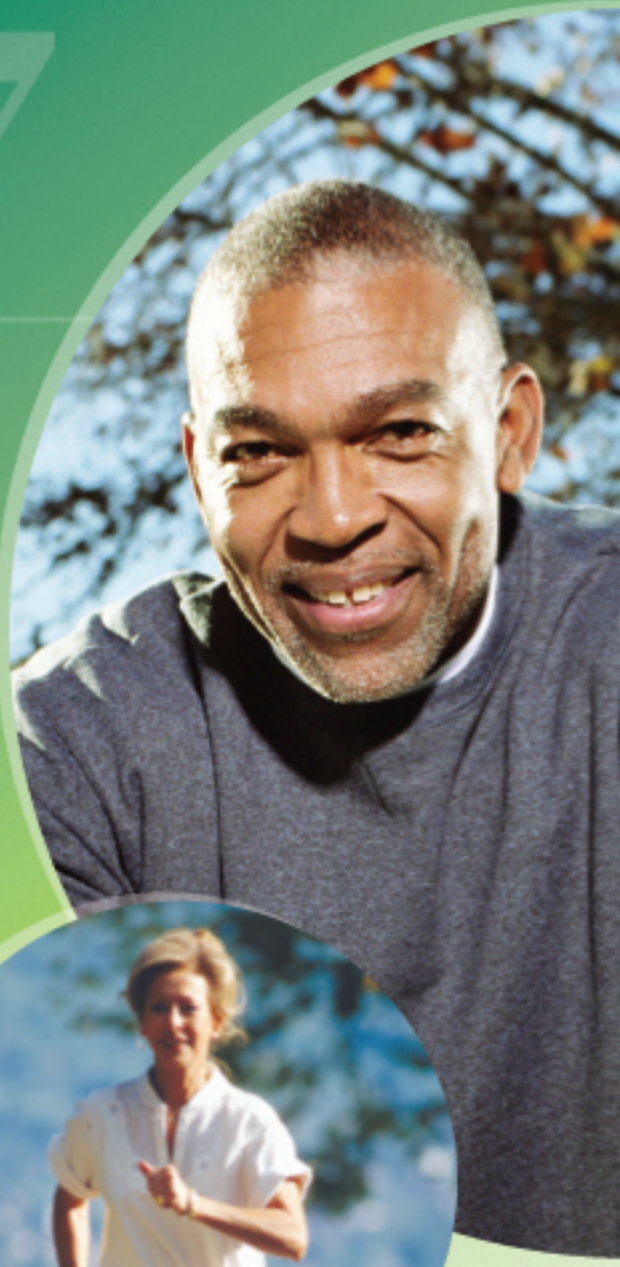
2007

Evidence Of Coverage

SecurityBlue℠
Medicare Advantage
Health Maintenance
Organization

•Standard Plan •Deluxe Plan
•Value Plan •Employer Group Plans



HIGHMARK. SECURITYBLUE℠

A Medicare Advantage HMO
from Keystone Health Plan West

Highmark Blue Cross Blue Shield and Keystone Health Plan West are Independent Licensees of the Blue Cross and Blue Shield Association

H3957_6568 (12/2006)
Contract Number H3957

SecurityBlue Welcome

Welcome to SecurityBlue, a Medicare Advantage Coordinated Health Care Plan from Keystone Health Plan West, Inc., a Highmark Blue Cross Blue Shield HMO

SECURITYBLUE℠ HIGMARK BLUE CROSS BLUE SHIELD

We are pleased that you've chosen SecurityBlue, a Medicare Advantage Health Maintenance Organization (HMO) from Keystone Health Plan West, Inc. This booklet, along with your enrollment form and any amendments that we may send you, is our contract with you. It explains your rights and responsibilities, what is and what is not covered, and how to take the best advantage of your SecurityBlue health care benefits. The information in this booklet is in effect for the contract period of January 1, 2007 through December 31, 2007. Benefits, premiums and other out-of-pocket expenses are reviewed annually and are subject to change annually at contract renewal with Medicare.

Please take some time to read over this booklet. The Table of Contents on the next pages can help you locate the information you're looking for. This booklet can help you take full advantage of the valuable health care benefits you have selected. It can also answer most questions you may have about your health plan. Please keep it in a convenient place where you can refer to it in the future.

Thank you for enrolling in SecurityBlue.

Member Service Gives You Constant Support

Call 1-800-935-2583 and choose the option to speak with a SecurityBlue Member Service Representative. (Hearing impaired TTY users, please call 1-800-988-0668). A Member Service Representative can help you:

- Understand your SecurityBlue benefits.
- Select or change your Primary Care Physician (PCP).
- Explain how to see a specialist or other health care provider.
- Resolve claims issues, such as out-of-area claims, claims appeals, etc.

– Take care of any other concerns you may have about your SecurityBlue health care plan.

Our knowledgeable representatives are available to answer your questions Monday through Sunday, between 8:00 a.m. and 8:00 p.m. If you prefer, you may write to us at Keystone Health Plan West, Inc., P.O. Box 1068, Pittsburgh, PA 15230-1068.

This *Evidence of Coverage* is available in an audio format for our visually impaired members. Call SecurityBlue Member Service at the number below to request a copy.

Remember:
We're here to serve you.
Call 1-800-935-2583,
Monday-Sunday, 8:00 a.m. - 8:00 p.m.
TTY users, call 1-800-988-0668.

SecurityBlue Table Of Contents

SECTION 1
Getting Started With SecurityBlue

You cannot be denied membership on the basis of your health. Pre-existing conditions are covered without a waiting period. To be eligible to enroll in SecurityBlue, you must meet *all* of the following requirements:

1. Be entitled to Medicare Part A Hospital Insurance and enrolled in Medicare Part B Medical Insurance. If you do not have Medicare Part A, you must purchase this coverage from the Social Security Administration or Railroad Retirement Board. See page 47, "Your Financial Liability as a SecurityBlue Member." You must continue to pay Medicare Part B Medical Insurance premiums.
2. Applicants must live in the 17-county western Pennsylvania service area described in Section 12, page 97, Appendix D, "Service Area." Once you are enrolled, you will be disenrolled if you permanently move out of the SecurityBlue service area. An absence of more than six months in a row will be considered a permanent move. See page 68, "Leaving the Plan."
3. You may enroll in SecurityBlue if you have elected hospice coverage. After you become a member of SecurityBlue, you may elect to receive hospice benefits from a hospice certified by Medicare. If you elect hospice care, the hospice and not SecurityBlue will be responsible for care related to your terminal illness.
4. You may not, at the time of enrollment, have End Stage Renal Disease (ESRD), that is, permanent kidney failure that requires regular kidney dialysis or a transplant to maintain life. This does not apply if you are already a non-Medicare member of KeystoneBlue℠ HMO when you enroll in SecurityBlue. An individual who receives a transplant that restores kidney function and who no longer requires a regular course of dialysis to maintain life is not considered to have ESRD for purposes of Medicare Advantage Plan eligibility. If you develop ESRD after enrollment in SecurityBlue, you may continue to be enrolled in SecurityBlue. Furthermore, if you had ESRD when you were a member of another Medicare Advantage Plan that chose not to renew its contract with

Medicare or withdrew from your service area on or after December 31, 1998, you are eligible to enroll in SecurityBlue.

5. You may not be enrolled in more than one Medicare Advantage Plan at any given time. If you are already a member of a Medicare Advantage Plan when you elect enrollment with a different Medicare Advantage Plan, membership in the old plan will be terminated automatically on the effective date of your enrollment in the new plan.
6. If you have a Medicare supplement (Medigap) policy, you may not be reimbursed for Medicare services that are not covered by SecurityBlue. Most Medigap policies will not pay for any portion of such services because supplemental insurance covers the Medicare deductible and coinsurance only after a claim is processed by Original Medicare. As long as you are a member of SecurityBlue, SecurityBlue will process any claims for medical services you receive. Medicare will not process your claims while you are enrolled under SecurityBlue (except for services for members who have elected to participate in the Medicare hospice program).

