Blue Advantage®

from Blue Cross and Blue Shield of Alabama

Evidence of Coverage

SPECIAL NEEDS PLAN

Your Medicare Health Benefits and Services as a Member of Blue Cross and Blue Shield of Alabama/ Blue Advantage

January, 1 2006 - December 31, 2006

Alabama - PPO

For help or information, please call Member Services Monday through Friday, 7:30 am – 6:00 pm. Calls to these numbers are free:

1-888-234-8266
TTY: 1-800-257-3384

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association.

EVIDENCE OF COVERAGE:

Your Medicare Health Benefits and Services
as a Member of Blue Cross and Blue Shield of Alabama/Blue Advantage

Option VI

Special Needs Plan

January 1 – December 31, 2006

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

Blue Cross and Blue Shield of Alabama **Member Services:**

For help or information, please call Member Services Monday through Friday, 7:30 am – 6:00 pm. Calls to these numbers are free:

1-888-234-8266

TTY: 1-800-257-3384

Welcome to Blue Advantage

We are pleased that you've chosen Blue Advantage.

Blue Advantage's Special Needs Plan **is a Preferred Provider Organization (PPO) for people with Medicare and Medicaid.**

Now that you are enrolled in Blue Advantage, you are getting your care through Blue Cross and Blue Shield of Alabama. Blue Advantage, a PPO, is offered by Blue Cross and Blue Shield of Alabama. **(**Blue Advantage **is *not* a "Medigap" or supplemental Medicare insurance policy.)**

This booklet explains how to get your Medicare services through Blue Advantage.

This booklet, together with your enrollment form and any amendments that we may send to you, is our contract with you. It explains your rights, benefits, and responsibilities as a member of Blue Advantage. It also explains our responsibilities to you. The information in this booklet is in effect for the time period from January 1, 2006, through December 31, 2006.

You are still covered by Original Medicare, but you are getting your Medicare services as a member of Blue Advantage. This booklet gives you the details, including:

- What is covered in Blue Advantage and what is not covered.
- How to get the care you need, including some rules you must follow.
- What you will have to pay for your health plan.
- What to do if you are unhappy about something related to getting your covered services.
- How to leave Blue Advantage, and other Medicare options that are available. How to leave Blue Advantage, and other Medicare options that are available after you leave that plan

If you need to receive this booklet in a different format (such as Spanish, large print, or audio tapes), please call us so we can send you a copy. Section 1 of this booklet tells you how to contact us.

Please tell us how we're doing.

We want to hear from you about how well we are doing as your health plan. You can call or write to us at any time (Section 1 of this booklet tells you how to contact us). Your comments are always welcome, whether they are positive or negative. From time to time, we do surveys that ask our members to tell about their experiences with Blue Advantage. If you are contacted, we hope you will participate in a member satisfaction survey. Your answers to the survey questions will help us know what we are doing well and where we need to improve.

Table of Contents

Section 1 Telephone numbers and other information for reference

How to contact Blue Cross and Blue Shield of Alabama Member Services

If you have any questions or concerns, please call or write to Blue Cross and Blue Shield of Alabama. Member Services. We will be happy to help you. Our business hours are Monday through Friday 7:30 am – 6:00 pm.

CALL	1-888-234-8266. This number is also on the cover of this booklet for easy reference. Calls to this number are free.
TTY	1-800-257-3384. This number requires special telephone equipment. It is on the cover of this booklet for easy reference. Calls to this number are free.
WRITE	P. O. Box 995, Birmingham, Alabama 35298.
VISIT	450 Riverchase Parkway East, Birmingham, Alabama 35244.

How to contact the Medicare program and the 1-800-MEDICARE (TTY 1-877-486-2048) helpline

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). CMS is the federal agency in charge of the Medicare program. CMS stands for **C**enters for **M**edicare & Medicaid **S**ervices. CMS contracts with and regulates Medicare Health Plans (including Blue Cross and Blue Shield of Alabama) and Medicare Private Fee-for-Service organizations.

Here are ways to get help and information about Medicare from CMS:

Call **1-800-MEDICARE** (1-800-633-4227) to ask questions or get free information booklets from Medicare. You can call this national Medicare helpline 24 hours a day, 7 days a week. TTY users should call1-877-486-2048. Calls to these numbers are free.

Use a computer to look at www.medicare.gov, the official government Web site for Medicare information. This Web site gives you a lot of up-to-date information about Medicare and nursing homes and other current Medicare issues. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Prescription Drug Plans in your area. You can also search the "Helpful Contacts" section for the Medicare contacts in your state. If you do not have a computer, your local library or senior center may be able to help you visit this Web site using their computer.

Alabama Department of Senior Services / SHIP – An organization in your state that provides free Medicare help and information

"SHIP" stands for **S**tate **H**ealth **I**nsurance Assistance **P**rogram. Alabama Department of Senior Services is a state organization paid by the federal government to give free health insurance information and help to people with Medicare. Your SHIP can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. Your SHIP has information about Medicare Advantage Plans and about Medigap (Medicare supplement insurance) policies. This includes information about special Medigap rights for people who have tried a Medicare Advantage plan (like Blue Advantage) for the first time. (Medicare Advantage is the new name for Medicare + Choice). Section 6 has more information about your Medigap guaranteed issue rights.

You can contact Alabama Department of Senior Services at 770 Washington Avenue, Suite 470, P. O. Box 301851, Montgomery, Alabama 36130, local at 1-334-242-5743 or toll free at 1-800-242-5743. You can also find the Web site for Alabama Department of Senior Services at www.medicare.gov on the Web.

Alabama Quality Assurance Foundation / Quality Improvement Organization] – a group of doctors and health professionals in your state who review medical care and handle certain types of complaints from patients with Medicare

"QIO" stands for **Q**uality **I**mprovement **O**rganization. The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIOs have different names, depending on which state they are in. In Alabama, the QIO is called Alabama Quality Assurance Foundation. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their hospital, skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation stay is ending too soon. See Section 10 for more information about complaints.

You can contact Alabama Quality Assurance Foundation at 2 Perimeter Park South, Suite 200 West, Birmingham, Alabama 35243, local at 1-205-970-1600 or toll free at 1-800-760-3540.

Other Organizations (including Medicaid, Social Security Administration)

Medicaid Agency – a State Government Agency that handles health care programs for people with low incomes

Medicaid is a joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Some people with Medicare are also eligible for Medicaid. Most health care costs are covered if you qualify for both Medicare and Medicaid. Medicaid also has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, contact Medicaid Agency of Alabama, 501 Dexter Avenue, P. O. Box 5624, Montgomery, Alabama 36103, local 1-334-242-5000 or toll free at 1-800-362-1504 or Alabama Department of Public Health, 201 Monroe Street, Montgomery, Alabama 36104, local, 1-334-206-5175.

Social Security Administration

The Social Security Administration provides economic protection for Americans of all ages. Social Security programs include retirement benefits, disability, family benefits, survivors' benefits, and benefits for the aged, blind, and disabled. You can call the Social Security Administration at 1-800-772-1213. TTY users should call 1-800-325-0778. Calls to these numbers are free. You can also visit www.ssa.gov on the Web.

Railroad Retirement Board

If you get benefits from the Railroad Retirement Board, you can call your local Railroad Retirement Board office or 1-800-808-0772 (calls to this number are free). TTY users should call 312-751-4701. You can also visit www.rrb.gov on the Web.

Employer (or "Group") Coverage

If you get your benefits from your current or former employer, or your spouse's current or former employer, call the employer's benefits administrator if you have any questions about your benefits, plan premiums, or the open enrollment season.

Section 2 Getting the care you need, including some rules you must follow

Section 6 describes our coverage rules associated with our outpatient prescription drug coverage

What is Blue Advantage?

Now that you are enrolled in Blue Advantage, you are getting your Medicare through Blue Cross and Blue Shield of Alabama. Blue Advantage's Special Needs Plan is offered by Blue Cross and Blue Shield of Alabama, and is a PPO for people with Medicare and Medicaid. The Medicare program pays us to manage health services for people with Medicare who are members of Blue Advantage. (Blue Advantage is **not** a Medicare supplement policy. See Section 15 for a definition of Medicare supplement policy. Medicare supplement policies are sometimes called "Medigap" insurance policies.) Blue Cross and Blue Shield of Alabama provides medical services through Medicare-certified health care facilities. In addition, our health care professionals are in compliance with Medicare credentialing standards.

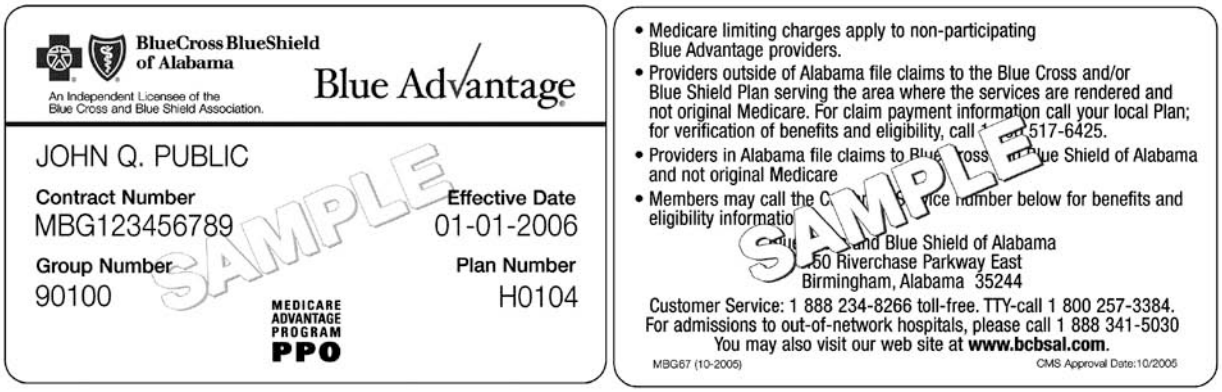
This booklet explains your benefits and services, what you have to pay, and the rules you must follow to get your care. Blue Advantage gives you all of the usual Medicare services that are covered for everyone with Medicare. We also give you some additional services and supplies, such as routine chiropractic care, annual routine physical examination, routine vision and routine hearing.

Since Blue Advantage is a PPO, this means that you should get most or all of your health services from the doctors, hospitals, and other health providers that are part of Blue Advantage. You may also use non-plan providers to get covered services. However, if you use non-plan providers for care that is not emergency care, it may cost you more to use them. See Section 8 for more details on why it costs less to see plan providers.

Use your plan membership card instead of your red, white, and blue Medicare card

Now that you are a member of Blue Advantage, you have Blue Advantage membership cards. Here are sample cards to show what they look like:

Use this card for your health care services (except prescriptions):



Use this card to buy prescription drugs:

During the time you are a plan member and using plan services, **you *must* use your plan membership card instead of your red, white, and blue Medicare card to get covered services.** (See Section 4 for a definition and list of covered services.) Keep your red, white, and blue Medicare card in a safe place in case you are asked to show it, but for the most part you will not use it to get services while you are a member. If you get covered services using your red, white, and blue Medicare card instead of your Blue Advantage membership card while you are a plan member, the Medicare program will not pay for these services and you may have to pay the full cost yourself.

Please carry your Blue Advantage membership cards with you at all times. You will need to show these cards when you get covered services. You will need to show your Part D card to get your prescriptions at the pharmacy. If your membership card is ever damaged, lost, or stolen, call Member Services right away and we will send you a new card.

Help us keep your membership record up-to-date

Blue Cross and Blue Shield of Alabama has a file of information about you as a plan member. Doctors, hospitals, pharmacists, and other plan providers use this membership record to know what services and drugs are covered for you. The membership record has information from your enrollment form, including your address and telephone number. It shows your specific Blue Advantage coverage and other information. Section 9 tells how we protect the privacy of your personal health information.

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

What is the geographic service area for Blue Advantage?

The counties in our service area are listed below.

Autauga	Chilton	Limestone	Morgan
Baldwin	Elmore	Lowndes	Shelby
Bibb	Etowah	Madison	St. Clair
Blount	Jefferson	Mobile	Walker
Calhoun	Lawrence	Montgomery	

Using plan and non-plan providers to get services covered by Blue Advantage

Why should you use plan providers to get your covered services?

Except for emergency care, your out-of-pocket costs will be lower if you use plan providers.

What are "plan providers"? "Providers" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. We call them "plan providers" when they participate in Blue Advantage. When we say that plan providers "participate in Blue Advantage," this means that we have arranged with them to coordinate or provide covered services to members of Blue Advantage.

What are "covered services"? "Covered services" is the general terms we use in this booklet to mean all of the health care services and supplies that are covered by Blue Advantage. Covered services are listed in the Benefits Chart in Section 4.

What if you use non-plan providers to get your covered services?

"Non-plan providers" are providers that are not part of Blue Advantage**.** You may use non-plan providers to get your covered services. However, your out-of-pocket costs may be higher than if you use our plan providers. The exception is if you use non-plan providers for emergency care. See Section 8 for more detail on why it costs less when you get services from plan providers. Medicare requires that we have or arrange for enough providers to give you all medically necessary plan covered services at the in-network cost sharing level. This is called our "network" of providers. When you get services from non-plan providers, we call these "out-of-network" services. For more detail on why it costs less to see plan providers. Certain services that we offer are not covered out-of-network. You do not need to get a referral or prior authorization when you get care from non-plan providers. However, before receiving services

from non-plan providers you may want to confirm with your plan that the services you receive are covered by your plan and are medically necessary. Refer to Section 4 for more information.

The Provider Directory gives you a list of plan providers

Every year as long as you are a member of Blue Advantage, we will send you either a Provider Directory or an update to your Provider Directory, which gives you a list of plan providers. If you don't have the Provider Directory, you can get a copy from Member Services (call the number on the cover of this booklet for information on how to contact Member Services). You may also note that a complete list of plan providers is available on our Web site (www.bcbsal.com). You can ask Member Services for more information about plan providers, including their qualifications and experience. Member Services can give you the most up-to-date information about changes in plan providers.

Access to care and information from plan providers

You have the right to get timely access to plan providers and to all services covered by the plan. ("Timely access" means that you can get appointments and services within a reasonable period of time.) You have the right to get full information from your doctors when you go for medical care. You have the right to participate fully in decisions about your health care, which includes the right to refuse care. Please see Section 9 for more information about these and other rights you have, and what you can do if you think your rights have not been respected.

What if you need medical care when your doctor's office is closed?

What to do if you have a medical emergency or urgent need for care

In an emergency, you should get care immediately. You can dial 911 for immediate help by phone, or go directly to the nearest emergency room, hospital, or urgent care center. Section 3 tells what to do if you have a medical emergency or urgent need for care.

What to do if it is not a medical emergency

If you need to talk with your doctor or get medical care when the doctor's office is closed, and it is *not* a medical emergency, call your doctor's office. Your doctor's answering service will direct you on how to reach your doctor or another doctor to provide advice or direct you to receive treatment. Or you can call Member Services, at the number listed in Section 1. After hours and on weekends and holidays your call will be directed to a voice mailbox. You will be asked to leave information and on the next business day, a care coordinator will call you with further instructions.

See Section 3 for more information about what to do if you have an urgent need for care.

Getting care from specialists

A specialist is a doctor who provides health care services for a specific disease or part of the body. Examples include oncologists (who care for patients with cancer), cardiologists (who care for patients with heart conditions), and orthopedists (who care for patients with certain bone, joint, or muscle conditions). If you use our plan specialists, your costs for covered services will be lower than if you used non-plan specialists.

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

You can get care when you are outside the service area. You will usually pay higher costs for the care because you will get your care from non-plan providers, but you will not pay extra if you are getting care for a medical emergency. See Section 3 for more information about care for a medical emergency. If you have questions about your medical costs when you travel, please call Member Services at the telephone number on the cover of this booklet. See Section 6 for more information about how to fill your outpatient prescriptions when you travel or are away from the plan service area.

What if your doctor leaves Blue Advantage?

Sometimes a doctor, specialist, clinic, or other plan provider you are using might leave the plan. If this happens, you will have to switch to another provider who is part of Blue Advantage.

Section 3 Getting care if you have a medical emergency or an urgent need for care

What is a "medical emergency"?

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

What should you do if you have a medical emergency?

If you have a medical emergency:

- Get medical help as quickly as possible. Call 911 for help or go to the nearest emergency room.
- Make sure that Blue Cross and Blue Shield of Alabama / Health Management knows about your emergency, because we will need to be involved in following up on your emergency care. You or someone from the medical facility where treatment is being given should call to tell us about your emergency care as soon as your condition has been stabilized, preferably within 48 hours by calling the number on the back of your membership card.

Blue Advantage /Health Management will help manage and follow up on your emergency care

Blue Cross and Blue Shield of Alabama / Health Management will talk with the doctors who are giving you emergency care to help manage and follow up on your care. When the doctors who are giving you emergency care say that your condition is stable and the medical emergency is over, what happens next is called "post-stabilization care." Your follow-up care (post-stabilization care) will be covered according to Medicare guidelines. In general, we will try to arrange for plan providers to take over your care as soon as your medical condition and the circumstances allow. If you choose to remain in a non-plan facility after your condition has been stabilized, the remainder of your care will be paid at the Out-of-Network level (see Benefits Chart in Section 4 for additional details).

What is covered if you have a medical emergency?

- You can get covered emergency medical care whenever you need it, anywhere in the United States. *See Section 6 for more information on how we cover outpatient prescription drugs in an emergency situation while you are outside the service area*.
- **Ambulance** services are covered in situations where other means of transportation in the United States would endanger your health.

What if it wasn't really a medical emergency?

Sometimes it can be hard to know if you have a real medical emergency. For example, you might go in for emergency care- thinking that your health is in serious danger- and the doctor may say that it was not a medical emergency after all. If this happens to you, you are still covered for the care you got to determine what was wrong, (as long as you thought your health was in serious danger, as explained in "What is a 'medical emergency'" above). However, please note that:

- If you get any additional care after the doctor says it was *not* a medical emergency, the amount of the covered additional care that we pay will depend on whether you get the care from plan providers. If you get the care from plan providers, your costs will usually be lower than if you get the care from non-plan providers.

What is "urgently needed care"? (This is different from a medical emergency)

"Urgently needed care" is **when you need medical attention right away for an unforeseen illness or injury,** and it is not reasonable given the situation for you to get medical care from other plan providers. In these cases, your health is *not* in serious danger. As we explain below, how you get "urgently needed care" depends on whether you need it when you are in the plan's service area, or outside the plan's service area. Section 2 tells about the plan's service area.

What is the difference between a "medical emergency" and "urgently needed care"?

The main difference between an urgent need for care and a medical emergency is in the danger to your health. "Urgently needed care" is if you need medical help immediately, but your health is not in serious danger. A "medical emergency" is if you believe that your health is in serious danger.

Getting urgently needed care when you are <u>in</u> the plan's service area

If you have a sudden illness or injury that is not a medical emergency, and you are in the plan's service area, please call your doctor. There will always be a doctor on call to help you. You can also call Member Services, at the number listed on the cover of this booklet. After business hours and on weekends and holidays your call will be directed to a voicemail box. You will be asked to leave information and on the next business day, a care coordinator will call you with further instructions. Keep in mind that if you have an urgent need for care while you are in the plan's service area, we encourage you to get this care from plan providers. You can get urgently needed care from a non-plan provider. However, using our plan providers will result in lower costs to you.

Getting urgently needed care when you are <u>outside</u> the plan's service area

Blue Advantage covers urgently needed care that you get from non-plan providers when you are outside the plan's service area (but still in the United States). If you are treated for an urgent care condition while out of the service area, we prefer that you return to the service area to get follow-up care from plan providers. However, we will cover follow-up care that you get from non-plan

providers outside the plan's service area as long as the care you are getting still meets the definition of "urgently needed care."

We cover renal (kidney) dialysis services that you get when you are temporarily outside the plan's service area. See Section 6 for more information on filling your prescription drugs when you are getting urgently needed care and when you are outside the plan's service area.

Section 4 Benefits chart – a list of the covered services you get as a member of Blue Advantage

What are "covered services"?

This section describes the medical benefits and coverage you get as a member of Blue Advantage. "Covered services" means the medical care, services, supplies, and equipment that Blue Advantage will pay for. This section has a Benefits Chart that gives a list of your covered services and tells what you must pay for each covered service. The section that follows (Section 5) tells about services that are not covered (these are called "exclusions"). Section 5 also tells about limitations on certain services.

You can get covered benefits out-of-network from any provider qualified to furnish the benefit in question. We urge you to call Member Services at the phone number on the cover of this booklet to ask if a particular out-of-network is covered by your plan. Your plan does not have to pay for out-of-network services that are not covered by the plan.

If you have both Medicare and full Medicaid, you will not be responsible for the prescription drug deductible or for copays and coinsurance required for in-network medical services while you are a member of the Special Needs Plan. For example, if you have Medicare and are fully eligible for Medicaid (QMB, QMB+ or other full Medicaid), you will not be responsible for the in-network $5, $10, $50, or 20% copay/coinsurance per visit for medical services. You would also not be responsible for the Part D deductible. You may have Medicare Part D copays for prescription drug coverage.

If you cease to be fully eligible for Medicaid, you can remain in the Special Needs Plan as long as you receive some form of Medicaid benefit. During this time you will be responsible for the prescription drug deductible, copays and coinsurance amounts listed in the benefits chart below.

There are some conditions that apply in order to get covered services

Some general requirements apply to *all* covered services

The covered services listed in the Benefits Chart in this section are covered only when *all* requirements listed below are met:

- Services must be provided according to the Medicare coverage guidelines established by the Medicare program.
- The medical care, services, supplies, and equipment that are listed as covered services must be medically necessary. Certain preventive care and screening tests are also covered. (See Section 15 for a definition of "medically necessary.")

Benefits Chart – a list of covered services

Benefits Chart – your covered services	What you must pay when you get these covered services In-Network	What you must pay when you get these covered services Out-of-Network
Inpatient Services		
Inpatient hospital care For more information about hospital care, see Section 7. Inpatient days are limited to 90 days each benefit period. Covered services include, but are not limited to, the following: • Semiprivate room (or a private room, if medically necessary). • Meals including special diets. • Regular nursing services. • Costs of special care units (such as intensive or coronary care units). • Drugs and medications. • Lab tests. • X-rays and other radiology services. • Necessary surgical and medical supplies. • Use of appliances, such as wheelchairs. • Operating and recovery room costs. • Rehabilitation services, such as physical therapy, occupational therapy, and speech therapy services. • *Under certain conditions, the following types of transplants are covered:* corneal, kidney, pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, intestinal/multivisceral. See Section 7 for more information about transplants. • Blood: Coverage begins with the fourth pint of blood that you need – you pay for the first 3 pints of unreplaced blood. Coverage of storage and administration begins with the first pint of blood that you need. • Physician Services.	No deductible or copay A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or skilled nursing facility. The benefit period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.	$1,000 calendar year deductible and 30% coinsurance If you get inpatient care at a non-plan hospital after your emergency condition is stabilized, your cost will include the $1,000 calendar year deductible, 30% coinsurance and any amount above the allowed amount. If you are admitted to an out-of-network hospital, please notify Blue Cross and Blue Shield of Alabama by calling 1-888-341-5030 24 hours a day, 7 days a week.

