other Part D vaccines, you'll be reimbursed the amount you paid less any copayment for the vaccine (including administration).

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

- For most adult Part D vaccines, you pay nothing for the vaccine itself.
- For other Part D vaccines, you pay the pharmacy your copayment for the vaccine itself.
- When your doctor gives you the vaccine, you may have to pay the entire cost for this service.
- You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.
- For most adult Part D vaccines, you'll be reimbursed the full amount you paid. For other Part D vaccines, you will be reimbursed the amount you paid less any copay for the vaccine administration.

CHAPTER 7:
Asking us to pay our share of a bill for covered medical services or drugs

SECTION 1 Situations when you should ask us to pay our share for covered services or drugs

Sometimes when you get medical care or a prescription drug, you may need to pay the full cost. Other times, you may you pay more than you expected under the coverage rules of our plan, or you may get a bill from a provider. In these cases, you can ask our plan to pay you back (reimburse you). It's your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs covered by our plan. There may be deadlines that you must meet to get paid back. Go to 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 got or for more than your share of cost sharing. First, try to resolve the bill with the provider. If that doesn't work, send the bill to us instead of paying it. We'll look at the bill and decide whether the services should be covered. If we decide they should be covered, we'll pay the provider directly. If we decide not to pay it, we'll 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.

Examples of situations in which you may need to ask our plan to pay you back or to pay a bill you got:

1. **When you got medical care from a provider who's not in our plan's network**

   When you got care from a provider who isn't part of our network, you're only responsible for paying your share of the cost. Ask the provider to bill our plan for our share of the cost.

   - Emergency providers are legally required to provide emergency care. You're only responsible for paying your share of the cost for emergency or urgently needed services. If you pay the entire amount yourself at the time you get 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 made.
   - You may get a bill from the provider asking for payment you think you don't owe. Send us this bill, along with documentation of any payments you already made.
     - If the provider is owed anything, we'll pay the provider directly.
     - If you have already paid more than your share of the cost of the service, we'll determine how much you owed and pay you back for our share of the cost.

- 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 can't pay a provider who isn't eligible to participate in Medicare. If the provider isn't eligible to participate in Medicare, you'll be responsible for the full cost of the services you get.

2. When a network provider sends you a bill you think you shouldn't pay

Network providers should always bill our 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 don't 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.
- Whenever you get a bill from a network provider you think is more than you should pay, send us the bill. We'll contact the provider directly and resolve the billing problem.
- If you already paid a bill to a network provider, but feel you paid too much, send us the bill along with documentation of any payment you made and ask us to pay you back the difference between the amount you paid and the amount you owed under our plan.

3. If you're retroactively enrolled in our plan

Sometimes a person's enrollment in our 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 or drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You need to submit paperwork such as receipts and bills for us to handle the reimbursement.

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

If you go to an out-of-network pharmacy, the pharmacy may not be able to submit the claim directly to us. When that happens, you have to pay the full cost of your prescription.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out-of-network pharmacies in limited circumstances. Go to Chapter 5, Section 2.5 to learn about these circumstances. We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount we'd pay at an in-network pharmacy.

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

If you don't have our plan membership card with you, you can ask the pharmacy to call our plan or look up our plan enrollment information. If the pharmacy can't get the enrollment

information they need right away, you may need to pay the full cost of the prescription yourself.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

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

You may pay the full cost of the prescription because you find that the drug isn't covered for some reason.

- For example, the drug may not be on our plan's Drug List, or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

When you send us a request for payment, we'll review your request and decide whether the service or drug should be covered. This is called making a **coverage decision**. If we decide it should be covered, we'll pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 9 has information about how to make an appeal.

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

You can ask 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 medical claim to us within one (1) year and your Part D claim to us within three (3) years** of the date you got the service, item, or drug.

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

- Download a copy of the form from our website (www.carefirst.com/myaccount) or call Member Services at 833-939-4103 (TTY users call 711) and ask for the form.

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

For Medical Claims:

CareFirst BlueCross BlueShield Medicare Advantage
Attention: Member Claims Reimbursement
P.O. Box 915
Owings Mills, MD 21117

For Part D Claims:

CVS Caremark Medicare Part D Claims Processing
P.O. Box 52066
Phoenix, AZ 85072-2066

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

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

- If we decide the medical care or drug is covered and you followed all the rules, we'll pay for our share of the cost. Our share of the cost might not be the full amount you paid (for example, if you got a drug at an out-of-network pharmacy or if the cash price you paid for a drug is higher than our negotiated price). If you already paid for the service or drug, we'll mail your reimbursement of our share of the cost to you. If you haven't paid for the service or drug yet, we'll mail the payment directly to the provider.
- If we decide the medical care or drug is *not* covered, or you did *not* follow all the rules, we won't pay for our share of the cost. We'll send you a letter explaining the reasons why we aren't sending the payment and your right to appeal that decision.

Section 3.1 If we tell you that we won't pay for all or part of the medical care or drug, you can make an appeal

If you think we made a mistake in turning down your request for payment or the amount we're paying, you can make an appeal. If you make an appeal, it means you're 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 9.

CHAPTER 8:
Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities

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, braille, large print, or other alternate formats, etc.)
Debemos brindar información de una manera que sea apropiada para usted (en otros idiomas además del inglés, en letra grande o en formatos alternativos, etc.)

Our 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 our plan may meet these accessibility requirements include, but aren't 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, large print or other alternate formats at no cost if you need it. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services at 833-939-4103 (TTY users call 711).

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

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with Member Services, or file a grievance by writing to CareFirst BlueCross BlueShield Medicare Advantage Attention: Appeals & Grievances Department P.O. Box 915 Owings Mills, MD 21117. You can 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.

Su plan tiene la obligación de garantizar que todos los servicios, tanto clínicos como no clínicos, se presten de manera competente desde el punto de vista cultural y que sean accesibles para

todos los afiliados, incluidos aquellos que tienen un dominio limitado del inglés, una capacidad limitada de lectura, una incapacidad auditiva o un origen cultural y étnico distinto. Algunos ejemplos de cómo un plan puede cumplir estos requisitos de accesibilidad incluyen, entre otros, la prestación de servicios de traducción, servicios de interpretación, teletipos o conexión TTY (teléfono de texto o teletipo).

Nuestro plan cuenta con servicios gratuitos de interpretación para responder a las preguntas de los afiliados que no hablan inglés. También podemos brindarle información en letra grande u otros formatos alternativos sin costo alguno si lo necesita. Debemos brindarle información sobre los beneficios del plan en un formato que sea accesible y apropiado para usted. Para obtener información de nosotros de una manera que funcione para usted, llame a Servicios para Miembros.

Nuestro plan está obligado a ofrecer a las mujeres inscritas la opción de acceso directo a un especialista en atención médica para la mujer dentro de la red para los servicios de atención médica preventiva y de rutina para la mujer.

Si los proveedores de la red del plan para una especialidad no están disponibles, es responsabilidad del plan encontrar proveedores especializados fuera de la red que le proporcionarán la atención necesaria. Solo pagará el costo compartido dentro de la red. Si se encuentra en una situación en la que no hay especialistas en la red del plan que cubran un servicio que necesita, llame al plan para obtener información sobre dónde acudir para obtener este servicio.

Si tiene algún problema para obtener información de nuestro plan en un formato que sea accesible y apropiado para usted, llame a Servicios para Miembros o presente una queja por escrito a CareFirst BlueCross BlueShield Medicare Advantage Attention: Appeals & Grievances Department P.O. Box 915 Owings Mills, MD 21117. También puede presentar una queja ante Medicare llamando al 1-800-MEDICARE (1-800-633-4227) o directamente a la Office for Civil Rights al 1-800-368-1019 o TTY 1-800-537-7697.

Section 1.2 We must ensure you get timely access to covered services and drugs

You have the right to choose a provider in our plan's network. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral and still pay the in-network cost-sharing amount.

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

If you think you aren't getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9 tells what you can do.

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're *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 don't require us to get your written permission first. These exceptions are allowed or required by law.
    - We're required to release health information to government agencies that are checking on quality of care.
    - Because you’re a member of our plan through Medicare, we’re required to give Medicare your health information including information about your Part D drugs. 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's been shared with others

You have the right to look at your medical records held at our plan, and to get a copy of your records. We're 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'll work with your health care 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 aren't routine.

If you have questions or concerns about the privacy of your personal health information, please call Member Services at 833-939-4103 (TTY users call 711).

Notice of Privacy Practices

This notice describes how medical and financial information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your medical and financial information is important to us.

This notice applies to members of fully-insured groups and individual policyholders only. If you are a member of a self-insured group, while we continue to safeguard your personal information with the same safety mechanisms, you will get a Notice of Privacy Practices from your group health plan. If you are unsure if you are a fully insured or self-insured member, please contact your group administrator. This notice applies to the privacy practices of CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst BlueChoice, Inc., FirstCare, Inc. (CareFirst), CareFirst Advantage, Inc. and CareFirst Advantage PPO, Inc. We may share your financial and protected health information (oral, written or electronic) as well as the protected health information of others on your insurance policy as needed for payment or health care operations purposes.

Uses & disclosures of medical information

Our legal duty

This notice describes our privacy practices, which include how we may use, disclose (share or give out), collect, handle and protect our members' protected health information. We are required by certain federal and state laws to maintain the privacy of your protected health information. We also are required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice took effect October 1, 2016 and is intended to amend the notice of CareFirst privacy practices with an effective date of April 14, 2003.

We reserve the right to change our privacy practices and the terms of this notice at any time, as long as law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including protected health information we created or received before we made the changes. If we make a significant change in our privacy practices, we will change this notice and post the new notice on our website, www.carefirst.com, and provide the revised notice or information about the changes and how to get the revised notice in our next annual mailing to our health plan subscribers.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

We maintain physical, electronic and procedural safeguards in accordance with federal and state standards to protect your health information. All of our associates receive training on these standards at the time they are hired and thereafter receive annual refresher training. Access to your protected health information is restricted to appropriate business purposes and requires pass codes to access our computer systems and badges to access our facilities. Associates who violate our standards are subject to disciplinary actions.

Primary uses and disclosures of protected health information

We use and disclose protected health information about you for payment and health care operations. The federal health care privacy regulations ("HIPAA Privacy Rule") generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, applicable state or federal privacy laws might impose a privacy standard under which we will be required to operate. For example, we will follow more stringent state privacy laws that relate to uses and disclosures of the protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing and reproductive rights. In addition to these state law requirements, we also may use or disclose your protected health information for health benefits administration purposes (such as claims and enrollment processing, care management and wellness offerings, claims payment, and fraud detection and prevention efforts), for our business operations (including for quality measurement and enhancement and benefit improvement and development) and in the following situations:

- ***Payment:*** We may use and disclose your protected health information for all activities that are included within the definition of "payment" as written in the HIPAA Privacy Rule. For example, we might use and disclose your protected health information to pay claims for services provided to you by doctors, hospitals, pharmacies and others that are covered by your health plan. We also may use your information to determine your eligibility for benefits, coordinate benefits, examine medical necessity, obtain premiums and issue explanations of benefits to the person who subscribes to the health plan in which you participate.
- ***Health care operations:*** We may use and disclose your protected health information for all activities that are included within the definition of "health care operations" as defined in the HIPAA Privacy Rule. For example, we may use and disclose your protected health information to determine our premiums for your health plan, conduct quality assessment and improvement activities, engage in care coordination or case management, and manage our business.
- ***Business associates:*** In connection with our payment and health care operations activities, we contract with individuals and entities (called "business associates") to perform various functions on our behalf or to provide certain types of services (such as member service support, utilization management, subrogation or pharmacy benefit management). We may share your contact information and phone number including your mobile number with our business associates. To perform these functions or to provide the services, our business associates will receive, create, maintain, use or disclose protected health information, but only after we require the business associates to agree in writing to contract terms designed to appropriately safeguard your information.

- ***Other covered entities:*** We may use or disclose your protected health information to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with certain aspects of their health care operations. For example, we may disclose your protected health information to a health care provider when needed by the provider to render treatment to you, and we might disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing.

Other possible uses and disclosures of protected health information

The following is a description of other possible ways in which we may (and are permitted to) use and/or disclose your protected health information:

- ***To you or with your authorization:*** We must disclose your protected health information to you, as described in the Individual Rights section of this notice. You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose not listed in this notice. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures that we made as permitted by your authorization while it was in effect. To the extent (if any) that we maintain or receive psychotherapy notes about you, most disclosures of these notes require your authorization. Also, to the extent (if any) that we use or disclose your information for our fundraising practices, we will provide you with the ability to opt out of future fundraising communications. In addition, most (but not all) uses and disclosures of medical information for marketing purposes, and disclosures that constitute a sale of protected health information, require your authorization. Without your written authorization, we may not use or disclose your protected health information for any reason except those described in this notice.
- ***Disclosures to the Secretary of the U.S. Department of Health and Human Services:*** We are required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services (DHHS) when the Secretary is investigating or determining our compliance with the federal Privacy Regulations.
- ***To plan sponsors:*** Where permitted by law, we may disclose your protected health information to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan sponsor may contact us seeking information to evaluate future changes to your benefit plan. We also may disclose summary health information (this type of information is defined in the HIPAA Privacy Rule) about the enrollees in your group health plan to the plan sponsor to obtain premium bids for the health insurance coverage offered through your group health plan or to decide whether to modify, amend or terminate your group health plan.
- ***To family and friends:*** If you agree (or if you are unavailable to agree), such as in a medical emergency situation, we may disclose your protected health information to a family member, friend or other person to the extent necessary to help with your health care or with payment of your health care.