Once you are a member of SecurityBlue, you still have Medicare, but now you are getting your Medicare as a SecurityBlue member. SecurityBlue is *not* a "Medigap" or "Medicare supplement insurance" policy that pays your Medicare deductibles and coinsurance. Instead, Keystone Health Plan West, Inc. has a contract with Medicare to provide your health care when you enroll in SecurityBlue. As a SecurityBlue member, you no longer have to pay Original Medicare deductibles and coinsurance charges because SecurityBlue will cover all services and supplies offered by Original Medicare, plus some additional services and supplies not covered by Original Medicare. SecurityBlue does require you to pay a copayment or a coinsurance amount for certain services you receive. The copayment/coinsurance is generally paid to the provider at the time you receive services. Your copayment/coinsurance obligations are listed on pages 79-84 for direct payment members. Employer group members, see the separate insert titled "Schedule of Copayments."

To be covered by SecurityBlue, all of your health care services must be received from providers in the Keystone Health Plan West Medicare Advantage Network, except for emergency and urgently needed care (see definition for "emergency services" on page 92 and for "urgently needed care" on page 97) or out-of-area renal dialysis services. Neither Medicare nor SecurityBlue will pay for services you receive from out-of-network providers, except for emergency, urgently needed and out-of-area renal dialysis care. When you enroll in SecurityBlue, you must select a Primary Care Physician (PCP) from the PCPs listed in the SecurityBlue *Provider Directory*. Annual physical exams must be received from your PCP or Ob/Gyn to be covered by SecurityBlue. See page 37, "Physical Examinations."

Where To Get Help And Information

State Health Insurance Program (SHIP)—

"SHIP" stands for State Health Insurance Assistance Program. SHIPs are organizations 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 our problems with Medicare bills. You can contact the Pennsylvania Department of Aging, APPRISE Health Insurance Counseling Program, at 1-800-783-7067, Monday through Friday, 9:00 a.m. to 4:00 p.m.

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. If you have questions about any of these benefits, you can call the Social Security Administration at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also visit www.ssa.gov.

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. TTY users should call 1-312-751-4701. You can also visit www.rrb.gov.

How To Enroll

Eligible individuals may enroll in SecurityBlue by completing a SecurityBlue Enrollment Application. Fill in all information requested on the application. Be careful to accurately complete your Medicare information. Return your completed and signed application to the location specified by SecurityBlue. SecurityBlue will send you a letter that tells you when your coverage begins.

In general, your enrollment will be effective the first day of the month after the month your completed enrollment application is received by SecurityBlue/Keystone Health Plan West, Inc. For example, if SecurityBlue receives your completed application on February 28, your Effective Date will be March 1.

There are two exceptions to this general rule:

Initial Election Period—

If you are enrolling when you first become entitled to both Part A Hospital Insurance and Part B Medical Insurance of Medicare, your enrollment will be effective as of the first day of the month that you have coverage under both Medicare Part A and Medicare Part B, as long as your completed application is received prior to your Medicare effective date.

Annual Election Periods—

Enrollment elections received during the Annual Election Period (November 15 through December 31) are effective on January 1. During the Annual Election Period, you may also disenroll from SecurityBlue and return to Original Medicare or enroll in another Medicare Advantage Plan. See page 68, "Leaving the Plan," for more information.

Note: If you are a member of an employer group plan, follow the enrollment guidelines of your former employer or trust fund regarding open enrollment or special election periods.

Effective Date

Your effective date of enrollment in SecurityBlue is the date indicated on the letter we will send you to confirm your enrollment in SecurityBlue. Membership begins on the first day of the specified month. From that date forward, you must receive all health care from SecurityBlue providers, except for emergencies, urgently needed care and out-of-area renal dialysis.

When And How Often Can You Change Your Medicare Choices, And What Choices Can You Make?

There are limits on when and how often you can change the way you get Medicare. Even if you just switch from one SecurityBlue Plan to one of the other SecurityBlue Plans we offer, it still counts as making a change.

Here are the new rules:

1. From November 15, 2006 through December 31, 2006, anyone with Medicare will have an opportunity to switch from one way of getting Medicare to another.

2. From January 1, 2007 through March 31, 2007, anyone with Medicare (including members of SecurityBlue) has another chance to make a change in the way they get Medicare.

However, during the period January 1 through March 31, you are limited in the type of plan you can join. If you don't have Medicare prescription drug coverage when you make this change, you can only choose to join another plan that doesn't offer Medicare prescription drug coverage, or you can choose to return to the Original Medicare Plan without prescription drug coverage. If you have Medicare prescription drug coverage, you cannot use this chance to drop it.

3. Generally, you can't make any other changes during the year unless you meet special exceptions described later in this section. Later in the year, from November 15, 2007 through December 31, 2007, anyone with Medicare can switch their way of getting Medicare to another way for the following year.

4. Under certain conditions, you may be allowed to make a change regardless of the time of year and any previous changes you may have made. Please call Member Service at the number on your SecurityBlue membership card if you need to know if you might be able to use one of these circumstances to leave SecurityBlue.

   These conditions include:

   - Permanently moving out of our service area;
   - Joining a retiree plan offered by your current or former employer;
   - Being eligible for Medicaid;
   - Being eligible for the Federal Program of All-Inclusive Care for the Elderly;
   - Living in a long-term care facility, like a nursing home; and
   - Loss of creditable prescription drug coverage.

Your SecurityBlue Membership Card

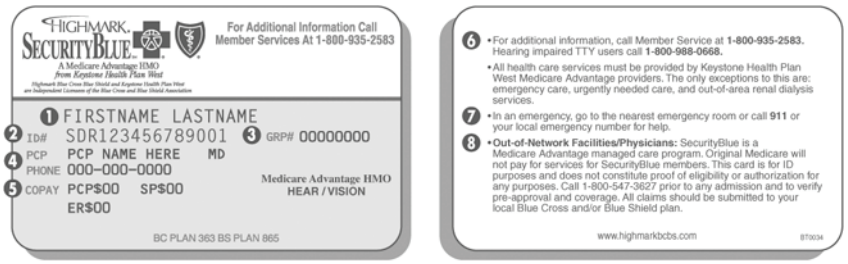
Your SecurityBlue membership or identification (ID) card is your "passport" to good health care. Carry it with you at all times, and keep your card in a handy place

when you're at home. When you receive your card, check it carefully to make sure all of the information is correct. If any information is incorrect, call Member Service at 1-800-935-2583, Monday through Sunday, between 8:00 a.m. and 8:00 p.m., immediately so that we can send you a new card. TTY users, please call 1-800-988-0668.

You will need the information on your card whenever you phone or visit your SecurityBlue Primary Care Physician (PCP) or any provider or hospital. Call Member Service at 1-800-935-2583, Monday through Sunday, between 8:00 a.m. and 8:00 p.m., for help locating a provider or to request that a copy of the *Provider Directory* be sent to you. It includes a list of all participating providers, hospitals and pharmacies. TTY users, please call 1-800-988-0668. You can also locate providers by visiting our Web site at www.highmarkbcbs.com.

It's important that you show your card to the provider when you seek medical care. You should not need to use your Medicare card for health care services while you're enrolled in SecurityBlue. You may wish to keep your Medicare card with you, however, in order to obtain discounts on non-health-related services which are often given to Medicare beneficiaries.

If your SecurityBlue membership card is damaged, lost or stolen, please notify Member Service immediately and it will be replaced promptly. Of course, your SecurityBlue benefits are not transferable, so do not let anyone else use your card.