Benefits Chart – your covered services	What you must pay when you get these covered services In-Network	What you must pay when you get these covered services Out-of-Network
Inpatient mental health care		
Includes mental health care services that require a hospital stay. 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital.	No deductible or copay	$1,000 CALENDAR YEAR DEDUCTIBLE AND 30% COINSURANCE IF YOU ARE ADMITTED TO AN OUT-OF-NETWORK HOSPITAL, PLEASE NOTIFY BLUE CROSS AND BLUE SHIELD OF ALABAMA BY CALLING 1-888-341-5030, 24 HOURS A DAY, 7 DAYS A WEEK
Skilled nursing facility care For more information about skilled nursing facility care, see Section 7. 100 DAYS PER BENEFIT PERIOD. PRIOR HOSPITAL STAY IS NOT REQUIRED TO BE ELIGIBLE FOR SKILLED NURSING FACILITY CARE. Covered services include, but are not limited to, the following: • Semiprivate room (or a private room, if medically necessary). • Meals, including special diets. • Regular nursing services. • Physical therapy, occupational therapy, and speech therapy. • Drugs (this includes substances that are naturally present in the body, such as blood clotting factors). • Blood, including storage and administration: Coverage begins with the fourth pint of blood that you need – you pay for the first 3 pints of unreplaced blood. • Medical and surgical supplies. • Laboratory tests.	No deductible or copay A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or skilled nursing facility. The benefit period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods	$1,000 CALENDAR YEAR DEDUCTIBLE AND 30% COINSURANCE IF YOU ARE ADMITTED TO AN OUT-OF-NETWORK HOSPITAL, PLEASE NOTIFY BLUE CROSS AND BLUE SHIELD OF ALABAMA BY CALLING 1-888-341-5030, 24 HOURS A DAY, 7 DAYS A WEEK

Benefits Chart – your covered services	What you must pay when you get these covered services In-Network	What you must pay when you get these covered services Out-of-Network
• X-rays and other radiology services. • Use of appliances, such as wheelchairs. • Physician services.	you can have.	
Inpatient services (when the hospital or SNF days are not or no longer covered)		
For more information, see Section 7. • Physician services.	$5 COPAY PER VISIT $10 COPAY PER VISIT FOR SPECIALISTS	$1,000 CALENDAR YEAR DEDUCTIBLE AND 30% COINSURANCE
• Diagnostic tests (like X-ray or lab tests). • X-ray, radium, and isotope therapy, including technician materials and services. • Surgical dressings, splints, casts, and other devices used to reduce fractures and dislocations. • Prosthetic 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.	NO COPAY NO COPAY NO COPAY NO COPAY NO COPAY $10 COPAY PER VISIT	
Home health care		
For more information about home health care, see Section 7. Home Health Agency Care: • Part-time or intermittent skilled nursing and home health aide services. • Physical therapy, occupational therapy, and speech	NO COPAY	$1,000 CALENDAR YEAR DEDUCTIBLE AND 30% COINSURANCE

Benefits Chart – your covered services	What you must pay when you get these covered services In-Network	What you must pay when you get these covered services Out-of-Network
therapy. • Medical social services. • Medical equipment and supplies.		
Hospice care For more information about hospice services, see Section 7. • Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by Medicare. • Home care. • Hospice consultation services (one time only) for a terminally ill individual who has not yet elected the hospice benefit.	When you enroll in a Medicare-certified Hospice, your hospice services are paid by Medicare (see Section 7 for more information about hospice services).	
Outpatient Services		
Physician services, including doctor office visits • Office visits, including medical and surgical care in a physician's office or certified ambulatory surgical center. • Consultation, diagnosis, and treatment by a specialist. • Second opinion by another plan provider prior to surgery. • Outpatient hospital services. • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor).	$5 COPAY PER VISIT $10 COPAY PER VISIT FOR SPECIALISTS	$1,000 CALENDAR YEAR DEDUCTIBLE AND 30% COINSURANCE
Chiropractic services • Manual manipulation of the spine to correct subluxation.	$10 COPAY PER VISIT	$1,000 CALENDAR YEAR DEDUCTIBLE AND 30% COINSURANCE CO-INSURANCE.

Benefits Chart – your covered services	What you must pay when you get these covered services In-Network	What you must pay when you get these covered services Out-of-Network
Podiatry services • 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.	$10 COPAY PER VISIT	$1,000 CALENDAR YEAR DEDUCTIBLE AND 30% COINSURANCE
Outpatient mental health care (including Partial Hospitalization Services) Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other mental health care professional as allowed under applicable state laws. "Partial hospitalization" is a structured program of active treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	$10 COPAY PER VISIT	$1,000 CALENDAR YEAR DEDUCTIBLE AND 30% COINSURANCE
Outpatient substance abuse services	$10 COPAY PER VISIT	$1,000 CALENDAR YEAR DEDUCTIBLE AND 30% COINSURANCE
Outpatient surgery	NO COPAY	$1,000 CALENDAR YEAR DEDUCTIBLE AND 30% COINSURANCE
Ambulance services Includes ambulance services to an institution (like a hospital or SNF), from an institution to another institution and services dispatched through 911, where other means of transportation could endanger your health.	$50 COPAY ONE WAY	$1,000 CALENDAR YEAR DEDUCTIBLE AND 30% COINSURANCE
Emergency care For more information, see Section 3. (COVERAGE PROVIDED WITHIN THE UNITED STATES)	$50 COPAY PER VISIT FOR IN AND OUT OF NETWORK	

Benefits Chart – your covered services	What you must pay when you get these covered services In-Network	What you must pay when you get these covered services Out-of-Network
	THE $50 COPAY IS WAIVED IF MEMBER IS ADMITTED INTO THE HOSPITAL AS AN INPATIENT AND YOUR COST SHARNG IS THE HIGHEST COST SHARING YOU WOULD PAY AT A PLAN HOSPITAL. If you get inpatient care at a non-plan hospital after your emergency condition is stabilized, your cost sharing increases to the out-of-network level.	
Urgently needed care For more information, see Section 3. (COVERAGE PROVIDED WITHIN THE UNITED STATES)	$50 COPAY PER VISIT	$1,000 CALENDAR YEAR DEDUCTIBLE AND 30% COINSURANCE
Outpatient rehabilitation services (physical therapy, occupational therapy, cardiac rehabilitation, and speech and language therapy) Cardiac rehabilitation therapy covered for patients who have had a heart attack in the last 12 months, have had coronary bypass surgery, and/or have stable angina pectoris.	$10 COPAY PER VISIT	$1,000 CALENDAR YEAR DEDUCTIBLE AND 30% COINSURANCE
Durable medical equipment and related supplies- such as wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker. (See definition of "durable medical equipment" in Section 14.)	NO COPAY	$1,000 CALENDAR YEAR DEDUCTIBLE AND 30% COINSURANCE
Prosthetic devices and related supplies—(other than dental) which replace a body part or function. These include colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" below for more detail.	NO COPAY	$1,000 CALENDAR YEAR DEDUCTIBLE AND 30% COINSURANCE
Diabetes self-monitoring, training and supplies-		

Benefits Chart – your covered services	What you must pay when you get these covered services In-Network	What you must pay when you get these covered services Out-of-Network
for all people who have diabetes (insulin and non-insulin users). • Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose control solutions for checking the accuracy of test strips and monitors. • One pair per calendar year of therapeutic shoes for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts. • Self-management training is covered under certain conditions. *For persons at risk of diabetes:* Fasting plasma glucose tests. CONTACT MEMBER SERVICES FOR INFORMATION ON HOW OFTEN WE WILL COVER THESE TESTS.	NO COPAY	$1,000 CALENDAR YEAR DEDUCTIBLE AND 30% COINSURANCE
Medical nutrition therapy—for people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by a doctor.	$10 COPAY PER VISIT	$1,000 CALENDAR YEAR DEDUCTIBLE AND 30% COINSURANCE
Outpatient diagnostic tests and therapeutic services and supplies • X-rays. • Outpatient radiation therapy. • Surgical supplies, such as dressings. • Supplies, such as splints and casts. • Laboratory tests. • Blood: Coverage begins with the fourth pint of blood that you need – you pay for the first 3 pints of unreplaced blood. Coverage of storage and administration begins with the first pint of blood that you need.	NO COPAY	$1,000 CALENDAR YEAR DEDUCTIBLE AND 30% COINSURANCE
Preventive Care and Screening Tests		
Bone mass measurements *For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following*	NO COPAY	$1,000 CALENDAR YEAR DEDUCTIBLE

Benefits Chart – your covered services	What you must pay when you get these covered services In-Network	What you must pay when you get these covered services Out-of-Network
services are covered every 2 years or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.		AND 30% COINSURANCE
Colorectal screening *For people 50 and older, the following are covered:* • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months. • Fecal occult blood test, every 12 months. *For people at high risk of colorectal cancer, the following are covered:* • Screening colonoscopy (or screening barium enema as an alternative) every 24 months. *For people not at high risk of colorectal cancer, the following is covered:* • Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy.	NO COPAY	$1,000 CALENDAR YEAR DEDUCTIBLE AND 30% COINSURANCE
Immunizations • Pneumonia vaccine. • Flu shots, once a year in the fall or winter. • *If you are at high or intermediate risk of getting Hepatitis B*: Hepatitis B vaccine. • Other vaccines, if you are at risk.	NO COPAY	$1,000 CALENDAR YEAR DEDUCTIBLE AND 30% COINSURANCE
Mammography screening • One baseline exam between the ages of 35 and 39. • One screening every 12 months for women age 40 and older.	NO COPAY	$1,000 CALENDAR YEAR DEDUCTIBLE AND 30% COINSURANCE
Pap smears, pelvic exams, and clinical breast		$1,000 CALENDAR

Benefits Chart – your covered services	What you must pay when you get these covered services In-Network	What you must pay when you get these covered services Out-of-Network
exam • For all women, Pap tests, pelvic exams, and clinical breast exams are covered once every calendar year.	NO COPAY	YEAR DEDUCTIBLE AND 30% COINSURANCE
Prostate cancer screening exams *For men over age 50, the following are covered once every 12 months:* • Digital rectal exam. • Prostate Specific Antigen (PSA) test.	NO COPAY	$1,000 CALENDAR YEAR DEDUCTIBLE AND 30% COINSURANCE
Cardiovascular disease testing Blood tests for the early detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease). CONTACT MEMBER SERVICES FOR INFORMATION ON HOW OFTEN WE WILL COVER THESE TESTS.	NO COPAY	$1,000 CALENDAR YEAR DEDUCTIBLE AND 30% COINSURANCE
Physical Exams • One routine physical exam each calendar year.	$5 COPAY PER VISIT	$1,000 CALENDAR YEAR DEDUCTIBLE AND 30% COINSURANCE
Other Services		
Renal Dialysis (Kidney) • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Sections 2 and 3). • Inpatient dialysis treatments (if you are admitted to a hospital for special care.) • Self-dialysis training (includes training for you and for the person helping you with your home dialysis treatments). • Home dialysis equipment and supplies. Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies when needed, and check your dialysis	NO COPAY	$1,000 CALENDAR YEAR DEDUCTIBLE AND 30% COINSURANCE

Benefits Chart – your covered services	What you must pay when you get these covered services In-Network	What you must pay when you get these covered services Out-of-Network
equipment and water supply).		
Prescription Drugs		
"Drugs" includes substances that are naturally present in the body, such as blood clotting factors. • Drugs that usually are not self-administered by the patient and are injected while receiving physician services. • Drugs you take using durable medical equipment (such as nebulizers) that was authorized by Blue Cross and Blue Shield of Alabama. • Clotting factors you give yourself by injection if you have hemophilia. • Immunosuppressive drugs, if you have had an organ transplant that was covered by Medicare. • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug. • Antigens. • Certain oral anti-cancer drugs and anti-nausea drugs. • Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary), topical anesthetics, Erythropoietin (Epogen®) or Epoetin alfa, and Darboetin Alfa (Aranesp®). • Intravenous Immune Globulin for the treatment of primary immune deficiency diseases in your home.	20% coinsurance There is no benefit limit on drugs covered under Original Medicare.	$1,000 calendar year deductible and 30% coinsurance
Other outpatient prescription drugs, such as Crestor or Fosamax, are covered by Blue Advantage because you are enrolled in a Medicare Prescription Drug Plan Section 6 explains about the prescription drug benefit, including rules you must follow to have prescriptions covered. Section 6	$0 - $50 calendar year deductible and $1 - $5, or 15% coinsurance, depending on your income level, per 30-day supply at a	Out-of-network pharmacies are covered only in special circumstances. $0 - $50 calendar year deductible and

Benefits Chart – your covered services	What you must pay when you get these covered services In-Network	What you must pay when you get these covered services Out-of-Network
also tells about drugs that are not covered by this benefit.	retail pharmacy See section 6 for more information	$1 - $5, or 15% coinsurance, depending on your income level, per 30-day supply at a retail pharmacy, plus the difference between the billed amount and the in-network allowed amount. See Section 6 for more information.
Additional Benefits		
Dental services • Limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor.	NO COPAY	$1,000 CALENDAR YEAR DEDUCTIBLE AND 30% COINSURANCE
Hearing services • Diagnostic hearing exams	NO COPAY	$1,000 CALENDAR YEAR DEDUCTIBLE AND 30% COINSURANCE
Vision care • Outpatient physician services for eye care. • For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year. • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.	NO COPAY	$1,000 CALENDAR YEAR DEDUCTIBLE AND 30% COINSURANCE

What if you have problems getting services you believe are covered for you?

If you have any concerns or problems getting the services that you believe are covered for you as a member, we want to help. Please call us at Member Services at the telephone number on the cover of this booklet. You have the right to make a complaint if you have problems related to getting services or payment for services that you believe are covered for you. See Section 10 for information about making a complaint.

Can your benefits change during the year?

The Medicare program does not allow us to *decrease* your benefits during the calendar year. We are allowed to decrease your benefits only on January 1, at the beginning of the next calendar year. The Medicare program must approve any *decreases* we make in your benefits. We will tell you in advance (in October 2006) if there are going to be any increases or decreases in your benefits for the next calendar year that begins on January 1, 2007.

At any time during the year, the Medicare program can change its national coverage. Since we cover what Original Medicare covers, we would have to make any change that the Medicare program makes. These changes could be to increase or decrease your benefits, depending on what change the Medicare program makes. In some cases, if your benefits increase, Original Medicare will pay for the benefit for the rest of the calendar year. In those cases, you will have to pay Original Medicare out-of-pocket amounts for those services. We will let you know in advance if you will have to pay Original Medicare out-of-pocket amounts for an increased benefit.

Can the prescription drugs that we cover change during the year?

The Medicare program allows us to make changes in our prescription drug formulary list at any time. As we explain in Section 6, the formulary is a list of drugs. A change in our drug formulary list could which drugs are covered for you and/or how much you have to pay when you fill a covered prescription. Note that the formulary list applies only to the covered services listed in the Benefits Chart under the heading that says, "*Outpatient* Prescription Drugs."

Section 5 Medical care and services that are NOT covered (list of exclusions and limitations)

Introduction

The purpose of this section is to tell you about medical care and services that are not covered ("excluded") or are limited by Blue Advantage. The list below tells about these exclusions and limitations. The list describes services that are not covered under *any* conditions, and some services that are covered only under specific conditions. (The Benefits Chart in Section 4 also explains about some restrictions or limitations that apply to certain services).

If you get services that are not covered, you must pay for them yourself

We will not pay for the exclusions that are listed in this section (or elsewhere in this booklet), and neither will Original Medicare, unless they are found upon appeal to be services that we should have paid or covered (appeals are discussed in Sections 10 and 11).

What services are not covered by Blue Advantage?

In addition to any exclusions or limitations described in the Benefits Chart in Section 4, or anywhere else in this booklet **the following items and services are <u>not</u> covered by** Blue Advantage**:**

1. Services that are not covered under Original Medicare, *unless* such services are specifically listed as covered in Section 4.
2. Services that are not part of your plan's Medicare-approved benefit package. If you obtain services from a provider who contracts with your plan, the service will be treated as an in-network covered service unless the provider advises you otherwise. However, if you obtain a service from a non-plan provider, you may want to confirm in advance with your plan that the service you obtain is medically necessary and a plan-covered service.
3. Even though you are not required to get prior authorization for services from non-plan providers, you can ask us for prior authorization to make sure that we agree that the services are covered and medically necessary.
4. Services that are not reasonable and necessary under Original Medicare Plan standards, unless otherwise listed as a covered service. As noted in Section 4, we provide all covered services according to Medicare guidelines.
5. Emergency facility services for non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency. (See Section 3 for more information about getting care for a medical emergency).
6. Experimental or investigational medical and surgical procedures, equipment, and medications, unless covered by Original Medicare or under an approved clinical trial. Experimental procedures and items are those items and procedures determined by Blue Cross and Blue Shield of Alabama and Original Medicare to not be generally accepted by

the medical community. See Section 7 for information about participation in clinical trials while you are a member of Blue Advantage.

7. Surgical treatment of morbid obesity *unless* medically necessary and covered under Original Medicare.
8. Private room in a hospital, *unless* medically necessary.
9. Private duty nurses.
10. Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility.
11. Nursing care on a full-time basis in your home.
12. Custodial care is not covered by Blue Advantage *unless* it is provided in conjunction with skilled nursing care and/or skilled rehabilitation services. "Custodial care" includes care that helps people with activities of daily living, like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
13. Homemaker services.
14. Charges imposed by immediate relatives or members of your household.
15. Meals delivered to your home.
16. Unless medically necessary, elective or voluntary enhancement procedures, services, supplies and medications including, but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance.
17. Cosmetic surgery or procedures, *unless* it is needed because of accidental injury or to improve the function of a malformed part of the body. Breast surgery and all stages of reconstruction for the breast on which a mastectomy was performed and, to produce a symmetrical appearance, surgery and reconstruction of the unaffected breast, is covered.
18. Routine dental care (such as cleanings, fillings, or dentures) or other dental services. Certain dental services that you get when you are in the hospital will be covered.
19. Chiropractic care is generally not covered under the plan, (with the exception of manual manipulation of the spine, as outlined in Section 4) and is limited according to Medicare guidelines.
20. Routine foot care is generally not covered under the plan and is limited according to Medicare guidelines.
21. Orthopedic shoes *unless* they are part of a leg brace and are included in the cost of the leg brace. There is an exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease (as shown in Section 4, in the Benefits Chart under "Outpatient Medical Services").

22. Supportive devices for the feet. *There is an exception*: orthopedic or therapeutic shoes are covered for people with diabetic foot disease (as shown in Section 4, in the Benefits Chart under "Outpatient Medical Services").

23. Routine Hearing aids and routine hearing examinations.

24. Routine eye examinations and eyeglasses (*except* after cataract surgery), radial keratotomy, LASIK surgery, vision therapy, and other low vision aids and services.

25. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy.

26. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices. (Medically necessary services for infertility are covered according to Original Medicare guidelines.)

27. Acupuncture.

28. Naturopaths' services.

29. Services provided to veterans in **V**eteran's **A**ffairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost sharing is more than the cost sharing required under Blue Advantage, we will reimburse veterans for the difference. Members are still responsible for the Blue Advantage cost sharing amount.

Section 6 Coverage For Outpatient Prescription Drugs

This section describes the prescription drug coverage you get as a member of our Plan. There are some special rules that apply to your prescription drug coverage. This section contains:

- What a formulary is and how to use it.
- Drug Management Program.
- How much you will pay when you fill a prescription for a covered drug.
- What an "Explanation of Benefits" is and how to get additional copies.
- If you have limited income and resources, you may be able to get extra help from Medicare to pay your Medicare drug plan costs so that you get your prescription drugs for little or no cost.

Using plan pharmacies to get your outpatient prescription drugs covered by us

What are network pharmacies?

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

What is a "network pharmacy"? A network pharmacy is a pharmacy where you can get your prescription drugs through your prescription drug coverage. We call them "network pharmacies" because they contract with our Plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. Once you go to one, you are not required to continue going to the same pharmacy to fill your prescription; you can go to any of our network pharmacies.

What are "covered drugs"? "Covered drugs" is the general term we use to mean all of the outpatient prescription drugs that are covered by our Plan. Covered drugs are listed in the formulary.

How do I fill a prescription at a network pharmacy?

To fill your prescription, you must show your Plan membership card at one of our network pharmacies. If you do not have your membership card with you when you fill your prescription, you may have to pay the full cost of the prescription (rather than paying just your co-payment). If this happens, you can ask us to reimburse you for our share of the cost by submitting a claim to us. To learn how to submit a paper claim, please refer to the paper claims process described at the end of this section.

The Blue Advantage Participating Pharmacy Directory gives you a list of Plan network pharmacies.

As a member of our Plan you will get a Blue Advantage Participating Pharmacy Directory, which gives you a list of our network pharmacies. You can use it to find a network pharmacy

closest to you. If you don't have the Blue Advantage Participating Pharmacy Directory, you can get a copy from Member Services. They can also give you the most up-to-date information about changes in this Plan's pharmacy network. In addition, you can find this information on our website.

What if a pharmacy is no longer a "network pharmacy"?

Sometimes a pharmacy might leave the plan's network. If this happens, you will have to get your prescriptions filled at another plan network pharmacy. Please refer to your Blue Advantage Participating Pharmacy Directory or call Member Services to find another network pharmacy in your area.

How do I fill a prescription through Plan's network mail order pharmacy service?

You can use our Plan's network mail-order pharmacy service to fill prescriptions for any drug that is included on the Blue Advantage formulary list.

When you order prescription drugs through one of the network mail-order pharmacies, you must order at least a 30-day supply, and no more than a 90-day supply of the drug.

Generally, it takes 14 days for your order to be processed and shipped to you. However, sometimes your mail order may be delayed. If your mail order prescription is delayed beyond 14 days after you place your order, you may have it filled at one of our local network pharmacies. The pharmacy may be required to contact us for approval if the mail order company has already processed your order and is in the process of shipping it to you.

You are not required to use a mail-order pharmacy to obtain an extended supply of maintenance medications. You can also get an extended supply through some retail network pharmacies.

Filling prescriptions outside the network

We have network pharmacies outside of the service area where you can get your drugs covered as a member of our plan. Generally, we only cover drugs filled at an out-of-network pharmacy in limited circumstances when a network pharmacy is not available. Below are some circumstances when we would cover prescriptions filled at an out-of-network pharmacy. Before you fill a prescription at an out-of-network pharmacy, please call Member Service to see if there is a network pharmacy in your area where you can fill your prescription. If you do go to an out-of-network pharmacy for the reasons listed below, you may have to pay the full cost (rather than paying just your co-payment) when you fill your prescription. You can ask Blue Advantage to reimburse you for our share of the cost by submitting a claim form. You should submit a claim to Blue Advantage if you fill a prescription at an out-of-network pharmacy and you have already reached your initial coverage limit as any amount you pay will help you qualify for catastrophic coverage. To learn how to submit a paper claim, please refer to the paper claims process described next.

What if I need a prescription because of a medical emergency?

We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgently needed care. In this situation, you will have to pay the full cost (rather than paying just your co-payment) when you fill your prescription.

You can ask us to reimburse you for our share of the cost by submitting a paper claim form. To learn how to submit a paper claim, please refer to the paper claims process described below.

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

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

If you are traveling within the US, but outside of the Plan's service area, and you become ill, lose, or run out of your prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy if you follow all other coverage rules identified within this document and a network pharmacy is not available. In this situation, you will have to pay the full cost (rather than paying just your co-payment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a claim form. To learn how to submit a paper claim, please refer to the paper claims process described below.

Prior to filling your prescription at an out-of-network pharmacy, call our Member Services to find out if there is a network pharmacy in the area where you are traveling. If there are no network pharmacies in that area, our Member Services may be able to make arrangements for you to get your prescriptions from an out-of-network pharmacy.

We cannot pay for any prescriptions that are filled by pharmacies outside the United States, even for a medical emergency.