- ***Underwriting:*** We might receive your protected health information for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits. We will not use or disclose protected health information that is genetic information of an individual for such purposes. We will not use or further disclose this protected health information received under these circumstances for any other purpose, except as required by law, unless and until you enter into a contract of health insurance or health benefits with us.
- ***Health oversight activities:*** We might disclose your protected health information to a health oversight agency for activities authorized by law, such as: audits, investigations, inspections, licensure or disciplinary actions, or civil, administrative or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system, (ii) government benefit programs, (iii) other government regulatory programs and (iv) compliance with civil rights laws.
- ***Abuse or neglect:*** We may disclose your protected health information to appropriate authorities if we reasonably believe that you might be a possible victim of abuse, neglect, domestic violence or other crimes.
- ***To prevent a serious threat to health or safety:*** Consistent with certain federal and state laws, we may disclose your protected health information if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- ***Coroners, medical examiners, funeral directors and organ donation:*** We may disclose protected health information to a coroner or medical examiner for purposes of identifying you after you die, determining your cause of death or for the coroner or medical examiner to perform other duties authorized by law. We also might disclose, as authorized by law, information to funeral directors so that they may carry out their duties on your behalf. Further, we might disclose protected health information to organizations that handle organ, eye or tissue donation and transplantation.
- ***Research:*** We may disclose your protected health information to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information and (2) approved the research.
- ***Inmates:*** If you are an inmate of a correctional institution, we may disclose your protected health information to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to you, (2) your health and safety and the health and safety of others or (3) the safety and security of the correctional institution.
- ***Workers' compensation:*** We may disclose your protected health information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.
- ***Public health and safety:*** We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety or the health or safety of others.

- ***Required by law:*** We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to DHHS upon their request for purposes of determining whether we are in compliance with federal privacy laws.
- ***Legal process and proceedings:*** We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.
- ***Law enforcement:*** We may disclose to a law enforcement official limited protected health information of a suspect, fugitive, material witness, crime victim or missing person. We might disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.
- ***Military and national security:*** We may disclose to military authorities the protected health information of Armed Forces personnel under certain circumstances. We might disclose to federal officials protected health information required for lawful counterintelligence, intelligence and other national security activities.
- ***Other uses and disclosures of your protected health information:*** Other uses and disclosures of your protected health information that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of protected health information. However, the revocation will not be effective for information that we already have used or disclosed in reliance on your authorization.

Individual rights

Access: You have the right to look at or get copies of the protected health information contained in a designated record set, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot reasonably do so. You must make a request in writing to obtain access to your protected health information. You may request the information be as an electronic copy in certain circumstance, if you make the request in writing. You also may request access by sending a letter to the address at the end of this notice. If you request copies, we might charge you a reasonable fee for each page and postage if you want the copies mailed to you. If you request an alternative format, we might charge a cost-based fee for providing your protected health information in that format. If you prefer, we will prepare a summary or an explanation of your protected health information, but we might charge a fee to do so.

We may deny your request to inspect and copy your protected health information in certain limited circumstances. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable. If you are denied access to your information and the denial is subject to review, you may request that the denial be reviewed. A licensed health care professional chosen by us will review your request and the

denial. The person performing this review will not be the same person who denied your initial request.

- ***Disclosure accounting:*** You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes other than treatment, payment, health care operations and certain other activities. We will provide you with the date on which we made the disclosure, the name of the person or entity to which we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure and certain other information. Your request may be for disclosures made up to six years before the date of your request.

You may request an accounting by submitting your request in writing using the information listed at the end of this notice. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency) until or unless we receive a written request from you to terminate the restriction. Any agreement that we might make to a request for additional restrictions must be in writing and signed by a person authorized to make such an agreement on our behalf. We will not be liable for uses and disclosures made outside of the requested restriction unless our agreement to restrict is in writing. We are permitted to end our agreement to the requested restriction by notifying you in writing.

You may request a restriction by writing to us using the information listed at the end of this notice. In your request tell us: (1) the information of which you want to limit our use and disclosure and (2) how you want to limit our use and/or disclosure of the information. You may also use the information listed at the end of this notice to send a written request to terminate an agreed upon restriction.

- ***Confidential communication:*** If you believe that a disclosure of all or part of your protected health information may endanger you, you have the right to request that we communicate with you in confidence about your protected health information. This means that you may request that we send you information by alternative means, or to an alternate location. We may accommodate your request if it is reasonable, specifies the alternative means or alternate location, and specifies how payment issues (premiums and claims) will be handled. You may request a confidential communication by writing to us using the information listed at the end of this notice.

- ***Amendment:*** You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic notice: Even if you agree to receive this notice on our Website or by electronic mail (email), you are entitled to receive a paper copy as well. Please contact us using the information listed at the end of this notice to obtain this notice in written form. If the email transmission has failed, and CareFirst is aware of the failure, then we will provide a paper copy of the notice to you.

- ***Breach Notification:*** In the event of breach of your unsecured health information, we will provide you notification of such a breach as required by law or where we otherwise deem appropriate.

Collection of Personal Financial Information & Uses and disclosures of financial information

We may collect personal financial information about you from many sources, including:

- Information you provide on enrollment applications or other forms, such as your name, address, social security number, salary, age and gender.
- Information about your relationship with CareFirst, our affiliates and others, such as your policy coverage, premiums and claims payment history.
- Information as described above that we obtain from any of our affiliates.
- Information we receive about you from other sources such as your employer, your provider, your broker and other third parties.
- Information we receive about you when you log on to our Website. We have the capability through the use of "cookies" to track certain information, such as finding out if members have previously visited the CareFirst Website or to track the amount of time visitors spend on the Website. These cookies do not collect personally identifiable information and we do not combine information collected through cookies with other personal financial information to determine the identity of visitors to its Website. We will not disclose cookies to third parties.

How your information is used

We use the information we collect about you in connection with underwriting or administration of an insurance policy or claim or for other purposes allowed by law. At no time do we disclose your financial information to anyone outside of CareFirst unless we have proper authorization from you, or we are permitted or required to do so by law. We maintain physical, electronic and procedural safeguards in accordance with federal and state standards that protect your information. In addition, we limit access to your financial information to those CareFirst employees, business partners, providers, benefit plan administrators, brokers, consultants and

agents who need to know this information to conduct CareFirst business or to provide products or services to you.

Disclosure of your financial information

In order to protect your privacy, third parties that are either affiliated or nonaffiliated with CareFirst are also subject to strict privacy laws. Affiliated entities are companies that are part of the CareFirst corporate family and include health maintenance organizations (HMOs), third party administrators, health insurers, long term care insurers and insurance agencies. In some situations, related to our insurance transactions involving you, we will disclose your personal financial information to a non-affiliated third party that helps us to provide services to or for you.

When we disclose information to these third parties, we require them to agree to protect your financial information and to use it only for its intended purpose, and to comply with all relevant laws.

Changes in our privacy policy

CareFirst periodically reviews its policies and reserves the right to change them. If we change the substance of our privacy policy, we will continue our commitment to keep your financial information secure — it is our highest priority. Even if you are no longer a CareFirst customer, our privacy policy will continue to apply to your records.

Questions and complaints

Information on CareFirst privacy practices

You may request a copy of our notices at any time. If you want more information about our privacy practices, if you would like additional copies of this notice, or have questions or concerns, please call the Member Services number on your ID card or contact the CareFirst Privacy Office using the information below.

Filing a complaint

If you are concerned that we might have violated your privacy rights, or you disagree with a decision we made about your individual rights, you may use the contact information listed at the end of this notice to complain to us. You also may submit a written complaint to DHHS. We will provide you with the contact information for DHHS upon request.

We support your right to protect the privacy of your protected health and financial information. We will not retaliate in any way if you choose to file a complaint with us or with DHHS.

Contact Information:

CareFirst BlueCross BlueShield Medicare Advantage
Attention: Appeals & Grievances Department
P.O. Box 915
Owings Mills, MD 21117

Phone: 800-853-9236

Fax: 410-505-6692

Email: privacy.office@carefirst.com

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst BlueCross BlueShield Medicare Advantage is the business name of CareFirst Advantage, Inc. and CareFirst Advantage PPO, Inc. CareFirst BlueCross BlueShield Community Health Plan District of Columbia is the business name of Trusted Health Plan (District of Columbia), Inc. In the District of Columbia and Maryland, CareFirst MedPlus is the business name of First Care, Inc. In Virginia, CareFirst MedPlus is the business name of First Care, Inc. of Maryland (used in VA by: First Care, Inc.). CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst Advantage, Inc. and CareFirst Advantage PPO, Inc., Trusted Health Plan (District of Columbia), Inc., CareFirst BlueChoice, Inc., First Care, Inc., and The Dental Network, Inc. are independent licensees of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

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

As a member of CareFirst BlueCross BlueShield Group Advantage, 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 Services at 833-939-4103 (TTY users call 711):

- **Information about our plan.** This includes, for example, information about our plan's financial condition.
- **Information about our network providers and pharmacies.** 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. Chapters 5 and 6 provide information about Part D drug coverage.
- **Information about why something is not covered and what you can do about it.** Chapter 9 provides information on asking for a written explanation on why a medical service or Part D drug isn't covered or if your coverage is restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 You have the right to know your treatment options and participate in decisions about your 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're covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no.**" You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. If you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

You have the right to give instructions about what's to be done if you can't 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're 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.

Legal documents you can use to give your directions in advance in these situations are called **advance directives**. Documents like a **living will** and **power of attorney for health care** are examples of advance directives.

How to set up an advance directive to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill out the form and sign it.** No matter where you get this form, keep in mind that it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people.** Give 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're 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 signed an advance directive form and whether you have it with you.
- If you didn't sign an advance directive form, the hospital has forms available and will ask if you want to sign one.

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

If your instructions aren’t followed

If you sign an advance directive and you believe that a doctor or hospital didn't follow the instructions in it, you can file a complaint with the appropriate state-specific agency—for example, your State Department of Health. Contact your State Health Insurance Assistance Program (contact information is located in Exhibit A following this Evidence of Coverage) for more information.

Section 1.6 You have the right to make complaints and to ask us to reconsider decisions we made

If you have any problems, concerns, or complaints and need to ask for coverage, or make an appeal, Chapter 9 of this document tells what you can do. Whatever you do— ask for a coverage decision, make an appeal, or make a complaint— **we're required to treat you fairly.**

Section 1.7 If you believe you're being treated unfairly, or your rights aren't being respected

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

If you believe you've been treated unfairly or your rights haven't been respected, *and* it’s *not* about discrimination, you can get help dealing with the problem you’re having from these places:

- **Call Member Services at 833-939-4103 (TTY users call 711).**
- **Call your local SHIP.** A list of State Health Insurance Programs can be found in Exhibit A at the end of this *Evidence of Coverage.*
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

Section 1.8 How to get more information about your rights

Get more information about your rights from these places:

- **Call Member Services at 833-939-4103 (TTY users call 711).**

- **Call your local SHIP.** A list of State Health Insurance Programs can be found in Exhibit A at the end of this *Evidence of Coverage.*
- **Contact Medicare**
  - Visit www.Medicare.gov to read the publication *Medicare Rights & Protections* (available at: (https://www.medicare.gov/publications/11534-medicare-rights-and-protections.pdf)
  - Call 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of the plan are listed below. For questions, call Member Services at 833-939-4103 (TTY users call 711).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* to learn what's covered for you and the rules you need to follow to get covered services.
  - Chapters 3 and 4 give details about your medical services.
  - Chapters 5 and 6 give details about your Part D drug coverage.
- **If you have any other health insurance coverage or drug coverage in addition to our plan, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show our plan membership card whenever you get your medical care or Part D drugs.
- **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 on.
  - Make sure your doctors know all of the drugs you're 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're responsible for these payments:
  - If your plan requires a premium, you must pay your premium to your employer group or union. Premium information and how to pay will be located in your employer group materials.
  - You must continue to pay your Medicare Part B premiums to stay a member of our plan.
  - For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug.

  - If you're required to pay a late enrollment penalty, you must pay the penalty to keep your drug coverage.
  - If you're required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to stay a member of our plan.
- **If you move *within* our plan service area, we 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 can't remain a member of our plan.**
- **If you move, tell Social Security (or the Railroad Retirement Board).**

CHAPTER 9: If you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 What to do if you have a problem or concern

This chapter explains 2 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 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 information in this chapter will help you identify the right process to use and what to do.

Section 1.1 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. To make things easier, this chapter uses more familiar words in place of some legal terms.

However, it's sometimes important to know the correct legal terms. To help you know which terms to use to get the right help or information, we include these legal terms when we give details for handling specific situations.

SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Member Services at 833-939-4103 (TTY users call 711) for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help are:

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're having. They can also answer questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. A list of State Health Insurance Assistance Programs (SHIP) can be found in Exhibit A located at the end of this *Evidence of Coverage*.

Medicare

You can also contact Medicare for help:

- Call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.
- Visit www.Medicare.gov

SECTION 3 Which process to use for your problem

Is your problem or concern about your benefits or coverage?

This includes problems about whether medical care (medical items, services and/or Part B drugs) are covered or not, the way they're covered, and problems related to payment for medical care.

Yes.

Go to **Section 4, A guide to coverage decisions and appeals.**

No.

Go to **Section 10**, **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 coverage decisions and appeals

Coverage decisions and appeals deal with problems related to your benefits and coverage for your medical care (services, items, and Part B drugs, including payment). To keep things simple, we generally refer to medical items, services, and Medicare Part B drugs as **medical care**. You use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions before you get services

If you want to know if we'll cover medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical care. For example, if our plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either you or your network doctor can show that you got a

standard denial notice for this medical specialist, or the *Evidence of Coverage* makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we'll cover a particular medical service or refuses to provide medical care you think you need.

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'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we might decide medical care isn't covered or is no longer covered 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 you get a benefit, and you aren't satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we made. Under certain circumstances, you can ask for 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 properly followed the rules. When we complete 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'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we say no to all or part of your Level 1 appeal for medical care, your appeal will automatically go on to a Level 2 appeal conducted by an independent review organization not connected to us.

- You don't need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we don't fully agree with your Level 1 appeal.
- Go to **Section 5.4** of this chapter for more information about Level 2 appeals for medical care.
- Part D appeals are discussed further in Section 6.