1 Your Name
2 Identification Number
3 Group Number
4 PCP's Name and Telephone
5 Copayment Amounts for PCP, Specialist Office and Emergency Room Visits
6 Member Information
7 What to Do in an Emergency
8 Out-of-Network Facilities/Physicians Information

Note: **You will receive a separate membership/identification card for your Medicare prescription drug coverage, if you have it. Please see the separate *Addendum to the Evidence of Coverage* for more information about prescription drug coverage.**

How Your Program Works

SecurityBlue is offered to you through a contract with the Centers for Medicare and Medicaid Services (CMS), the Federal government agency that administers Medicare. Under this agreement, the government agrees to pay Keystone Health Plan West, the Medicare Advantage Organization through which SecurityBlue is provided, a fixed monthly amount to provide health care to you. In return, SecurityBlue provides or arranges to provide all of the medical care you need that is covered under Medicare. SecurityBlue also provides any other benefits agreed to under the contract with CMS and you.

As a member of SecurityBlue, you may go to any provider in the Keystone Health Plan West Medicare Advantage Network whenever you need care. No referrals are needed; however, your Keystone Health Plan West Medicare Advantage provider may be required to obtain authorization from SecurityBlue. In order for your care to be covered, you must use network providers for all of your health care *except* for emergency care, urgently needed care and out-of-area renal dialysis treatment. These services will be covered if you need to receive them from out-of-network providers. Neither Medicare nor SecurityBlue will pay for non-emergency or non-urgently needed care that you receive from out-of-network providers.

When you enrolled in SecurityBlue, you chose a Primary Care Physician (PCP). Your PCP or Ob/Gyn must provide routine physical examinations for them to be covered by SecurityBlue. Although you don't need to contact your PCP before you receive specialty care, we encourage you to do so and to develop a relationship with your PCP. He or she can become familiar with your medical history, so you can enjoy the personal attention and trust that develops through a strong personal physician relationship. In addition, it makes sense to have your PCP know about all of the care you receive, to help keep it consistent.

See the section "All About Your Benefits," page 17, for complete details of what is and what is not covered by SecurityBlue.

Your Rights And Responsibilities

As a SecurityBlue member, you have certain rights and responsibilities of which you should be aware in order to take the best advantage of your benefits:

You Have The Right To…

1. Be assured you will not be discriminated against in the delivery of health care services consistent with the benefits covered in your plan based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information or source of payment.
2. Receive considerate and courteous care, with respect for personal privacy and dignity.
3. Select your own personal physician or physician group from the SecurityBlue Primary Care Physicians (PCP) network.
4. Expect your Primary Care Physician's team of health care workers to provide or to help you arrange for all the care that you need.
5. Participate in the health care process. If you are unable to fully participate in this discussion, you have the right to name a representative to act on your behalf.
6. Receive enough information to help you make a thoughtful decision before you receive any recommended treatment.
7. Be informed of your diagnosis and treatment plans in terms you understand and participate in decisions involving your medical care.
8. Talk openly with your PCP and other network providers about appropriate and medically necessary treatment options for your condition, regardless of cost or benefit coverage.
9. Have reasonable access to appropriate medical services.
10. Be provided with complete information about SecurityBlue, including the services it provides, the practitioners who provide care and information on member rights and responsibilities.
11. Confidential health records, except when disclosure is required by law or permitted in writing by you with adequate notice. You have the right to review your medical records with your PCP or other network providers.
12. Express a complaint and to receive an answer to your complaint within a reasonable period of time.
13. Appeal a decision by SecurityBlue if you feel you have been denied a covered service.
14. Immediate Quality Improvement Organization review of decisions for hospital discharges, as explained in the Centers for Medicare and Medicaid Services' "Important Message," which is given to Medicare members at the time of admission to a hospital, and in the Notice of Discharge and Medicare Appeal Rights given prior to discharge.

15. Call Member Service, Monday through Sunday, between 8:00 a.m. and 8:00 p.m., at 1-800-935-2583 to request the following information about Keystone Health Plan West, Inc./SecurityBlue (TTY users, please call 1-800-988-0668):

    - How we control the use of medical services.
    - The number of appeals and grievances we have received and how these cases were resolved.
    - How we pay our participating doctors.
    - The financial condition of our plan.

16. Make suggestions about SecurityBlue's policies on members' rights and responsibilities.

You Have The Responsibility To…

1. Read all SecurityBlue materials carefully and immediately upon enrollment and ask questions when necessary. You have the responsibility to follow the rules of SecurityBlue membership.
2. Identify yourself as a SecurityBlue member when scheduling appointments, seeking consultations with your physician and upon entering any SecurityBlue provider's office.
3. Treat all SecurityBlue physicians and personnel respectfully and courteously as your partners in good health care.
4. Communicate openly with the physician you choose. You have the responsibility to develop a physician-patient relationship based on trust and cooperation.
5. Keep scheduled appointments or give adequate notice of delay or cancellation.
6. Ask questions and make certain that you understand the explanations and instructions you are given.
7. Consider the potential consequences if you refuse to comply with treatment plans or recommendations.
8. Pay any applicable copayments at the time of service.
9. Pay any applicable SecurityBlue premiums on time.
10. Pay your Medicare Part B premiums (and Part A, if applicable).
11. Help maintain your health and prevent illness and injury.
12. Help SecurityBlue maintain accurate and current medical records by being honest and complete when providing information to your health care professionals.

13. Express your opinions, concerns or complaints in a constructive manner to the appropriate people at SecurityBlue.
14. Notify the SecurityBlue Member Service Department, Monday through Sunday, between 8:00 a.m. and 8:00 p.m., at 1-800-935-2583 of any changes in your personal situation which may affect our ability to communicate with you or provide health care to you, including any changes in your address or phone number, any extended trips or vacations, and of your return to the service area from a trip of up to six consecutive months. TTY users, please call 1-800-988-0668.
15. Understand your health problems and participate in developing mutually agreed upon treatment goals to the degree possible.

SECTION 2
The Provider Network

The Keystone Health Plan West Medicare Advantage Network includes family doctors, general practitioners, internists and all types of specialists, hospitals and many additional providers. **You must use network providers and facilities to receive coverage for eligible services from your SecurityBlue Plan (except for emergency care, urgently needed care and out-of-area renal dialysis services).**

You can call a Member Service Representative for help finding network providers and facilities or to request that a printed copy of the *Provider Directory* be mailed to you. Call 1-800-935-2583, Monday through Sunday, between 8:00 a.m. and 8:00 p.m. TTY users, call 1-800-988-0668. You also can locate network providers on our Web site at www.highmarkbcbs.com.

The Important Role Of Your Primary Care Physician (PCP)

Your PCP is much like the old-fashioned "family doctor"—the doctor who knows your current health as well as your medical history; a doctor with whom you feel comfortable discussing all of your health care needs. Your PCP or your Ob/Gyn provides your routine physical exams. You are encouraged, but not required, to see your PCP whenever you need care. This helps to ensure that you receive the right care for your needs, when you need it.

For your convenience and security, network PCPs or their covering doctors are on call 24 hours a day, seven days a week.

How To Get Your Physicians' Professional Qualifications

To view board certification information and the hospital affiliation of your PCP or network specialist, visit our Web site at www.highmarkbcbs.com and click on "Find a Provider." Search for the physician, then click on the provider's name to view this information. In addition to this information, to obtain the full professional qualifications of network providers, including medical schools attended and residencies completed, call a Member Service Representative at 1-800-935-2583, Monday through Sunday, between 8:00 a.m. and 8:00 p.m. TTY users, call 1-800-988-0668.

How To Change Your PCP

Since the doctor/patient relationship is the basis of quality care, we encourage you to build a relationship with your PCP based on trust. We also encourage you to talk openly with your PCP about your feelings, concerns and questions. If you are not comfortable with your PCP, you may change doctors at any time.

Simply call Member Service at 1-800-935-2583, Monday through Sunday, between 8:00 a.m. and 8:00 p.m. TTY users, call 1-800-988-0668. The Member Service Representative will take your PCP change over the phone if you have the new information needed. If you need help choosing a new PCP, the representative can send you a copy of the latest *Provider Directory*. Or you can locate participating PCPs on our Web site—www.highmarkbcbs.com.