Other times you can get your prescription covered if you go to an out-of-network pharmacy

We will cover your prescription at an out-of-network pharmacy if at least one of the following applies:

- If you are unable to get a covered drug in a timely manner within our service area because there are no network pharmacies within a reasonable driving distance that provide 24-hour service.
- If you are trying to fill a covered prescription drug that is not regularly stocked at an in-network retail or mail order pharmacy (these drugs include orphan drugs or other specialty pharmaceuticals).

THE SAME PLAN LIMITATIONS APPLY TO IN AND OUT-OF-NETWORK PRESCRIPTIONS. REFER TO THE BLUE ADVANTAGE FORMULARY TO DETERMINE IF ANY OF THE MEDICATIONS YOU ARE PURCHASING REQUIRE A PRIOR AUTHORIZATION, QUANTITY LIMITATION, OR STEP THERAPY.

Before you fill your prescription in either of these situations, call Member Services to see if there is a network pharmacy in your area where you can fill your prescription. If you do go to an out-of-network pharmacy for the reasons listed above, you will have to pay the full cost (rather than paying just your co-payment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a claim form. To learn how to submit a paper claim, please refer to the paper claims process described below.

How do I submit a paper claim?

When you go to a network pharmacy, your claim is automatically submitted to us by the pharmacy. However, if you go to an out-of-network pharmacy for one of the reasons listed above, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. To submit a claim, contact Member Services for a claim form. Attach copies of your prescription drug receipts to the completed claim form and mail the claim to P. O. Box 995, Birmingham, Alabama 35298. If you have questions or need assistance completing this form, call Member Services at the telephone number listed on the cover of this booklet.

Specialty Pharmacies

Home infusion pharmacies

- The Plan will cover home infusion therapy if:
- Your prescription drug is on our Plan's formulary,
- You have followed all required coverage rules and our Plan has approved your prescription for home infusion therapy,
- Your prescription is written by a doctor, and
- You get your home infusion services from a Plan network pharmacy.

Please refer to your Pharmacy Directory to find a home infusion pharmacy in your area. For more information, please contact Member Services.

Long-term care pharmacies

Residents of a long-term care facility may get their prescription drugs through a long-term care pharmacy in the plan's network of long-term care pharmacies. In some cases this will be the long-term care pharmacy that contracts directly with the long-term care facility. If it is not, or for more information, please contact Member Service.

Indian Health Service / Tribal / Urban Indian Health Program (I/T/U) Pharmacies

Native Americans and Alaska Natives have access to Indian Health Service / Tribal / Urban Indian Health Program (I/T/U) Pharmacies through the Plan's pharmacy network.

Please refer to your Pharmacy Directory to find an I/T/U pharmacy in your area. For more information, please contact Member Services.

What drugs are covered by this Plan?

What is a formulary?

A formulary is a list of all the drugs we cover. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a network pharmacy or through our network mail order pharmacy service, and other coverage rules are followed. For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits are described in Section 4. As a person with Medicare you are also entitled to coverage of those drugs that are covered under Medicare Part A and B.

The drugs on the formulary are selected by our Plan with the help of a team of health care providers. We select the prescription therapies believed to be a necessary part of a quality treatment program and both brand-name drugs and generic drugs are included on the formulary. A generic drug has the same active-ingredient formula as the brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as brand-name drugs.

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

In certain situations, prescriptions filled at an out-of-network pharmacy may also be covered.

How do you find out what drugs are on the formulary?

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

What are drug tiers?

Drugs on our formulary are organized into different drug tiers, or groups of different drug types. Your co-payment depends on which drug tier your drugs is in. The table below shows the co-payment amount you pay for each tier when you are in your initial coverage level. (See "How Much Do I Pay for My Prescriptions?" in the chart later in this Section for more information about the Initial Coverage Level.).

You can ask us to make an exception to your drug's tier placement. See "How Do I Request an Exception to the Formulary?" described below.

Can the formulary change?

We may add or remove drugs from the formulary during the year. Changes in the formulary may affect which drugs are covered and how much you will pay when filling your prescription. If we remove drugs from the formulary, add prior authorizations, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, and you are taking the drug affected by the change, we will notify you of the change at least 60 days before the date that the change becomes effective. If we don't notify you of the change in advance, you will get a 60-day supply of the drug when you request a refill of the drug. However, if a drug is removed from our

formulary because the drug has been recalled from the market, we will not give 60-day's notice before removing the drug from the formulary. Instead, we will remove the drug from our formulary immediately and notify members about the change as soon as possible.

What if your drug is not on the formulary?

If your prescription is not listed on the formulary, you should first contact Member Services to be sure it is not covered.

If Member Services confirms that we do not cover your drug, you have three options:

- You can ask your doctor if you can switch to another drug that is covered by us. If you would like to give your doctor a list of covered drugs that are used to treat similar medical conditions, please contact Member Services.
- You can ask us to make an exception for us to cover your drug. See the section, "How do you request an exception to the Plan's formulary?" below for more information.
- You can pay out-of-pocket for the drug and request that the plan reimburse you by means of an exceptions request. This does not obligate the plan to reimburse you if the exception request is not approved. See Section 12 for more information on how to request an appeal.

If you recently joined this Plan and you learn that we do not cover a drug you were taking when you joined our plan, you may be able to get a one-time fill of that prescription. You can get a one-time fill of the non-covered drug if one of the following applies:

- You didn't know that your drug wasn't covered by this Plan, or
- You knew it wasn't covered, but you didn't know that you could request an exception to the Plan's formulary.

After your one-time fill, you can ask Member Services if we cover another drug to treat your medical condition. If we cover another drug, you can ask your doctor if this drug is an option for your treatment. You can also file a request for an exception to our formulary. See the section, "How do you request an exception to the Plan's formulary?" for more information.

In some cases, we will contact you if you are taking a drug that is not on our formulary. We can give you the names of covered drugs that may be used to treat similar conditions so you can ask your doctor if any of these drugs are an option for your treatment. TO REQUEST A ONE-TIME APPROVAL FOR THE FILL OF A NON-COVERED DRUG THAT IS PART OF AN ON-GOING THERAPY, THE PHARMACIST FILLING YOUR PRESCTIPTION MUST CALL THE PHARMACY HELP DESK AT BLUE CROSS AND BLUE SHIELD OF ALABAMA FOR AN APPROVAL.

How can you request an exception to the Plan's formulary?

You can ask us to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it is not on our formulary.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, we limit the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.

- You can ask us to provide a higher level of coverage for your drug. For example, if your drug is usually considered a Specialty drug, you can ask us to cover it as an Alternative Brand drug instead. This would lower the co-payment amount you must pay for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug.

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

Please go to Section 12, "Detailed information about how to request a coverage determination and an appeal" below, to learn more about requesting an exception. In order to help us make a decision more quickly, you should include supporting medical information from your doctor when you submit your exception request.

If we approve your exception request, our approval is valid for the remainder of the plan year, so long as your doctor continues to prescribe the drug for you and it continues to be safe and effective for treating your condition. If we deny your exception request, you can appeal our decision. Please see Section 12 for more information about how to request an appeal below.

Drug exclusions

By law, certain types of drugs or categories of drugs are not covered by Medicare Drug Plans. These drugs or categories of drugs are called "exclusions" and include:

- Nonprescription drugs, unless they are part of an approved step therapy
- Drugs when used for anorexia, weight loss, or weight gain
- Drugs when used to promote fertility
- Drugs when used for cosmetic purposes or hair growth
- Drugs when used for the symptomatic relief of cough or colds
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Barbiturates
- Benzodiazepines

In addition, a Prescription Drug Plan cannot cover a drug that is covered under Medicare Part A or Part B. See "How does your enrollment in this Plan affect coverage for drugs covered under Medicare Part A or Part B?" below.

For more information about catastrophic coverage, and out-of-pocket costs, see below.

Drug Management Programs

Utilization management

For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits ensure that our members use these drugs in the most effective way and also help us control drug plan costs. A team of doctors and pharmacists developed these requirements and limits for our Plan to help us to provide quality coverage to our members. Examples of utilization management tools are described below:

- **Prior Authorization:** We require you to get prior authorization for certain drugs. This means that your prescribing physician will need to get approval from us before you fill your prescription. If they don't get approval, we may not cover the drug.
- **Quantity Limits:** For certain drugs, we limit the amount of the drug that we will cover per prescription or for a defined period of time. For example, we will provide up to 9 tablets per month for Imitrex 25 mg tablets.
- **Step Therapy:** In some cases, we require you to first try one drug to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may require your doctor to prescribe Drug A first. If Drug A does not work for you, then we will cover Drug B.
- **Generic Substitution:** When there is a generic version of a brand-name drug available, our network pharmacies will automatically give you the generic version, unless your doctor has told us that you must take the brand-name drug.

You can find out if your drug is subject to these additional requirements or limits by looking in the formulary. If your drug does have these additional restrictions or limits, you can ask us to make an exception to our coverage rules. See Section 6, "How do I request an exception to the formulary?" described above for more information.

Drug utilization review

We conduct drug utilization reviews for all of our members to make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one doctor who prescribe their medications. We conduct drug utilization reviews each time you fill a prescription and on a regular basis by reviewing our records. During these reviews, we look for medication problems such as:

- Possible medication errors.
- Duplicate drugs that are unnecessary because you are taking another drug to treat the same medical condition.
- Drugs that are inappropriate because of your age or gender.
- Possible harmful interactions between drugs you are taking.
- Drug allergies.
- Drug dosage errors.

If we identify a medication problem during our drug utilization review, we will work with your doctor to correct the problem.

Medication therapy management program

We offer a medication therapy management program at no additional cost for members who have multiple medical conditions, who are taking many prescription drugs, or who have high drug costs. This program was developed for us by a team of pharmacists and doctors. We use this medication therapy management program to help us provide better coverage for our members. For example, this program helps us make sure that our members are using appropriate drugs to treat their medical conditions and helps us identify possible medication errors.

We offer a medication therapy management program for members that meet specific criteria. We may contact members who qualify for this program. If we contact you, we hope you will join so that we can help you manage your medications. Remember, you do not need to pay anything extra to participate.

If you are selected to join a medication therapy management program, we will send you information about the specific program, including information about how to get the program.

How does your enrollment in this Plan affect coverage for the drugs covered under Medicare Part A or Part B?

As a person with Medicare, you are entitled to coverage of those drugs that are covered under Medicare Parts A and B, and the drugs that are covered in your Medicare drug plan.

Your enrollment in Blue Advantage does not affect Medicare coverage for drugs. You are entitled to all medically necessary A and B services including drugs that are covered under A and B. In addition, Blue Advantage also covers your Part D benefit.

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

Some vaccines and drugs may be administered in your doctor's office

We cover vaccines that are medically necessary but are not already covered by Medicare Part B. In addition we cover some drugs that may be administered in your doctor's office. ("How does your enrollment in Plan affect coverage for drugs covered under Medicare Part A or Part B?" for more information.)

How much do you pay for drugs covered by this Plan?

If you qualify for extra help with your Medicare prescription drug coverage your costs for your drugs may be different than those described below. See Section 6 "Extra Help with Drug Plan Costs for People with Limited Income and Resources" and the "Low Income Subsidy Rider" for those who get extra help paying for their prescription drugs."

When you fill a prescription for a covered drug, you may pay part of the costs for your drug. The amount you pay for your drug depends on what coverage level you are in (i.e., initial coverage level, after you reach your initial coverage limit, and catastrophic level), the type of drug it is,

and whether you are filling your prescription at an in-network or out-of-network pharmacy. Your drug costs for each coverage level are described below.

Deductible

You, or others on your behalf, will pay a yearly deductible of $0 - $50 depending on your income level. This is the amount that must be paid each year before we will begin paying for part of your drug costs. After you meet the deductible of $50 deductible amount, if applicable, you will reach the initial coverage level.

Initial Coverage Level

During the **initial coverage level**, we will pay part of the costs for your covered drugs and you (or others on your behalf) will pay the other part. The amount you pay when you fill a covered prescription is called the co-payment. Your co-payment will vary depending on the drug and where the prescription is filled.

Drug Tier	**Retail Co-payment (30-day Supply)**	**Retail Co-payment (90-day Supply)**	**Mail-Order Co-payment (30-day supply)**	**Mail-Order Co-payment (90-day supply)**	**Out-of-Network Co-payment (30 day supply)**
Generics	$1 or $2, or 15% depending on your income level	$3 or $6, or 15% depending on your income level	$1 or $2, or 15% depending on your income level	$3 or $6, or 15% depending on your income level	See Note below
Preferred Brand	$1 or $2, or 15% depending on your income level	$3 or $6, or 15% depending on your income level	$1 or $2, or 15% depending on your income level	$3 or $6, or 15% depending on your income level	See Note below
Alternate Brand	$3 or $5, or 15% depending on your income level	$9 or $15, or 15% depending on your income level	$3 or $5, or 15% depending on your income level	$9 or $15, or 15% depending on your income level	See Note below
Specialty Brand	$3 or $5, or 15% depending on your income level	$9 or $15, or 15% depending on your income level	$3 or $5, or 15% depending on your income level	$9 or $15, or 15% depending on your income level	See Note below

Note: Part D covered drugs are available at out-of-network pharmacies in special circumstances, including your illness while traveling outside of the Plan's service area and where there is no network pharmacy.

If you purchase drugs from a non-participating pharmacy, you will pay the applicable copay or coinsurance plus the difference between the out-of-network retail price and the participating pharmacy allowed amount. If you use a non-participating pharmacy, you will pay the full amount at the time of purchase and file the hardcopy claim to Blue Cross and Blue Shield of Alabama for consideration.

Your initial coverage limit is calculated by adding payments made by this Plan and you. If other individuals, organizations, current or former employer/union, and another insurance plan or policy help pay for your drugs under this plan, the amount they spend may count towards your initial coverage limit.

Once your total out-of-pocket drug costs reach $3,600, you will qualify for catastrophic coverage.

Catastrophic Coverage

All Medicare Prescription Drug Plans include catastrophic coverage for people with high drug costs. In order to qualify for catastrophic coverage, you must spend $3,600 out-of-pocket for the year. When the total amount you have paid toward co-payments, and the cost for covered Part D drugs after you reach the initial coverage limit reaches $3,600, you will qualify for catastrophic coverage. During catastrophic coverage you will pay:

> The greater of $0 or $2 for generics or preferred brand that is a multi-source drugs, depending on your income level and $0 or $5 for all other drugs, depending on your income level. We will pay the rest.

How is your out-of-pocket cost calculated?

What type of prescription drug payments count toward your out-of-pocket costs?

The following types of payments for prescription drugs can count toward your out-of-pocket costs and help you qualify for catastrophic coverage so long as the drug is on the formulary (or if you get a favorable decision on a coverage determination, exception request or appeal), and it was obtained at a network pharmacy (or you have an approved claim from an out-of-network pharmacy):

- Your annual deductible.
- Your co-insurance or co-payments made on drugs that are:
    - Covered by the Plan up to the initial coverage level,
    - Not on our Plan's formulary, but were determined to count towards your out-of-pocket costs through the coverage determination, exceptions, or appeals process; and
    - Filled at an out-of-network pharmacy in accordance with our Plan's out-of-network access rules.
- Any payments you make after the initial coverage limit for drugs.

When you have spent a total of $3,600 for these items, you will reach the catastrophic coverage level. (The amount you pay for your monthly premium **does not** count toward reaching the catastrophic coverage level.)

Purchases that will **not** count toward your out-of-pocket costs:

- Prescription drugs purchased outside the United States and its territories.
- Prescription drugs not covered by the Plan.

Who can pay for your prescription drugs, and how do these payments apply to your out-of-pocket costs?

Except for your premium payments, any payments you make for covered Part D drugs count toward your out-of-pocket costs and will help you qualify for catastrophic coverage. In addition, when the following individuals or organizations pay your prescription drug costs, these payments will count toward your out-of-pocket costs (and will help you qualify for catastrophic coverage):

- Family members or other individuals;
- Qualified State Pharmacy Assistance Programs (SPAPs);
- Medicare programs that provide extra help with prescription drug coverage; and
- Most charities or charitable organizations. Please note that if the charity is established, run or controlled by your current or former employer or union, the payments usually will not count toward your out-of-pocket costs.

Payments made by the following do **not** count toward your out-of-pocket costs:

- Group Health Plans;
- Insurance Plans and government funded health programs; and
- Third party arrangements that obligate the third party to pay for prescription costs (e.g., TRICARE, Workers Compensation).

If you have coverage from a third party that pays part (or all) of your out-of-pocket costs, you must disclose this information to us. An example of third party coverage would be an employer-sponsored health plan that offers prescription drug coverage.

We are responsible for keeping track of your out-of-pocket cost amount and will let you know when you have qualified for catastrophic coverage. If you or another party on your behalf have purchased drugs outside of our plan benefit, you will be responsible for submitting appropriate documentation of such purchases to Blue Advantage. In addition, every month you purchase covered prescription drugs through us, you will get an Explanation of Benefits that shows your out-of-pocket cost amount to date.

Explanation of Benefits

What is the Explanation of Benefits?

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

What information is included in the Explanation of Benefits?

Your Explanation of Benefits will contain the following information:

- A list of prescriptions you get during the month, as well as the amount paid for each prescription.
- Information about how to request an exception and appeal our coverage decisions.
- A description of changes to the formulary that will occur at least 60 days in the future.
- A summary of your coverage this year, including information about:
  - **Annual Deductible –** the amount you and/or others pay before you start receiving prescription coverage.
  - **Amount Paid For Prescriptions-**the amounts paid that count towards your initial coverage limit.
  - **Out-Of-Pocket Payments after you reach the initial coverage limit-**The amount you and/or others make after you reach the initial coverage limit before you qualify for Catastrophic Coverage.
    - **Total Out-Of-Pocket Costs That Count Towards Catastrophic Coverage-**the total amount you and/or others have spent on prescription drugs that count towards your qualifying for catastrophic coverage. This total includes the amounts spent for your co-payments, and payments made on covered Part D drugs after you reach the initial coverage limit. (This amount does not include payments made by your current or former employer/union, another insurance plan or policy or other excluded parties.)

When will you get an Explanation of Benefits?

You will get an Explanation of Benefits in the mail each month that you use the coverage provided by us. You will also receive a Summary Explanation of Benefits whenever we make a payment directly to you.

What should you do if you haven't received an Explanation of Benefits or if you wish to request one?

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

How does your prescription drug coverage work if you go to a hospital or skilled nursing facility?

If you are admitted to a hospital for a Medicare-covered stay, Blue Advantage will provide your prescription drugs under your medical benefit. Once you are released from the hospital, we will provide your prescription drugs under your outpatient drug benefit.

If you are admitted to a skilled nursing facility for a Medicare-covered stay, we will arrange for any medically necessary Part A prescription drugs for the first 100 days that you are in the facility. After the first 100 days, we will cover your prescriptions as long as the skilled nursing facility's pharmacy is in our pharmacy network. Once you enter a skilled nursing facility you are entitled to a special enrollment period, during which time you will be able to leave this Plan and select another Medicare Advantage plan or original Medicare. Please see Section 13 of this document for more information about leaving this Plan.

If You Have Other Prescription Drug Coverage

We will send you Coordination of Benefits (COB) Survey so that we can know what other drug coverage you have in addition to the coverage you get through this plan. CMS requires us to collect this information from you, so when you get the survey, please fill it out and send it to us. The information you provide helps us calculate how much you and others have paid for your drugs. In addition, if you lose or get additional prescription drug coverage, please call customer service to update your membership records.

If you have Medicare and Medicaid

Beginning January 1, 2006, your prescription drug coverage will change. Blue Advantage, not Medicaid, will pay for most of your prescription drugs.

If you are a member of a State Pharmacy Assistance Program (SPAP)

If you are currently enrolled in a SPAP, you may get help paying your premiums, and/or co-payments. Please contact your SPAP to determine what benefits are available to you. Please see the Introduction for more information.

If you have a Medigap policy with prescription drug coverage

If you currently have a Medicare Supplement (Medigap) policy that includes coverage for prescription drugs, you must contact your Medigap issuer and tell them you have enrolled in our Plan. You cannot use it for out-of-pocket costs under the plan. You cannot change to another Medigap policy while you are in our plan, and if you decide to drop the policy you will not be able to get it back and in no case will you be able to get the prescription drug coverage under the policy. If you do, however, decide to keep your current Medigap policy, your Medigap issuer will remove the prescription drug coverage portion of your policy and adjust your premium. You should have received a letter in the fall of 2005 from your Medigap issuer explaining your options and how the removal of drug coverage from your Medigap policy will affect your premiums. If you do not receive this letter, please contact your Medigap issuer.

If you are a member of an employer or Union group

If you currently have prescription drug coverage through your employer or union group, you should have received information from your employer or Union group indicating whether or not your prescription drug coverage is *creditable* (meaning whether or not it covers at least as much as Medicare's prescription drug plan coverage) and the options available to you. If you did not receive this letter, please contact your benefits administrator to find out how your current prescription drug coverage will work with this plan. In general, if you are currently employed, the prescription drug coverage you get from us will be secondary to your employer or union group coverage.

If you have a Medicare-approved drug discount card

If you are a member of a Medicare-approved drug discount card program, you may continue to use your card to get discounts on your prescription drugs until the effective date of your enrollment in this Plan or until May 15, 2006 (whichever comes first).

If you are a member of a Medicare-approved drug discount card and are getting up to $600 credit in help paying for your prescription drugs, you will be able to use any remaining credit you have towards your prescription drug purchases until the effective date of your enrollment in this Plan or until May 15, 2006 (whichever comes first).

If you have a non-Medicare approved drug discount card

If you are a member of a drug discount card program that is not Medicare-approved, please contact your drug card issuer to determine what benefits are available to you. Any amount you pay while using a discount card for drugs normally covered by Medicare prescription drug Plans and are covered by Blue Advantage can count towards your out-of-pocket expenses. Your pharmacist may be able to submit these claims online directly to Blue Advantage. If not, you may complete a claim form and submit these claims directly to us. You should include copies of the original pharmacy receipts so that we will have all the necessary information to process your claims for you.

Extra help with drug plan costs for people with limited income and resources

What extra help is available?

Starting January 1, 2006, Medicare prescription drug coverage will be available to everyone with Medicare. If you have limited income and resources, you may qualify for extra help paying your prescription drug plan costs. If you qualify, you will get help paying for your drug plan's monthly premium and prescription co-payments.

Do you qualify for extra help?

People with limited income and resources may qualify for extra help. To qualify, your annual income must be below $14,355 (or $19,245, if you are married). In addition, your resources (including your savings and stocks, but not your home or car) must not exceed $11,500 (or $23,000, if you are married). The amount of extra help you get will depend on your income and resources.

Note: Amounts shown above are for 2005. If you live in Alaska or Hawaii, or pay more than half of the living expenses of dependent family members, income limits are higher. Please call Member Services to find out what the income limits are.

Some people automatically qualify for extra help and do not have to apply for it. If you answer "yes" to any of the questions below, you automatically qualify for extra help:

- Do you have Medicare and full coverage from a state Medicaid program?
- Do you get Supplemental Security Income?
- Do you get help from your state Medicaid program paying your Medicare premiums? That is, do you belong to a Medicare Savings Program, such as the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), or Qualified Individual (QI) program?

How do you apply for extra help?

Medicare mailed letters to people who automatically qualify for extra help in May or June. If you did not automatically qualify, the Social Security Administration (SSA) sent people with certain incomes an application for this extra help. If you got this application, fill it out and send it back to SSA as soon as possible. If you did not get an application but think you may qualify, call 1-800-772-1213, visit www.socialsecurity.gov on the Web, or apply at your State Medical Assistance office. After you apply, you will get a letter in the mail letting you know if you qualify or not and what you need to do next.