If you aren't satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.1 Get help asking for a coverage decision or making an appeal

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- **Call Member Services at 833-939-4103 (TTY users call 711).**
- **Get free help** from your State Health Insurance Assistance Program.
- **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. Call Member Services at 833-939-4103 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.carefirst.com/myaccount.)
  - For medical care or Part B drugs, your doctor can ask for 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.
  - For Part D drugs, your doctor or other prescriber can ask for a coverage decision or a Level 1 or Level 2 Appeal on your behalf. If your Level 1 appeal is denied your doctor or prescriber can ask for a Level 2 appeal.
- **You can ask someone to act on your behalf.** 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 Services at 833-939-4103 (TTY users call 711) and ask for the *Appointment of Representative form*. (The form is also available at www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.carefirst.com/myaccount). This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.
  - We can accept an appeal request from a representative without the form, but we can't complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll 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 can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.2 Rules and deadlines for different situations

There are 4 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give the details for each of these situations in this chapter:

- **Section 5**: Medical care: How to ask for a coverage decision or make an appeal
- **Section 6**: Part D drugs: How to ask for a coverage decision or make an appeal

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

If you're not sure which information applies to you, call Member Services at 833-939-4103 (TTY users call 711). You can also get help or information from your SHIP.

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

Section 5.1 What to do if you have problems getting coverage for medical care or want us to pay you back for our share of the cost of your care

Your benefits for medical care are described in Chapter 4 in the *Medical Benefits Chart*. In some cases, different rules apply to a request for a Part B drug. In those cases, we'll explain how the rules for Part B drugs are different from the rules for medical items and services.

This section tells what you can do if you're in any of the 5 following situations:

1. You aren't getting certain medical care you want, and you believe this is covered by our plan. **Ask for a coverage decision. Section 5.2.**
2. Our plan won't approve the medical care your doctor or other medical provider wants to give you, and you believe this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**
3. You got medical care that you believe should be covered by our plan, but we said we won't pay for this care. **Make an appeal. Section 5.3.**
4. You got and paid for medical care that you believe should be covered by our plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5.**
5. You're told that coverage for certain medical care you've 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, go to Sections 7 and 8. Special rules apply to these types of care.

Section 5.2 How to ask for a coverage decision

Legal Terms:

A coverage decision that involves your medical care is called an **organization determination.**

Legal Terms:

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 7 calendar days when the medical item or service is subject to our prior authorization rules, 14 calendar days for all other medical items and services, 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. To get a fast coverage decision, you must meet 2 requirements:

- You may *only* ask for coverage for medical items and/or services (not requests for payment for items and/or services you already got).
- 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 regain function.

If your doctor tells us that your health requires a fast coverage decision, we'll 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 don't approve a fast coverage decision, we'll send you a letter that:

- Explains that we'll use the standard deadlines.
- Explains if your doctor asks for the fast coverage decision, we'll 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 asked for.

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'll give you an answer within 7 calendar days after we get your request for a medical item or service that is subject to our prior authorization rules. If your requested medical item or service is not subject to our prior authorization rules, we'll give you an answer within 14 calendar days after we get your request. or service. If your request is for a Part B drug, we'll give you an answer within 72 hours after we get 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 calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.

- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. We'll 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. Go to Section 10 for information on complaints.)

For fast coverage decisions we use an expedited timeframe.

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

- **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'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. (Go to Section 10 for information on complaints.) We'll call you as soon as we make the decision.
- If our answer is no to part or all of what you asked for, we'll 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're going on to Level 1 of the appeals process.

Section 5.3 How to make a Level 1 appeal

Legal Terms:

An appeal to our 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 calendar days or 7 calendar days for Part B drugs. A fast appeal is generally made within 72 hours.

- If you're appealing a decision we made about coverage for care, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we'll 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.

Step 2: Ask our plan for an appeal or a fast appeal.

- **If you're asking for a standard appeal, submit your standard appeal in writing.** Chapter 2 has contact information.
- **If you're 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 65 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 asking for 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'll gather more information if needed and may contact you or your doctor.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
  - 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, tell you in writing. We can't take extra time if your request is for a Part B drug.
  - If we don't give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we're required to automatically send your request 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 ask for,** we must authorize or provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for,** we'll 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 gets your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer within **30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we get your appeal. We'll 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'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we shouldn't take extra days, you can file a fast complaint. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (Go to Section 10 of this chapter for information on complaints.)
- If we don't give you an answer by the deadline (or by the end of the extended time period), we'll 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 asked for,** 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 Part B drug.
- **If our plan says no to part or all of your appeal,** we'll automatically send your appeal to the independent review organization for Level 2 appeal.

Section 5.4 The Level 2 appeal process

Legal Term

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 isn't connected with us and isn't 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'll 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 the information about your appeal.

If you had a fast appeal at Level 1, you'll also have a fast appeal at Level 2.

- For the fast appeal, the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it gets your appeal.
- 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 Part B drug.

If you had a standard appeal at Level 1, you'll also have a standard appeal at Level 2.

- For the standard appeal, if your request is for a medical item or service, the independent review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it gets your appeal. If your request is for a Part B drug, the independent review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** of when it gets your appeal.
- 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 Part B drug.

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

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

- **If the independent 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 get the decision from the independent review organization for **standard requests**. For **expedited requests**, we have **72 hours** from the date we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of a request for a Part B drug,** we must authorize or provide the Part B drug within **72 hours** after we get the decision from the independent review organization for **standard requests**. For **expedited requests** we have **24 hours** from the date we get the decision from the independent 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 shouldn't 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 that:
  - Explains the decision.
  - Lets you know about your 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.
  - Tells 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.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 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 9 explains the Level 3, 4, and 5 appeals processes.

Section 5.5 If you're asking us to pay you for our share of a bill you got for medical care

Chapter 7 describes when you may need to ask for reimbursement or to pay a bill you got 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're asking for a coverage decision. To make this decision, we'll check to see if the medical care you paid for is covered. We'll also check to see if you followed 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 the rules, we'll send you the payment for our share of the cost typically within 30 calendar days, but no later than 60 calendar days after we get your request. If you haven’t paid for the medical care, we'll 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 won't send payment. Instead, we'll send you a letter that says we won't pay for the medical care and the reasons why.

If you don't agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you're 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 in Section 5.3. For appeals concerning reimbursement, note:

- We must give you our answer within 60 calendar days after we get your appeal. If you're asking us to pay you back for medical care you already got and paid for, you aren't 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 ask for to you or the provider within 60 calendar days.

SECTION 6 Part D drugs: How to ask for a coverage decision or make an appeal

Section 6.1 What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (Go to Chapter 5 for more information about a medically

accepted indication.) For details about Part D drugs, rules, restrictions, and costs, go to Chapters 5 and 6. **This section is about your Part D drugs only.** To keep things simple, we generally say *drug* in the rest of this section, instead of repeating *covered outpatient prescription drug* or *Part D drug* every time. We also use the term Drug list instead of *List of Covered Drugs* or *formulary*.

- If you don't know if a drug is covered or if you meet the rules, you can ask us. Some drugs require you to get approval from us before we'll cover it.
- If your pharmacy tells you that your prescription can't be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

Legal Term:

An initial coverage decision about your Part D drugs is called a **coverage determination.**

A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your drugs. This section tells what you can do if you're in any of the following situations:

- Asking to cover a Part D drug that's not on our plan's Drug List. **Ask for an exception. Section 6.2**
- Asking to waive a restriction on our plan's coverage for a drug (such as limits on the amount of the drug you can get, prior authorization criteria, or the requirement to try another drug first). **Ask for an exception. Section 6.2**
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier. **Ask for an exception. Section 6.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 6.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 6.4**

If you disagree with a coverage decision we made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal.

Section 6.2 Asking for an exception

Legal Terms:

Asking for coverage of a drug that's not on the Drug List is a **formulary exception.**

Asking for removal of a restriction on coverage for a drug is a **formulary exception.**

Asking to pay a lower price for a covered non-preferred drug is a **tiering exception.**

If a drug isn't covered in the way you'd like it to be covered, you can ask us to make an **exception**. An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are 3 examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug that's not on our Drug List.** If we agree to cover a drug not on the Drug List, you'll need to pay the cost-sharing amount that applies to drugs in Tier 3 (Non-Preferred Drug). You can't ask for an exception to the cost-sharing amount we require you to pay for the drug.
2. **Removing a restriction for a covered drug.** Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our Drug List. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.
3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of four cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you'll pay as your share of the cost of the drug.

- If our Drug List contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s).
- If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.
- If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
- You cannot ask us to change the cost-sharing tier for any drug in Tier 4 Specialty. Exceptions will not be considered for changes to cost sharing for any drug in tier 4 specialty or any drug on the non Part D enhanced drug list.
- If we approve your tiering exception request and there is more than one lower cost-sharing tier with alternative drugs you can't take, you usually pay the lowest amount.

Section 6.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons you're asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Our Drug List typically includes more than one drug for treating a particular condition. These different possibilities are called **alternative** drugs. If an alternative drug would be just as effective as the drug requesting and wouldn't cause more side effects or other health problems, we generally *won't* approve your request for an exception. If you ask us for a tiering exception, we generally *won't* approve your request for an exception unless all the alternative drugs in the

lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of our plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request, you can ask for another review by making an appeal.

Section 6.4 How to ask for a coverage decision, including an exception

Legal Term

A fast coverage decision is called an **expedited coverage determination.**

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

Standard coverage decisions are made within **72 hours** after we get your doctor's statement. **Fast coverage decisions** are made within **24 hours** after we get your doctor's statement.

If your health requires it, ask us to give you a fast coverage decision. **To get a fast coverage decision, you must meet 2 requirements:**

- You must be asking for a drug you didn't get yet. (You can't ask for a fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we'll automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we'll decide whether your health requires that we give you a fast coverage decision.** If we don't approve a fast coverage decision, we'll send you a letter that:
  - Explains that we'll use the standard deadlines.
  - Explains if your doctor or other prescriber asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
  - Tells you how you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for. We'll answer your complaint within 24 hours of receipt.

Step 2: Ask for a standard coverage decision or a fast coverage decision.

Start by calling, writing, or faxing our plan to ask us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the CMS

Model Coverage Determination Request Form or on our plan's form, which is available on our website. Chapter 2 has contact information. You may access a printable version of the form or submit your coverage determination request electronically through our secure member portal, which you can find on our website at https://www.carefirst.com/learngroupma/prescription-drug-coverage/drug-management-programs.html. To help us process your request, include your name, contact information, and information that shows which denied claim is being appealed.

You, your doctor, (or other prescriber) or your representative can do this. You can also have a lawyer act on your behalf. Section 4 tells how you can give written permission to someone else to act as your representative.

- **If you're asking for an exception, provide the supporting statement,** which is the medical reason for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

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

Deadlines for a fast coverage decision

- We must generally give you our answer **within 24 hours** after we receive your request.
  - For exceptions, we'll give you our answer within 24 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
  - If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for,** we must provide the coverage we agreed to within 24 hours after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Deadlines for a standard coverage decision about a drug you didn't get yet

- We must generally give you our answer **within 72 hours** after we get your request.
  - For exceptions, we'll give you our answer within 72 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
  - If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it'll be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for,** we must provide the coverage we agreed to within 72 hours after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for,** we will send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Deadlines for a standard coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we get your request.

- If we do not meet this deadline, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

- **If our answer is yes to part or all of what you asked for,** we're also required to make payment to you within 14 calendar days after we get your request.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Step 4: If we say no to your coverage request, you can make an 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 drug coverage you want. If you make an appeal, it means you're going to Level 1 of the appeals process.

Section 6.5 How to make a Level 1 appeal

Legal Terms:

An appeal to the plan about a Part D drug coverage decision is called a **plan redetermination.**

A fast appeal is called an **expedited redetermination.**

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

A standard appeal is usually made within 7 calendar days. A fast appeal is generally made within 72 hours. If your health requires it, ask for a fast appeal.

- If you're appealing a decision we made about a drug you didn't get yet, you and your doctor or other prescriber will need to decide if you need a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 6.4 of this chapter.

Step 2: You, your representative, doctor or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a **fast appeal**.

- **For standard appeals, submit a written request.** Chapter 2 has contact information.
- **For fast appeals either submit your appeal in writing or call us at** 888-970-0917. Chapter 2 has contact information.
- **We must accept any written request,** including a request submitted on the CMS Model Coverage *Redetermination* Request Form, which is available on our website. Include your name, contact information, and information about your claim to help us process your request. You may submit your coverage determination request electronically through our secure member portal, which you can find on the following website: https://www.carefirst.com/learngroupma/prescription-drug-coverage/drug-management-programs.html.

- **You must make your appeal request within 65 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 in your appeal and add more information.** You and your doctor may add more information to support your appeal.

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

- When we review your appeal, we take another careful look at all the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a fast appeal

- For fast appeals, we must give your our answer **within 72 hours after we get your appeal.** We'll give you our answer sooner if your health requires us to.
  - If we don't give you an answer within 72 hours, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal for a drug you didn't get yet

- For standard appeals, we must give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if you didn't get the drug yet and your health condition requires us to do so.
  - If we don't give you a decision within 7 calendar days, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we get your appeal.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal about payment for a drug you already bought

- We must give you our answer **within 14 calendar days** after we get your request.

- If we don't meet this deadline, we're required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

- **If our answer is yes to part or all of what you asked for,** we're also required to make payment to you within **30 calendar days** after we get your request.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

Section 6.6 How to make a Level 2 appeal

Legal Term

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: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the review organization.
- **You must make your appeal request within 65 calendar days** from the date on the written notice.
- If we did not complete our review within the applicable timeframe or make an unfavorable decision regarding an **at-risk** determination under our drug management program, we'll automatically forward your request to the IRE.
- We'll send the information about your appeal to the independent review 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.

Step 2: The independent review organization reviews your appeal.

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

Deadlines for fast appeal

- If your health requires it, ask the independent review organization for a fast appeal.
- If the organization agrees to give you a fast appeal, the organization must give you an answer to your Level 2 appeal **within 72 hours** after it gets your appeal request.

Deadlines for standard appeal

- For standard appeals, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it gets your appeal if it is for a drug you didn't get yet. If you're asking us to pay you back for a drug you already bought, the independent review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it gets your request.

Step 3: The independent review organization gives you its answer.

For fast appeals:

- **If the independent review organization says yes to part or all of what you asked for,** we must provide the drug coverage that was approved by the independent review organization **within 24 hours** after we get the decision from the independent review organization.

For standard appeals:

- **If the independent review organization says yes to part or all of your request for coverage,** we must **provide the drug coverage** that was approved by the independent review organization **within 72 hours** after we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we're required to **send payment to you within 30 calendar days** after we get the decision from the independent review organization.