– If your request for change is received between the 1st and 15th day of the month, your PCP change will become effective the first day of the following month.

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

When you change to a new PCP, you will receive a new SecurityBlue membership card with your new PCP's name and telephone number printed on it. To avoid confusion, please throw away your old card when you receive your new card.

About Your Medical Records

To give you the best possible care, your PCP should have your complete medical history and previous medical records. If you change your PCP, ask your previous doctor's office to send your records or photocopies of them to your current doctor. The previous doctor may ask you to submit your request in writing. Please arrange for the release of your records before your first appointment with your new PCP. If both your previous doctor and your new PCP are in the Keystone Health Plan West Medicare Advantage Network, there is no charge for this service. However, if you are a new SecurityBlue member and your previous doctor is not participating in the Keystone Health Plan West Medicare Advantage Network, you may be asked to pay a small fee for this service. SecurityBlue does not cover this fee.

Provider Network Changes

SecurityBlue will provide written notice of the termination of network providers (e.g., PCPs or specialist doctors) 30 days before the effective date of the termination. This will be sent to all members who are patients seen on a regular basis by the provider whose contract is terminating, whether the termination is for cause or without cause.

When the termination of one or more network PCPs or specialists is for a reason other than for cause, SecurityBlue will notify you at the time of termination of your right to maintain access to other PCPs or specialists.

Five Tips For Making An Appointment With Your Doctor

1. When you schedule an appointment, have your SecurityBlue membership card ready. That way, you can give the doctor's office your membership information in addition to the nature of your medical problem.
2. Write down the time, date and location of your appointment and put this information in a safe place.
3. Try to schedule appointments in advance. If you must request a same-day or urgent appointment and your doctor of choice is not available, you may have to see another physician in the group practice. If your doctor is not part of a group practice, you will have to see the physician who is "covering" for your doctor.
4. For routine appointments, it's usually best to call your doctor's office in the morning; Mondays and Tuesdays are often the busiest phone days.
5. If you're going to be late for your appointment, let the office know. Of course, if you need to cancel your appointment, call your doctor's office as soon as possible—some physicians will charge for missed appointments (especially if canceled at the last minute). These charges are not covered by SecurityBlue.

SECTION 3
All About Your Benefits

Routine And Preventive Care

We all want to be as healthy as possible. To do this, we need to take care of ourselves every day by practicing "preventive health care."

Preventive health care refers to the basic steps you can take to control many health problems and to prevent them from becoming more serious. Some of these steps can be as simple as eating well-balanced meals or walking each day to keep fit. Others, such as controlling high blood pressure, may require you to work with your physician.

One easy but very important way to add preventive health care to your life is by following the guidelines for adults suggested in the following chart. These guidelines were developed by a committee of physicians from the Keystone Health Plan West Medicare Advantage Network. They are based on guidelines recommended by the following national health organizations: American Academy of Family Physicians, U.S. Preventive Services Task Force, American College of Obstetricians and Gynecologists, American Geriatrics Society, American Diabetes Association, Center for Disease Control, and National Institutes of Health.

All SecurityBlue members, especially high-risk individuals, should get a flu shot each year in the fall. You're at high risk if you're 65 or older or have a chronic condition such as heart, lung or kidney problems, diabetes, or a weakened immune system.

Make sure you get a pneumonia shot, too. Unlike the flu shot, which you must get every year, the pneumonia shot is needed only once per lifetime. Yet it prevents one of the major deadly complications of the flu—pneumococcal pneumonia.

Women members of SecurityBlue are encouraged to visit the gynecologist of their choice each calendar year for a routine gynecological exam. When you use a network provider, the only cost is the office visit copayment. This exam includes a pelvic exam, a clinical breast exam and a PAP test. Women aged 40 and over are also covered for an annual mammogram. Additional mammograms as recommended by your gynecologist are also covered.

We encourage you to take advantage of the preventive health care benefits covered by your SecurityBlue Plan. Call a Member Service Representative if you have questions about what guidelines are covered benefits under your plan. Please read these guidelines now, then talk to your doctor to learn how they can help you stay healthy.

Guidelines For Adult Preventive Medical Care—Age 19 And Over

	19 – 64 years	65 + years
Physical Exam/ Health Guidance	Annually	
Blood Pressure Screening	At each physician visit. Minimum of once every 1 to 2 years. Annually, if diastolic > 85 mmHg or systolic > 130 mmHg.	
Breast and Pelvic Exam	Annually unless determined by physician as not clinically indicated.	
Lipid Panel	Beginning at age 20, every 5 years or at a frequency recommended by physician.	
Fasting Blood Glucose	Beginning at age 45, every 3 years for high risk patients or at a frequency recommended by physician.	
Mammography (Women)	Beginning at age 40, every 1-2 years.	Age 65 years and older, every 1-2 years unless determined by physician as not clinically indicated.
PAP Test (Women)	Based on history, every 1-3 years beginning 3 years after initiation of sexual activity or no later than age 21.	At age 65 and older, screening as determined by physician's assessment of history and risk factors.
STD Screening	Screening as determined by a physician's assessment of history and risk factors.	
Colorectal Cancer Screening	Starting at age 50: Screening options include: • colonoscopy every 10 years; or • fecal occult blood test annually; or • flexible sigmoidoscopy with or without annual fecal occult blood testing every 5 years; or • double contrast barium enema every 5 years	
Bone Mineral Density (Women)	No more often than every 2 years for younger post	Age 65 and older, no more often than every 2

	menopausal women with risk factor or post menopausal women with a fracture.	years.
Prostate Cancer Screening (Men)	Screening as determined by a physician's assessment of history and risk factors.	
Screening for Abdominal Aortic Aneurysm (Men)		Between ages 65 and 75, one-time screening for those who have never smoked.
	19-64 Years	65 +Years
Immunizations		
Diphtheria, Tetanus	1 booster every 10 years.	
Influenza	Annually for adults at high risk or age 50 and older.	Annually.
Pneumococcal	Recommend for adults at high risk.	Once after age 65, consider revaccination after 5 years
Measles, Mumps, Rubella	Recommend for adults age 19-49 that lack evidence of immunity. Age 50 and older recommended if at high risk.	Recommended if at high risk.
Varicella	Recommended for adults age 19-49 without evidence of immunity to varicella (chicken pox). Age 50 and older recommended if at high risk.	Recommended if at high risk.
Meningococcal	Recommended for adults at high risk if not previously immunized.	
Hepatitis A	Age 50 and older recommended if at high risk.	
Hepatitis B	Age 50 and older recommended if at high risk.	
HPV (Women)	Age 19-26	
Other	There may be a specific vaccination(s) recommended	

	by your physician based on history or risk factors.

Guidelines For Daily Preventive Health Measures

- *When you drive or ride in a car*…always wear your seatbelt.

- *If you drive*…ask your doctor if medications or health conditions might cause driving problems.

- *In your home*…be sure to have smoke detectors with good batteries. You should set the temperature of your hot water heater below 120 degrees Fahrenheit, have handrails on all stairs and install safety devices in each bathroom.

- *Work to break dangerous personal habits*…such as smoking, excessive alcohol drinking and misuse of prescription and over-the-counter drugs. Your doctor can help you overcome any harmful habits you may have.

- *Practice good personal habits*…such as regular walking or other exercise. Avoid too much sun and keep your weight down. See a dentist regularly, eat well-balanced meals including plenty of calcium. Women should perform monthly breast self-exams.

- *For long-term peace of mind*…keep active social relationships with your family and friends. Arrange for a living will and/or durable power of attorney so someone you trust can carry out your wishes in case you become unable to make decisions yourself. If you feel you are being abused or neglected—physically, emotionally or financially—talk with your doctor immediately. Such problems can affect your health.

- *Keep regular appointments with your PCP*…get the health care services listed in the guidelines for preventive health care at the recommended times.