How do you get more information?

For more information on who can get extra help with prescription drug costs and how to apply, call the Social Security Administration at 1-800-772-1213, or visit www.socialsecurity.gov on the Web. TTY/TDD users should call 1-800-325-0778.

In addition, you can look at the 2006 *Medicare & You* Handbook, visit www.medicare.gov on the Web, or call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048.

If you have any questions about our Plan, please refer to our Member Services numbers listed on the cover and in the introduction section. Or, visit www.bcbsal.com.

What is the late enrollment penalty?

You will have to pay a penalty in addition to your monthly plan premium if you do not enroll in a Medicare Drug Plan during your initial enrollment period and you do not have *creditable* coverage for a continuous period of 63 days or more after your initial enrollment period. *Creditable* prescription drug coverage is coverage that is at least as good as the standard Medicare prescription drug coverage. You pay this late enrollment penalty for as long as you have Medicare prescription drug coverage. The amount of the penalty may increase every year.

The late enrollment penalty also applies to individuals who qualify for extra help with their drug plan costs. However, Medicare helps pay for the penalty for individuals who qualify for the most

help. People who qualify for the most help will pay 20% of the penalty for the first 60 months and none of the penalty afterwards.

Section 7 Hospital care, skilled nursing facility care, and other services (this section gives additional information about some of the covered services that are listed in the benefits chart in section 4)

Hospital care

If you need hospital care, we will arrange covered services for you. Covered services are listed in the Benefits Chart in Section 4 under the heading "Inpatient Hospital Care." We use "hospital" to mean a facility that is certified by the Medicare program and licensed by the state to provide inpatient, outpatient, diagnostic, and therapeutic services. The term "hospital" does not include facilities that mainly provide custodial care (such as convalescent nursing homes or rest homes). By "custodial care," we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living. (See Section 14 for the definition of "Inpatient Care")

IF YOU GET INPATIENT CARE AT A NON-PLAN HOSPITAL, YOUR OUT-OF-POCKET COSTS WILL BE HIGHER THAN IF YOU USE A PLAN HOSPITAL. THE EXCEPTION IS IF YOU USE A NON-PLAN HOSPITAL FOR EMERGENCY CARE. SEE SECTION 8 FOR MORE DETAIL ON WHY IT COSTS LESS TO SEE PLAN PROVIDERS.

What is a "benefit period" for hospital care?

Blue Advantage uses benefit periods to determine your coverage for inpatient services during a hospital stay (generally, you are an inpatient of a hospital if you are receiving inpatient services in the hospital). A "**benefit period**" begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility (SNF). The benefit period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. (Later in this section, we explain about SNF services).

Please note that after your hospital day limits are used up, we will still pay for covered physician services and other medical services. These services are listed in the Benefits Chart in Section 4 under the heading, "Inpatient services (when the hospital or SNF days are not or are no longer covered)."

Notification of Out-of-Network Hospital Admissions

IF YOU ARE ADMITTED TO AN OUT-OF-NETWORK HOSPITAL, PLEASE NOTIFY BLUE CROSS AND BLUE SHIELD OF ALABAMA BY CALLING 1-888-341-5030, 24 HOURS A DAY, 7 DAYS A WEEK (TTY 1-800-257-3384).

What happens if you join or drop out of Blue Advantage during a hospital stay?

If you either join or leave Blue Advantage during an inpatient hospital stay, special rules apply to your coverage for the stay and to what you owe for this stay. If this situation applies to you, please call Member Services at the telephone number on the cover of this booklet. Member Services can explain how your services are covered for this stay, and what you owe to Blue

Cross and Blue Shield of Alabama, if anything, for the periods of your stay when you were and were not a plan member.

Skilled nursing facility care (SNF care)

If you need skilled nursing facility care, we will arrange these services for you. Covered services are listed in the Benefits Chart in Section 4 under the heading "Skilled nursing facility care." The purpose of this subsection is to tell you more about some rules that apply to your covered services.

A skilled nursing facility is **a place that provides skilled nursing or skilled rehabilitation services**. It can be a separate facility, or part of a hospital or other health care facility. A **S**killed **N**ursing **F**acility is called a "SNF" for short. The term "skilled nursing facility" does not include places that mainly provide custodial care, such as convalescent nursing homes or rest homes. (By "custodial care," we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living.)

YOUR COST SHARING IS HIGHER IF YOU USE A NON-PLAN SKILLED NURSING FACILITY.

What is skilled nursing facility care?

"Skilled nursing facility care" means a level of care ordered by a physician that must be given or supervised by licensed health care professionals. It can be skilled nursing care, or skilled rehabilitation services, or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitation services include physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body, and training on how to use special equipment, such as how to use a walker or get in and out of a wheel chair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps you learn how to do usual daily activities, such as eating and dressing by yourself.

To be covered, the care you get in a SNF must meet certain requirements

To be covered, you must need daily skilled nursing or skilled rehabilitation care, or both. If you do not need daily skilled care, other arrangements for care would need to be made. Note that medical services and other skilled care will still be covered when you start needing less than daily skilled care in the SNF.

Stays that provide custodial care only are not covered

"Custodial care" is care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who do not have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Custodial care is not covered by Blue Advantage unless it is provided as other care you are getting *in addition to* daily skilled nursing care and/or skilled rehabilitation services.

There are benefit period limitations on coverage of skilled nursing facility care

Inpatient skilled nursing facility coverage is limited to 100 days each benefit period. A "**benefit period**" begins on the first day you go to a Medicare-covered inpatient hospital or a SNF. The benefit period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

Please note that after your SNF day limits are used up, physician services and other medical services will still be covered. These services are listed in the Benefits Chart in Section 4 under the heading, "Inpatient services (when the hospital or SNF days are not or are no longer covered)."

In some situations, you may be able to get care in a SNF that is not a plan provider

Generally, you will probably get your skilled nursing facility care from SNFs that are plan providers for Blue Advantage. In general, if you get your SNF care from SNFs that are not plan providers, your cost sharing will be much higher. However, *if certain conditions are met*, you may be able to get your skilled nursing facility care from a SNF that is not a plan provider at the same cost sharing that you would have paid if you used plan providers. One of the conditions is that the SNF that is not a plan provider must be willing to accept Blue Cross and Blue Shield of Alabama's rates for payment. At your request, we may be able to arrange for you to get your skilled nursing facility care from one of the facilities listed below (in these situations, the facility is called a "Home SNF"):

- A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as the place gives skilled nursing facility care).
- A SNF where your spouse is living at the time you leave the hospital.

Notification of Out-of-Network SNF Admissions

IF YOU ARE ADMITTED TO AN OUT-OF-NETWORK SNF, PLEASE NOTIFY BLUE CROSS AND BLUE SHIELD OF ALABAMA BY CALLING 1-888-341-5030, 24 HOURS A DAY, 7 DAYS A WEEK (TTY 1-800-257-3384).

What happens if you join or drop out of Blue Advantage during a SNF stay?

If you either join or leave Blue Advantage during a SNF stay, please call Member Services at the telephone number on the cover of this booklet. Member Services can explain how your services are covered for this stay, and what you owe to Blue Cross and Blue Shield of Alabama, if anything, for the periods of your stay when you were and were not a plan member.

Home health agency care

Home health care is skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Benefits Chart in Section 4 under the heading "Home health care." If you need home health care services, we will arrange these services for you if the requirements described below are met.

What are the requirements for getting home health agency services?

To get home health agency care benefits, you must meet all of these conditions:

1. You must be **home-bound**. This means that you are normally unable to leave your home and that leaving home is a major effort. When you leave home, it must be to get medical treatment or be infrequent, for a short time. You may attend religious services. You can also get care in an adult day care program that is licensed or certified by a state or accredited to furnish adult day care services in a state.

   Occasional absences from the home for non-medical purposes, such as an occasional trip to the barber or a walk around the block or a drive, would not mean that you are not homebound if the absences are on infrequent or are of relatively short duration. The absences cannot indicate that you have the capacity to obtain the health care provided outside of your home.

   Generally speaking, you will be considered to be homebound if you have a condition due to an illness or injury that restricts your ability to leave your home except with the aid of supportive devices or if leaving home is medically contraindicated. "Supportive devices" include crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person.

2. Your doctor must decide that you need medical care in your home, and must make a plan for your care at home. Your **plan of care** describes the services you need, how often you need them, and what type of health care worker should give you these services.

3. The home health agency caring for you must be approved by the Medicare program.

4. You must need *at least one* of the following types of skilled care:

   - Skilled nursing care on an "intermittent" (not full time) basis. Generally, this means that you must need at least one skilled nursing visit every 60 days and not require daily skilled nursing care for more than 21 days. Skilled nursing care includes services that can only be performed by or under the supervision of a licensed nurse.
   - Physical therapy, which includes exercise to regain movement and strength to an area of the body, and training on how to use special equipment or do daily activities, such as how to use a walker or get in and out of a wheel chair or bathtub.
   - Speech therapy, which includes exercise to regain and strengthen speech skills or to treat a swallowing problem.
   - Continuing occupational therapy, which helps you learn how to do usual daily activities by yourself. For example, you might learn new ways to eat or new ways to get dressed.

Home health care can include services from a home health aide, as long as you are <u>also</u> getting skilled care

As long as some qualifying skilled services are *also* included, the home health care you get can include services from a home health aide. A home health aide does not have a nursing license.

The home health aide provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care such as bathing, using the toilet, dressing, or carrying out the prescribed exercises. The services from a home health aide must be part of the home care of your illness or injury, and they are not covered unless you are *also* getting a covered skilled service. Home health services do not include the costs of housekeepers, food service arrangements, or full-time nursing care at home.

What are "part time" and "intermittent" home health care services?

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

- **"Part-time" or "Intermittent"** means your skilled nursing and home health aide services combined total less than 8 hours per day and 35 or fewer hours each week.

Hospice care for people who are terminally ill

"Hospice" is a special way of caring for people who are terminally ill, and for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients make the most of the last months of life by giving comfort and relief from pain. The focus is on care, not cure.

As a member of Blue Advantage, you may receive care from any Medicare-certified hospice. Your doctor can help you arrange for your care in a hospice. If you are interested in using hospice services, you can call Member Services at the number on the cover of this booklet to get a list of the Medicare-certified hospice providers in your area or you can call the Regional Home Health Intermediary at 1-866-801-5301.

If you enroll in a Medicare-certified hospice, Original Medicare (rather than Blue Advantage) pays the hospice for the hospice services you receive. Your hospice doctor can be a plan provider or a non-plan provider. If you choose to enroll in a Medicare-certified hospice, you are still a plan member and continue to get the rest of your care that is unrelated to your terminal condition through Blue Advantage.

The Medicare program has written a booklet about "Medicare Hospice Benefits." To get a free copy call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048), which is the national Medicare help line, or visit the Medicare Web site at www.medicare.gov. Section 1 tells more about how to contact the Medicare program and about the Web site.

Organ transplants

If you need an organ transplant, we will arrange to have your case reviewed by one of the transplant centers that is approved by Medicare (some hospitals that perform transplants are approved by Medicare, and others are not). The Medicare-approved transplant center will decide whether you are a candidate for a transplant. When all requirements are met, the following types of transplants are covered: corneal, kidney, pancreas (when performed with or after a Medicare-

covered kidney transplant), liver, heart, lung, heart-lung, bone marrow, intestinal/multivisceral, and stem cell. Please be aware that the following transplants are covered only if they are performed in a Medicare-approved transplant center: heart, liver, lung, heart-lung, and intestinal/multivisceral transplants. [Note: If enrollees are sent outside of their community for a transplant, the plan must arrange or pay for appropriate lodging and transportation costs for the member and a companion as well as ensuring post transplant continuity of care.]

Participating in a clinical trial

A "clinical trial" is a way of testing new types of medical care, like how well a new cancer drug works. Clinical trials are one of the final stages of a research process to find better ways to prevent, diagnose, or treat diseases. The trials help doctors and researchers see if a new approach works and if it is safe.

There are certain requirements for Medicare coverage of clinical trials. If you participate as a patient in a clinical trial that meets Medicare requirements, Original Medicare (and not Blue Advantage) pays the clinical trial doctors and other providers for the covered services you receive that are related to the clinical trial. When you are in a clinical trial, you may stay enrolled in Blue Advantage and continue to get the rest of your care that is unrelated to the clinical trial through Blue Advantage. You will have to pay the Original Medicare co-insurance for the clinical trial services.

The Medicare program has written a booklet about "Medicare and Clinical Trials." To get a free copy, call 1-800-MEDICARE (1-800-633-4227) or visit www.medicare.gov on the Web. Section 1 tells more about how to contact the Medicare program and about Medicare's Web site.

You do *not* need to get a referral from a plan provider to join a clinical trial, and the clinical trial providers do *not* need to be plan providers. However, please be sure to **tell us before you start a clinical trial** so that we can keep track of your health care services. When you tell us about starting a clinical trial, we can let you know what services you will get from clinical trial providers.

Care in Religious Non-medical Health Care Institutions

Care in a Medicare-certified **R**eligious **N**on-medical **H**ealth **C**are **I**nstitution (RNHCI) is covered by Blue Advantage under certain conditions. Covered services in a RNHCI are limited to non-religious aspects of care. To be eligible for covered services in a RNHCI, you must have a medical condition that would allow you to receive inpatient hospital care or extended care services. In addition, you must sign a legal document that says you are conscientiously opposed to the acceptance of "non-excepted" medical treatment. ("Excepted" medical treatment is medical care or treatment that you receive involuntarily or that is required under federal, state or local law. "Non-excepted" medical treatment is any other medical care or treatment.) You must also get authorization (approval) in advance from Blue Advantage, or your stay in the RNHCI may not be covered.

Section 8 What you must pay for your Medicare health plan coverage and for the care you receive

Paying the plan premium for your coverage as a member of Blue Advantage

To be a member of Blue Advantage, you must continue to pay your Medicare Part B premium. If you have to pay a Medicare Part A premium (most people do not), you must continue paying that premium to be a member. You also have Blue Advantage premiums that you must pay.

How much is your monthly plan premium and how do you pay it?

In Blue Advantage Option VI**, you must pay an** $18.47 **premium each month**. Your premium could be less if you qualify for extra help paying your premium. If you are voluntarily or involuntarily disenrolled from Alabama's Medicaid Program you will be given the opportunity to join one of our other Blue Advantage Plans.

Blue Advantage offers four methods for paying your monthly plan premiums. You can use one of these methods to pay your plan premium that you may owe Blue Cross and Blue Shield of Alabama. These methods for paying your premiums are:

- Automatic Premium Payment through Bank Draft method, where payment can be automatically deducted from your bank account each month.
- Coupon Book method, where you can submit payment by mail, by sending us a check or money order (please do not send cash by mail) with a coupon from a coupon book that we will provide for you.
- Credit card method, where we can collect payment monthly from a major credit card.
- Social Security Administration Check method, where you can have the monthly premium automatically deducted from your Social Security check.

If you have any questions about your plan premiums or the payment methods, please call Member Services at the number on the cover of this booklet.

What happens if you don't pay your plan premiums or don't pay them on time?

Your plan premiums are due on the first of each month. If your plan premiums are past due, we will tell you in writing. If the premiums are not received by the end of the month we will disenroll you. Disenrolling you ends your membership in Blue Advantage with Blue Cross and Blue Shield of Alabama. You will then have Original Medicare coverage (Section 12 explains about disenrollment and Original Medicare coverage). Should you decide later to re-enroll in Blue Advantage, or to enroll in another plan offered by Blue Cross and Blue Shield of Alabama, you will have to pay any past-due plan premiums that you still owe from your previous enrollment in Blue Advantage.

Can your plan premiums change during the year?

We are allowed to *decrease* your plan premium at any time during the calendar year, but we are not allowed to increase it (the current calendar year is the period from January 1 through December 31, 2006). If we decide to decrease your plan premium during the calendar year, we will let you know in writing. **Increases in your plan premium are only allowed at the beginning of each calendar year, and must be approved by Medicare.** We will tell you in advance if there will be any changes for the next calendar year in your plan premiums or in the amounts you will have to pay when you get covered services. If there are any changes for the next calendar year, they will take effect on January 1, 2007.

Paying your share of the cost when you get covered services

What are "deductibles," "co-payments," and "co-insurance"?

The "**deductible**" is the amount you must pay for the out-of-network health care services you receive before Blue Cross and Blue Shield of Alabama begins to pay its share of your covered services. The benefits chart in Section 4 lists the deductible amount for out-of-network services.

A **"co-payment"** is a payment you make for your share of the cost of certain covered services you receive. A co-payment is **a set amount per service** (such as paying $5 for a doctor visit or $10 for a visit to a specialist). You pay it when you get the service. The Benefits Chart in Section 4 gives your co-payments for covered services. SECTION 6 GIVES YOUR CO-PAYMENTS FOR PRESCRIPTION DRUGS.

"**Co-insurance**" is a payment you make for your share of the cost of certain covered services you receive. Co-insurance is a *percentage* of the cost of the service (such as paying 20% for Part B Prescription Drugs that are covered for everyone with Medicare). You pay your co-insurance when you get the service. The Benefits Chart in Section 4 gives your co-insurance for covered services.

You must pay the full cost of services that are not covered

You are personally responsible to pay for care and services that are not covered by Blue Advantage. Other sections of this booklet tell about covered services and the rules that apply to getting your care as a plan member.

For covered services that have a benefit limitation, **you must pay the full cost of any services you get after you have used up your benefit for that type of covered service.** For example, you have to pay the full cost of any routine physical examinations that you get within the same calendar year after Blue Advantage has made payment for one routine physical examination. You can call Members Services when you want to know how much of your benefit limit you have already used.

You may pay more to see non-plan providers

Your out-of-pocket costs will be higher if you use non-plan providers than if you use plan providers. We will pay for covered care that you get from non-plan providers. However, unless it was emergency care, you will pay more for the care you receive from non-plan providers. You will pay less to see our plan providers because these providers have an agreement with us to

accept a specific negotiated amount as payment in full for services provided to you. There are a lot of doctors, hospitals, and other health care providers who are Blue Advantage providers. If you do not have a list of our plan providers (called the "Provider Directory") and would like to have one, please call Member Services at the telephone number on the cover of this booklet.

Please keep us up-to-date on any other health insurance coverage you have

Using *all* of your insurance coverage

If you have other health insurance coverage besides Blue Advantage, it is important to use this other coverage *in combination with* your coverage as a member to pay for the care you receive. This is called "coordination of benefits" because it involves *coordinating* all of the health *benefits* that are available to you. Using all of the coverage you have helps keep the cost of health care more affordable for everyone.

Let us know if you have additional insurance

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

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

Who pays first when you have additional insurance?

When you have additional insurance coverage, how we coordinate your benefits as a member of Blue Advantage with your benefits from other insurance depends on your situation. With coordination of benefits, you will often get your care as usual through Blue Advantage, and the other insurance you have will simply help pay for the care you receive. In other situations, such as for benefits that are not covered by Blue Advantage, you may get your care outside of Blue Advantage.

In general, the insurance company that pays its share of your bills *first* is called the "**primary payer**." Then the other company or companies that are involved—called the "**secondary payers**"—each pay their share of what is left of your bills. Often your other insurance company will settle its share of payment directly with us and you will not have to be involved. However, if payment owed to us is sent directly to you, you are required under Medicare law to give this payment to us. When you have additional health insurance, **whether we pay first or second—or at all—depends on what type or types of additional insurance you have and the rules that apply to your situation**. Many of these rules are set by Medicare. Some of them take into account whether you have a disability or have End-Stage Renal Disease (permanent kidney failure), or how many employees are covered by an employer's group insurance.

If you have additional health insurance, please call Member Services at the phone number on the cover of this booklet to find out which rules apply to your situation, and how payment will be handled. Also, the Medicare program has written a booklet with general information about what happens when people with Medicare have additional insurance. It's called "Medicare and Other Health Benefits: Your Guide to Who Pays First." You can get a copy by calling 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048), or by visiting the www.medicare.gov Web site.

What should you do if you have bills from non-plan providers that you think we should pay?

If a non-plan provider asks you to pay for covered services, please contact us at P. O. BOX 995, BIRMINGHAM, ALABAMA 35298 OR CALL US AT 1-888-234-8266 (TTY 1-800-257-3384). It is best to ask a non-plan provider to bill us first, but if you have already paid for the covered services, we will reimburse you for our share of the cost. If you received a bill for the services, you can send the bill to us for payment. We will pay your doctor for our share of the bill and will let you know what, if anything, you must pay. A non-plan provider will not be paid any more than what he or she would have received if you had been covered with Original Medicare.

Section 9 Your rights and responsibilities as a member of Blue Advantage

Introduction about your rights and protections

Since you have Medicare, you have certain rights to help protect you. In this first part of Section 9, we explain your Medicare rights and protections as a member of Blue Advantage. Then, after we have explained your rights, we tell you what you can do if you think you are being treated unfairly or your rights are not being respected. If you want to receive Medicare publications on your rights, you may call and request them at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Your right to be treated with fairness and respect

You have the right to be treated with dignity, respect, and fairness at all times. Blue Cross and Blue Shield of Alabama must obey laws against discrimination that protect you from unfair treatment. These laws say that we cannot discriminate against you (treat you unfairly) because of your race or color, age, religion, national origin, or any mental or physical disability you may have. If you need help with communication, such as help from a language interpreter, please call Member Services at the number on the cover of this booklet. Member Services can also help if you need to file a complaint about access (such as wheel chair access). You can also call the Office of Civil rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or, call the Office for Civil Rights in your area.

Your right to the privacy of your medical records and personal health information

There are federal and state laws that protect the privacy of your medical records and personal health information. We keep your personal health information private as protected under these laws. Any personal information that you give us when you enroll in this plan is protected. We will make sure that unauthorized people do not see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who is not providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. For example, you have the right to look at your medical records, and to get a copy of the records (there may be a fee charged for making copies). You also have the right to ask plan providers to make additions or corrections to your medical records (if you ask plan providers to do this, they will review your request and figure out whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about privacy of your personal information and medical records, please call Member Services at the phone number on the cover of this booklet.

Your right to see plan and non-plan providers, get covered services, and get prescription drugs filled within a reasonable period of time

As explained in this booklet, you can get your care from plan providers, that is, from doctors and other health providers who are part of Blue Advantage. You can also get most or all of your care from non-plan providers, that is, from doctors and other health providers who are not part of Blue Advantage. You have the right to choose a provider for your care. You have the right to timely access to your providers and to see specialists when care from a specialist is needed. "Timely access" means that you can get appointments and services within a reasonable amount of time. Section 2 explains how to use plan providers to get the care and services you need. Section 3 explains your rights to get care for a medical emergency and urgently needed care.

Your right to know your treatment choices and participate in decisions about your health care

You have the right to get full information from your providers when you go for medical care, and the right to participate fully in decisions about your health care. Your providers must explain things in a way that you can understand. Your rights include knowing about all of the treatment choices that are recommended for your condition, no matter what they cost or whether they are covered by Blue Advantage. This includes the right to know about the Medication Management Treatment Program we offer. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment, and be given the choice of refusing experimental treatments.

You have the right to receive a detailed explanation from us if you believe that a plan provider has denied care that you believe you are entitled to receive or care you believe you should continue to receive. In these cases, you must request an initial decision. "Initial decisions" are discussed in Sections 10 and 11.