What if the independent review organization says no to your appeal?

If this organization says no **to part or all of** your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called **upholding the decision**. It's also called **turning down your appeal**.). In this case, the independent review organization will send you a letter that:

- Explains the decision.
- Lets you know about your right to a Level 3 appeal, if the dollar value of the drug coverage you're asking for meets a certain minimum. If the dollar value of the drug coverage you're asking for is too low, you can't make another appeal and the decision at Level 2 is final.
- Tells you that the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 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 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon

When you're admitted to a hospital, you have the right to get all covered hospital services necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day you leave the hospital. They'll 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're being asked to leave the hospital too soon, you can ask for a longer hospital stay, and your request will be considered.

Section 7.1 During your inpatient hospital stay, you'll get a written notice from Medicare that tells you about your rights

Within 2 calendar days of being admitted to the hospital, you'll 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 don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Member Services at 833-939-4103 (TTY users should call 711) or 1-800-MEDICARE (1-800-633-4227). (TTY users call 1-877-486-2048).

1. **Read this notice carefully and ask questions if you don’t understand it.** It tells you:
   - Your right to get 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 quality of your hospital care.
   - Your right to **request an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date, so we'll cover your hospital care for a longer time.

2. **You'll be asked to sign the written notice to show that you got 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 got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date.
3. **Keep your copy** of the notice so you have the information about making an appeal (or reporting a concern about quality of care) if you need it.
   - If you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
   - To look at a copy of this notice in advance, call Member Services at 833-939-4103 (TTY users should call 711) or 1-800 MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can also get notice online at www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Section 7.2 How to make a Level 1 appeal to change your hospital discharge date

To ask us to cover your inpatient hospital services for a longer time 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 Services at 833-939-4103 (TTY users should call 711) Or, call your State Health Insurance Assistance Program, (SHIP) for personalized help. A list of State Health Insurance Programs can be found in Exhibit A at the end of this document.

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. These experts aren’t 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 got (*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 can 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 don't meet this deadline, contact us**. If you decide to stay in the hospital after your planned discharge date, *you may have to pay all the costs* for hospital care you get after your planned discharge date.
- Once you ask for an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we're contacted, we'll 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 Services at 833-939-4103. (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. Or you can get a sample notice online at www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

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 can if you want.
- The reviewers will also look at your medical information, talk with your doctor, and review information that we and the hospital gave them.
- By noon of the day after the reviewers told us of your appeal, you’ll 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 independent review organization says *yes*, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You'll 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 independent review organization says *no,* they're 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 independent review organization says *no* to your appeal and you decide to stay in the hospital, **you may have to pay the full cost** of hospital care you get after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

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

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

Section 7.3 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 its 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 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 the information about 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 its decision.

If the independent review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you got 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 independent review organization says no:

- It means they agree with the decision they made on 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.

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

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 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 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

When you're getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your 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's time to stop covering any of these 3 types of care for you, we're required to tell you in advance. When your coverage for that care ends, *we'll stop paying our share of the cost for your care.*

If you think we're ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 8.1 We'll tell you in advance when your coverage will be ending

Legal Term:

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

1. **You get a notice in writing** at least 2 calendar days before our plan is going to stop covering your care. The notice tells you:
   - The date when we'll stop covering the care for you.
   - How to request a fast-track appeal to ask 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 got it.** Signing the notice shows *only* that you got the information about when your coverage will stop. **Signing it doesn't mean you agree** with our plan's decision to stop care.

Section 8.2 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, call Member Services at 833-939-4103. (TTY users call 711). Or call your State Health Insurance Assistance Program, (SHIP) for personalized help. A list of State Health Insurance Programs can be found in Exhibit A at the end of this document.

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 aren't 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 got (*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*.
- If you miss the deadline, and you want to file an appeal, you still have appeal rights. Contact the Quality Improvement Organization using the contact information on the Notice of Medicare Non-coverage. The name, address, and phone number of the Quality Improvement Organization for your state may also be found in Chapter 2.

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

Legal Term:

Detailed Explanation of Non-Coverage. Notice that gives details on reasons for ending coverage.

What happens during this review?

- 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 can if you want.
- The independent review organization will also look at your medical information, talk with your doctor, and review information our plan gives them.
- By the end of the day the reviewers tell us of your appeal, you'll 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 its decision.

What happens if the reviewers say yes?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered service for as long as it's medically necessary.**
- You'll 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 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, **you'll 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 8.3 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 calendar days** after the day when the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you continued getting care after the date 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 the information about your appeal.

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

What happens if the review organization says yes?

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

What happens if the independent 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 want to continue with the review process. It will give you details about how to go 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'll need to decide whether you want to take your appeal further.

- There are 3 additional levels of appeal after Level 2, for a total of 5 levels of appeal. If you want go on to 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 9 tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 Taking your appeal to Level 3, 4, and 5

Section 9.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

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

If the dollar value of the item or medical service you 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 can't appeal any further. The written response you get to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's 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 a Level 2 appeal, we have the right to appeal a Level 3 decision that's 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 medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision.
  - If we decide to appeal the decision, we'll 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 medical care 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 the decision that turns down your appeal, the appeals process is over.
  - If you don't 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'll 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 medical care within 60 calendar days after getting the Council's decision.
  - If we decide to appeal the decision, we'll 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 don't 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 to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal

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

- A judge will review all 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.

Section 9.2 Appeal Levels 3, 4 and 5 for Part D Drug Requests

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

If the value of the drug you appealed meets a certain dollar amount, you may be able to go to additional levels of appeal. If the dollar amount is less, you can't appeal any further. The written response you get to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's 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 answer is yes, the appeals process is over**. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision.
- **If the answer is no, the appeals process *may* or *may not* be over**.
  - If you decide to accept the decision that turns down your appeal, the appeals process is over.
  - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you 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, the appeals process is over**. We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision.
- **If the answer is no, the appeals process *may* or *may not* be over**.
  - If you decide to accept the decision that turns down your appeal, the appeals process is over.
  - If you don't 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 or denies your request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 appeal

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

- 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.

Making complaints

SECTION 10 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 10.1 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 customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you got (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Member Services? • Do you feel you're being encouraged to leave our plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at our plan? ◦ Examples include waiting too long on the phone, in the waiting or exam room, or when getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor’s office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?

Complaint	Example
Timeliness (These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals)	If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples: • You have asked us for a fast coverage decision or a fast appeal, and we said no; you can make a complaint. • You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we aren't meeting deadlines for covering or reimbursing you for certain medical items or services or drugs 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 10.2 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.**

Step 1: Contact us promptly – either by phone or in writing.

- **Calling Member Services at 833-939-4103 (TTY users should call 711) is usually the first step.** If there's anything else you need to do, Member Services will let you know.
- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing.
- **Standard Grievance Process** - You can file a grievance through a call to Member Services at the number on the back of this document. Often we can resolve your grievance during the call. If we cannot resolve your grievance during the call we will forward your concern for more investigation. You can also send your concern to us in writing.

Send written complaints about your medical coverage to:

CareFirst BlueCross BlueShield Medicare Advantage
Attention: Appeals & Grievances Department
P.O. Box 915
Owings Mills, MD 21117

Send written complaints about your Part D drug coverage to:

Grievance Department
P.O. Box 30016
Pittsburgh, PA 15222-0330

Your grievance must be forwarded to us orally or in writing within 60 days of the event or incident. We will respond to your grievance within 30 calendar days.

- **Expedited Grievances** - Call Member Services if you have an Expedited Grievance, which is a complaint about:
  - Our decision to request an extension to a coverage determination or appeal which would extend the timeframe to provide a decision by 14 days, or;
  - Our decision not to expedite your request for a coverage determination or appeal
- An Expedited Grievance will be reviewed within 24 hours of receipt. We will call you with the outcome of your Expedited Grievance.
- 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'll 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'll tell you in writing.
- **If you're making a complaint because we denied your request for a fast coverage decision or a fast appeal, we'll automatically give you a fast complaint.** If you have a fast complaint, it means we'll give you **an answer within 24 hours.**
- **If we don't agree** with some or all of your complaint or don't take responsibility for the problem you're complaining about, we'll include our reasons in our response to you.

Section 10.3 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you have 2 extra options:

- **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 10.4 You can also tell Medicare about your complaint

You can submit a complaint about CareFirst BlueCross BlueShield Group Advantage directly to Medicare. To submit a complaint to Medicare, go to www.Medicare.gov/my/medicare-complaint. You can also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048.

CHAPTER 10:
Ending membership in our plan

SECTION 1 Ending your membership in our plan

Ending your membership in CareFirst BlueCross BlueShield Group Advantage may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you decide you *want* to leave. Sections 2 and 3 give information on ending your membership voluntarily.
  - Because you are a member of an employer group retiree plan, your group establishes the timeframes when you can make changes to your coverage. You are eligible to make changes during those times. You may wish to talk to your employer group to verify what impact leaving your plan will have and what other options exist within your retiree program. Failing to contact your employer to discuss your options could negatively impact your current and future retiree benefits. More details on when you can leave your plan can be found in Section 2.
- There are also limited situations where we're required to end your membership. Section 5 tells you about situations when we must end your membership.

If you're leaving our plan, our plan you must continue to provide your medical care and prescription drugs, and you'll continue to pay your cost share until your membership ends.

SECTION 2 When can you end your membership in our plan?

You can make changes to your plan during your employer's annual Open Enrollment Period (OEP). Your employer will provide information on what your plan enrollment options are and when the OEP begins and ends. Should you choose to disenroll from all of your employer group offerings, you should discuss this decision with your former employer group to determine what the impacts of that disenrollment would be.

All Medicare beneficiaries can make a change to their Medicare Advantage plan during the Annual Enrollment Period from October 15 to December 7 each year and during the Medicare Advantage Open Enrollment Period from January 1 to March 31. Should you choose to leave your employer group's retiree plan at this time, you should discuss this change with your employer group to understand how this disenrollment will impact your retiree coverage.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

Section 2.1 Get more information about when you can end your membership

If you have questions about ending your membership you can:

- **Contact your employer.**
- **Call Member Services at 833-939-4103 (TTY users should call 711).**
- Find the information in the ***Medicare & You 2026*** Handbook.
- Call **Medicare** at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

SECTION 3 How to end your membership in our plan

Prior to disenrolling from your employer's retiree plan, it is important that you understand how this disenrollment could impact your other retiree benefits. It is critical to discuss this impact with your employer group administrator to make sure you clearly understand the effects of disenrollment, as you could lose other retiree benefits and be unable to regain them in the future.

After you discuss this with your employer group administrator to ensure you understand any impact to other retiree benefits, consider the following options:

To switch from our plan to:	Here's what to do:
Another Medicare health plan	• Enroll in the new Medicare health plan. • Send a written request to your group retiree benefit contact to disenroll. • You'll automatically be disenrolled from CareFirst BlueCross BlueShield Group Advantage when your new plan's coverage starts.
Original Medicare *with* a separate Medicare drug plan	• Enroll in the new Medicare drug plan. • Send a written request to your group retiree benefit contact to disenroll. • You can also call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users call 1-877-486-2048. • You'll automatically be disenrolled from CareFirst BlueCross BlueShield Group Advantage when your new drug plan's coverage starts.
Original Medicare *without* a separate Medicare drug plan	• **Send a written request to your group retiree benefit contact to disenroll.**

To switch from our plan to:	Here's what to do:
	• You can also call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users call 1-877-486-2048. • You'll be disenrolled from CareFirst BlueCross BlueShield Group Advantage when your coverage in Original Medicare starts.

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

Until your membership ends, and your new Medicare coverage starts, you must continue to get your medical items, services and prescription drugs through our plan.

- **Continue to use our network pharmacies or mail order to get your prescriptions filled.**
- **If you're hospitalized on the day your membership ends, your hospital stay will be covered by our plan until you're discharged** (even if you're discharged after your new health coverage starts).

SECTION 5 CareFirst BlueCross BlueShield Group Advantage must end our plan membership in certain situations

CareFirst BlueCross BlueShield Group Advantage must end your membership in our plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If your employer group retiree plan advises that you're no longer eligible for the plan.
- If you move out of our service area.
- If you're away from our service area for more than 6 months.
  - If you move or take a long trip, call Member Services at 833-939-4103 (TTY users should call 711) to find out if the place you're moving or traveling to is in our plan’s area.
- If you become incarcerated (go to prison).
- If you're no longer a United States citizen or lawfully present in the United States.
- If you lie or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you're enrolling in our plan, and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)

- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We can't 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 can't 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 your employer group or union informs us that you have not paid your plan premium per your employer group or union's rules and you must be disenrolled.
- If you're required to pay the extra Part D amount because of your income and you don't pay it, Medicare will disenroll you from our plan and you'll lose drug coverage.

If you have questions or want more information on when we can end your membership, call Member Services at 833-939-4103 (TTY users should call 711).

Section 5.1 We can't ask you to leave our plan for any health-related reason

CareFirst BlueCross BlueShield Group Advantage isn't allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel you're being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 5.2 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 11: 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 (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 aren't included or explained in this document.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, age, 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, 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 www.HHS.gov/ocr/index.html.

If you have a disability and need help with access to care, call us at Member Services at 833-939-4103 (TTY users call 711). If you have a complaint, such as a problem with wheelchair access, Member Services 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, CareFirst BlueCross BlueShield Group Advantage, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in

subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

SECTION 4 Third Party Liability and Subrogation

CareFirst BlueCross BlueShield Group Advantage has subrogation and reimbursement rights. Subrogation requires that you turn over to CareFirst BlueCross BlueShield Group Advantage any rights you may have against a third party. A third party is any person, corporation, insurer or other entity that may be liable to you for an injury or illness. This right applies to the amount of benefits paid by CareFirst BlueCross BlueShield Group Advantage for injuries or illnesses where a third party could be liable. The Plan is given the same rights of subrogation and recovery that are available to the Medicare Program under the Medicare Secondary Payer rules. CareFirst BlueCross BlueShield Group Advantage may use whatever rights of recovery are available to the Medicare program under 42 U.S.C. § 1395mm(e)(4), 42 U.S.C. §1395w-22(a)(4), 42 C.F.R. Part 411, and 42 C.F.R. Part 422.