- *Be sure to talk with your PCP or other personal physician*…discuss ways to improve your health and prevent further problems. Issues to discuss include prostate screenings for men and hormone replacement therapy for women during and after menopause.

Hospital Care

Covered hospital care includes the entire range of services from pre-admission testing…to surgery…to any consultations with specialists that are needed.

SecurityBlue must authorize all hospital care to ensure that you receive the best possible care in the most appropriate setting, and to ensure that your care is covered. This includes both inpatient care (care that requires an overnight stay) and outpatient care (no overnight stay is required). There are exceptions to this: emergency or urgently needed care and out-of-area renal dialysis.

Care In Religious Non-Medical Health Care Institutions

Care in a Medicare-certified Religious Non-medical Health Care Institution (RNHCI) is covered by SecurityBlue 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 "nonexcepted" medical treatment. ("Excepted" medical treatment is medical care or treatment that you receive involuntarily or that is required under Federal, state or local law. "Nonexcepted" medical treatment is any other medical care or treatment.) You must also get authorization (approval) in advance from SecurityBlue, or your stay in the RNHCI may not be covered.

RNHCI services furnished in the home are also covered by SecurityBlue, but only with respect to items and services ordinarily furnished by home health agencies that are not RNHCIs.

Specialist Care

When you need specialty care, you may go to any participating network specialist. You are encouraged to coordinate and record your treatment with your PCP at each stage of your care.

Getting Your Specialty Care Through Your PCP Gives You Several Advantages—

- You can be sure that your need for specialty care is based on an informed diagnosis. Your PCP knows you and your medical history, so he or she is the person who is best qualified to determine what type of specialty care you need.

– You can be confident that your specialty care will complement other care you may be receiving. When your PCP and specialist work together, your total well-being is carefully considered, and your treatment is consistent.

– You know that your care is convenient and cost-effective. Your PCP will direct you to the right specialist promptly. You waste no time or money tracking down the best doctor for your case. And receiving the right care from the start helps to avoid unnecessary tests and wrong diagnoses, which contribute to higher health care costs.

Women's Care

SecurityBlue recognizes the importance of a woman's relationship with her gynecologist. That's why every SecurityBlue female member can visit any gynecologist of her choice listed in the SecurityBlue *Provider Directory* for a routine gynecological exam each calendar year. Your only cost is the office visit copayment. This exam includes a pelvic exam, a clinical breast exam and a PAP test. Women aged 40 and over are also covered for an annual mammogram. Additional mammograms as recommended by your PCP or gynecologist are also covered.

SecurityBlue also covers maternity care, from confirmation that you are pregnant through delivery and postpartum care. You may contact the SecurityBlue obstetrician of your choice as soon as you believe you are pregnant.

Mental Health Care

Mental health and substance abuse problems require individualized, knowledgeable care. If you believe you need treatment, you may contact the network behavioral health provider of your choice. However, we recommend that you talk with your PCP, who can coordinate your care. Or you may contact Member Service by calling 1-800-935-2583 and selecting the behavioral health (mental health, drug or alcohol treatment) option. This option is available 24 hours a day, seven days a week. TTY users, call 1-866-634-6467.

SecurityBlue utilizes a large behavioral health provider network. It is made up of mental health and substance abuse facilities and professional providers, including psychiatrists, doctoral-level psychologists, licensed certified social workers and other graduate-level providers. These professionals can determine the best type of treatment for you. They will thoroughly evaluate your situation and needs, then find the provider who is best able to address and answer those needs...so you can get the level of care

appropriate for your situation. See the following pages of this section for coverage details about mental health and substance abuse benefits.

Vision Care/Medical Treatment Of The Eyes

SecurityBlue provides benefits for routine vision care as well as for medical treatment of the eyes. It is not always easy to know how serious your eye problem may be. You may not want to call your doctor because you feel you may be bothering him or her with a minor problem. Yet you don't want to let a condition that can be treated easily today grow into a more serious or complicated illness. A Blues On Call℠ health coach can help.

If you have a question or concern about your eyesight or the health of your eyes—and it is *not* an emergency—please call SecurityBlue Member Service at 1-800-935-2583 and select the Blues On Call option from the menu. Listen carefully for further selections and choose the option to speak with a health coach. Hearing-impaired TTY users can reach Blues On Call by dialing 1-877-888-7834. Blues On Call is available 24 hours a day, seven days a week. You will be connected to a specially-trained professional who will discuss your concerns with you and help you determine the right kind of care you need for your eyes when you need it. Importantly, the health coach can also help you determine what kind of provider to see—an optometrist or an ophthalmologist—so you use your SecurityBlue vision care benefits to your best advantage.

When You Need Specialist Care For Your Eyes—

When you call a Blues On Call health coach, you may be told that you need to see an ophthalmologist. Ophthalmologists are specialists who treat medical conditions of the eye, such as glaucoma, cataracts and other diseases. You can be sure that your care will be covered when you go to a network specialist.

When You Need Routine Care For Your Eyes—

All SecurityBlue Plans include benefits for **routine** vision care. This includes coverage for one routine eye exam each year. You are responsible for a copayment for this visit. **You must use one of the Davis Vision providers listed in the Vision section of the SecurityBlue *Provider Directory* for your routine exam.** The Blues On Call health coach can help you find a SecurityBlue participating provider near you and confirm that the provider you've chosen is the right one for your needs. You can call the provider yourself and make your appointment. When you visit the provider, show your SecurityBlue membership card and pay your copayment. You do not need to file a claim.

Your routine vision care benefits also include an allowance for contact lenses or eyeglass lenses, and an eyeglass frame, once every two years. You may need these

as a result of your routine eye exam. Your SecurityBlue Plan also provides this allowance after you have had cataract surgery on each eye. **You must purchase your eyeglasses or contacts from one of the providers listed in the Vision section of the SecurityBlue *Provider Directory*.** Call the Blues On Call health coach and ask for help locating a participating provider near you. When you visit the provider, show your SecurityBlue membership card. You do not need to file a claim. See page 39 for more details about your vision care benefits.

While we do not require you to call Blues On Call, we encourage you to use the Blues On Call option—it can save you time and give you added support when making decisions about care you may need. However, if you already have a relationship with a participating SecurityBlue provider…or if you prefer to choose one from the Vision section of the *Provider Directory* yourself…you are always free to get routine vision care on your own.

Note: If you receive routine vision care services or supplies from providers who are not participating in the Davis Vision network, SecurityBlue will not pay for the service or supplies.

Hearing Care

All SecurityBlue Plans include benefits for **routine** hearing care. This includes coverage for one routine hearing exam each year. You are responsible for a copayment for this visit. **You must use one of the hearing care professionals listed in the Hearing section of the SecurityBlue *Provider Directory* for your routine exam.** A SecurityBlue Member Service Representative also can help you find a SecurityBlue participating provider near you. Call 1-800-935-2583, Monday through Sunday, between 8:00 a.m. and 8:00 p.m. TTY users, call 1-800-988-0668. You can call the provider yourself and make your appointment. When you visit the provider, show your SecurityBlue membership card and pay your copayment. You do not need to file a claim.

Your routine hearing care benefits also include an allowance for hearing aids—up to $500 every three years—and fittings. See page 31 for more details about your hearing care benefits.

Note: If you need a doctor's treatment for a medical condition detected during your routine hearing exam, be sure to talk to your PCP or call SecurityBlue Member Service for help finding the appropriate provider for your condition. Also, if you receive routine hearing care services or supplies from providers who are not participating in the Keystone Health Plan West Medicare Advantage Network, SecurityBlue will not pay for the service or supplies.

Emergency Care

SecurityBlue covers your emergency and urgently needed care worldwide. You are covered for both inpatient and outpatient services that are furnished in or outside the service area by a qualified provider and are needed to evaluate or stabilize an emergency medical condition.