You have the right to refuse treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. This includes the right to stop taking your medication. If you refuse treatment, you accept responsibility for what happens as a result of refusing treatment.

Your right to use advance directives (such as a living will or a power of attorney)

You have the right to ask someone, such as a family member or friend, to help you with decisions about your health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If you want to, you can use a special form to give someone you trust the legal authority to make decisions for you if you ever become unable to make decisions for yourself. You also have the right to give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself. The legal documents that you can use to give your directions in advance in these situations are called "**advance directives.**" There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

If you decide that you want to have an advance directive, there are several ways to get this type of legal form. You can get a form from your lawyer, from a social worker, or from some office

supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare, such as Alabama Department of Senior Services/ your SHIP (which stands for **S**tate **H**ealth **I**nsurance Assistance **P**rogram). Section 1 of this booklet tells how to contact Alabama Department of Senior Services. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital. If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you. If you have *not* signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is *your choice* whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive. If you *have* signed an advance directive, and you believe that a doctor or hospital has not followed the instructions in it, you may file a complaint with ALABAMA DEPARTMENT OF PUBLIC HEALTH AT 201 MONROE STREET, MONTGOMERY, ALABAMA 36104, 1-334-206-5175.

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage or care. "Appeals" and "grievances" are the two different types of complaints you can make. Which one you make depends on your situation. Appeals that involve your Medicare health benefits under Blue Advantage are discussed in Sections 10 and 11, Appeals and grievances that involve the Blue Advantage drug benefit are discussed in section 12.

If you make a complaint, we must treat you fairly (i.e., not discriminate against you) because you made a complaint. You have the right to get a summary of information about the appeals and grievances that members have filed *against* Blue Cross and Blue Shield of Alabama in the past. To get this information, call Member Services at the phone number on the cover of this booklet.

Your right to get information about your health care coverage and costs

This booklet tells you what medical services are covered for you as a plan member and what you have to pay. If you need more information, please call Member Services at the number on the cover of this booklet. You have the right to an explanation from us about any bills you may get for services not covered by Blue Advantage. We must tell you in writing why we will not pay for or allow you to get a service, and how you can file an appeal to ask us to change this decision. See Sections 10 and 11 for more information about filing an appeal.

Your right to get information about Blue Cross and Blue Shield of Alabama, Blue Advantage, plan providers, and your drug coverage and costs

You have the right to get information from us about Blue Cross and Blue Shield of Alabama and Blue Advantage. This includes information about our financial condition, our health care providers and their qualifications, and how Blue Advantage compares to other health plans. You have the right to find out from us how we pay our doctors. To get any of this information, call Member Services at the phone number on the cover of this booklet. You have the right to get information from us about Blue Cross and Blue Shield of Alabama and Part D. This includes information about our financial condition and about our network pharmacies. To get any of this information, call Member Services at the phone number listed on the cover of this booklet.

How to get more information about your rights

If you have questions or concerns about your rights and protections, please call Member Services at the number on the cover of this booklet. You can also get free help and information from Alabama Department of Senior Services / your State Health Insurance Assistance Program, or SHIP (Section 1 tells how to contact Alabama Department of Senior Services). In addition, the Medicare program has written a booklet called "Your Medicare Rights and Protections." To get a free copy, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, you can visit www.medicare.gov on the Web to order this booklet or print it directly from your computer.

What can you do if you think you have been treated unfairly or your rights are not being respected?

If you think you have been treated unfairly or your rights have not been respected, what you should do depends on your situation.

- If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, please let us know. Or, you can call the Office for Civil Rights in your area at 1-800-368-1019.
- For any other kind of concern or problem related to your Medicare rights and protections described in this section, you can call Member Services at the number on the cover of this booklet. You can also get help from Alabama Department of Senior Services (Section 1 tells how to contact Alabama Department of Senior Services).

What are your responsibilities as a member of Blue Advantage?

Along with the rights you have as a member of Blue Advantage, you also have some responsibilities. Your responsibilities include the following:

- To get familiar with your coverage and the rules you must follow to get care as a member. You can use this booklet and other information we give you to learn about your coverage, what you have to pay, and the rules you need to follow. Please call Member Services at the phone number on the cover of this booklet if you have any questions.

- To give your doctor and other providers the information they need to care for you, and to follow the treatment plans and instructions that you and your doctors agree upon. Be sure to ask your doctors and other providers if you have any questions.
- To act in a way that supports the care given to other patients and helps the smooth running of your doctor's office, hospitals, and other offices.
- To pay your plan premiums and any co-payments you may owe for the covered services you get. You must also meet your other financial responsibilities that are described in Section 8 of this booklet.
- To let us know if you have any questions, concerns, problems, or suggestions. If you do, please call Member Services at the phone number on the cover of this booklet.

Section 10 Appeals and grievances: what to do if you have complaints about your Medicare Advantage benefits

Introduction

We encourage you to let us know right away if you have questions, concerns, or problems related to your covered services or the care you receive. Please call Member Services at the number on the cover of this booklet.

NOTE THAT SECTIONS 10 AND 11 DO NOT APPLY TO PART D PRESCRIPTION DRUG BENEFITS. SEE SECTION 12 FOR DETAILED INFORMATION ABOUT HOW TO MAKE AN APPEAL THAT INVOLVES A REQUEST FOR PART D DRUG BENEFITS.

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

What are appeals and grievances?

You have the right to make a complaint if you have concerns or problems related to your coverage or care. "Appeals" and "grievances" are the two different types of complaints you can make.

- An **"appeal"** is the type of complaint you make **when you want us to reconsider and change a decision we have made about what services or benefits are covered for you or what we will pay for a service or benefit.** For example, if we refuse to cover or pay for services you think we should cover, you can file an appeal. If Blue Cross and Blue Shield of Alabama or one of our plan providers refuses to give you a service you think should be covered, you can file an appeal. If Blue Cross and Blue Shield of Alabama or one of our plan providers reduces or cuts back on services or benefits you have been receiving, you can file an appeal. If you think we are stopping your coverage of a service or benefit too soon, you can file an appeal.
- **A "grievance"** is the type of complaint you make **if you have any other type of problem with Blue Cross and Blue Shield of Alabama/ Blue Advantage or one of our plan providers.** For example, you would file a grievance if you have a problem with things such as the quality of your care, waiting times for appointments or in the waiting room, the way your doctors or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of the doctor's office.

This section tells how to make complaints in different situations

The rest of this section has separate parts that tell you how to make a complaint in each of the following situations:

1. **Complaints about what we will cover for you or what we will pay for.** If Blue Cross and Blue Shield of Alabama or your doctor or another plan provider has refused to give you a service you think is covered, you can make a complaint called an appeal. If we have refused to pay for a service you think is covered for you, you can make an appeal. If you have been receiving a covered service, and you think that service is being reduced or ending too soon, you can make an appeal. When you file an appeal, you are asking us to reconsider and change a decision we have made about what services we will cover for you (which includes whether we will pay for your care or how much we will pay).

2. **Complaints about your Part D prescription drug benefits that we will cover or pay for.** If Blue Cross and Blue Shield of Alabama refused to give you a Part D prescription drug benefit that you think is covered, you can request an appeal. If we have refused to pay for a Part D prescription drug that you have already received and you believe that it is covered, you can make an appeal. If you have been receiving a Part D prescription drug, and you think its coverage is being reduced or ending too soon, you can make an appeal. When you file an appeal, you are asking us to reconsider and change a decision we have made about what Part D prescription drug we will cover for you (which includes whether we will pay for a Part D prescription drug that you have already received, or how much we will pay). The rules that apply to appeals of drug coverage are different than the rules that apply to your health benefits. Be sure to read Section 12 so that you clearly understand the difference.

3. **Complaints if you think you are being discharged from the hospital too soon.** There is a special type of appeal that applies only to hospital discharges. If you think our coverage of your hospital stay is ending too soon, you can appeal directly and immediately to Alabama Quality Assurance Foundation, which is the Quality Improvement Organization in the state of Alabama / the QIO. Alabama Quality Assurance Foundation / The QIO is a group of health professionals in Alabama that is paid to handle this type of appeal from Medicare patients. If you make this type of appeal, your stay may be covered during the time period the QIO uses to make its determination. You must act very quickly to make this type of appeal, and it will be decided quickly.

4. **Complaints if you think your coverage for skilled nursing facility (SNF), home health (HHA) or comprehensive outpatient rehabilitation facility (CORF) services is ending too soon.** There is another special type of appeal that applies only when coverage will end for SNF, HHA, or CORF services. If you think your coverage is ending too soon, you can appeal directly and immediately to Alabama Quality Assurance Foundation/ the QIO if you make this type of appeal, your stay may be covered during the time period the QIO uses to make its determination. You must act very quickly to make this type of appeal, and it will be decided quickly.

5. **Complaints about any other type of problem you have with Blue Cross and Blue Shield of Alabama/Blue Advantage or one of our plan providers.** If you want to make a complaint about any type of problem other than those that are listed above, a grievance is the type of complaint you would make. For example, you would file a grievance to complain about problems with the quality or timeliness of your care, waiting times for appointments or in the waiting room, the way your doctors or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of the doctor's office. Generally, you would file the grievance with Blue Cross and Blue Shield of Alabama. But for many problems related to quality of care you get from plan providers, you can also complain to Alabama Quality Assurance Foundation, the QIO in Alabama.

Part 1. Complaints (appeals) to Blue Cross and Blue Shield of Alabama to change a decision about what services we will cover or what we will pay for

This part of Section 10 explains what you can do if you have problems getting the medical care you believe we should provide. We use the word "provide" in a general way to include such things as authorizing care, paying for care, arranging for someone to provide care, or continuing to provide a medical treatment you have been getting. Problems getting the medical care you believe we should provide include the following situations:

- If you are not getting the care you want, and you believe that this care is covered by Blue Advantage.
- If we will not authorize the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by Blue Advantage.
- If you are being told that coverage for a treatment or service you have been getting will be reduced or stopped, and you feel that this could harm your health.
- If you have received care that you believe was covered by Blue Advantage while you were a member, but we have refused to pay for this care.

Six possible steps for requesting care or payment from Blue Advantage.

If you are having a problem getting care or payment for care, there are six possible steps you can take to ask for the care or payment you want from us. At each step, your request is considered and a decision is made. If you are unhappy with the decision, you may be able to take another step if you want to continue requesting the care or payment.

- In Steps 1 and 2, you make your request directly to us. We review it and give you our decision.
- In Steps 3 through 6, people in organizations that are not connected to us make the decisions about your request. To keep the review independent and impartial, those who review the request and make the decision in Steps 3 through 6 are part of (or in some way connected to) the Medicare program or the federal court system.

The six possible steps are summarized below (they are covered in more detail in Section 11).

STEP 1: The initial decision by Blue Cross and Blue Shield of Alabama

The starting point is when we make an "initial decision" (also called an "organization determination") about your medical care or about paying for care you have already received. When we make an "initial decision," we are giving our interpretation of how the benefits and services that are covered for members of Blue Advantage apply to your specific situation. As explained in Section 11, you can ask for a "fast initial decision" if you have a request for medical care that needs to be decided more quickly than the standard time frame.

STEP 2: Appealing the initial decision by Blue Cross and Blue Shield of Alabama

If you disagree with the decision we make in Step 1, you may ask us to reconsider our decision. This is called an **"appeal"** or a "request for reconsideration." As explained in Section 11, you can ask for a "fast appeal" if your request is for medical care and it needs to be decided more quickly than the standard time frame. After reviewing your appeal, we will decide whether to stay with our original decision, or change this decision and give you some or all of the care or payment you want.

STEP 3: Review of your request by an Independent Review Organization

If we turn down part or all of your request in Step 2, we are **required** to send your request to an independent review organization that has a contract with the federal government and is not part of Blue Cross and Blue Shield of Alabama. This organization will review your request and make a decision about whether we must give you the care or payment you want.

STEP 4: Review by an Administrative Law Judge

If you are unhappy with the decision made by the independent review organization that reviews your case in Step 3, you may ask for an **Administrative Law Judge** to consider your case and make a decision. The Administrative Law Judge works for the federal government. The dollar value of your contested benefit must be at least $110 to be considered in Step 4.

STEP 5: Review by a Medicare Appeals Council

If you or we are unhappy with the decision made in Step 4, either of us may be able to ask a **Medicare Appeals Council** to review your case**.** This Council is part of the federal department that runs the Medicare program.

STEP 6: Federal Court

If you or we are unhappy with the decision made by the Medicare Appeals Council in Step 5, either of us may be able to take your case to a Federal Court. The dollar value of your contested medical care must at least $1,090 to go to a Federal Court.

For a more detailed explanation of all six steps outlined above, see Section 11.

Part 2. Complaints (appeals) to Blue Cross and Blue Shield of Alabama to change a decision about what Part D drugs we will cover or pay for

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

- If you are not able to get a prescription drug that you believe may be covered by Blue Advantage.
- If you have received a Part D prescription drug you believe may covered by Blue Advantage while you were a member, but we have refused to pay for the drug.
- If we will not provide or pay for a Part D prescription drug that your doctor has prescribed for you because it is not on our formulary.
- If you disagree with the amount that we require you to pay for a Part D prescription drug that your doctor has prescribed for you.
- If you are being told that coverage for a Part D prescription drug that you have been getting will be reduced or stopped.
- If there is a requirement that you try another drug before we pay for the drug your doctor prescribed, or if there is a limit on the quantity (or dose) of the drug and you disagree with the requirement or dosage limitation.

Six possible steps for requesting a Part D benefit or payment from Blue Advantage.

If you are having a problem getting a Part D benefit or payment for a Part D prescription drug that you have already received, there are six possible steps you can take to ask for the benefit or payment you want from us. At each step, your request is considered and a decision is made. If you are unhappy with the decision, you may be able to take another step if you want to continue requesting the benefit or payment.

- In Steps 1 and 2, you make your request directly to us. We review it and give you our decision.
- In Steps 3 through 6, people in organizations that are not connected to us make the decisions about your request. To keep the review independent and impartial, those who review the request and make the decision in Steps 3 through 6 are part of (or in some way connected to) the Medicare program or the federal court system.

The six possible steps are summarized below (they are covered in more detail in Section 12).

STEP 1: The initial decision by Blue Cross and Blue Shield of Alabama

The starting point is when we make an "initial decision" (also called a "coverage determination") about your Part D prescription drug or about paying for Part D drug that you have already received. When we make an "initial decision," we are giving our interpretation of how the

benefits that are covered for members of Blue Advantage apply to your specific situation. As explained in Section 12, you can ask for a "fast initial decision" if you have a request for benefits that needs to be decided more quickly than the standard time frame.

STEP 2: Appealing the initial decision by Blue Cross and Blue Shield of Alabama

If you disagree with the decision we make in Step 1, you may ask us to reconsider our decision. This is called an "**appeal**" or a "request for redetermination." As explained in Section 12, you can ask for a "fast appeal" if your request for benefits needs to be decided more quickly than the standard time frame. After reviewing your appeal, we will decide whether to stay with our original decision, or change this decision and give you the benefit or payment you want.

STEP 3: Review of your request by an Independent Review Organization

If we turn down your request in Step 2, you may ask an independent review organization to review our decision. The independent review organization has a contract with the federal government and is not part of Blue Cross and Blue Shield of Alabama. The independent review organization will review your request and make a decision about whether we must give you the benefit or payment you want.

STEP 4: Review by an Administrative Law Judge

If you are unhappy with the decision made by the independent review organization that reviews your case in Step 3, you may ask for an **Administrative Law Judge** to consider your case and make a decision. The Administrative Law Judge works for the federal government. The dollar value of your contested benefit must be at least $110 TO be considered in Step 4.

STEP 5: Review by a Medicare Appeals Council

If you are unhappy with the decision made in Step 4, you may be able to ask the **Medicare Appeals Council (MAC)** to review your case**.** The MAC is part of the federal department that runs the Medicare program.

STEP 6: Federal Court

If you are unhappy with the decision made by the MAC in Step 5, you may be able to take your case to a Federal Court. The dollar value of your contested benefit must be at least $1,090 to go to a Federal Court.

For a more detailed explanation of all six steps outlined above, see Section 12.

Part 3. Complaints (appeals) if you think you are being discharged from the hospital too soon

When you are hospitalized, you have the right to get all the hospital care covered by Blue Advantage that is necessary to diagnose and treat your illness or injury. The day you leave the hospital (your "discharge date") is based on when your stay in the hospital is no longer medically

necessary. This part of Section 10 explains what to do if you believe that you are being discharged too soon.

Information you should receive during your hospital stay.

When you are admitted to the hospital, someone at the hospital should give you a notice called the *Important Message from Medicare*. This notice explains:

- Your right to get all medically necessary hospital services covered.
- Your right to know about any decisions that the hospital, your doctor, or anyone else makes about your hospital stay and who will pay for it.
- That your doctor or the hospital may arrange for services you will need after you leave the hospital.
- Your right to appeal a discharge decision.

Review of your hospital discharge by the Alabama Quality Assurance Foundation/Quality Improvement Organization

If you think that you are being discharged too soon, ask your health plan to give you a notice called the *Notice of Discharge & Medicare Appeal Rights.* This notice will tell you:

- Why you are being discharged.
- The date that we will stop covering your hospital stay (stop paying our share of your hospital costs).
- What you can do if you think you are being discharged too soon.
- Who to contact for help.
- You (or someone you authorize) may be asked to sign and date this document, to show that you received the notice. Signing the notice does not mean that you agree that you are ready to leave the hospital—it only means that you received the notice. If you do not get the notice after you have said that you think you are being discharged too soon, be sure to ask for it immediately.
- You have the right by law to ask for a review of your discharge date. As explained in the Notice of Discharge & Medicare Appeal Rights, if you act quickly, you can ask an outside agency called the Quality Improvement Organization to review whether your discharge is medically appropriate.

What is the "Quality Improvement Organization"?

"QIO" stands for **Q**uality **I**mprovement **O**rganization. The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of Blue Cross and Blue Shield of Alabama or your hospital. There is one QIO in each state. QIOs have different names, depending on which state they are in. In Alabama, the QIO is called Alabama Quality Assurance Foundation. The doctors

and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their hospital stay is ending too soon. Section 1 tells how to contact the QIO.

Getting a QIO review of your hospital discharge

If you want to have your discharge reviewed, you must act quickly to contact the QIO. The *Notice of Discharge & Medicare Appeal Rights* gives the name and telephone number of your QIO and tells you what you must do.

- You must ask Alabama Quality Assurance Foundation / the QIO for a **"fast review"** of whether you are ready to leave the hospital. This "fast review" is also called a "fast appeal" because you are appealing the discharge date that has been set for you.
- You must be sure that you have made your request to the QIO **no later than noon** on the first working day after you are given written notice that you are being discharged from the hospital. This deadline is very important. If you meet this deadline, you are allowed to stay in the hospital past your discharge date without paying for it yourself, while you wait to get the decision from the QIO (see below).

If the QIO reviews your discharge, it will first look at your medical information. Then it will give an opinion about whether it is medically appropriate for you to be discharged on the date that has been set for you. The QIO will make this decision within one full working day after it has received your request and all of the medical information it needs to make a decision.

- If the QIO decides that your discharge date was medically appropriate, you will not be responsible for paying the hospital charges until noon of the calendar day after the QIO gives you its decision.
- If the QIO agrees with you, then we will continue to cover your hospital stay for as long as medically necessary.

What if you do not ask the QIO for a review by the deadline?

You still have another option: asking Blue Cross and Blue Shield of Alabama for a "fast appeal" of your discharge

If you do not ask Alabama Quality Assurance Foundation / the QIO for a "fast review" ("fast appeal") of your discharge by the deadline, you can ask us for a "fast appeal" of your discharge. How to ask us for a fast appeal is covered briefly in the first part of this section and in more detail in Section 11.

If you ask us for a fast appeal of your discharge and you stay in the hospital past your discharge date, you run the risk of having to pay for the hospital care you receive past your discharge date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to stay in the hospital, we will continue to cover your hospital care for as long as medically necessary.

- If we decide that you should not have stayed in the hospital beyond your discharge date, then we will **not** cover any hospital care you received if you stayed in the hospital after the discharge date. UNLESS THE IRE OVERTURNS OUR DECISION.

You may have to pay if you stay past your discharge date

If you stay in the hospital after your discharge date and do not ask for immediate QIO review, you may be financially responsible for the cost of many of the services you receive. However, you can appeal any bills for hospital care you receive, using Step 1 of the appeals process described in Section 11.

Part 4. Complaints (appeals) if you think your coverage for SNF, home health or comprehensive outpatient rehabilitation facility services is ending too soon.

When you are a patient in a SNF, home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF), you have the right to get all the SNF, HHA, or CORF care covered by Blue Advantage that is necessary to diagnose and treat your illness or injury. The day we end your SNF, HHA, or CORF coverage is based on when your stay is no longer medically necessary. This part of Section 10 explains what to do if you believe that your coverage is ending too soon.

Information you will receive during your SNF, HHA, or CORF stay

If we decide to end our coverage for your SNF, HHA, or CORF services, you will get written notice either from us or your provider at least 2 calendar days before your coverage ends. You (or someone you authorize) will be asked to sign and date this document to show that you received the notice. Signing the notice does not mean that you agree that coverage should end—it only means that you received the notice.

How to get a review of your coverage by Alabama Quality Assurance Foundation / the Quality Improvement Organization

You have the right by law to ask for an appeal of our termination of your coverage. As will be explained in the notice you get from us or your provider, you can ask the **Q**uality **I**mprovement **O**rganization (the QIO) to do an independent review of whether our terminating your coverage is medically appropriate.

How soon you have to ask the QIO to review your coverage?

If you want to have the termination of your coverage appealed, you must act quickly to contact Alabama Quality Assurance Foundation. The written notice you got from us or your provider gives the name and telephone number of your QIO and tells you what you must do.

- If you get the notice 2 days before your coverage ends, you must be sure to make your request **no later than noon** of the day after you get the notice.
- If you get the notice and you have more than 2 days before your coverage ends, then you must make your request **no later than noon** of the day before the date that your Medicare coverage ends.

What will happen during the review?

If the QIO reviews your case, the QIO will ask for your opinion about why you believe the services should continue. You do not have to prepare anything in writing, but you may do so if you wish. The QIO will also look at your medical information, talk to your doctor, and review other information that we have given to the QIO. You and the QIO will each get a copy of our explanation about why your services should not continue.

After reviewing all the information, the QIO will give an opinion about whether it is medically appropriate for your coverage to be terminated on the date that has been set for you. The QIO will make this decision within one full day after it receives the information it needs to make a decision.

What happens if the QIO decides in your favor?

If the QIO agrees with you, then we will continue to cover your SNF, HHA, or CORF services for as long as medically necessary.

What happens if the QIO denies your request?

If the QIO decides that our decision to terminate coverage was medically appropriate, you will be responsible for paying the SNF, HHA, or CORF charges after the termination date on the advance notice you got from us or your provider. Neither Original Medicare nor Blue Cross and Blue Shield of Alabama will pay for these services. If you stop receiving services on or before the date given on the notice, you can avoid any financial liability.

What if you do not ask the QIO for a review in time?

You still have another option: asking Blue Cross and Blue Shield of Alabama **for a "fast appeal" of your discharge**

If you do not ask the QIO for a "fast appeal" of your discharge by the deadline, you can ask us for a "fast appeal" of your discharge. How to ask us for a fast appeal is covered briefly in the first part of this section and in more detail in Section 11.

If you ask us for a fast appeal of your termination and you continue getting services from the SNF, HHA, or CORF, you run the risk of having to pay for the care you receive past your termination date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to continue to get your services covered, then we will continue to cover your care for as long as medically necessary.
- If we decide that you should not have continued getting coverage for your care, then we will **not** cover any care you received if you stayed after the termination date.