Recovery means to be successful in a lawsuit, to collect or obtain an amount; to obtain a favorable or final judgment; to obtain an amount in any legal manner; an amount finally collected or the amount of judgment as a result of an action brought against a third party or involving uninsured or underinsured motorist claims. A Recovery does not include payments made to you under a personal injury protection policy. CareFirst BlueCross BlueShield Group Advantage will not recover medical expenses from you unless you recover for medical expenses in a cause of action.

- **A.** You must notify CareFirst BlueCross BlueShield Group Advantage as soon as reasonably possible that a third party may be liable for the injuries or illnesses for which benefits are being provided or paid.
- **B.** To the extent that actual payments made by CareFirst BlueCross BlueShield Group Advantage result from the occurrence that gave rise to the cause of action, CareFirst BlueCross BlueShield Group Advantage shall be subrogated and succeed to any right of recovery you have against any person or organization.
- **C.** You shall pay CareFirst BlueCross BlueShield Group Advantage the amount recovered by suit, settlement, or otherwise from any third party's insurer, any uninsured or underinsured motorist coverage, or as permitted by law, to the extent that any actual payments made by CareFirst BlueCross BlueShield Group Advantage result from the occurrence that gave rise to the cause of action.
- **D.** You shall furnish information and assistance, and execute papers that CareFirst BlueCross BlueShield Group Advantage may require to facilitate enforcement of these rights. You shall not commit any action prejudicing the rights and interests of CareFirst BlueCross BlueShield Group Advantage.

E. In a subrogation claim arising out of a claim for personal injury, the amount recovered by CareFirst BlueCross BlueShield Group Advantage may be reduced by:

1. Dividing the total amount of the personal injury recovery into the total amount of the attorney's fees incurred by the injured person for services rendered in connection with the injured person's claim; and

2. Multiplying the result by the amount of CareFirst BlueCross BlueShield Group Advantage's subrogation claim. This percentage may not exceed one-third (1/3) of CareFirst BlueCross BlueShield Group Advantage's subrogation claim.

F. On written request by CareFirst BlueCross BlueShield Group Advantage, you or your attorney demanding a reduction of the subrogation claim shall provide CareFirst BlueCross BlueShield Group Advantage with your certification that states the amount of the attorney's fees incurred.

CHAPTER 12: Definitions

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 doesn't exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already got. You may also make an appeal if you disagree with our decision to stop services that you're getting.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than our plan's allowed cost-sharing amount. As a member of CareFirst BlueCross BlueShield Group Advantage, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We don't allow Medicare participating and Medicare non-participating providers to **balance bill** or otherwise charge you more than the amount of cost sharing our plan says you must pay.

Benefit Period – The way that our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. For both Original Medicare and our plan, a benefit period begins the day you go into a skilled nursing facility. The benefit period ends when you have not received any skilled care in a SNF for 60 days in a row. If you go into a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods. For our plan, a benefit period begins the day you go into an inpatient hospital. The benefit period ends when you are discharged from the hospital. If you go into an inpatient hospital after one benefit period has ended, a new benefit period begins in which copays restart. There is no limit to the number of benefit periods.

Biological Product – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can't be copied exactly, so alternative forms are called biosimilars. (Go to "**Original Biological Product**" and "**Biosimilar**").

Biosimilar – A biological product that's very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars substituted for the original biological product at the pharmacy without needing a new prescription (go to "**Interchangeable Biosimilar**").

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are

manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent $2,100 for Part D covered drugs during the covered year. During this payment stage, you pay nothing for your covered Part D drugs and for excluded drugs that are covered under our enhanced benefit.

Centers for Medicare & Medicaid Services (CMS) – The federal agency that administers Medicare.

Chronic-Care Special Needs Plan(C-SNP) - C-SNPs are SNPs that restrict enrollment to MA eligible people who have specific severe and chronic diseases.

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services or prescription drugs after you pay any deductibles.

Combined Maximum Out-of-Pocket Amount – This is the most you'll pay in a year for all Part A and Part B services from both network (preferred) providers and out-of-network (non-preferred) providers. Go to Chapter 4, Section 1.2 for information about your combined maximum out-of-pocket amount.

Complaint – The formal name for making a complaint is **filing a grievance**. 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 you get. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, 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 drug. A copayment is a set amount (for example $10), rather than a percentage.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services or drugs are gotten. This is in addition to our plan's monthly premium. Cost sharing includes any combination of the following 3 types of payments: 1) any deductible amount a plan may impose before services or drugs are covered; 2) any fixed copayment amount that a plan requires when a specific service or drug is gotten; or 3) any coinsurance amount, a percentage of the total amount paid for a service or drug, that a plan requires when a specific service drug is gotten.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of four cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by our plan and the amount, if any, you're required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under our plan, that isn't a coverage determination. You need to call or write to our plan to ask

for a formal decision about the coverage. Coverage determinations are called **coverage decisions** in this document.

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

Covered Services – The term we use in this EOC to mean all of the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – 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 don't need skilled medical care or skilled nursing care. Custodial care, provided by people who don't have professional skills or training, includes 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.

Daily cost-sharing rate – A daily cost-sharing rate may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in our plan is 30 days, then your daily cost-sharing rate is $1 per day.

Disenroll or **Disenrollment** – The process of ending your membership in our plan.

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll people who are entitled to both Medicare (Title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (Title XIX). States cover some Medicare costs, depending on the state and the person's eligibility.

Dually Eligible Individual – A person who is eligible for Medicare and Medicaid coverage.

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 (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of 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.

Emergency Care – Covered services that are: 1) provided 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.

Exception – A type of coverage decision that, if approved, allows you to get a drug that isn't on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also ask for an exception if our plan requires you to try another drug before getting the drug you're asking for, if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction, or if our plan limits the quantity or dosage of the drug you're asking for (a formulary exception).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Generic Drug – A prescription drug that is approved by the FDA as having the same active ingredient(s) as the brand name drug. Generally, a generic drug works the same as a brand name drug and usually costs less.

Grievance - A type of complaint you make about our plan, providers, or pharmacies, including a complaint concerning the quality of your care. This doesn't involve coverage or payment disputes.

Home Health Aide – A person who 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 prescribed exercises).

Hospice - A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. Our plan must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you're still a member of our plan. You can still get all medically necessary services as well as the supplemental benefits we offer.

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.

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people won't pay a higher premium.

Initial Coverage Stage – This is the stage before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

Initial Enrollment Period – When you're first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Interchangeable Biosimilar – A biosimilar that may be used as a substitute for an original biosimilar product at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

List of Covered Drugs (formulary or Drug List) – A list of prescription drugs covered by our plan.

Low Income Subsidy (LIS) – Go to Extra Help.

Manufacturer Discount Program – A program under which drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics. Discounts are based on agreements between the federal government and drug manufacturers.

Maximum Fair Price – The price Medicare negotiated for a selected drug.

Medicaid (or Medical Assistance) – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Accepted Indication – A use of a drug that is either approved by the FDA or supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information system.

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).

Medicare Advantage Open Enrollment Period – The time period from January 1 to March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan or get 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. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after a person 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 i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP) 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**.

Medicare Cost Plan - A Medicare Cost Plan is a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all the services that are covered by Medicare Part A and B. The term Medicare-Covered Services doesn't include the extra benefits, such as vision, dental, or hearing, that a Medicare Advantage plan may offer.

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 our plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs 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.

Medication Therapy Management (MTM) program – A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications.

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

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

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Network Pharmacy – A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider – Provider is the general term 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. **Network providers** 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. Network providers are also called **plan providers**.

Organization Determination – A decision our plan makes 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 document.

Original Biological Product – A biological product that has been approved by the FDA and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

Original Medicare (Traditional Medicare or Fee-for-Service Medicare) – Original Medicare is offered by the government, and not a private health plan such as 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 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies aren't covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that doesn't have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that aren't employed, owned, or operated by our plan.

Out-of-Pocket Costs – Go to the definition for cost sharing above. A member's cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member's out-of-pocket cost requirement.

Out-of-Pocket Threshold – The maximum amount you pay out of pocket for Part D drugs.

PACE Plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Part C – Go to Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded as covered Part D drugs by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late Enrollment Penalty – An amount added to your monthly premium plan for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you're first eligible to join a Part D plan.

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 gotten from network or out-of-network providers. PPO plans have an annual limit on

your out-of-pocket costs for services gotten 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.

Preventive services – Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

Primary Care Provider (PCP) – The doctor or other provider you see first for most health problems.

Prior Authorization – Approval in advance to get services and/or certain drugs based on specific criteria. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other network provider gets prior authorization from our plan. In a PPO, you don't need prior authorization to get out-of-network services. However, you may want to check with our plan before getting services from out-of-network providers to confirm that the service is covered by our plan and what your cost-sharing responsibility is. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary and our criteria are posted on our website.

Prosthetics and Orthotics – Medical devices including, but aren't 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.

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

"Real-Time Benefit Tool" – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost-sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

Rehabilitation Services – These services include inpatient rehabilitation care, physical therapy (outpatient), speech and language therapy, and occupational therapy.

Selected Drug – A drug covered under Part D for which Medicare negotiated a Maximum Fair Price.

Service Area – A geographic area where you must live to join a particular health plan. 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. Our plan must disenroll you if you permanently move out of our 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 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 plan 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're getting Extra Help with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who live in a nursing home, or who have certain chronic medical conditions.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we'll cover the drug your physician may have initially prescribed.

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

Urgently Needed Services – A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

Exhibit A: Contact Information for AIDS Drug Assistance Programs (ADAP), State Medicaid Offices, State Health Insurance Assistance Programs (SHIP) and State Pharmaceutical Assistance Programs (SPAP)

Alabama	
ADAP Alabama AIDS Drug Assistance Program Office of HIV Prevention and Care Alabama Department of Public Health The RSA Tower 201 Monroe Street, Suite 1400 Montgomery, AL 36104 http://www.alabamapublichealth.gov/hiv/adap.html	1-866-574-9964
Medicaid Alabama Medicaid P.O. Box 5624 Montgomery, AL 36103-5624 http://www.medicaid.alabama.gov/	1-800-362-1504 TTY 800-253-0799
SHIP Alabama State Health Insurance Assistance Program (SHIP) 201 Monroe ST, STE 350 Montgomery, AL 36104 https://alabamaageline.gov/ship/	1-800-243-5463
Alaska	
ADAP Alaskan AIDS Assistance Association 1057 W Fireweed LN, #102 Anchorage, AK 99503 http://www.alaskanaids.org/index.php/client-services/adap	1-800-478-2437
Medicaid State of Alaska Department of Health & Social Services, Division of Health Care Services 4601 Business Park Blvd, Bldg. K Anchorage, AK 99503-7167 http://dhss.alaska.gov/dhcs/Pages/default.aspx#medicaid	1-800-780-9972 TTY 1-907-465-5430
SHIP Alaska Medicare Information Office 550 W 7th Ave, Suite 1230 Anchorage, AK 99501 http://dhss.alaska.gov/dsds/Pages/medicare/default.aspx	1-907-269-3680
American Samoa	
ADAP American Samoa Department of Health Faagaalu RD 1 Pago Pago, AS 96799 https://www.americansamoa.gov/	1-684-633-2437 8 a.m. - 5 p.m. local time, Monday - Friday

Exhibit A: Contact Information for AIDS Drug Assistance Programs (ADAP), State Medicaid Offices, State Health Insurance Assistance Programs (SHIP) and State Pharmaceutical Assistance Programs (SPAP)

American Samoa	
Medicaid American Samoa Medicaid State Agency ASCTA Executive BLDG #304 P.O. Box 998383 Pago Pago, AS 96799 https://www.amsamoamedicaid.com	1-684-699-4777 TTY 711
Arizona	
ADAP Arizona Department of Health Services ADAP 150 N 18th AVE Phoenix, AZ 85007 https://www.azdhs.gov/preparedness/bureau-of-infectious-disease-and-services/hiv-hepatitis-c-services/index.php#aids-drug-assistance-program-home	1-800-334-1540
Medicaid Arizona Health Care Cost Containment System (AHCCCS) 801 E Jefferson ST Phoenix, AZ 85034 https://www.azahcccs.gov/	1-855-432-7587 TTY 711
SHIP Arizona State Health Insurance Assistance Program 1366 E Thomas RD, STE 108 ATTN: SHIP Phoenix, AZ 85104 https://des.az.gov/medicare-assistance	1-800-432-4040 TTY 711
Arkansas	
ADAP Arkansas Department of Health, Ryan White Program - Part B 4815 W Markham ST, Slot 33 Little Rock, AR 72205 https://www.healthy.arkansas.gov/programs-services/topics/ryan-white-program	1-501-661-2408
Medicaid Arkansas Division of Medical Services Department of Human Services Donaghey Plaza S, P.O. Box 1437 Slot S401 Little Rock, AR 72203-1437 https://humanservices.arkansas.gov/divisions-shared-services/medical-services/	1-800-482-8988 TTY 1-800-285-1131

Exhibit A: Contact Information for AIDS Drug Assistance Programs (ADAP), State Medicaid Offices, State Health Insurance Assistance Programs (SHIP) and State Pharmaceutical Assistance Programs (SPAP)

Arkansas	
SHIP Arkansas Senior Health Insurance Information Program (SHIIP) 1 Commerce Way Little Rock, AR 72202 https://www.insurance.arkansas.gov/pages/consumer-services/senior-health/	1-800-224-6330 TTY 711
California	
ADAP Department of Health Services - ADAP P.O. Box 997426 Sacramento, CA 95899-7426 https://www.cdph.ca.gov/Programs/CID/DOA/pages/OA_adap_eligibility.aspx	1-844-421-7050
Medicaid Medi-Cal - Managed Care Operations Division Department of Health Care Services P.O. Box 989009 West Sacramento, CA 95798-9850 http://www.healthcareoptions.dhcs.ca.gov/	1-800-430-4263 TTY 1-800-430-7077
SHIP California Health Insurance Counseling & Advocacy Program (HICAP) 2880 Gateway Oaks Drive, Suite 200 Sacramento, CA 95833 https://www.aging.ca.gov/Programs_and_Services/Medicare_Counseling/	1-800-434-0222 TTY 1-800-735-2929
SPAP Department of Health Services P.O. Box 997377 Sacramento, CA 95899-7377 https://www.pharmacy.ca.gov/consumers/medicare_discount.shtml	1-844-421-7050 TTY 711
Colorado	
ADAP Colorado AIDS Drug Assistance Program (ADAP) ADAP-3800, 4300 Cherry Creek DR S Denver, CO 80246-1530 https://cdphe.colorado.gov/state-drug-assistance-program	1-303-692-2716
Medicaid Colorado Department of Health Care Policy and Financing 1570 Grant St.	