An emergency medical condition is a medical condition that shows itself by acute symptoms (including severe pain) of sufficient severity such that a prudent layperson, with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

(1) serious jeopardy to the health of the individual (or an unborn child);
(2) serious impairment to bodily functions; or
(3) serious dysfunction of any bodily organ or part.

You are responsible for paying a copayment for each emergency room visit unless you are admitted to the hospital for the same condition within three days and the admission is authorized. See Section 11, "Summary of Your Financial Responsibilities," page 79, for your copayment amount.

If your condition allows, we encourage you to call your PCP before receiving emergency medical services. However, if you believe that your condition requires immediate medical attention, go directly to a hospital emergency room or call "911" or your local area emergency number for help. Show the hospital staff your SecurityBlue membership card.

Examples of emergency situations in which you may *not* be able to call your doctor first include:

- loss of consciousness
- severe chest pain or possible heart attack
- uncontrollable bleeding
- extensive or massive injuries

Once the crisis has passed, we recommend that you contact your PCP as soon as possible to help arrange for any follow-up care you may need.

Some situations require prompt medical attention, but may not require a visit to the emergency room.

Examples of situations in which you may be able to call your doctor first include:

- a cut with controllable bleeding
- an illness, such as the flu, which has been present for several hours or days without a sudden change in condition
- a sprained wrist or ankle

By calling your PCP first, you can save hours of waiting in a crowded emergency room or treatment by a doctor you don't know. Your PCP can perform some services in his or her office, such as stitching cuts. And keep in mind that your PCP or designated covering physician is on call 24 hours a day, seven days a week.

Urgently Needed Care

Urgently needed care is also covered after you pay any applicable copayment. Urgently needed care includes services which are provided while you are temporarily outside SecurityBlue's service area, or in extraordinary cases, while you are in the plan's service area when the SecurityBlue network is unavailable or inaccessible due to an unusual event. They are services which appear to you to be required in order to prevent serious deterioration of your health resulting from an unforeseen illness, injury or condition if:

- You are temporarily absent from SecurityBlue's service area (an absence lasting up to six months in a row).
- You are in the SecurityBlue service area, but the plan's network is unavailable or inaccessible due to an unusual event.
- Such services are medically necessary and immediately required.
- It is not reasonable, given the circumstances, to obtain the services through the SecurityBlue network.

If you need urgent care while you are out of the SecurityBlue service area, get the care you need from any provider of your choice. Then contact your PCP within 48 hours, if possible, to arrange for any follow-up care you may need.

If you need urgent care while you are within the SecurityBlue service area, we recommend that you contact your PCP first, if possible, and follow his or her instructions.

Send any bills you receive from providers you see on your own to SecurityBlue at the address below. Each bill should describe the circumstances of your illness or injury and itemize the services you received.

SecurityBlue Member Service
P.O. Box 1068

Pittsburgh, PA 15230-1068

SecurityBlue Covered Benefits

Subject to the terms of this agreement, the following medical services will be provided and paid for by SecurityBlue when medically necessary and appropriate for the diagnosis or treatment of an illness or injury. SecurityBlue covers all Medicare-covered services, plus certain other services not covered by Medicare. Since Medicare benefits may change from time-to-time, SecurityBlue reserves the right to revise the benefits it provides to conform with changes made by Medicare.

The following information describes benefits provided by SecurityBlue, as well as limitations applicable to your benefit plan.

The services described here are covered by SecurityBlue only if:

a. The services or supplies are medically necessary, and
b. The services or supplies are provided by a SecurityBlue contracting provider or facility, and
c. The services or supplies are authorized by SecurityBlue.

The only exceptions to this are emergency services, urgently needed care and out-of-area renal dialysis.

All services described in this section must be rendered or delivered while you are enrolled in SecurityBlue to be considered for coverage. Payments made under other Highmark Medicare Advantage Plans will be considered when determining coverage.

Specific applicable copayments, coinsurance amounts and any limitations for direct payment members are listed in Section 11, "Summary of Your Financial Responsibilities," on pages 79-84 of this booklet. Employer group members, see your separate "Schedule of Copayments."

1. ***Allergy Testing And Treatment—*** Allergy tests, testing materials and treatment. **Covered in full after copayment per visit. No copayment for visits for injections only. Additional copayments may apply for Allergy Testing for members of the Value Plan.**

2. ***Ambulance Services—*** Medically necessary ambulance services, including ground, air, wheelchair accessible and other types of ambulance transportation services, both inside and outside the SecurityBlue service area, when other means

of transportation would endanger the member's health. **Covered in full after a copayment per one-way trip; no copayment for inter-hospital ambulance services. Non-emergency ambulance transportation is covered in full after a copayment per one-way trip. You may use only SecurityBlue's network transport provider for non-emergency ambulance transport. Ambulance benefit is strictly for medically necessary transport and does not cover services provided by independent paramedic intercept at the scene.**

3. ***Anesthesia—*** Anesthesia and certified registered nurse anesthetist services when performed in connection with covered services which have been pre-approved by SecurityBlue. **Covered in full.**

4. ***Chiropractic Care—*** Manual manipulation of the spine to correct a subluxation that can be demonstrated by an x-ray or other diagnostic test ordered and obtained by your PCP for diagnostic purposes as medically necessary before you go to a chiropractor for treatment. **Covered in full after copayment per visit.** Deluxe Plan members can receive six visits each calendar year to a network chiropractor for routine manual manipulation of the spine—covered in full after a copayment per visit.

5. ***Clinical Trials—*** Original Medicare covers routine costs of qualifying clinical trials. If you join a clinical trial, you will be responsible for any coinsurance under Original Medicare. When you enroll in a clinical trial, the providers are paid directly by Original Medicare for all the covered services you receive. Clinical trial providers do not have to be SecurityBlue network providers. This means that you do not need to get a referral to join a clinical trial; however, you should inform your PCP or SecurityBlue before you begin a clinical trial, so that we can keep track of your health care services. You may remain enrolled in SecurityBlue even if you elect to participate in a clinical trial. Care you receive that is not related to the clinical trial will continue to be covered by SecurityBlue, and you will be responsible for any applicable copayments, maximums, etc.

6. ***Colorectal Screening—*** Includes fecal-occult blood screenings, screening flexible sigmoidoscopies, screening colonoscopies and screening barium enema. **Covered in full. Office visit copayments may apply.**

7. ***Dental Care—*** Deluxe Plan members only can receive routine dental care, including one oral exam and cleaning every six months, bitewing x-rays once a year, full-mouth x-rays once every five years, and simple extractions and restorative services (fillings) at any time. SecurityBlue pays 60% of the plan's established fee schedule; you are responsible for 40%. Participating network

dentists have a complete fee schedule for your reference. For more information about Deluxe Plan benefits, please call a Member Service Representative at 1-800-935-2583, Monday through Sunday, between 8:00 a.m. and 8:00 p.m. TTY users, call 1-800-988-0668.