You may have to pay if you stay past your discharge date (The QIO does not decide in your favor)

If you do not ask the QIO by noon after the day you are given written notice that we will be terminating coverage for your SNF, HHA, or CORF services, and if you stay in the SNF, HHA,

or CORF after this date, you run the risk of having to pay for the SNF, HHA, or CORF care you receive on and after this date. However, you can appeal any bills for SNF, HHA, or CORF care you receive using Step 1 of the appeals process described in Section 11.

Part 5. Complaints (grievances) about any other type of problem you have with Blue Cross and Blue Shield of Alabama/Blue Advantage or one of our plan providers

This last part of Section 10 explains how to make complaints about any *other* type of problem that has not already been discussed earlier in this section. (The problems that have already been discussed are problems related to coverage or payment for care or Part D benefits, problems about being discharged from the hospital too soon, and problems about coverage for SNF, HHA, or CORF services ending to soon.)

What is included in "all other types of problems"?

Here are some examples of problems that are included in this category of "all other types of problems":

- Problems with the quality of the medical care you receive, including quality of care during a hospital stay.
- If you feel that you are being encouraged to leave (disenroll from) Blue Advantage.
- Problems with the Member Services you receive.
- Problems with how long you have to spend waiting on the phone, in the waiting room, or in the exam room.
- Problems with getting appointments when you need them, or having to wait a long time for an appointment.
- Disrespectful or rude behavior by doctors, nurses, receptionists, or other staff.
- Cleanliness or condition of doctor's offices, clinics, or hospitals.

If you have one of these types of problems and want to make a complaint, it is called "filing a grievance." In addition, you have the right to ask for a "fast grievance" if you disagree with our decision to not give you a "fast appeal" or if we take an extension on our initial decision or appeal. See below for more detail.

Filing a grievance with Blue Advantage

If you have a complaint, we encourage you to first call Member Services at the number on the cover of this booklet. **We will try to resolve any complaint that you might have over the phone.** If you request a written response to your phone complaint, we will respond in writing to you. **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this** BLUE ADVANTAGE GRIEVANCE PROCEDURE. We must notify you of our decision about your grievance as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend

the time frame by up to 14 calendar days if you request the extension, or if we justify a need for additional information and the delay is in your best interest.

For quality of care problems, you may also complain to the QIO.

If you are concerned about the quality of care you received, including care during a hospital stay, you can also complain to an independent organization called the QIO. See Section 1 for more information about the QIO

Section 11 Detailed information about how to make an appeal that involves your MA benefits

What is the purpose of this section?

The purpose of this section is to give you more information about a topic that is summarized briefly in the previous section of this booklet (Section 10). Section 10 outlines the six possible steps in the appeals process for making complaints about your coverage or payment for your care. This section goes through the same six steps in more detail. Since Section 10 also gives general information about making complaints, and discusses how to deal with other types of problems besides problems with coverage or payment for care, you should read Section 10 before you read this section.

Note that Section 11 does not apply to Part D prescription drug benefits. See Section 12 for detailed information about how to make an appeal that involves a request for Part D drug benefits.

A note about terminology. In this Section, we tend to use simpler language instead of certain legal language, including terms that appear in the government regulations for the appeals process. For example, we generally say "initial decision" instead of "initial organization determination," and we generally use the word "fast" rather than "expedited" when referring to decisions that are made more quickly than the standard time frame. Instead of saying "adverse decision," we may say "deny your request," or "turn down your appeal." We use "independent review organization" rather than "independent review entity."

What are "complaints about your coverage or payment for your care"?

Complaints about your coverage or payment for your care are complaints you may have if you are not getting medical benefits and services you believe are covered for you as a plan member. This includes payment for care received while a member of the Blue Advantage. Complaints about your coverage or payment for your care include complaints about the following situations:

- If you are not getting the care you want, and you believe that this care is covered by Blue Advantage.
- If we will not authorize the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by Blue Advantage.
- If you are being told that coverage for a treatment or service you have been getting will be reduced or stopped, and you feel that this could harm your health.
- If you have received care that you believe is covered by Blue Advantage, but we have refused to pay for this care because we say it is not covered.

How does the appeals process work?

The six possible steps you can take to make complaints related to your coverage or payment for your care are described below. Here are a few things to keep in mind as you read the description of these steps in the appeals process:

Moving from one step to the next. At each step, your request for care or payment is considered and a decision is made. The decision may be partly or completely in your favor (giving you some or all of what you have asked for), or it may be completely denied (turned down). If you are unhappy with the decision, there may be another step you can take to get further review of your request. Whether you are able to take the next step may depend on the dollar value of the medical care involved or on other factors.

"Initial decision" vs. "making an appeal." Step 1 deals with the starting point for the appeals process. The decision made in Step 1 is called an "initial decision" or "organization determination." If you continue with your complaint by going on to Step 2, it is called making an "appeal" or a "request for reconsideration" of our initial decision because you are "appealing" for a change in the initial decision that was made in Step 1. Step 2, and all of the remaining possible steps, also involve *appealing* a decision.

Who makes the decision at each step? In Step 1, you make your request for coverage of care or payment for care directly to us. We review this request, then make an initial decision. If our initial decision is to turn down your request, you can go on to Step 2, where you appeal this initial decision (asking us to reconsider). **After Step 2, your appeal goes outside of** Blue Cross and Blue Shield of Alabama**, where people who are not connected to us conduct the review and make the decision.** To help ensure a fair, impartial decision, those who make the decision about your appeal in Steps 3-6 are part of (or in some way connected to) the Medicare program, the Social Security Administration, or the federal court system.

Step 1: Blue Cross and Blue Shield of Alabama makes an "initial decision" about your medical care, or about paying for care you have already received.

What is an "initial decision"?

The "initial decision" made by Blue Cross and Blue Shield of Alabama is the starting point for dealing with requests you may have about your coverage or payment for your care. With this decision, we inform you whether we will provide the medical care or service you request, or pay for a service you have already received. (This "initial decision" is sometimes called an "organization determination.") If our initial decision is to deny your request (this is sometimes called an "adverse initial decision"), you can "appeal" the decision by going on to Step 2 (see below). You may also go on to Step 2 if we fail to make a timely "initial decision" on your request.

- If you ask us to pay for medical care you have already received, this is a request for an "initial decision" about payment for your care. You can call us at 1-888-234-8266 to get help in making this request.
- If you ask for a specific type of medical treatment from your doctor or other medical provider, this is a request for an "initial decision" about whether the treatment you want

is covered by Blue Advantage. Depending on the situation, your doctor or other medical provider may make this decision on behalf of Blue Cross and Blue Shield of Alabama, or may ask us whether we will authorize the treatment. You may want to ask us for an initial decision without involving your doctor. You can call us at 1-888-234-8266 to ask for an initial decision.

When we make an "initial decision," we are giving our interpretation of how the benefits and services that are covered for members of Blue Advantage **apply to your specific situation.** This booklet and any amendments you may receive describe the benefits and services covered by Blue Advantage, including any limitations that may apply to these services. This booklet also lists exclusions (services that are "not covered" by Blue Advantage).

Who may ask for an "initial decision" about your medical care or payment?

You can ask us for an initial decision yourself, or you can name someone to do it for you. This person you name would be your *authorized representative*. You can name a relative, friend, advocate, doctor, or someone else to act for you. Some other persons may already be authorized under State law to act for you. If you want someone to act for you, then you and the person you want to act for you must sign and date a statement that gives this person legal permission to act as your authorized representative. This statement must be sent to us at P. O. Box 995, Birmingham, Alabama 35298. You can call us at 1-888-234-8266 (TTY 1-800-257-3384) to learn how to name your authorized representative.

You also have the right to have an attorney ask for an initial decision on your behalf. You can contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. You may want to contact American Bar Association at 1-202-662-8684.

"Standard decisions" vs. "fast decisions" about medical care

Do you have a request for medical care that needs to be decided more quickly than the standard time frame?

A decision about whether we will cover medical care can be a "standard decision" that is made within the standard time frame (typically within 14 days; see below), or it can be a "fast decision" that is made more quickly (typically within 72 hours; see below). A fast decision is sometimes called a 72-hour decision or an "expedited organization determination."

You can ask for a fast decision **only** if you or any doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. (Fast decisions apply only to requests for medical care. You cannot get a fast decision on requests for payment for care you have already received.)

Asking for a standard decision

To ask for a standard decision about medical care or payment for care, you or your authorized representative should mail or deliver a request in writing to the following address: Blue Cross and Blue Shield of Alabama, Attention: CSD Appeals, P. O. Box 12185, Birmingham, Alabama 35202-2185.

Asking for a fast decision

You, any doctor, or your authorized representative can ask us to give a "fast" decision (rather than a "standard" decision) about medical care by calling us at 1-888-234-8266 (for TTY, call 1-800-257-3384). Or, you can deliver a written request to Blue Cross and Blue Shield of Alabama, 450 Riverchase East, Birmingham, Alabama 35244, or fax it to 1-888-243-0031. REQUESTS SUBMITTED AFTER HOURS OR ON THE WEEKEND CAN BE FAXED TO THE FAX NUMBER LISTED ABOVE. Be sure to ask for a "fast" or "72-hour" review.

If **any** doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.

If you ask for a fast initial decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast initial decision, we will send you a letter informing you that if you get a doctor's support for a "fast" review, we will automatically give you a fast decision. The letter will also tell you how to file a "grievance" if you disagree with our decision to deny your request for a fast review. It will also tell you about your right to ask for a "fast grievance." If we deny your request for a fast initial decision, we will instead give you a standard decision (typically within 14 calendar days; see below).

What happens when you request an "initial decision"?

What happens, including how soon we must decide, depends on the type of decision.

For a decision about payment for care you already received.

We have 30 calendar days to make a decision after we have received your request. However, if we need more information, we can take up to 30 more days. You will be told in writing when we make a decision. If we do not approve your request for payment, we must tell you why, and tell you how you can appeal this decision. If you have not received an answer from us within 60 calendar days of your request for payment, then the failure to receive an answer is the same as being told that your request was not approved. You may then appeal this decision. (An appeal is also called a reconsideration.) Step 2 tells how to file this appeal.

For a <u>standard</u> initial decision about medical care.

We have up to 14 calendar days to make a decision after we have received your request, but we will make it sooner if your health condition requires. However, we are allowed to take up to an additional 14 calendar days to make a decision if you request the additional time, or if we need more time to gather information that may benefit you. For example, we may need more time to get information that would help us approve your request for medical care (such as medical records). When we take additional days, we will notify you in writing of this extension. If you feel that we should not take additional days, you can make a specific type of complaint called a "grievance." Section 10 of this booklet tells how to file a grievance.

We will tell you in writing of our initial decision concerning the medical care you have requested. You will receive this notification when we make our decision, under the time frame

explained above. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. Step 2 tells how to file this appeal.

If you have not received an answer from us within 14 calendar days of your request for the initial decision, the failure to receive an answer is the same as being told that your request was not approved, and you have the right to appeal. Step 2 tells how to file this appeal. If we tell you that we extended the number of days needed for a decision and you have not received an answer from us by the end of the extension period, the failure to receive an answer is the same as being told that your request was not approved, and you do have the right to appeal.

For a fast initial decision about medical care.

If you receive a "fast" review, we will give you our decision about your medical care within 72 hours after you or your doctor ask for a "fast" review- sooner if your health requires. However, we are allowed to take up to 14 more calendar days to make this decision if we find that some information is missing which may benefit you, or if you need more time to prepare for this review. If you feel that we should not take any additional days, you can make a specific type of complaint called a "grievance." Section 10 of this booklet tells how to file a grievance.

We will tell you our decision by phone as soon as we make the decision. If we deny your request (completely or in part), then within three calendar days after we tell you of our decision in person or by phone, we will send you a letter that explains the decision. If we do not tell you about our decision within 72 hours (or by the end of any extended time period), this is the same as denying your request. If we deny your request for a fast decision, you may file a grievance. Section 10 of this booklet tells how to file a grievance.

What happens next if we decide completely in your favor?

If we make an "initial decision" that is completely in your favor, what happens next depends on the situation.

For a decision about payment for care you already received.

We must pay within 30 calendar days of your request for payment, unless your request has errors or missing information. Then, we must pay within 60 calendar days.

For a standard decision about medical care.

We must authorize or provide you with the care you have requested as quickly as your health requires, but no later than 14 calendar days after we received the request you made for the initial decision. If we extended the time needed to make the decision, we will approve or provide your medical care when we make our decision.

For a fast decision about medical care.

We must authorize or provide you with the medical care you have requested within 72 hours of receiving your request. If your health would be affected by waiting this long, we must provide it sooner.

What happens next if we deny your request?

If we deny your request, we may decide *completely* or only *partly* against you. For example, if we deny your request for payment for care that you have already received, we may say that we will pay nothing or only part of the amount you requested. In denying a request for medical care, we might decide not to approve any of the care you want, or only some of the care you want. If any initial decision does not give you *all* that you requested, you have the right to ask us to reconsider the decision. (See Step 2).

Step 2: If we deny part or all of your request in Step 1, you may ask us to reconsider our decision. This is called an "appeal" or "request for reconsideration."

Please call us at 1-888-234-8266 if you need help in filing your appeal. You may ask us to reconsider the initial decision we made in Step 1, even if only part of our decision is not what you requested. When we receive your request to reconsider the initial decision, we give the request to different people than those who were involved in making the initial decision. This helps ensure that we will give your request a fresh look.

How you make your appeal depends on whether it is about payment for care you already received, or about authorizing medical care. If your appeal concerns a decision we made about authorizing medical care, then you and/or your doctor will first need to decide whether you need a "fast" appeal. The procedures for deciding on a "standard" or a "fast" *appeal* are the same as those described for a "standard" or "fast" *initial decision* in Step 1. Please see the discussion in Step 1 under *"*Do you have a request for medical care that needs to be decided more quickly than the standard time frame?" and "Asking for a fast decision

Getting information to support your appeal

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

You can give us your additional information in any of the following ways:

In writing, to Blue Cross and Blue Shield of Alabama, Attention: CSD Appeals, P. O. Box 12185, Birmingham, Alabama 35202-2185.

By fax, at 1-888-243-0031.

By telephone—if it is a "fast" appeal—at 1-888-234-8266.

In person, at 450 Riverchase Parkway East, Birmingham, Alabama 35244.

You also have the right to ask us for a copy of information regarding your appeal. You can call or write us at 1-888-234-8266, Blue Cross and Blue Shield of Alabama, Attention: CSD Appeals, P.O. Box 12185, Birmingham, Alabama 35202-2185. We are allowed to charge a fee for copying and sending this information to you.

How do you file your appeal of the initial decision?

The rules about who may file an appeal in Step 2 are the same as the rules about who may ask for an "initial decision" in Step 1. Follow the instructions in Step 1 under "Who may ask for an 'initial decision' about medical care or payment?"

Either you, your representative, or your provider may file this appeal.

However, providers who do not have a contract with Blue Cross and Blue Shield of Alabama must sign a "waiver of payment" statement that says that they will not ask you to pay for the medical service under review, regardless of the outcome of the appeal.

How soon must you file your appeal?

You need to file your appeal within 60 calendar days after we notify you of the initial decision from Step 1. We can give you more time if you have a good reason for missing the deadline. To file your appeal, you can call us at the telephone number on the cover of this booklet or send the appeal to us in writing at Blue Cross and Blue Shield of Alabama, Attention: CSD Appeals, P. O. Box 12185, Birmingham, Alabama 35202-2185.

You may also send your appeal to your Social Security Administration office. Please note that sending your appeal to this office instead of to us will cause a delay when we begin the appeal, since this office must forward your appeal request to us.

What if you want a "fast" appeal?

The rules about asking for a "fast" appeal in Step 2 are the same as the rules about asking for a "fast" initial decision in Step 1. If you want to ask for a "fast" appeal in Step 2, please follow the instructions in Step 1 under "Asking for a fast decision."

How soon must we decide on your appeal?

How quickly we decide on your appeal depends on the type of appeal:

- For a decision about payment for care you already received.
- After we receive your appeal, we have 60 calendar days to make a decision. If we do not decide within 60 calendar days, your appeal *automatically* goes to Step 3, where an independent organization will review your case.
- For a standard decision about medical care.
- After we receive your appeal, we have up to 30 calendar days to make a decision, but will make it sooner if your health condition requires. However, if you request it, or if we find that some information is missing which can help you, we can take up to 14 more calendar days to make our decision. If we do not tell you our decision within 30 calendar days (or by the end of the extended time period), your request will *automatically* go to Step 3, where an independent organization will review your case.

For a fast decision about medical care.

After we receive your appeal, we have up to 72 hours to make a decision, but will make it sooner if your health requires. However, if you request it, or if we find that some information is missing which can help you, we can take up to 14 more calendar days to make our decision. If we do not tell you our decision within 72 hours (or by the end of the extended time period), your request will automatically go to Step 3, where an independent organization will review your case.

What happens next if we decide completely in your favor?

For a decision about payment for care you already received.

We must pay within 60 calendar days of the day we received your request for us to reconsider our initial decision. If we decide only partially in your favor, your appeal automatically goes to Step 3, where an independent organization will review your case.

For a standard decision about medical care.

We must authorize or provide you with the care you have asked for as quickly as your health requires, but no later than 30 calendar days after we received your appeal. If we extend the time needed to decide your appeal, we will authorize or provide your medical care when we make our decision.

For a fast decision about medical care.

We must authorize or provide you with the care you have asked for within 72 hours of receiving your appeal- or sooner, if your health would be affected by waiting this long. If we extended the time needed to decide your appeal, we will authorize or provide your medical care at the time we make our decision.

What happens next if we deny your appeal?

If we deny any part of your appeal in Step 2, then your appeal *automatically* goes on to Step 3 where an independent organization will review your case. This independent review organization contracts with the federal government and is not part of Blue Cross and Blue Shield of Alabama. We will tell you in writing that your appeal has been sent to this organization for review. How quickly we must forward your appeal to the independent review organization that performs the review in Step 3 depends on the type of appeal:

For a decision about payment for care you already received.

We must send all the information about your appeal to the independent review organization within 60 calendar days from the date we received your appeal in Step 2.

For a standard decision about medical care.

We must send all of the information about your appeal to the independent review organization as quickly as your health requires, but no later than 30 calendar days after we received your appeal in Step 2.

For a fast decision about medical care.

We must send all of the information about your appeal to the independent review organization within 24 hours of our decision.

Step 3: If we deny any part of your appeal in Step 2, your appeal automatically goes on for review by a government-contracted independent review organization.

What independent review organization does this review?

In Step 3, your appeal is given a new review by an outside, independent review organization that has a contract with CMS (**C**enters for **M**edicare & Medicaid **S**ervices), the government agency that runs the Medicare program. This organization has no connection to us. We will tell you when we have sent your appeal to this organization. You have the right to get a copy from us of your case file that we sent to this organization. We are allowed to charge you a fee for copying and sending this information to you.

How soon must the independent review organization decide?

After the independent review organization receives your appeal, how long the organization can take to make a decision depends on the type of appeal:

For an appeal about payment for care.

The independent review organization has up to 60 calendar days to make a decision.

For a standard appeal about medical care.

The independent review organization has up to 30 calendar days to make a decision. This time period can be extended by up to 14 calendar days if more information is needed and the extension will benefit you.

For a fast appeal about medical care.

The independent review organization has up to 72 hours to make a decision. This time period can be extended by up to 14 calendar days if more information is needed and the extension will benefit you.

If the independent review organization decides completely in your favor

The independent review organization will tell you in writing about its decision and the reasons for it. What happens next depends on the type of appeal:

For an appeal about payment for care.

We must pay within 30 calendar days after receiving the decision.

For a standard appeal about medical care.

We must *authorize* the care you have asked for within 72 hours after receiving notice of the decision from the independent review organization, or *provide* the care as quickly as your health requires, but no later than 14 calendar days after receiving the decision.

For a fast appeal about medical care.

We must authorize or provide you with the care you have asked for within 72 hours of receiving the decision.

What happens next if the review organization decides against you (either partly or completely)?

The independent review organization will tell you in writing about its decision and the reasons for it. You may continue your appeal by asking for a review by an Administrative Law Judge (see Step 4), provided that the dollar value of the medical care or the payment in your appeal is $110 or more.

You must make a request for review by an Administrative Law Judge in writing within 60 calendar days after the date you were notified of the decision made in Step 3. You can extend this deadline for good cause. You must send your written request to the entity specified in the decision made in Step 3.

Directly to the independent review organization that reviewed your appeal in Step 3. They will then send your request along with your appeal information to the Administrative Law Judge who will hear your appeal.

To Blue Cross and Blue Shield of Alabama, or to your local Social Security Administration office. If you do this, starting Step 4 will take longer because your request must first be forwarded to the independent review organization that reviewed your appeal in Step 3. The independent review organization will then send your request along with your appeal information to the Administrative Law Judge who will hear your appeal.

Step 4: If the organization that reviews your case in Step 3 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge

As stated in Step 3, if the independent review organization does not rule completely in your favor, you may ask them to forward your appeal for a review by an Administrative Law Judge. During this review, you may present evidence, review the record, and be represented by counsel. The Administrative Law Judge will not review the appeal if the dollar value of the medical care is less than $110. If the dollar value is less than $110, you may not appeal any further.

How soon does the Judge make a decision?

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

If the Judge decides in your favor

We must pay for, authorize, or provide the service you have asked for within 60 calendar days from the date we receive notice of the decision. We have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Step 5).

If the Judge rules against you

You have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Step 5). The letter you get from the Administrative Law Judge will tell you how to request this review.

Step 5: Your case may be reviewed by a Medicare Appeals Council.

This Council will first decide whether to review your case

The Medicare Appeals Council does not review every case it receives. When it gets your case, it will first decide whether to review your case. If they decide not to review your case, then either you or Blue Cross and Blue Shield of Alabama may request a review by a Federal Court Judge. However, the Federal Court Judge will only review cases when the amount involved is $1,090 or more. If the dollar value is less than $1,090, you may not appeal any further.

How soon will the Council make a decision?

If the Medicare Appeals Council reviews your case, they will make their decision as soon as possible.

If the Council decides in your favor

We must pay for, authorize, or provide the medical service you have asked for within 60 calendar days from the date we receive notice of the decision. However, we have the right to appeal this decision by asking a Federal Court Judge to review the case (Step 6), provided the amount involved is at least $1,090. If the dollar value is less than $1,090, the Council's decision is final.

If the Council decides against you

If the amount involved is $1,090 or more, you or we have the right to continue your appeal by asking a Federal Court Judge to review the case (Step 6). If the value is less than $1,090 the Council's decision is final and you may not take the appeal any further.

Step 6: Your case may go to a Federal Court.

If the contested amount is $1,090 or more, you or we may ask a Federal Court Judge to review the case.

Section 12 Appeals and grievances: What to do if you have complaints about your Part D prescription drug benefits

What to do if you have complaints

Introduction

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

Please note that section 12 addresses complaints about your Part D prescription drug benefits. If you have complaints about your MA benefits, you must follow the rules outlined in sections 10 and 11.

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

A complaint will be handled as a grievance, coverage determination, or an appeal, depending on the subject of the complaint. The following section briefly discusses grievances, coverage determinations, and appeals.

What is a grievance?

A grievance is any complaint other than one that involves a coverage determination. You would file a grievance if you have any type of problem with Blue Advantage or one of our network pharmacies that does not relate to coverage for a prescription drug. For example, you would file a grievance if you have a problem with things such as waiting times when you fill a prescription, the way your network pharmacist or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of a network pharmacy.