Exhibit A: Contact Information for AIDS Drug Assistance Programs (ADAP), State Medicaid Offices, State Health Insurance Assistance Programs (SHIP) and State Pharmaceutical Assistance Programs (SPAP)

Colorado	
Denver, CO 80203-1818 https://hcpf.colorado.gov/	1-800-221-3943 TTY 711
SHIP Colorado Senior Health Insurance Assistance Program (SHIP) 1560 Broadway, STE 850 Denver, CO 80202 https://doi.colorado.gov/insurance-products/health-insurance/senior-health-care-medicare	1-888-696-7213 TTY 711
SPAP Colorado Department of Health Care Policy & Financing 1570 Grant ST Denver, CO 80103-1818 https://hcpf.colorado.gov/	1-800-221-3943 TTY 711
Connecticut	
ADAP Connecticut ADAP Magellan Health Services P.O. Box 9971 Glen Allen, VA 23060 https://portal.ct.gov/dss/health-and-home-care/cadap/connecticut-aids-drug-assistance-program-cadap?language=en_US	1-800-424-3310
Medicaid Connecticut Department of Social Services 55 Farmington AVE Hartford, CT 06105-3730 https://portal.ct.gov/husky	1-877-284-8759 TTY 1-866-492-5276
SHIP Connecticut CHOICES Senior Health Insurance Program 55 Farmington AVE, FL 12 Hartford, CT 06105-3730 https://portal.ct.gov/AgingandDisability/Content-Pages/Programs/CHOICES-Connecticuts-program-for-Health-insurance-assistance-Outreach-Information-and-referral-Couns	1-800-994-9422 TTY 711
Delaware	
ADAP Delaware Division of Public Health Ryan White Program 540 S DuPont HWY Dover, DE 19901	1-302-744-1050

Exhibit A: Contact Information for AIDS Drug Assistance Programs (ADAP), State Medicaid Offices, State Health Insurance Assistance Programs (SHIP) and State Pharmaceutical Assistance Programs (SPAP)

Delaware	
http://www.dhss.delaware.gov/dhss/dph/dpc/hivtreatment.html	
Medicaid Delaware Health and Social Services 1901 N Dupont HWY, Lewis BLDG New Castle, DE 19720 https://dhss.delaware.gov/dhss/dmma/	866-843-7212 TTY 711
SHIP Delaware Medicare Assistance Bureau (DMAB) 1351 WN ST, STE 101 Dover, DE 19904 https://insurance.delaware.gov/divisions/dmab/	1-800-336-9500 TTY 711
SPAP Delaware Prescription Assistance Program P.O. Box 950, MANOR BRANCH New Castle, DE 19720 https://dhss.delaware.gov/dhss/dmma/dpap.html	1-844-245-9580 TTY 711
District of Columbia	
ADAP District of Columbia ADAP 899 N Capitol ST NE, STE 400 Washington, DC 20002 https://dchealth.dc.gov/node/137072	1-202-671-4815
Medicaid DC Department of Human Services 64 New York AVE NE, FL 6 Washington, DC 20002 https://dhs.dc.gov/service/medical-assistance	1-202-671-4200 TTY 711
SHIP Department of Aging and Community Living 500 K ST NE Washington, DC 20002 https://dacl.dc.gov/service/health-insurance-counseling	202-727-8370 TTY 711
SPAP District of Columbia Department of Health AIDS Drug Assistance Program (ADAP) 899 N Capitol ST NE Washington, DC 20002 https://dchealth.dc.gov/node/137072	1-202-671-4815 TTY 711

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Florida	
ADAP Florida Department of Health ADAP HIV/AIDS Section 4052 Bald Cypress Way Tallahassee, FL 32399 http://www.floridahealth.gov/diseases-and-conditions/aids/adap/index.html	1-800-352-2437
Medicaid Florida Medicaid Agency for Health Care Administration (AHCA) 2727 Mahan DR, MS 6 Tallahassee, FL 32308 https://quality.healthfinder.fl.gov/medicaid/florida-medicaid-general	1-888-419-3456 TTY 1-800-955-8771
SHIP Florida Serving Health Insurance Needs of Elders (SHINE) 4040 Esplanade Way, STE 270 Tallahassee, FL 32399-7000 www.floridashine.org	1-800-963-5337 TTY 1-800-955-8770
Georgia	
ADAP Georgia AIDS Drug Assistance Program (ADAP) 2 Peachtree ST NW, FL 15 Atlanta, GA 30303-3186 https://dph.georgia.gov/health-topics/office-hivaids/hiv-care/aids-drug-assistance-program-adap	1-404-656-9805
Medicaid Georgia Department of Community Health 1249 Donald Lee Hollowell Parkway Atlanta, GA 30318 https://medicaid.georgia.gov/	1-866-552-4464 TTY 711
SHIP GeorgiaCares Senior Health Insurance Plan 2 Peachtree ST NW, FL 33 Atlanta, GA 30303 https://aging.georgia.gov/georgia-ship	1-866-552-4464 (Option 4) TTY 711
Guam	
ADAP Bureau of Communicable Disease Control - STD/HIV 123 Chalan Kareta, RM 156 Mangilao, GU 96913	1-671-734-2437 8 a.m. - 5 p.m. local time, Monday – Friday

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Guam	
http://dphss.guam.gov/ryan-white-hiv-aids-program/	
Medicaid Guam Department of Public Health and Social Services Bureau of Health Care Financing 123 Chalan Kareta Mangilao, GU 96913-6304 https://dphss.guam.gov/wp-content/uploads/2019/05/GUAM-MEDICAID-Handbook-Revised-3-12-19-Individual-Pages-for-website.pdf	1-671-735-7243 TTY 711
SHIP Guam Medicare Assistance Program (GUAM MAP) 130 University DR, STE 8, University Castle Mall Mangilao, GU 96913 https://dphss.guam.gov/	1-671-735-7421 TTY 1-671-735-7415
Hawaii	
ADAP Hawaii Harm Reduction Services Branch 3627 Kilauea AVE, STE 306 Honolulu, HI 96816 https://health.hawaii.gov/harmreduction/about-us/hiv-programs/hiv-medical-management-services/	1-808-733-9360
Medicaid Department of Human Services 1390 Miller ST, RM 209 Honolulu, HI 96813 https://medquest.hawaii.gov/	808-586-4993 TTY 711
SHIP Hawaii SHIP No. 1 Capitol District, 250 S Hotel ST, STE 406 Honolulu, HI 96813-2831 www.hawaiiship.org	808-586-7299 TTY 1-866-810-4379
Idaho	
ADAP Idaho AIDS Drug Assistance Program (IDADAP) 450 W State ST, FL 4 Boise, ID 83720-0036 https://healthandwelfare.idaho.gov/health-wellness/diseases-conditions/hiv	1-208-334-5612
Medicaid Idaho Department of Health and Welfare P.O. Box 83720 Boise, ID 83720-0026	

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Idaho	
https://healthandwelfare.idaho.gov/services-programs/medicaid-health	1-877-456-1233
SHIP Idaho Senior Health Insurance Benefits Advisors (SHIBA) 700 W State ST, P.O. Box 83720 Boise, ID 83720-0043 http://www.doi.idaho.gov/SHIBA/	1-800-247-4422
SPAP Idaho AIDS Drug Assistance Program (IDADAP) 450 W State ST, P.O. Box 83720 Boise, ID 83720-0036 http://www.healthandwelfare.idaho.gov/Health/HIV,STD,HepatitisPrograms/HIVCare/tabid/391/Default.aspx	1-208-334-6657 TTY 711
Illinois	
ADAP Illinois ADAP 525 W Jefferson ST, FL 1 Springfield, IL 62761 https://www.dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids/ryan-white-care-and-hopwa-services	1-800-825-3518
Medicaid Illinois Department of Healthcare and Family Services 100 S Grand AVE E Springfield, IL 62704 https://enrollhfs.illinois.gov/en	1-800-843-6154 TTY 866-324-5553
SHIP Illinois Senior Health Insurance Program (SHIP) One Natural Resources Way, STE 100 Springfield, IL 62702-1271 https://ilaging.illinois.gov/ship.html	1-800-252-8966 TTY 711
Indiana	
ADAP Indiana HIV Medical Services Program 2 N Meridian ST, STE 6C Indianapolis, IN 46206 https://www.in.gov/health/hiv-std-viral-hepatitis/hiv-services/	1-800-382-9480
Medicaid Indiana Family and Social Services Administration 402 W. Washington Street, P.O. Box 7083 Indianapolis, IN 46207-7083	

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Indiana	
https://www.in.gov/medicaid/	1-800-403-0864 TTY 1-800-743-3333
SHIP Indiana State Health Insurance Assistance Program (SHIP) 311 W Washington ST, STE 300 Indianapolis, IN 46204-2787 http://www.in.gov/idoi/2495.htm	1-800-452-4800 TTY 1-866-846-0139
SPAP HoosierRx P.O. Box 6224 Indianapolis, IN 49206 https://www.in.gov/medicaid/members/194.htm	1-866-267-4679 TTY 711
Iowa	
ADAP Iowa Ryan White Part B Program Lucas State Office Building 321 E. 12th Street Des Moines, IA 50319-0075 https://hhs.iowa.gov/health-prevention/hiv-sti-and-hepatitis/hivaids-program	1-515-281-7689 TTY 1-800-735-2942
Medicaid Iowa Medicaid P.O. Box 36510 Des Moines, IA 50315 https://hhs.iowa.gov/programs/welcome-iowa-medicaid	1-800-338-8366 TTY 1-800-735-2942
SHIP SHIIP--SMP Iowa Insurance Division 1963 Bell Avenue Suite 100 Des Moines, Iowa 50315 https://shiip.iowa.gov	1-800-351-4664 TTY 1-800-735-2942
Kansas	
ADAP Kansas AIDS Drug Assistance Program 1000 SW Jackson ST, STE 210 Topeka, KS 66612 https://www.kdhe.ks.gov/359/AIDS-Drug-Assistance-Program-ADAP	1-785-296-6174
Medicaid KanCare (Kansas Department of Health and Environment)	

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Kansas	
1000 SW Jackson ST Topeka, KS 66612-1220 www.kancare.ks.gov	1-800-792-4884 TTY 1-800-766-3777
SHIP Senior Health Insurance Counseling for Kansas (SHICK) New England BLDG, 503 S Kansas AVE Topeka, KS 66603-3404 http://www.kdads.ks.gov/SHICK/shick_index.html	1-800-860-5260 TTY 1-785-291-3167
Kentucky	
ADAP Kentucky AIDS Drug Assistance Program (KADAP) HIV/AIDS Branch, 275 E Main ST, HS2E-C Frankfort, KY 40621 https://chfs.ky.gov/agencies/dph/dehp/hab/Pages/services.aspx	1-800-420-7431
Medicaid Kentucky Cabinet for Health and Family Services 275 E Main ST Frankfort, KY 40621 https://chfs.ky.gov/agencies/dms/Pages/default.aspx	502-564-4321 TTY 711
SHIP Kentucky State Health Insurance Assistance Program (SHIP) 275 E Main ST, 3E-E Frankfort, KY 40621 https://chfs.ky.gov/agencies/dail/Pages/ship.aspx	1-877-293-7447 (Option 2) TTY 1-800-627-4702
Louisiana	
ADAP Louisiana Office of Public Health STD/HIV Program, 1450 Poydras ST, STE 2136 New Orleans, LA 70112 http://new.dhh.louisiana.gov/index.cfm/page/1099	1-504-568-7474
Medicaid Louisiana Department of Health P.O. Box 629 Baton Rouge, LA 70821-0629 https://ldh.la.gov/healthy-louisiana	1-888-342-6207 TTY 711
SHIP Louisiana Senior Health Insurance Information Program (SHIIP) P.O. Box 94214	

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Louisiana	
Baton Rouge, LA 70804 http://www.ldi.la.gov/SHIIP/	1-800-259-5300 TTY 711
Maine	
ADAP Maine AIDS Drug Assistance Program 11 State House Station, 286 Water ST Augusta, ME 04330 https://www.maine.gov/dhhs/mecdc/infectious-disease/hiv-std/services/ryan-white-b.shtml	1-207-287-3747
Medicaid Office of MaineCare Services 11 State House Station Augusta, ME 04333-0011 https://www.maine.gov/dhhs/oms/	1-800-977-6740 TTY 711
SHIP Maine State Health Insurance Assistance Program (SHIP) 11 State House Station, 41 Anthony AVE Augusta, ME 04333 https://www.maine.gov/dhhs/oads/get-support/older-adults-disabilities/older-adult-services/ship-medicare-assistance	1-800-262-2232 TTY 711
SPAP Office of MaineCare Services 11 State House Station Augusta, ME 04333-0011 https://www.maine.gov/dhhs/oms	1-800-977-6740 TTY 711
Maryland	
ADAP Maryland AIDS Drug Assistance Program Prevention and Health Promotion Administration 1223 W Pratt Street Baltimore, MD 21223 https://health.maryland.gov/phpa/OIDPCS/Pages/MADAP.aspx	1-410-767-6535
Medicaid Maryland Department of Health 201 West Preston ST Baltimore, MD 21201-2399 https://health.maryland.gov/mmcp/Pages/home.aspx	1-877-463-3464 TTY 1-800-735-2258
SHIP Maryland Department of Aging - Senior Health Insurance Assistance Program (SHIP)	