8. ***Diabetic Education Programs—*** Education program on the successful self-management of diabetes. **Covered in full. Office visit copayments may apply.**

9. ***Diabetic Screening Tests—*** Diabetes screening tests for persons at risk of diabetes, including a fasting plasma glucose test. **Covered in full. Copayment may apply depending on plan. Office visit copayments may apply.**

10. ***Diagnostic, Laboratory And X-ray Services—*** Medically necessary x-ray and laboratory tests, procedures and materials, including diagnostic x-rays. **Covered in full. Copayment may apply depending on plan.**

11. ***Dialysis—*** Dialysis services when provided in the outpatient facilities of a hospital, a freestanding renal dialysis facility which has been approved by SecurityBlue or, with SecurityBlue approval, in the home when provided by an eligible provider. In the case of home dialysis, covered services will include equipment, training and medical supplies. The decision to provide benefits for the purchase or rental of necessary equipment for home dialysis will be made by SecurityBlue. Renal dialysis services when out of the SecurityBlue service area for up to six months in a row. **Covered in full.**

12. ***Durable Medical Equipment (DME) And Medical Supplies—*** When pre-approved by SecurityBlue or its designated agent, in accordance with Medicare law, regulations and guidelines, the rental, or at the option of SecurityBlue, the purchase of DME for therapeutic use in your home, such as diabetic testing devices (glucometers and testing strips); wheelchairs and oxygen equipment; medical supplies (such as dressings); and prosthetic devices and foot orthotics as follows:

a. prosthetic devices (other than dental) which replace all or part of the function of a permanently inoperative or malfunctioning body organ;
b. prosthetic devices, such as braces for a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body;
c. hydrophilic lenses which can be used as prosthetic lenses for the aphakic patient or as a cornea bandage;

d. breast prostheses and brassiere for post-mastectomy patients;
e. foot orthotics (including shoes, inserts and modifications) for conditions other than diabetes are covered in limited circumstances; therapeutic shoes for patients with severe diabetes;
f. replacement and maintenance of prosthetic devices resulting from normal wear and tear is covered except for contact lenses after cataract surgery and when specifically limited by Medicare. **Covered at 85 percent of the approved amount (you are responsible for 15 percent coinsurance) up to an out-of-pocket maximum of $500 per calendar year, then covered in full. Oxygen supplies and equipment are covered in full.**

13. Glaucoma Screening— For individuals at high risk for glaucoma, individuals with family history of glaucoma, or individuals with diabetes. **Covered in full annually after office visit copayment.**

14. Gynecological Visits— One routine examination each calendar year. A routine exam consists of: pelvic exam, interval history, appropriate physical exam, breast exam and Papanicolaou (PAP) test. **Covered in full after copayment per visit.**

15. Hearing Coverage— All SecurityBlue members are covered for *Medicare-covered* hearing services and for *routine* hearing care. Routine hearing services are covered only when received from participating network providers after you pay a copayment for each hearing exam. A list of SecurityBlue participating hearing care providers and suppliers is included in the SecurityBlue *Provider Directory* or you can locate providers on our Web site at www.highmarkbcbs.com. If a problem that requires further treatment is diagnosed during your routine hearing exam, talk to your PCP or call SecurityBlue Member Service for help finding the appropriate provider for your condition. Routine hearing services and supplies received from non-participating providers must be paid for in full by you and will not be covered by SecurityBlue. See page 25 of this booklet for more details.

a. You pay a copayment for each audiological exam.
b. You are entitled to one audiological exam per year.
c. SecurityBlue will provide you with up to $500 for the purchase of one or more hearing aids every three years when provided by a SecurityBlue contracting provider.

16. ***Home Health Care—*** Care provided by a Medicare-certified Home Health Care Provider in the member's home. **Covered in full when part of an approved plan of care.**

17. ***Home Visits—*** Physician visits to the member's home, if within the service area. **Covered in full after copayment per visit.**

18. ***Hospice Consultation Services—*** A one-time consultation for a terminally ill member who has not yet elected the hospice benefit. Once a member has elected the hospice benefit, Medicare, and not SecurityBlue, will cover the services provided by a Medicare-certified hospice. **Covered in full. Office visit copayment may apply.**

19. ***Immunizations—*** Medically necessary immunizations and their administration, including influenza vaccine, pneumococcal and Hepatitis B vaccines for members considered to be at high or intermediate risk of contracting these diseases, excluding those required for foreign travel. **Covered in full, except as specifically limited in Section 4, "Summary of Exclusions and Limitations," page 42. Influenza (flu) shots also covered in full as long as provided by your PCP or other SecurityBlue provider; access to other immunization sites provided to you annually.**

20. ***Injections—*** Injectable medications administered by a health care professional for the treatment of an illness or injury. **Covered in full. Office visit copayment may apply.**

21. ***Inpatient Services—*** When you are admitted to a hospital, skilled nursing facility or other Medicare-approved facility with the authorization of SecurityBlue (or for a medical emergency), the following services are covered when medically necessary:
    - anesthesia
    - blood, including the initial three pints not covered by Medicare
    - chemotherapy
    - diagnostic, laboratory and x-ray
    - dialysis
    - dressings and casts
    - drugs, medications and biologicals
    - medical equipment, appliances and oxygen
    - medical/surgical care
    - occupational therapy
    - physical therapy

- physician care
- radiation therapy
- regular nursing services
- rehabilitation services
- respiratory therapy
- room and board (semi-private room unless private room is medically necessary)
- special diets when medically necessary
- speech therapy
- surgery
- supplies
- use of operating room, intensive care or cardiac care units
- use of recovery room.

If you are an inpatient of an acute care hospital, rehabilitation hospital, a distinct rehabilitation unit within an acute care hospital or long-term care hospital at the time of your disenrollment from SecurityBlue, SecurityBlue will continue to provide payment to the facility until at least one of the following conditions has been met:

- The care being provided is determined to be no longer medically necessary;
- Your physician has discharged you to a home or an alternative level of care;
- Benefit maximums have been reached.

Once it has been determined that one or more of the conditions listed above have been met, SecurityBlue will discontinue payment to the facility. **Covered in full after copayment per admission, when pre-approved by SecurityBlue except as specifically limited above.**

a. *Mental Health Care—* In a Medicare-participating psychiatric-only hospital or a distinctly certified psychiatric unit of an acute care hospital up to a lifetime limit of 190 days, when determined to be medically necessary and arranged through appropriate authorization by SecurityBlue (or its designated agent) to a provider designated by SecurityBlue to provide mental health covered services to members. **Covered in full after copayment per admission, when pre-approved by SecurityBlue.**

b. *Skilled Nursing Facility Care—* Limited to a maximum of 100 days per Benefit Period (see the definition of "Benefit Period" on page 91); benefits are limited to semi-private accommodations or an allowance equal to SecurityBlue's established payment for

semi-private accommodations which may be applied to the cost of private accommodations. Private accommodations will be covered when medically necessary. Custodial care or domiciliary care in a skilled nursing facility or elsewhere is not covered. Post-hospitalization skilled nursing care is covered through an individual's (or their spouse's) home skilled nursing facility if the member elects to receive coverage through their facility and SecurityBlue has a contract with the facility or the facility agrees to accept similar payment under the same terms and conditions that would apply to similarly situated skilled nursing facilities that are under contract with SecurityBlue. **Covered in full when approved by SecurityBlue, except as specifically limited above. Copayment may apply depending on plan.**

c. *Long-Term Acute Care Facility (LTAC)*— A LTAC is a provider that is certified by Medicare as an acute care hospital, but provides long-term patient care resulting in average lengths of stay of at least 25 days or longer. **Covered in full when pre-approved by SecurityBlue. Copayment may apply depending on plan.**

22. ***Mammograms*—** One screening mammographic examination per calendar year for women age 40 or over. One baseline screening mammographic examination for women between the ages of 35 to 40. Services must be provided by a SecurityBlue contracting (network) provider. Except for the screening mammographic examination for women between the ages of 35 to 40, mammographic examinations for women under age 40 will be covered only when recommended by a SecurityBlue provider. Additional diagnostic examinations will be covered when medically necessary. **Covered in full.**

23. ***Medical Nutrition Therapy Services*—** For individuals with diabetes, renal disease or other conditions when determined to be medically necessary. **Covered in full. Office visit copayment may apply.**

24. ***Medicare-Covered Part B Drugs*—** Medicare covers certain drugs as part of your basic benefits, such as:

– Drugs that in general are not self-administered by the patient, but are administered by a health professional, and include substances that are naturally present in the body, such as blood clotting factors and insulin.

- Drugs you take using durable medical equipment (such as insulin pumps) and nebulizers that was authorized by SecurityBlue (see Section 12, Appendix C for a definition of durable medical equipment).

- Clotting factors 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 (IVIG) for treatment of primary immune deficiency diseases in the home.

- Chemotherapy.