What is a coverage determination?

Whenever you ask for a Part D prescription drug benefit, the first step is called "requesting a coverage determination." When we make a coverage determination, we are making a decision whether or not to provide or pay for a Part D drug and what your share of the cost is for the drug. Coverage determinations include exception requests. You have the right to ask us for an "exception" if you believe you need a drug that is not on our list of covered drugs (formulary) or believe you should get a drug at a lower co-payment. If you request an exception, your physician must provide a statement to support your request.

You must contact us if you would like to request a coverage determination (including an exception). You cannot request an appeal if we have not issued a coverage determination.

What is an appeal?

An appeal is any of the procedures that deal with the review of an unfavorable coverage determination. You would file an appeal if you want us to reconsider and change a decision we have made about what Part D prescription drug benefits are covered for you or what we will pay for a prescription drug.

How to file a grievance

This part of Section 12 explains how to file a grievance. A grievance is different from a request for a coverage determination because it usually will not involve coverage or payment for Part D prescription drug benefits (concerns about our failure to cover or pay for a certain drug should be addressed through the coverage determination process discussed below).

What types of problems might lead to you filing a grievance?

- You feel that you are being encouraged to leave (disenroll from) Blue Advantage.
- Problems with the Member Services you receive.
- Problems with how long you have to spend waiting on the phone or in the pharmacy.
- Disrespectful or rude behavior by pharmacists or other staff.
- Cleanliness or condition of pharmacy.
- If you disagree with our decision not to expedite your request for an expedited coverage determination or redetermination.
- You believe our notices and other written materials are difficult to understand.
- Failure to give you a decision within the required time frame.
- Failure to forward your case to the independent review entity if we do not give you a decision within the required time frame.
- Failure by the plan to provide required notices.
- Failure to provide required notices that comply with CMS standards.

In certain cases, you have the right to ask for a "fast grievance," meaning your grievance will be decided within 24 hours. We discuss these fast-track grievances in more detail below.

If you have a grievance, we encourage you to first call Member Services at the number on the cover of this booklet. We will try to resolve any complaint that you might have over the phone. If you request a written response to your phone complaint, we will respond in writing to you. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this our Blue Advantage Grievance Review. Once your written grievance is received, we will review it and respond back to you within 30 days. You should mail the explanation of your grievance with all necessary information to us at P. O. Box 995, Birmingham, Alabama 35298. To request an expedited review of a grievance, you should call Member Services with the details of your grievance. We will review your request and notify you within 24 hours. If we deny your request for an expedited grievance, we will still notify you

within 24 hours that your request has been denied. Your review will then fall to the 30-calendar day review time. We must notify you of our decision about your grievance as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the time frame by up to 14 calendar days if you request the extension, or if we justify a need for additional information and the delay is in your best interest.

For quality of care complaints, you may also complain to the Quality Improvement Organization (QIO).

Complaints concerning the quality of care received under Medicare may be acted upon by the plan sponsor under the grievance process, by an independent organization called the QIO, or by both. For example, if an enrollee believes his/her pharmacist provided the incorrect dose of a prescription, the enrollee may file a complaint with the QIO in addition to or in lieu of a complaint filed under the plan sponsor's grievance process. For any complaint filed with the QIO, the plan sponsor must cooperate with the QIO in resolving the complaint.

How to file a quality of care complaint with the QIO

Quality of care complaints filed with the QIO must be made in writing. An enrollee who files a quality of care grievance with a QIO is not required to file the grievance within a specific time period. See page 72 for more information about how to file a quality of care complaint with the QIO.

How to request a coverage determination

This part of Section 12 explains what you can do if you have problems getting the prescription drugs you believe we should provide and you want to request a coverage determination. We use the word "provide" in a general way to include such things as authorizing prescription drugs, paying for prescription drugs, or continuing to provide a Part D prescription drug that you have been getting.

If your doctor or pharmacist tells you that Blue Advantage will not cover a prescription drug, you should contact us and ask for a coverage determination. The following are examples of when you may want to ask us for a coverage determination:

- If you are not getting a prescription drug that you believe may be covered by Blue Advantage.
- If you have received a Part D prescription drug you believe may be covered by Blue Advantage while you were a member, but we have refused to pay for the drug.
- If we will not provide or pay for a Part D prescription drug that your doctor has prescribed for you because it is not on our list of covered drugs (called a "formulary"). You can request an exception to our formulary. See "How Can I Request an Exception" in Section 6 for more information about the exceptions process.
- If you disagree with the amount that we require you to pay for a Part D prescription drug that your doctor has prescribed for you. You can request an exception to the co-payment we require you to pay for a drug. See "How Can I Request an Exception" in Section 6 for more information about the exceptions process.

- If you are being told that coverage for a Part D prescription drug that you have been getting will be reduced or stopped.
- If there is a limit on the quantity (or dose) of the drug and you disagree with the requirement or dosage limitation. See "How Can I Request an Exception" in Section 6 for more information about the exceptions process.
- If there is a requirement that you try another drug before we will pay for the drug you are requesting. See "How Can I Request an Exception" in Section 6 for more information about the exceptions process.
- You bought a drug at a pharmacy that is not in our network and you want to request reimbursement for the expense.
- The process for requesting a coverage determination is discussed in greater detail below in the section titled, "Detailed information about how to request a coverage determination and an appeal."

How to request an appeal

This part of Section 12 explains what you can do if you disagree with our coverage determination. If you are unhappy with the coverage determination, you can ask for an appeal. The first level of appeal is called a redetermination. There are also four other levels of appeal that an enrollee may request.

What kinds of decisions can be appealed?

You can generally appeal our decision not to cover a drug, vaccine, or other Part D benefit. You may also appeal our decision not to reimburse you for a Part D drug that you paid for. You can appeal if you think we should have reimbursed you more than you received or if you are asked to pay a different cost-sharing amount than you think you are required to pay for a prescription. Finally, if we deny your exception request (described in Section 6 of this brochure), you can appeal. A coverage determination, which includes those described on page 32, may be appealed if you disagree with our decision.

Note: If we approve your exception request for a non-formulary drug, you cannot request an exception to the co-payment we require you to pay for the drug.

How does the appeals process work?

There are five levels to the appeals process. Here are a few things to keep in mind as you read the description of these steps in the appeals process:

Moving from one level to the next. At each level, your request for Part D prescription drug benefits or payment is considered and a decision is made. The decision may be partly or completely in your favor (giving you some or all of what you have asked for), or it may be completely denied (turned down). If you are unhappy with the decision, there may be another step you can take to get further review of your request. Whether you are able to take the next step may depend on the dollar value of the requested drug or on other factors.

Who makes the decision at each level? You make your request for coverage or payment of a Part D prescription drug directly to us. We review this request and make a coverage determination. If our coverage determination is to deny your request (in whole or in part), you can go on to the first level of appeal by asking us to review our coverage determination. If you are still dissatisfied with the outcome, you can ask for further review. If you ask for further review, your appeal is then sent outside of Blue Advantage, where people who are not connected to us conduct the review and make the decision. After the first level of appeal, all subsequent levels of appeal will be decided by someone who is connected to the Medicare program or the federal court system. This will help ensure a fair, impartial decision.

Each appeal level is discussed in greater detail below in the section titled, "Detailed information about how to request a coverage determination and an appeal."

Detailed information about how to request a coverage determination and an appeal

What is the purpose of this section?

The purpose of this section is to give you more information about how to request a coverage determination, or appeal a decision by us not to cover or pay for all or part of a drug, vaccine, or other Part D benefit.

Coverage Determinations: Blue Advantage makes a coverage determination about your Part D prescription drug, or about paying for a Part D prescription drug you have already received.

What is a coverage determination?

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

The following are examples of coverage determinations:

- You ask us to pay for a prescription drug you have already received. This is a request for a coverage determination about payment. You can call us at 1-888-234-8266 to get help in making this request.
- You ask for a Part D drug that is not on your plan's list of covered drugs (called a "formulary"). This is a request for a "formulary exception." You can call us at 1-888-234-8266 to ask for this type of decision.
- You ask for an exception to our plan's utilization management tools - such as dosage limits, quantity limits, or step therapy requirements. Requesting an exception to a

utilization management tool is a type of formulary exception. You can call us at 1-888-234-8266 to ask for this type of decision.

- You ask for a non-preferred Part D drug at the preferred cost-sharing level. This is a request for a "tiering exception." You can call us at 1-888-234-8266 to ask for this type of decision.
- You ask that we reimburse you for a purchase you made from an out-of-network pharmacy. In certain circumstances, out-of-network purchases, including drugs provided to you in a physician's office, will be covered by the plan. See the Benefits Chart in Section 4 for a description of these circumstances. You can call us at 1-888-234-8266 to make a request for payment or coverage for drugs provided by an out-of-network pharmacy or in a physician's office.

When we make a coverage determination, we are giving our interpretation of how the Part D prescription drug benefits that are covered for members of Blue Advantage **apply to your specific situation.** This booklet and any amendments you may receive describe the Part D prescription drug benefits covered by Blue Advantage, including any limitations that may apply to these benefits. This booklet also lists exclusions (benefits that are "not covered" by Blue Advantage).

Who may ask for a coverage determination?

You can ask us for a coverage determination yourself, or your prescribing physician or someone you name may do it for you. The person you name would be your *appointed representative*. You can name a relative, friend, advocate, doctor, or anyone else to act for you. Some other persons may already be authorized under State law to act for you. If you want someone to act for you, then you and that person must sign and date a statement that gives the person legal permission to act as your appointed representative. This statement must be sent to us at Blue Cross and Blue Shield of Alabama, Attention: Customer Service Appeals, P. O. Box 12185, Birmingham, Alabama 35202-2185. You can call us at 1-888-234-8266 and TTY 1-800-257-3384 to learn how to name your appointed representative.

You also have the right to have an attorney ask for a coverage determination on your behalf. You can contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify.

Asking for a "standard" or "fast" coverage determination

Do you have a request for a Part D prescription drug that needs to be decided more quickly than the standard time frame?

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

You can ask for a fast decision **only** if you or your doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. (Fast decisions apply only

to requests for Part D drugs that you have not received yet. You cannot get a fast decision if you are requesting payment for a Part D drug that you already received.)

Asking for a standard decision

To ask for a standard decision, you, your doctor, or your appointed representative should call us at 1-888-234-8266 (for TTY, call 1-800-257-3384). Or, you can deliver a written request to Blue Cross and Blue Shield of Alabama, 450 Riverchase Parkway East, Birmingham, Alabama 35244 or mail a written request to Blue Cross and Blue Shield of Alabama, Attention: CSD Appeals, P. O. Box 12185, Birmingham, Alabama 35202-2185, or fax it to 205-220-2939. Requests submitted after hours or on the weekend can be faxed to the fax number listed above.

Asking for a fast decision

You, your doctor, or your appointed representative can ask us to give a fast decision (rather than a standard decision) by calling us at 1-888-234-8266 (for TTY, call 1-800-257-3384). Or, you can deliver a written request to Blue Cross and Blue Shield of Alabama, 450 Riverchase Parkway East, Birmingham, Alabama 35244 or mail a written request to Blue Cross and Blue Shield of Alabama, Attention: CSD Appeals, P. O. Box 12185, Birmingham, Alabama 35202-2185, or fax it to 205-220-2939. Requests submitted after hours or on the weekend can be faxed to the fax number listed above. Be sure to ask for a "fast," "expedited," or "24-hour" review.

If your doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.

If you ask for a fast coverage determination without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast coverage determination, we will send you a letter informing you that if you get a doctor's support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a "grievance" if you disagree with our decision to deny your request for a fast review. If we deny your request for a fast coverage determination, we will give you our decision within the 72 hour standard time frame.

What happens when you request a coverage determination?

What happens, including how soon we must decide, depends on the type of decision.

For a standard coverage determination about a Part D drug, which includes a request about payment for a Part D drug that you already received.

> Generally, we must give you our decision no later than 72 hours after we have received your request, but we will make it sooner if your health condition requires. However, if your request involves a request for an exception (including a formulary exception, tiering exception, or an exception from utilization management rules - such as dosage or quantity limits or step therapy requirements), we must give you our decision no later than 72 hours after we have received your physician's "supporting statement," which explains why the drug you are asking for is medically necessary. **If you are requesting an exception, you**

should submit your prescribing physician's supporting statement with the request, if possible.

We will give you a decision in writing about the prescription drug you have requested. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. The section, "Appeal Level 1" explains how to file this appeal.

If you have not received an answer from us within 72 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

For a <u>fast</u> coverage determination about a Part D drug that you have not received.

If you receive a fast review, we will give you our decision within 24 hours after you or your doctor ask for a fast review - sooner if your health requires. If your request involves a request for an exception, we will give you our decision no later than 24 hours after we have received your physician's "supporting statement," which explains why the non-formulary or non-preferred drug you are asking for is medically necessary.

We will give you a decision in writing about the prescription drug you have requested. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. The section, "Appeal Level 1" explains how to file this appeal.

If we decide you are eligible for a fast review, and you have not received an answer from us within 24 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

If we do not grant your or your physician's request for a fast review, we will give you our decision within the standard 72- hour time frame discussed above. If we tell you about our decision not to provide a fast review by phone, we will send you a letter explaining our decision within three calendar days after we call you. The letter will also tell you how to file a "grievance" if you disagree with our decision to deny your request for a fast review, and will explain that we will automatically give you a fast decision if you get a doctor's support for a fast review.

What happens if we decide completely in your favor?

If we make a coverage determination that is completely in your favor, what happens next depends on the situation.

1. *For a <u>standard</u> decision about a Part D drug, which includes a request about payment for a Part D drug that you already received.*

   We must authorize or provide the benefit you have requested as quickly as your health requires, but no later than 72 hours after we received the request. If your request involves a request for an exception, we must authorize or provide the benefit no later than 72 hours after we have received your physician's "supporting statement." If you are requesting reimbursement for a drug that you already paid for and received, we must send payment to you no later than 30 calendar days after we receive the request.

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

We must authorize or provide you with the benefit you have requested no later than 24 hours of receiving your request. If your request involves a request for an exception, we must authorize or provide the benefit no later than 24 hours after we have received your physician's "supporting statement."

What happens if we deny your request?

If we deny your request, we will send you a written decision explaining the reason why your request was denied. We may decide *completely* or only *partly* against you. For example, if we deny your request for payment for a Part D drug that you have already received, we may say that we will pay nothing or only part of the amount you requested. If a coverage determination does not give you *all* that you requested, you have the right to appeal the decision. (See Appeal Level 1.)

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

Please call us at 1-888-234-8266 if you need help with filing your appeal. You may ask us to reconsider our coverage determination, even if only part of our decision is not what you requested. When we receive your request to reconsider the coverage determination, we give the request to people at our organization who were not involved in making the coverage determination. This helps ensure that we will give your request a fresh look.

How you make your appeal depends on whether you are requesting reimbursement for a Part D drug you already received and paid for, or authorization of a Part D benefit (that is, a Part D drug that you have not yet received). If your appeal concerns a decision we made about authorizing a Part D benefit that you have not received yet, then you and/or your doctor will first need to decide whether you need a fast appeal. The procedures for deciding on a standard or a fast *appeal* are the same as those described for a standard or fast *coverage determination*. Please see the discussion under *"*Do you have a request for a Part D prescription drug that needs to be decided more quickly than the standard time frame?" and "Asking for a fast decision."

Getting information to support your appeal

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

You can give us your additional information in any of the following ways:

- In writing, to Blue Cross and Blue Shield of Alabama, Attention: Pharmacy Part D Review, 450 Riverchase Parkway East, Birmingham, Alabama 35244.
- By fax, at 205-220-2939.
- By telephone —if it is a fast appeal—at 1-888-234-8266.
- In person, at 450 Riverchase Parkway East, Birmingham, Alabama 35244.

You also have the right to ask us for a copy of information regarding your appeal. You can call or write us at 1-888-234-8266 (TTY 1-800-257-3384), Blue Cross and Blue Shield of Alabama, Attention: CSD Appeals, P. O. Box 12185, Birmingham, Alabama 35202-2185. We are allowed to charge a fee for copying and sending this information to you.

Who may file your appeal of the coverage determination?

The rules about who may file an appeal are almost the same as the rules about who may ask for a coverage determination. For a standard request, you or your appointed representative may file the request. A fast appeal may be filed by you, your appointed representative, or your prescribing physician.

How soon must you file your appeal?

You need to file your appeal within 60 calendar days from the date included on the notice of our coverage determination. We can give you more time if you have a good reason for missing the deadline.

To file a standard appeal, you can send the appeal to us in writing at Blue Cross and Blue Shield of Alabama, Attention: Pharmacy Part D Review, 450 Riverchase Parkway East, Birmingham, Alabama 35244. To file a standard appeal, you can call us at the telephone number on the cover of this booklet or send the appeal to us in writing at the address above.

What if you want a fast appeal?

The rules about asking for a fast appeal are the same as the rules about asking for a fast coverage determination. You, your doctor, or your appointed representative can ask us to give a fast appeal (rather than a standard appeal) by calling us at 1-888-234-8266 (for TTY, call 1-800-257-3384). Or, you can deliver a written request to Blue Cross and Blue Shield of Alabama, 450 Riverchase Parkway East, Birmingham, Alabama 35244 or mail a written request to Blue Cross and Blue Shield of Alabama, Attention: CSD Appeals, P. O. Box 12185, Birmingham, Alabama 35202-2185, or fax it to 205-220-2939. Requests submitted after hours or on the weekend can be faxed to the fax number listed above. Be sure to ask for a “fast,” "expedited," or “72-hour” review. (Remember, that if your prescribing physician provides a written or oral supporting statement explaining that you need the fast appeal, we will automatically treat you as eligible for a fast appeal.)

How soon must we decide on your appeal?

How quickly we decide on your appeal depends on the type of appeal:

1. *For a standard decision about a Part D drug, which includes a request for reimbursement for a Part D drug you already paid for and received.*

   After we receive your appeal, we have up to 7 calendar days to give you a decision, but will make it sooner if your health condition requires us to. If we do not give you our decision within 7 calendar days, your request will *automatically* go to the second level of appeal, where an independent organization will review your case.

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

After we receive your appeal, we have up to 72 hours to give you a decision, but will make it sooner if your health requires us to. If we do not give you our decision within 72 hours, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

What happens next if we decide completely in your favor?

1. *For a decision about reimbursement for a Part D drug you already paid for and received.*

   We must send payment to you no later than 30 calendar days after we receive your request to reconsider our coverage determination.

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

   We must authorize or provide you with the Part D drug you have asked for as quickly as your health requires, but no later than 7 calendar days after we received your appeal.

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

   We must authorize or provide you with the Part D drug you have asked for within 72 hours of receiving your appeal—or sooner, if your health would be affected by waiting this long.

What happens next if we deny your appeal?

If we deny any part of your appeal, you or your appointed representative have the right to ask an independent organization to review your case. This independent review organization contracts with the federal government and is not part of Blue Advantage.

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

What independent review organization does this review?

At the second level of appeal, your appeal is reviewed by an outside, independent review organization that has a contract with the **C**enters for **M**edicare & Medicaid **S**ervices (CMS), the government agency that runs the Medicare program. The independent review organization has no connection to us. You have the right to ask us for a copy of your case file that we sent to this organization. We are allowed to charge you a fee for copying and sending this information to you.

How soon must you file your appeal?

You or your appointed representative must make a request for review by the independent review organization in writing within 60 calendar days after the date you were notified of the decision on your first appeal. You must send your written request to the independent review organization whose name and address is included in the redetermination you receive from Blue Advantage.

What if you want a fast appeal?

The rules about asking for a fast appeal are the same as the rules about asking for a fast coverage determination, except your prescribing physician cannot file the request for you— only you or your appointed representative may file the request. If you want to ask for a fast appeal, please follow the instructions under "Asking for a fast decision." (Remember, if your prescribing physician provides a written or oral supporting statement explaining that you need the fast appeal, the IRE will automatically treat you as eligible for a fast appeal.)

How soon must the independent review organization decide?

After the independent review organization receives your appeal, how long the organization can take to make a decision depends on the type of appeal:

1. For a standard request about a Part D drug, which includes a request about reimbursement for a Part D drug that you already paid for and received, the independent review organization has up to 7 calendar days from the date it received your request to give you a decision.

2. For a fast decision about a Part D drug that you have not received, the independent review organization has up to 72 hours from the time it receives the request to give you a decision.

If the independent review organization decides completely in your favor

The independent review organization will tell you in writing about its decision and the reasons for it. What happens next depends on the type of appeal:

1. *For a decision about reimbursement for a Part D drug you already paid for and received.*

   We must pay within 30 calendar days from the date we receive notice reversing our coverage determination. We will also send the independent review organization a notice that we have abided by their decision.

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

   We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we receive notice reversing our coverage determination. We will also send the independent review organization a notice that we have abided by their decision.

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

   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we receive notice reversing our coverage determination. We will also send the independent review organization a notice that we have abided by their decision.

What happens next if the review organization decides against you (either partly or completely)?

The independent review organization will tell you in writing about its decision and the reasons for it. You or your appointed representative may continue your appeal by asking for a review by an Administrative Law Judge (see Appeal Level 3), provided that the dollar value of the contested Part D benefit is $110 or more.

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

As stated above, if the independent review organization does not rule completely in your favor, you or your appointed representative may ask for a review by an Administrative Law Judge. You must make a request for review by an Administrative Law Judge in writing within 60 calendar days after the date of the decision made at Appeal Level 2. You may request that the Administrative Law Judge extend this deadline for good cause.

During the Administrative Law Judge review, you may present evidence, review the record (by either receiving a copy of the file or accessing the file in person when feasible), and be represented by counsel. The Administrative Law Judge will not review your appeal if the dollar value of the requested Part D benefit is less than $110. If the dollar value is less than $110, you may not appeal any further.

How is the dollar value (the "amount remaining in controversy") calculated?

If we have refused to provide Part D prescription drug benefits, the dollar value for requesting an Administrative Law Judge hearing is based on the projected value of those benefits. The projected value includes any costs you could incur based on the number of refills prescribed for the requested drug during the plan year. Projected value includes your co-payments, all expenditures incurred after your expenditures exceed the initial coverage limit, and expenditures paid by other entities.

You may also combine multiple Part D claims to meet the dollar value if:

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

How soon does the Judge make a decision?

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

If the Judge decides in your favor

The Administrative Law Judge will tell you in writing about his or her decision and the reasons for it. What happens next depends on the type of appeal:

1. *For a decision about payment for a Part D drug you already received.*

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

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

We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we receive notice reversing our coverage determination.

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

   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we receive notice reversing our coverage determination.

If the Judge rules against you

You have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4). The letter you get from the Administrative Law Judge will tell you how to request this review.

Appeal Level 4: Your case may be reviewed by the Medicare Appeals Council

The Medicare Appeals Council will first decide whether to review your case. There is no minimum dollar value for the Medicare Appeals Council to hear your case. If you got a denial at Appeal Level 3, you or your appointed representative can request review by filing a written request with the Council.

The Medicare Appeals Council does not review every case it receives. When it gets your case, it will first decide whether to review your case. If they decide not to review your case, then you may request a review by a Federal Court Judge (see Appeal Level 5). The Medicare Appeals Council will issue a written notice advising you of any action taken with respect to you request for review. The notice will tell you how to request a review by a Federal Court Judge.

How soon will the Council make a decision?

If the Medicare Appeals Council reviews your case, they will make their decision as soon as possible.