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Maryland	
301 W Preston ST, STE 1007 Baltimore, MD 21201 https://aging.maryland.gov/Pages/state-health-insurance-program.aspx	1-800-243-3425 TTY 711
SPAP Maryland Senior Prescription Drug Assistance Program (SPDAP) c/o International Software Systems Inc. P.O. Box 749 Greenbelt, Maryland 20768-0749 www.marylandspdap.com	1-800-551-5995 TTY 1-800-877-5156
Massachusetts	
ADAP Access Health MA/HDAP The Schrafft's City CTR, 529 Main ST, STE 301 Boston, MA 02129 https://crihealth.org/drug-assistance/hdap/	1-617-502-1700
Medicaid MassHealth Central Office 1 Ashburton Place Boston, MA 02108 https://www.mass.gov/topics/masshealth	1-800-841-2900 TTY 1-800-497-4648
SHIP Massachusetts Serving the Health Insurance Needs of Everyone (SHINE) 1 Ashburton Place, RM 517 Boston, MA 02108 https://www.mass.gov/health-insurance-counseling	1-800-243-4636 TTY 1-800-439-2370
SPAP Prescription Advantage Executive Office of Elder Affairs P.O. Box 15153 Worcester, MA 01615-0153 https://www.prescriptionadvantagema.org/	1-800-243-4636 TTY 1-877-610-0241
Michigan	
ADAP Attn: Michigan Drug Assistance Programs HIV Care & Prevention Section Division of HIV and STI Programs Michigan Department of Health and Human Services P.O. Box 30727 Lansing, MI 48909	1-888-826-6565

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Michigan	
https://www.michigan.gov/mdhhs/keep-mi-healthy/chronicdiseases/hivsti/michigan-drug-assistance-program	
Medicaid Department of Health and Human Services 333 S Grand AVE, P.O. Box 30195 Lansing, MI 48909 www.michigan.gov/medicaid	1-517-241-3740 TTY 711
SHIP Michigan Medicare/Medicaid Assistance Program (MMAP), Inc. 6105 W. Joe Hwy. Suite 204 Lansing, MI 48917 https://www.michigan.gov/mdhhs/adult-child-serv/adults-and-seniors/acls/state-health-insurance-assistance-program	1-800-803-7174 TTY 711
Minnesota	
ADAP Minnesota HIV/AIDS Programs Department of Human Services, P.O. Box 64972 St. Paul, MN 55164-0972 https://mn.gov/dhs/people-we-serve/seniors/health-care/hiv-aids/programs-services/	1-800-657-3761
Medicaid Minnesota Department of Human Services P.O. Box 64989 St. Paul, MN 55164-0989 https://mn.gov/dhs/medicaid-matters/	1-800-657-3739 TTY 1-800-627-3529
SHIP Minnesota State Health Insurance Assistance Program/Senior LinkAge Line P.O. Box 64976 St. Paul, MN 55164-0976 https://mn.gov/aging-pathways/	1-800-333-2433 TTY 1-800-627-3529
Mississippi	
ADAP Mississippi Department of Health, STD/HIV Office 570 E Woodrow Wilson DR, P.O. Box 1700 Jackson, MS 39215-1700 https://msdh.ms.gov/msdhsite/_static/14,13047,150.html	1-601-362-4879
Medicaid State of Mississippi Division of Medicaid	

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Mississippi	
550 High ST STE, 1000 Sillers BLDG Jackson, MS 39201-1399 http://www.medicaid.ms.gov/	1-800-421-2408 TTY 711
SHIP Mississippi Department of Human Services, Division of Aging & Adult Services 200 S Lamar ST Jackson, MS 39201 https://www.mdhs.ms.gov/post/ship-is-here-to-help-answer-your-medicare-questions/	1-601-359-4500 TTY 711
Missouri	
ADAP Missouri Department of Health and Senior Services Bureau of HIV, STD and Hepatitis P.O. Box 570 Jefferson City, MO 65102-0570 https://health.mo.gov/living/healthcondiseases/communicable/hivaids/casemgmt.php	1-573-751-6439
Medicaid MO HealthNet Division Department of Social Services 615 Howerton CT, P.O. Box 6500 Jefferson City, MO 65102-6500 https://www.dss.mo.gov/mhd/	1-573-751-3425 TTY 1-800-735-2966
SHIP Missouri CLAIM Senior Health Insurance Program 1105 Lakeview Avenue Columbia, MO 65201 www.missouriclaim.org	1-800-390-3330 TTY 711
SPAP MissouriRx Plan (MORx) P.O. Box 6500 Jefferson City, MO 65102-6500 https://mydss.mo.gov/mhd/pharmacy	1-800-392-2161 TTY 711
Montana	
ADAP Montana AIDS Drug Assistance Program (ADAP) DPHHS, Cogswell BLDG C-211 1400 Broadway ST Helena, MT 59620-2951 https://dphhs.mt.gov/publichealth/hivstd/treatment/mtryanwhiteprog	1-406-444-3565

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Montana	
Medicaid Montana Healthcare Programs P.O. 202951 Helena, MT 59620-2951 https://dphhs.mt.gov/MontanaHealthcarePrograms/welcome/memberservices/index	1-888-706-1535 TTY 1-800-833-8503
SHIP Montana State Health Insurance Assistance Program (SHIP) 1100 N Last Chance Gulch, FL 4 Helena, MT 59601 https://dphhs.mt.gov/sltc/aging/ship	1-800-551-3191 TTY 711
SPAP Montana Big Sky Rx P.O. Box 202915 Helena, MT 59620-2915 https://dphhs.mt.gov/SLTC/aging/BigSky	1-866-369-1233 TTY 711
Nebraska	
ADAP Nebraska Department of Health & Human Services Ryan White HIV/AIDS Program P.O. Box 95026 Lincoln, NE 68509-5026 https://dhhs.ne.gov/Pages/HIV-Care.aspx	1-402-471-2101
Medicaid NE Department of Health and Human Services 301 Centennial Mall S Lincoln, NE 68509 https://dhhs.ne.gov/Pages/General-Medicaid-Information.aspx	1-402-471-3121 TTY 711
SHIP Nebraska Senior Health Insurance Information Program (SHIIP) 2717 S. 8th Street, Suite 4 Lincoln, NE 68508 https://doi.nebraska.gov/ship-smp	1-800-234-7119 TTY 711
Nevada	
ADAP Office of HIV/AIDS 2290 S. Jones Blvd. Suite 110 Las Vegas, Nevada 89146	1-844-609-4623

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Nevada	
https://dpbh.nv.gov/Programs/HIV-Ryan/Ryan_White_Part_B_-_Home/	
Medicaid Nevada Medicaid Customer Service P.O. Box 30042 Reno, NV 89520-3042 https://www.medicaid.nv.gov/	877-638-3472
SHIP **Nevada Medicare Assistance Program (MAP)** **1550 E. College Parkway** **Carson City, NV 89706** **https://www.nevadacareconnection.org/care-options/types-of-services/medicare-assistance-program-map/**	1-800-307-4444 TTY 711
New Hampshire	
ADAP New Hampshire CARE Program Bureau Of Infectious Disease Control 29 Hazen Drive Concord, NH 03301 https://www.dhhs.nh.gov/programs-services/disease-prevention/infectious-disease-control/nh-ryan-white-care-program/nh-adap	1-603-271-4502
Medicaid New Hampshire Department of Health and Human Services 129 Pleasant ST Concord, NH 03301-3852 https://www.dhhs.nh.gov/ombp/medicaid/	1-844-275-3447 TTY 1-800-735-2964
SHIP New Hampshire SHIP - ServiceLink Aging and Disability Resource Center 2 Industrial Park DR, Concord, NH 03302 https://www.dhhs.nh.gov/programs-services/adult-aging-care/aging-and-disability-resource-centers/aging-disability-6	1-866-634-9412 TTY 1-800-735-2964
New Jersey	
ADAP New Jersey AIDS Drug Distribution Program (ADDP) P.O. Box 360 Trenton, NJ 08625-0360	1-877-613-4533

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New Jersey	
http://www.state.nj.us/health/hivstdtb/hiv-aids/medications.shtml	
Medicaid Department of Human Services Division of Medical Assistance & Health Services P.O. Box 712 Trenton, NJ 08625-0712 https://www.state.nj.us/humanservices/dmahs/clients/medicaid/	1-800-356-1561 TTY 711
SHIP New Jersey State Health Insurance Assistance Program (SHIP) P.O. Box 715 Trenton, NJ 08625-0715 https://www.nj.gov/humanservices/doas/services/q-z/ship/	1-800-792-8820 TTY 711
SPAP New Jersey Pharmaceutical Assistance to The Aged & Disabled (PAAD) P.O. Box 715 Trenton, NJ 08625-0715 https://www.nj.gov/humanservices/doas/services/q-z/ship/medicare_drug.shtml	1-800-792-9745 TTY 711
New Mexico	
ADAP New Mexico Department of Health AIDS Drug Assistance Program 1190 S Saint Francis DR, STE 1200 Santa Fe, NM 87505 http://nmhealth.org/about/phd/idb/hats/	1-833-796-8773
Medicaid NM Human Services Department P.O. Box 2348 Santa Fe, NM 87504-2348 https://www.hca.nm.gov/lookingforassistance/centennial-care-overview/	1-800-283-4465 TTY 1-855-227-5485
SHIP New Mexico Benefits Counseling Program SHIP 2550 Cerrillos Road Santa Fe, NM 87505 https://www.aging.nm.gov/consumer-and-elder-rights/ship/	1-505-476-4846 TTY 1-505-476-4937

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New York	
ADAP New York AIDS Drug Assistance Program HIV Uninsured Care Programs, Empire STA, P.O. Box 2052 Albany, NY 12220-0052 http://www.health.ny.gov/diseases/aids/general/resources/adap/	1-800-542-2437
Medicaid New York State Department of Health Corning Tower, Empire State Plaza Albany, NY 12237 http://www.health.state.ny.us/health_care/medicaid/index.htm	1-800-541-2831 TTY 711
SHIP New York Health Insurance Information Counseling and Assistance Program (HIICAP) 2 Empire State Plaza, FL 5 Albany, NY 12223 https://aging.ny.gov/health-insurance-information-counseling-and-assistance-program-hiicap	1-800-701-0501 TTY 711
SPAP New York State EPIC Program P.O. Box 15018 Albany, NY 12212-5018 http://www.health.ny.gov/health_care/epic/	1-800-332-3742 TTY 1-800-290-9138
North Carolina	
ADAP North Carolina Division of Public Health Communicable Disease Branch 1905 Mail Service CTR Raleigh, NC 27699-1905 https://epi.dph.ncdhhs.gov/cd/hiv/hmap.html	1-919-733-3419
Medicaid Division of Medical Assistance 2501 Mail Service CTR Raleigh, NC 27699-2501 https://dma.ncdhhs.gov/medicaid	1-888-245-0179 TTY 1-877-452-2514
SHIP North Carolina Seniors Health Insurance Information Program (SHIIP) 325 N Salisbury ST Raleigh, NC 27603 http://www.ncdoi.com/SHIIP/Default.aspx	1-855-408-1212 TTY 711

Exhibit A: Contact Information for AIDS Drug Assistance Programs (ADAP), State Medicaid Offices, State Health Insurance Assistance Programs (SHIP) and State Pharmaceutical Assistance Programs (SPAP)

North Dakota	
ADAP North Dakota Department of Health, Division of Disease Control 2635 E Main AVE Bismarck, ND 58506-5520 https://www.ndhealth.gov/hiv/RyanWhite/	1-701-328-2378
Medicaid North Dakota Department of Human Services 600 E BLVD AVE, Department 325 Bismarck, ND 58505-0250 http://www.nd.gov/dhs/services/medicalserv/medicaid	1-800-755-2604 TTY 1-800-366-6888
SHIP North Dakota Senior Health Insurance Counseling (SHIC) 600 E BLVD AVE Bismarck, ND 58505-0320 http://www.nd.gov/ndins/shic/	1-888-575-6611 TTY 1-800-366-6888
Northern Mariana Islands	
Medicaid State Medicaid Administration Office Government BLDG # 1252, Capital Hill RD, Caller Box 100007 Saipan, MP 96950 https://www.cnmimedicaid.org/medicaid-information-center	1-670-664-4880 TTY 711
SHIP Northern Mariana Islands Senior Health Insurance Program P.O. Box 5795 CHRB Saipan, MP 96950 http://commerce.gov.mp/	1-670-664-3000 TTY 711
Ohio	
ADAP Ohio Department of Health HIV Care Services Section, 246 N High ST Columbus, OH 43215 https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/Ryan-White-Part-B-HIV-Client-Services/welcome	1-800-777-4775
Medicaid Ohio Department of Medicaid 50 W Town ST, STE 400 Columbus, OH 43215	

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Ohio	
https://medicaid.ohio.gov/	1-800-324-8680 TTY 711
SHIP Ohio Senior Health Insurance Information Program (OSHIIP) 50 W Town ST, STE 300, FL 3 Columbus, OH 43215 https://insurance.ohio.gov/about-us/divisions/oshiip	1-800-686-1578 TTY 1-614-644-3745
Oklahoma	
ADAP Oklahoma State Department of Health Sexual Health and Harm Reduction Services 123 Robert S. Kerr Ave, Ste 1702 Oklahoma City, OK 73102-6406 https://oklahoma.gov/content/dam/ok/en/health/health2/aem-documents/prevention-and-preparedness/sexual-health-harm-reduction/provider-info/training-material/hiv-hdapbrochure14.pdf	1-405- 426-8400
Medicaid Oklahoma Health Care Authority 4345 N Lincoln BLVD Oklahoma City, OK 73105 http://www.okhca.org	1-800-987-7767 TTY 711
SHIP Oklahoma Medicare Assistance Program (MAP) 400 NE 50th ST Oklahoma City, OK 73105 https://www.oid.ok.gov/consumers/information-for-seniors/	1-405-521-2828 TTY 711
Oregon	
ADAP Oregon CAREAssist 800 NE Oregon ST, STE 1105 Portland, OR 97232 http://public.health.oregon.gov/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment/CAREAssist/Pages/index.aspx	1-971-673-0144
Medicaid Oregon Health Authority 500 Summer ST, NE, E-20 Salem, OR 97301-1097 https://www.oregon.gov/oha/HSD/OHP	800-699-9075 TTY 711