If the Council decides in your favor

The Medicare Appeals Council will tell you in writing about its decision and the reasons for it. What happens next depends on the type of appeal:

1. *For a decision about payment for a Part D drug you already received.*

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

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

   We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we receive notice reversing our coverage determination.

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

   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we receive notice reversing our coverage determination.

If the Council decides against you

If the amount involved is $1,090 or more, you have the right to continue your appeal by asking a Federal Court Judge to review the case (Appeal Level 5). The letter you get from the Medicare Appeals Council will tell you how to request this review. If the value is less than $1,090 the Council's decision is final and you may not take the appeal any further.

Appeal Level 5: Your case may go to a Federal Court.

In order to request judicial review of your case, you must file a civil action in a United States district court. The letter you get from the Medicare Appeals Council in Appeal Level 4 will tell you how to request this review. The Federal Court Judge will first decide whether to review your case.

If the contested amount is $1,090 or more, you may ask a Federal Court Judge to review the case.

How soon will the Judge make a decision?

The Federal judiciary is in control of the timing of any decision.

If the Judge decides in your favor

Once we receive notice of a judicial decision in your favor, what happens next depends on the type of appeal:

1. *For a decision about payment for a Part D drug you already received.*

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

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

   We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we receive notice reversing our coverage determination.

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

   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we receive notice reversing our coverage determination.

If the Judge decides against you

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

Section 13 Leaving Blue Advantage and your choices for continuing Medicare after you leave

What is "disenrollment"?

"Disenrollment" from Blue Advantage means **ending your membership** in Blue Advantage. Disenrollment can be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave Blue Advantage because you have decided that you *want* to leave. You can do this for any reason. However, as we explain in this section, **there are limits to when you may leave, how often you can make changes, and what type of plan you can join after you leave.**
- There are also a few situations where you would be *required* to leave. For example, you would have to leave Blue Advantage if you move out of our geographic service area or if Blue Advantage leaves the Medicare program. We are not allowed to ask you to leave the plan because of your health.

Whether leaving the plan is your choice or not, this section explains your Medicare coverage choices after you leave and the rules that apply.

Until your membership officially ends, you **should** keep getting your Medicare services through Blue Advantage or you will have to pay **more for your services**

If you leave Blue Advantage, it may take some time for your membership to end and your new way of getting Medicare to take effect (we discuss when the change takes effect later in this section). While you are waiting for your membership to end, you are still a member and **should** continue to get your care as usual through Blue Advantage.

Until your membership ends, you must keep getting your Medicare services through Blue Advantage or you will have to pay for them yourself

If you leave Blue Advantage, one choice for continuing with Medicare is to join a **Medicare plan or other Medicare Health Plan** *if* any of these types of plans are available in your area, and if they are accepting new members. You can also choose Original **Medicare Plan.** If you choose Original Medicare, you must choose a Prescription Drug Plan if you wish to continue to have Medicare prescription drug coverage.

- **Original Medicare** is available throughout the country. It is a "fee-for-service" health plan that lets you go to any doctor, hospital, or other health care provider *who accepts Medicare*. You must pay a deductible. Then Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance). If you choose Original Medicare and you want to continue to get Medicare prescription drug coverage, you will need to enroll in one of the **Prescription Drug Plans** that are available in your area. These plans only cover prescription drugs (not other benefits or services). If you switch to Original Medicare between January 1, 2006 and June 30, 2006 (see "When and how often can you

change your Medicare choices?" below), you may be required to join one of these plans if you join Original Medicare.

- **Other Medicare** Advantage Plans (including HMOs such as Blue Advantage or PPOs) are available in some parts of the country. In HMOs you go to the doctors, hospitals, and other providers *that are part of the plan*. In PPOs, you can usually see any doctor but you may pay more to see doctors, hospitals, and other providers that are *not* part of the plan. These plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like prescriptions drugs as part of the Medicare Part D (Prescription Drug) benefit. Blue Advantage is a Medicare Advantage Plan offered by Blue Cross and Blue Shield of Alabama.
- **Medicare Private Fee-for-Service Plans** are available in some parts of the country. In Private Fee-for-Service plans, you may go to *any* Medicare-approved doctor or hospital that accepts the plan's payment. The Private Fee-for-Service plan, rather than the Medicare program, decides how much it will pay and what you pay for the services you get. You may pay more for Medicare-covered benefits. You may get extra benefits that Original Medicare does not cover, like prescriptions drugs as part of the Medicare Part D (Prescription Drug) benefit (see "When and how often can you change your Medicare choices?" below. Private Fee-for-Service plans are *not* the same as Medigap (Medicare supplement insurance) policies.

When and how often can you change your Medicare choices, and what choices can you make?

Starting in 2006, there are limits to when and how often you can change the way you get Medicare and what choices you can make when you make the change.

Here are the new rules:

1. From November 15, 2005 through May 15, 2006, anyone with Medicare will have two chances to switch from one way of getting Medicare to another.

2. From January 1, 2006 until June 30, 2006, anyone with Medicare has another chance to make one change in the way they get Medicare. (It does not count as a change when we must end your membership, as discussed later in this section.) With this chance, you are limited in the type of plan you may join.

If you have Medicare prescription drug coverage when making your change, you will only be able to join a Medicare Advantage Plan or Medicare Private Fee-For-Service plan that offers the Medicare Part D (Prescription Drug), or you will have to go to Original Medicare and join a Prescription Drug Plan. If you do not have Medicare prescription drug coverage when making this change, you will only be able to join a Medicare Advantage Plan or Private Fee-For-Service plan that does not offer the Medicare Part D (Prescription Drug), or go to Original Medicare.

3. Generally, you can't make any other changes during the year unless you meet special exceptions, such as if you move or if you have Medicaid coverage. Contact us for more information. Later in the year, from November 15 through December 31, anyone with Medicare can switch their way of getting Medicare to another way for the following year.

4. There is a special election period for members who are entitled to Medicare Part A and Part B and receive any type of assistance from Title XIX (Medicaid) program. This special election period lasts from the time you become dually eligible and exists as long as you receive Medicaid benefits. The effective date of an election made using this special election period would be dependent upon your situation. If you become ineligible for Title XIX (Medicaid) benefits you have up to three (3) months after that determination to make an election. If you have any questions about your special election period, please call Member Services at the number on the cover of this booklet and in Section 1.

In most cases, your disenrollment date will be the first day of the month that comes *after* the month we receive your request to leave. For example, if we receive your request to leave during the month of February, your disenrollment date will be March 1.

What should you do if you decide to leave Blue Advantage?

If you want to leave Blue Advantage:

- The first step is to **be sure that the type of change** you **want to make and the timing of this change fit with the new rules** that we just explained above about changing from one of your Medicare choices to another. If you are not following these rules, you won't be allowed to make the change you request.
- Then, as we explain below, what you must do to leave Blue Advantage depends on whether you want to switch to Original Medicare or to one of your other choices.

How to change from Blue Advantage to Original Medicare

Do you need to join a Prescription Drug Plan?

Original Medicare does not cover very many prescription drugs outside a hospital. So, if you want to change from Blue Advantage to Original Medicare, you should think about whether you want to also join a Prescription Drug Plan. A Prescription Drug Plan will give you more prescription drug coverage. To get information about Prescription Drug Plans that you can join, you can call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY Users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Do you need to buy a Medigap (Medicare supplement insurance) policy?

If you want to change from Blue Advantage to Original Medicare, you should think about whether you need to buy a Medigap policy to supplement your Original Medicare coverage. For Medigap advice, you should contact Alabama Department of Senior Services/the SHIP in Alabama (the phone number is in Section 1). You can ask the SHIP about how and when to buy a Medigap policy if you need one. The SHIP can tell you if you have a guaranteed issue right to buy a Medigap policy.

If you are at least 65 and have been eligible for Part B for less than six months, you may still be in your Medigap open enrollment period. If you leave our plan while you are still in your open enrollment period, and you do not have a guaranteed issue right, the Medigap insurer can refuse to sell you a policy, or impose limits based on your health. If you have a "**guaranteed issue right,**" this means that for a limited period the Medigap insurer must sell you a Medigap policy,

even if you have health problems. This is a special, temporary right, which means that if you decide to change to Original Medicare, in certain situations you have a limited time to buy a Medigap policy on a guaranteed issue basis. For example, you have a guaranteed issue right to buy a Medigap policy if you are in a trial period." You may be in a trial period if, in the past 12 months you: (1) dropped a Medigap policy to join Blue Advantage or Medicare health plan for the first time; or (2) joined Blue Advantage or another Medicare health plan when you first became entitled to Medicare at age 65. Under certain circumstances, if you lose your health plan coverage while you are still in a trial period, the trial period can last for an extra 12 months. Alabama Department of Senior Services can tell you about other situations where you may have guaranteed issue rights. You may also have a guaranteed issue right if you move out of our service area, or if we stop providing Medicare benefits.

If you do want to buy a Medigap policy, you first have to follow the instructions below for changing from Blue Advantage to Original Medicare. (Buying a Medigap policy does not switch you from Blue Advantage to Original Medicare. In fact, while you are still enrolled in Blue Advantage it is against the law for a Medigap insurance company to sell you a policy. A Medigap sales person or insurance agent cannot cancel your Blue Advantage membership and put you in Original Medicare.)

How to change from Blue Advantage to Original Medicare

If you decide to change from Blue Advantage to Original Medicare, you must tell us or Medicare that you want to leave Blue Advantage. You do *not* have to enroll in Original Medicare, because you will automatically be in Original Medicare when you leave Blue Advantage. Here is how it works:

1. First, use any of the following ways to tell us that you want to leave Blue Advantage:

    - You can write or fax a letter to us or fill out a disenrollment form and send it to Member Services at P. O. Box 995, Birmingham, Alabama 35298 or to our fax number at 1-888-246-0230. Be sure to sign and date your letter/form. To get a disenrollment form, call us at 1-888-234-8266.

    - You can call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY Users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

2. We will then send you a letter that tells you when your membership will end. This is your **disenrollment date** – the day you officially leave Blue Advantage. In most cases, your disenrollment date will be the first day of the month that comes after the month we receive your request to leave. For example, if we receive your request to leave during the month of February, your disenrollment date will be March 1. Remember, while you are waiting for your membership to end, you are still a member of Blue Advantage and **should** continue to get your medical care as usual through Blue Advantage.

3. On your disenrollment date, your membership in Blue Advantage ends, and you can start using your red, white, and blue Medicare card to get services under Original Medicare**.** You will not get anything in writing that tells you that you have Original Medicare, because you will *automatically* be in Original Medicare when you leave Blue Advantage. (Call Social Security at 1-800-772-1213 if you need a new red, white, and blue Medicare card.)

How to change from Blue Advantage to another Medicare Advantage Plan or to a Private Fee-for-Service Plan

If you want to change from Blue Advantage to a different Medicare Advantage plan, including a Private Fee-for-Service plan, here is what to do:

1. Contact the plan you want to join to be sure it is accepting new members. Also ask the plan if it offers the Medicare Part D prescription drug benefit. (Remember, if the plan does not offer this benefit, you can only join it from January 1, 2006 to May 15, 2006, from November 15, 2006 to December 31, 2006 or during an "exception for special circumstances," as described in "When and how often can you change your Medicare choices and what choices can you make during these times?").

2. Apply for membership in the plan. **Once you are enrolled in your new plan, your membership in** Blue Advantage **will *automatically* end**. This means that you do not need to tell us that you are leaving. However, we encourage you to tell us why you left.

3. Your new plan will tell you the date when your membership in that plan begins, and your membership in Blue Advantage will end on that same day (this will be your "disenrollment date"). Remember, you are still a member until your disenrollment date, and **should** continue to get your medical care as usual through Blue Advantage until the date your membership ends.

What happens to you if Blue Cross and Blue Shield of Alabama leaves the Medicare program or Blue Advantage leaves the area where you live?

If we leave the Medicare program or change our service area so that it no longer includes the area where you live, we will tell you in writing. If this happens, your membership in Blue Advantage will end, and you will have to change to another way of getting your Medicare benefits. All of the benefits and rules described in this booklet will continue until your membership ends. This means that you must continue to get your medical care in the usual way through Blue Advantage until your membership ends.

Your choices for how to get your Medicare will always include Original Medicare and joining a Prescription Drug Plan to complement your Original Medicare coverage. Your choices may also include joining another Blue Cross and Blue Shield of Alabama plan, another Medicare Advantage Plan, or a Private Fee-for-Service plan, (even if they cover prescription drugs through Medicare Part D) if these plans are available in your area and are accepting new members. Once we have told you in writing that we are leaving the Medicare program or the area where you live, you will have a chance to change to another way of getting your Medicare benefits. If you decide to change from Blue Advantage to Original Medicare, you will have the right to buy a Medigap policy regardless of your health. This is called a "guaranteed issue right" and it is explained earlier in this section under the heading, "Do you need to buy a Medigap (Medicare supplement insurance) policy?"

Blue Cross and Blue Shield of Alabama has a contract with the **C**enters for **M**edicare & Medicaid **S**ervices (CMS), the government agency that runs Medicare. This contract renews each year. At the end of each year, the contract is reviewed, and either Blue Cross and Blue Shield of Alabama or CMS can decide to end it. You will get 90 days advance notice in this situation. It is also possible for our contract to end at some other time during the year, too. In these situations we will try to tell you 90 days in advance, but your advance notice may be as little as 30 or fewer days if CMS must end our contract in the middle of the year.

Whenever a Medicare health plan leaves the Medicare program or stops serving your area, you will be provided a special enrollment period to make choices about how you get Medicare, including choosing Medicare Prescription Drug Plan and guaranteed issue rights to a Medigap policy.

You must leave Blue Advantage if you move out of the service area or are away from the service area for more than six months in a row.

If you plan to move or take a long trip, please call Member Services at the number on the cover of this booklet to find out if the place you are moving to or traveling to is in Blue Advantage's service area. If you move permanently out of our service area, or if you are away from our service area for more than six months in a row, generally you cannot remain a member of Blue Advantage. In these situations, if you do not leave on your own, we must end your membership ("disenroll" you). An earlier part of this section tells about the choices you have if you leave Blue Advantage and explains how to leave.

Under certain conditions Blue Cross and Blue Shield of Alabama can end your membership and make you leave the plan

We cannot ask you to leave the plan because of your health

No member of any Medicare health plan can be asked to leave the plan for any health-related reasons. If you ever feel that you are being encouraged or asked to leave Blue Advantage because of your health, you should call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

We can ask you to leave the plan under certain special conditions

If any of the following situations occur, we will end your membership in Blue Cross and Blue Shield of Alabama.

- If you move out of our geographic service area or live outside the plan's service area for more than six months at a time (see Section 2 for information about the plan's service area).
- If you do *not* stay continuously enrolled in both Medicare Part A and Medicare Part B (see Section 8 for information about staying enrolled in Part A and Part B).
- If you give us information on your enrollment form that you know is false or deliberately misleading, and it affects whether or not you can enroll in Blue Advantage.
- If you behave in a way that is disruptive, to the extent that your continued enrollment seriously impairs our ability to arrange or provide medical care for you or for others who are members of Blue Advantage. We cannot make you leave Blue Advantage for this reason unless we get permission first from the Centers for Medicare & Medicaid Services, the government agency that runs Medicare.
- If you let someone else use your plan membership card to get medical care. If you are disenrolled for this reason, CMS may refer your case to the Inspector General, for additional investigation.

- If you do not pay the plan premiums, we will tell you in writing that you have a 30-day grace period during which you can pay the plan premiums before you are required to leave Blue Advantage.
- If it is determined that you have been voluntarily or involuntarily disenrolled from Alabama's Medicaid program, we will notify you that you have 30 days to elect coverage under another Blue Advantage Plan or your contract will be canceled. If you do not respond within 30 days, you will be disenrolled on the first day of the following month.

You have the right to make a complaint if we ask you to leave Blue Cross and Blue Shield of Alabama

If we ask you to leave Blue Advantage, we will tell you our reasons in writing and explain how you can file a complaint against us if you want to.

Section 14 Legal notices

Notice about governing law

Many different laws apply to this Evidence of Coverage. Some additional provisions may apply to your situation because they are required by law. This can affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the **C**enters for **M**edicare & Medicaid **S**ervices, or CMS. In addition, other federal laws may apply and, under certain circumstances, the laws of the State(s) of Alabama may apply.

Notice about non-discrimination

When we make decisions about the provision of health care services, we do not discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans, like Blue Cross and Blue Shield of Alabama, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that receive federal funding, and any other laws and rules that apply for any other reason.

Section 15 Definitions of some words used in this booklet

For the terms listed below, this section either gives a definition or directs you to a place in this booklet that explains the term

Appeal – A type of complaint you make when you want us to reconsider and change a decision we have made about what services are covered for you or what we will pay for a service. Sections 10 and 11 explain about appeals, including the process involved in making an appeal.

Benefit period – For both Blue Advantage and Original Medicare, a benefit period is used to determine coverage for inpatient stays in hospitals and skilled nursing facilities. A benefit period *begins* on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period *ends* when you have not been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. The type of care you actually receive during the stay determines whether you are considered to be an inpatient for SNF stays, but not for hospital stays.

You are an inpatient in a SNF only if your care in the SNF meets certain skilled level of care standards. Specifically, in order to have been an inpatient while in a SNF, you must need daily skilled nursing or skilled rehabilitation care, or both. (Section 7 tells what is meant by skilled care.)

Generally, you are an inpatient of a hospital if you are receiving inpatient services in the hospital (the type of care you actually receive in the hospital does not determine whether you are considered to be an inpatient in the hospital).

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

Centers for Medicare & Medicaid Services (CMS) – The federal agency that runs the Medicare program. Section 1 tells how you can contact CMS.

Coverage Determination - The plan sponsor has made a coverage determination when it makes a decision about the prescription drug benefits you can receive under the plan, and the amount that you must pay for a drug.

Covered services – The general term we use in this booklet to mean all of the health care services and supplies that are covered by Blue Advantage. Covered services are listed in the Benefits Chart in Section 4.

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

Disenroll or disenrollment – The process of ending your membership in Blue Advantage. Disenrollment can be voluntary (your own choice) or involuntary (not your own choice). Section 13 tells about disenrollment.

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

Emergency care – Covered services that are 1) furnished by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition. Section 3 tells about emergency services.

Evidence of coverage and disclosure information – This document along with your enrollment form explains your covered services, defines our obligations, and explains your rights and responsibilities as a member of Blue Advantage.

Exception – A type of coverage determination that, if approved, allows you to obtain a drug that is not on our formulary (a formulary exception), or receive a non-preferred drug at the preferred cost-sharing level (a tiering exception). You may also request an exception if we require you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Formulary – A list of covered drugs provided by the plan.

Generic Drug – A prescription drug that has the same active-ingredient formula as a brand name drug. Generic drugs usually cost less than brand name drugs and are rated by the **F**ood and **D**rug **A**dministration (FDA) to be as safe and effective as brand name drugs.

Grievance – A type of complaint you make about us or one of our plan providers, including a complaint concerning the quality of your care. This type of complaint does not involve payment or coverage disputes. See Section 10 for more information about grievances.

Inpatient Care – Health care that you get when you are admitted to a hospital.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you don't join a plan when you're first able. You pay this higher amount as long as you have Medicare. There are some exceptions. If you do not have creditable prescription drug coverage, you will have to pay a penalty in addition to your monthly plan premium.

Medically necessary – Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for the convenience of you or your doctor.

Medicare – 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 (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Organization – A public or private organization licensed by the State as a risk-bearing entity that is under contract with the **C**enters for **M**edicare & Medicaid **S**ervices (CMS) to provide covered services. Medicare Advantage Organizations can offer one or more Medicare Advantage Plans. Blue Cross and Blue Shield of Alabama is a Medicare Advantage Organization.

Medicare Advantage Plan – A benefit package offered by a Medicare Advantage Organization that offers a specific set of health benefits at a uniform premium and uniform level of cost-sharing to all people with Medicare who live in the service area covered by the Plan. A Medicare Advantage Organization may offer more than one plan in the same service area. Blue Advantage is a Medicare Advantage Plan.

Medicare Managed Care Plan – Means a Medicare Advantage HMO, Medicare Cost Plan, or Medicare Advantage PPO.

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

"Medigap" (Medicare supplement insurance) policy – Many people who get their Medicare through Original Medicare buy "Medigap" or Medicare supplement insurance policies to fill "gaps" in Original Medicare coverage.

Member (member of Blue Advantage, or "plan member") – A person with Medicare who is eligible to get covered services, who has enrolled in Blue Advantage, and whose enrollment has been confirmed by the **C**enters for **M**edicare & Medicaid **S**ervices (CMS).

Member services – A department within Blue Cross and Blue Shield of Alabama responsible for answering your questions about your membership, benefits, grievances, and appeals. See Section 1 for information about how to contact Member Services.

Network Pharmacy – A network pharmacy is a pharmacy where members of our Plan can receive covered prescription drug benefits. We call them "network pharmacies" because they contract with our Plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Non-plan provider or non-plan facility – A provider or facility that we have not arranged with to coordinate or provide covered services to members of Blue Advantage. Non-plan providers are providers that are not employed, owned, or operated by Blue Cross and Blue Shield of Alabama and are not under contract to deliver covered services to you. As explained in this booklet, you may pay more if you see non-plan providers unless it is for an emergency. Services provided by non-plan providers are subject to a $1,000 calendar year deductible. Payment will be based on the lesser of the actual charges or the Medicare Allowed Amount. In addition to the deductible, you will be responsible for 30% coinsurance.

Organization Determination - The MA organization has made an organization determination when it, or one of its providers, makes a decision about MA services or payment that you believe you should receive.

Original Medicare – Some people call it "traditional Medicare" or "fee-for-service" Medicare. Original Medicare is the way most people get their Medicare Part A and Part B health care. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health care provider who accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that we have not arranged with to coordinate or provide covered drugs to members of our Plan. As explained in this Evidence of Coverage, most services you get from non-network pharmacies are not covered by our Plan unless certain conditions apply. See Section 1.

Part D – The voluntary Prescription Drug Benefit Program. (For ease of reference, we will refer to the new prescription drug benefit program as Part D.)

Part D Drugs – Any drug that can be covered under a Medicare Prescription Drug Plan. Generally, any drug not specifically excluded under Medicare drug coverage is considered a Part D Drug.

Preferred Network Pharmacy – A network pharmacy that offers covered drugs to members of our Plan at lower cost-sharing levels than apply at another network pharmacy.

Plan provider – "Provider" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them "**plan providers**" when they have an agreement with Blue Advantage to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of Blue Advantage. Blue Cross and Blue Shield of Alabama pays plan providers based on the agreements it has with the providers.

Preferred Provider Organization Plan – A Preferred Provider Organization plan is an MA plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or non-network providers. Member cost sharing may be higher when plan benefits are received from non-network providers.

Quality Improvement Organization (QIO) – Groups of practicing doctors and other health care experts who are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by doctors in inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Private fee-for-service plans and ambulatory surgical centers. See Section 1 for information about how to contact the QIO in your state and Section 10 for information about making complaints to the QIO.

Rehabilitation services – These services include physical therapy, cardiac rehabilitation, speech and language therapy, and occupational therapy that are provided under the direction of a plan provider. See Section 7 for more information.

Service area – Section 2 tells about Blue Advantage's service area. "Service area" is the geographic area approved by the **C**enters for **M**edicare & Medicaid **S**ervices (CMS) within which an eligible individual may enroll in a particular plan offered by a Medicare Health Plan.

Urgently needed care – Section 3 explains about urgently needed services. These are different from emergency services.

BlueCross BlueShield
of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association.