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Oregon	
SHIP Oregon Senior Health Insurance Benefits Assistance (SHIBA) P.O. Box 14480 Salem, OR 97309-0405 http://healthcare.oregon.gov/shiba/Pages/index.aspx	1-800-722-4134 TTY 711
Pennsylvania	
ADAP Pennsylvania Special Pharmaceutical Benefits Program Department of Health Po Box 8808 Harrisburg, PA 17105-8088 https://www.health.pa.gov/topics/programs/HIV/Pages/Special-Pharmaceutical-Benefits.aspx	1-800-922-9384
Medicaid Pennsylvania Department of Human Services P.O. Box 5959 Harrisburg, PA 17110-0959 https://www.dhs.pa.gov/Services/Assistance/Pages/Medical-Assistance.aspx	1-866-550-4355 TTY 711
SHIP Pennsylvania APPRISE Senior Health Insurance Program 555 Walnut ST, FL 5 Harrisburg, PA 17101-1919 https://www.aging.pa.gov/aging-services/medicare-counseling/Pages/default.aspx	1-800-783-7067 TTY 711
SPAP Pennsylvania PACE P.O. Box 8806 Harrisburg, PA 17105-8806 https://www.pa.gov/agencies/aging/aging-programs-and-services/pace-program	1-800-225-7223 TTY 1-800-222-9004
Puerto Rico	
ADAP Puerto Rico Departmento de Salud, Programa Ryan White Parte B P.O. Box 70184 San Juan, PR 00936-8184 https://adap.directory/puerto-rico	1-787-765-2929
Medicaid Government of Puerto Rico, Department of Health Medicaid Program	

Exhibit A: Contact Information for AIDS Drug Assistance Programs (ADAP), State Medicaid Offices, State Health Insurance Assistance Programs (SHIP) and State Pharmaceutical Assistance Programs (SPAP)

Puerto Rico	
P.O. Box 70184 San Juan, PR 00936-8184 https://medicaid.pr.gov	1-787-765-2929 TTY 1-787-625-6955
SHIP Puerto Rico State Health Insurance Assistance Program (SHIP) Avenida Ponce de León Parada 16 Edificio 1064 tercer piso Santurce, San Juan, PR 00919-1179 https://www.oppea.pr.gov/programas-y-servicios	1-787-721-6121 TTY 711
Rhode Island	
ADAP Rhode Island AIDS Drug Assistance Program Department of Health 3 Capitol Hill Providence, RI 02908 https://eohhs.ri.gov/Consumer/Adults/RyanWhiteHIVAIDS.aspx	1-401-222-5960
Medicaid Executive Office of Health and Human Services (EOHHS) 3 W RD Cranston, RI 02920 https://eohhs.ri.gov/initiatives/integrated-care-initiative/medicare-medicaid-plan	1-844-602-3469 TTY 711
SHIP Rhode Island State Health Insurance Assistance Program (SHIP) 25 Howard AVE, BLDG 57 Cranston, RI 02920 https://oha.ri.gov/what-we-do/access/health-insurance-coaching/medicare-counseling	1-401-462-3000 TTY 1-401-462-0740
SPAP Rhode Island Office of Health Aging 25 Howard AVE, BLDG 57 Cranston, RI 02920 https://oha.ri.gov/what-we-do/access/health-insurance-coaching/drug-cost-assistance	1-401-462-3000 TTY 1-401-462-0740
South Carolina	
ADAP South Carolina AIDS Drug Assistance Program (ADAP) DHEC, STD/HIV Division, 2600 Bull ST Columbia, SC 29201	1-800-856-9954

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South Carolina	
https://dph.sc.gov/diseases-conditions/infectious-diseases/hivaids/aids-drug-assistance-program	
Medicaid South Carolina Department of Health and Human Services P.O. Box 8206 Columbia, SC 29202-8206 http://www.scdhhs.gov/	1-888-549-0820 TTY 1-888-842-3620
SHIP South Carolina (I-CARE) Insurance Counseling Assistance and Referrals for Elders 1301 Gervais ST, STE 350 Columbia, SC 29201 https://dph.sc.gov/diseases-conditions/infectious-diseases/hivaids/aids-drug-assistance-program	1-800-868-9095 TTY 711
South Dakota	
ADAP Ryan White Part B CARE Program South Dakota Department of Health 615 E 4th ST Pierre, SD 57501-1700 https://doh.sd.gov/topics/diseases/infectious/reportable-communicable-diseases/hivaids/ryan-white-part-b-program/	1-800-592-1861 8 a.m. - 5 p.m. local time, Monday - Friday
Medicaid South Dakota Department of Social Services, Division of Medical Services 700 Governors DR Pierre, SD 57501 http://dss.sd.gov/medicaid/	605-773-4678 TTY 711
SHIP South Dakota Senior Health Information & Insurance Education (SHIINE) 2520 E Franklin St Pierre, SD 57501 https://doh.sd.gov/about/ship-and-sha/	1-877-331-4834 TTY 711
Tennessee	
ADAP Tennessee HIV Drug Assistance Program (HDAP) Department of Health, Andrew Johnson Tower 710 James Robertson Pkwy, 4th floor Nashville, TN 37243	615-253-3937

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Tennessee	
https://www.tn.gov/health/health-program-areas/std/std/ryanwhite.html	
Medicaid Division of TennCare 310 Great Circle RD Nashville, TN 37243 https://www.tn.gov/tenncare/	1-800-342-3145 TTY 711
SHIP Tennessee Commission on Aging & Disability – TN SHIP Andrew Jackson BLDG, 502 Deaderick ST, FL 9 Nashville, TN 37243-0860 https://www.tn.gov/content/tn/aging/our-programs/state-health-insurance-assistance-program--ship-.html	1-877-801-0044 TTY 711
Texas	
ADAP Texas HIV Medication Program ATTN: MSJA, MC 1873, P.O. Box 149347 Austin, TX 78714-9387 www.dshs.state.tx.us/hivstd/meds	1-800-255-1090
Medicaid Texas Medicaid Health and Human Services Commission 4900 N Lamar BLVD, P.O. Box 1324 Austin, TX 78751 https://www.hhs.texas.gov/services/health/medicaid-chip	800-252-9240
SHIP Texas Department of Insurance (HICAP) P.O. Box 12030, Austin, TX 78711 https://www.hhs.texas.gov/services/health/medicare	1-800-252-3439 TTY 711
SPAP Texas HIV State Pharmaceutical Assistance Program (SPAP) P.O. Box 149347, MC 1873 Austin, TX 78714 https://www.dshs.state.tx.us/hivstd/meds/spap.shtm	1-800-255-1090 TTY 711
Utah	
ADAP Utah Department of Health, Bureau of Epidemiology 288 N 1460 W, P.O. Box 142104 Salt Lake City, UT 84114-2104 https://epi.utah.gov/ryan-white/	1-801-538-6197

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Utah	
Medicaid Utah Department of Health, Medicaid and Health Financing P.O. Box 143106 Salt Lake City, UT 84114-3106 https://medicaid.utah.gov/	1-800-662-9651 TTY 711
SHIP Utah Senior Health Insurance Information Program (SHIP) 195 N 1950 W Salt Lake City, UT 84116 https://daas.utah.gov/services/#ship	1-800-541-7735 TTY 711
Vermont	
ADAP VT Medication Assistance Program Health Surveillance Division P.O. Box 70 Burlington, VT 05402 https://www.healthvermont.gov/disease-control/hiv	802-863-7240
Medicaid Medicaid Department of Vermont Health Access 280 ST DR Waterbury, VT 05671 http://www.greenmountaincare.org/	1-800-250-8427 TTY 711
SHIP Vermont State Health Insurance Assistance Program (SHIP) 280 State DR, HC 2 S Waterbury, VT 05671-2070 http://asd.vermont.gov/services/ship	1-800-642-5119 TTY 711
SPAP Green Mountain Care Prescription Assistance Department of Vermont Health Access 280 State DR Waterbury, VT 05671-1020 https://dvha.vermont.gov/members/prescription-assistance	1-800-250-8427 TTY 711
Virgin Islands of the U.S.	
ADAP US Virgin Islands STD/HIV/TB Program USVI Department of Health, Old Municipal Hospital Complex, BLDG 1	1-340-774-9000

Exhibit A: Contact Information for AIDS Drug Assistance Programs (ADAP), State Medicaid Offices, State Health Insurance Assistance Programs (SHIP) and State Pharmaceutical Assistance Programs (SPAP)

Virgin Islands of the U.S.	
St. Thomas, VI 00802 https://doh.vi.gov/programs/communicable-diseases	
Medicaid U.S. Virgin Islands Bureau of Health Insurance & Medical Assistance 1303 Hospital Ground, Knud Hansen Complex, BLDG A St. Thomas, VI 00802 https://dhs.vi.gov/office-of-medicaid/	1-340-773-6449 TTY 711
SHIP Virgin Islands State Health Insurance Assistance Program (VISHIP) 1131 King ST, STE 101 St. Croix, VI 00820 https://ltg.gov.vi/departments/vi-ship-medicare/	1-340-773-6449 TTY 711
SPAP US Virgin Islands Pharmaceutical Assistance Program 1303 Hospital Ground, Knud Hansen Complex, BLDG A St. Thomas, VI 00802 https://dhs.vi.gov/senior-citizen-affairs/	1-340-774-0930 TTY 711
Virginia	
ADAP Virginia AIDS Drug Assistance Program (ADAP) Office of Disease Prevention 109 Governor ST, FL 6 Richmond, VA 23219 https://www.vdh.virginia.gov/disease-prevention/vamap/	855-362-0658
Medicaid Department of Medical Assistance Services 600 E Broad ST Richmond, VA 23219 http://www.dmas.virginia.gov/	1-855-242-8282 TTY 711
SHIP Virginia Insurance Counseling and Assistance Program (VICAP) 1610 Forest AVE, STE 100 Henrico, VA 23229 https://www.vda.virginia.gov/vicap.htm	1-800-552-3402 TTY 711
SPAP Virginia Medication Assistance Program (MAP) P.O. Box 2448 Richmond, VA 23218-2448 https://www.vdh.virginia.gov/disease-prevention/vamap/	1-855-362-0658 TTY 711

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Washington	
ADAP Washington Early Intervention Program (EIP) HIV Client Services P.O. Box 47841 Olympia, WA 98504-7841 https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/HIV/ClientServices/ADAPandEIP	1-877-376-9316
Medicaid Washington State Health Care Authority P.O. Box 45531 Olympia, WA 98504 https://www.dshs.wa.gov/altsa/home-and-community-services/medicaid	1-800-562-3022 TTY 711
SHIP Washington Statewide Health Insurance Benefits Advisors (SHIBA) P.O. Box 40255 Olympia, WA 98504-0255 https://www.insurance.wa.gov/statewide-health-insurance-benefits-advisors-shiba	1-800-562-6900 TTY 1-360-586-0241
West Virginia	
ADAP Jay Adams, HIV Care Coordinator PO Box 6360 Wheeling, WV 26003 https://oeps.wv.gov/rwp/pages/default.aspx	304-232-6822
Medicaid West Virginia Bureau for Medical Services 350 Capitol ST, RM 251 Charleston, WV 25301 https://dhhr.wv.gov/bms/Members/Apply/Pages/default.aspx	1-304-558-1700 TTY 711
SHIP West Virginia State Health Insurance Assistance Program (WV SHIP) 1900 Kanawha BLVD East Charleston, WV 25305 http://www.wvseniorservices.gov/StayingHealthy/SHIPMedicare/tabid/72/Default.aspx	1-877-987-4463 TTY 711
Wisconsin	
ADAP Wisconsin AIDS Drug Assistance Program (ADAP)	1-800-991-5532

Exhibit A: Contact Information for AIDS Drug Assistance Programs (ADAP), State Medicaid Offices, State Health Insurance Assistance Programs (SHIP) and State Pharmaceutical Assistance Programs (SPAP)

Wisconsin	
Department of Health Services 1 W Wilson ST Madison, WI 53703 https://www.dhs.wisconsin.gov/aids-hiv/adap.htm	
Medicaid Wisconsin Department of Health Services 1 W Wilson ST Madison, WI 53703 https://www.dhs.wisconsin.gov/medicaid/index.htm	1-800-362-3002 TTY 711
SHIP Wisconsin SHIP (SHIP) State Health Insurance Plan 1402 Pankratz ST, STE 111 Madison, WI 53704-4001 https://www.dhs.wisconsin.gov/benefit-specialists/medicare-counseling.htm	1-800-242-1060 TTY 711
SPAP Wisconsin SeniorCare Pharmaceutical Assistance Program Department of Health Services 1 W Wilson ST, P.O. Box 6710 Madison, WI 53716-0710 http://www.dhs.wisconsin.gov/seniorcare	1-800-657-2038 TTY 711 8 a.m. - 6 p.m. local time, Monday - Friday
Wyoming	
ADAP Wyoming Department of Health Communicable Disease Unit HIV Treatment Program 401 Hathaway BLDG Cheyenne, WY 82002 https://health.wyo.gov/publichealth/communicable-disease-unit/hivaids/	1-307-777-5856 8 a.m. - 5 p.m. local time, Monday - Friday
Medicaid Wyoming Department of Health 122 W 25th St., 4th Floor West Cheyenne, WY 82001 http://health.wyo.gov/healthcarefin/medicaid/	1-307-777-7531 TTY 855-329-5204
SHIP Wyoming State Health Insurance Information Program (WSHIIP) 106 W Adams AVE Riverton, WY 82501 http://www.wyomingseniors.com/services/wyoming-state-health-insurance-information-program	1-800-856-4398 TTY 711

CareFirst BlueCross BlueShield Group Advantage Member Services

Method	Member Services – Contact Information
Call	833-939-4103 Calls to this number are free. 8am-6pm EST, Monday - Friday. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. 8am-6pm EST, Monday - Friday.
Fax	844-961-0696
Write	CareFirst BlueCross BlueShield Medicare Advantage Attention: Member Services Department P.O. Box 915 Owings Mills, MD 21117
Website	www.carefirst.com/myaccount

State Health Insurance Assistance Program

State Health Insurance Assistance Programs are state programs that get money from the Federal government to give free local health insurance counseling to people with Medicare. A list of State Health Insurance Assistance Programs can be found in Exhibit A located at the end of this Evidence of Coverage.

PRA Disclosure Statement *According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

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