Limitations include drugs and biologicals considered experimental or investigational and/or not approved by the Federal Drug Administration (FDA) or Highmark Medicare Advantage Medical Policy, outpatient prescription drugs and biologicals covered exclusively under Medicare Part D, drugs and biologicals considered Medicare Part D exclusions, drugs and biologicals considered Medicare Part B exclusions, and drugs and biologicals received during a covered inpatient or skilled nursing stay. Some Medicare Part B drugs require prior authorization. Medicare Part B drugs cannot be obtained from a retail pharmacy. It is important that you work with your prescribing physician or SecurityBlue Member Service to determine how and if your medications will be covered under your SecurityBlue Plan.

25. ***Mental Health Care—***

a. *Outpatient Visits*— **Covered in full after copayment per visit** when determined to be medically necessary to a provider designated by SecurityBlue to provide mental health covered services to members, including the services of a psychiatrist, psychologist, clinical psychologist and clinical social worker.

b. *Partial Hospitalization Sessions*— **Covered in full** when determined to be medically necessary and arranged and authorized by SecurityBlue (or its designated agent) to a provider designated by SecurityBlue to provide mental health covered services to members.

26. ***Newborn Care—*** Care of a newborn child of a member for a period of 31 days following birth. Such care shall include routine nursery care, prematurity services, preventive health care services, as well as coverage for injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. **Covered in full after copayment per visit.**

27. ***Obstetrical Care—*** Obstetrical care, when provided by a SecurityBlue contracting (network) provider, including pre- and post-natal care, certified nurse-midwife services, complications of pregnancy and childbirth. **Covered in full after copayment per visit.**

28. ***Oral Surgery—*** Oral surgical procedures when required in connection with the following:

a. the removal of wisdom teeth which are partially or totally covered by bone;
b. the extraction of teeth in preparation for radiation therapy;
c. accidental injury to the jaw or structures contiguous to the jaw or injury to sound natural teeth;
d. the correction of a non-dental physiological condition which has resulted in a severe impairment;
e. treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
f. dental services related to surgery of the jaw or any structure adjacent to the jaw or fractures of the jaw or facial bones; dental services which are incidental and integral to a covered service performed by a dentist; and services which could be provided by a doctor, such as detection and treatment of infections prior to surgery and/or in connection with covered services;
g. lingual frenectomies/frenectomies performed to correct tongue-tie; or
h. vestibuloplasties when performed due to accident-related injuries only.

Covered in full when authorized in advance by SecurityBlue. Copayment may apply depending on place of service.

29. Organ Transplants— Medically necessary Medicare-approved transplant services for member recipients in a Medicare-certified and approved transplant facility which is in the SecurityBlue network, including heart, liver, cornea, bone marrow, lung, heart/lung, kidney and pancreas 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. Determinations of medical necessity shall take into account the proposed Medicare-approved procedure's suitability for the potential member recipient. If not covered by any other source, the following expenses of donors donating organs to member recipients are covered.

a. the removal of the organ from the donor;
b. donor preparatory pathologic and/or medical examinations;
c. donor post-surgical care.

Covered in full when authorized in advance by SecurityBlue, except as specifically limited.

30. Outpatient Hospital Services— With the exception of surgical services, services received at a participating SecurityBlue hospital for the diagnosis or treatment of an illness or injury. **Covered in full when authorized by SecurityBlue. Copayment applies if you are in the hospital for 24 to 72 hour observation or rapid treatment status, as these are not considered hospital admissions.**

31. Outpatient Surgery And Invasive Procedures— Outpatient surgical services. **Covered in full when pre-approved by SecurityBlue. Copayment may apply depending on plan.**

32. Physical Examinations— Annual physical examination. For members whose Medicare Part B coverage begins on or after January 1, 2005, and who have not already taken advantage of this benefit in another plan or Original Medicare: A one-time physical exam within six months of your first coverage under SecurityBlue. Includes measurement of height, weight and blood pressure; an electrocardiogram; education, counseling and referral with respect to covered screening and preventive services. **Covered in full after copayment per visit when performed by your PCP or Ob/Gyn. For members of the Value Plan, copayments are required for diagnostic tests when not performed as part of your one-time physical exam within six months of your first coverage under SecurityBlue.**

33. ***Podiatry—*** Services for the diagnosis and treatment of conditions involving the foot. Coverage is provided for those conditions covered by Medicare policy such as diabetes, peripheral neuropathy with loss of protective sensation and other circulatory disorders which can affect the lower limbs and feet. Routine foot care, for example, nail trimming, is covered only in the event a system disease (such as the conditions mentioned above) makes the service medically necessary. **Covered in full after copayment per visit.** Deluxe Plan members can receive eight visits each calendar year to a network podiatrist for routine foot care—covered in full after a copayment.

34. ***Post-Stabilization (Maintenance) Care—*** Medically necessary, non-emergency services needed to ensure that the member remains stabilized from the time the treating hospital requests authorization from Keystone Health Plan West, Inc. until the member is discharged from the hospital, a SecurityBlue participating physician arrives and assumes responsibility for the member's care, or the treating physician and SecurityBlue agree to another arrangement. **Covered in full.**

35. ***Preventive Health Services—***
Preventive health services, including bone mineral density screening, periodic health assessments, immunizations, PAP tests, and prostate cancer screenings, according to schedules approved by SecurityBlue. Also, coverage of screening blood tests for the early detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease), including tests for cholesterol and other lipid or triglyceride levels. **Covered in full after copayment per visit.**

36. ***Primary Care Physician And Specialist Office Visits—*** Medical and surgical care, including consultations, in a doctor's office, in the member's home or as an outpatient. This may include physicians' services, services and supplies incident to a physician's professional services, physician assistant services, nurse practitioner services and clinical nurse specialist services. **Covered in full after copayment per visit.**

37. ***Radiation Therapy—*** Radiation therapy services when pre-approved by SecurityBlue. **Covered in full.**

38. ***Rehabilitation Therapy Services—*** Rehabilitation therapy services provided by a hospital, skilled nursing facility, rehabilitation hospital or certified outpatient rehabilitation facility, including comprehensive outpatient rehabilitation facility services. Rehabilitation therapy covered services include:

a. Cardiac rehabilitation at an appropriate facility when the member (1) has a documented diagnosis of acute myocardial infarction within the preceding 12 months; (2) has had coronary bypass surgery; and/or (3) has stable angina pectoris;
b. Occupational therapy when provided by a licensed, Medicare-certified occupational therapist;
c. Physical therapy when provided by a licensed Medicare-certified physical therapist;
d. Speech therapy when provided by a licensed Medicare-certified speech therapist.

Inpatient services covered in full; outpatient services covered in full after a copayment per visit per type of therapy and when performed by an appropriately credentialed participating provider.

39. Respiratory Therapy— Respiratory therapy services provided by a licensed respiratory therapist on an inpatient or outpatient basis. **Inpatient services covered in full; outpatient services covered in full after a copayment per visit and when performed by an appropriately credentialed participating provider.**

40. Second Opinion Consultations— Second opinion by another SecurityBlue contracting provider. **Covered in full after copayment per consultation.**

41. Substance Abuse Treatment— Diagnosis and medical treatment, including detoxification, for the abuse of, or addiction to, alcohol and/or in an acute care hospital or substance abuse treatment facility. In addition, outpatient rehabilitative services for substance abuse are covered when determined to be medically necessary at a substance abuse treatment facility designated by SecurityBlue. Inpatient and outpatient benefits include:

a. detoxification;
b. lodging and dietary services;
c. diagnostic services, including psychiatric, psychological and medical laboratory tests;
d. services provided by a staff physician, psychologist, Registered or Licensed Practical Nurse and/or Certified Addictions Counselor;
e. rehabilitation therapy and counseling;
f. family counseling and intervention; and
g. drugs, medicines, supplies and use of equipment provided by a substance abuse treatment facility.

Covered in full after copayment per visit if outpatient service. Inpatient services covered in full after copayment per admission, when pre-approved by SecurityBlue.

42. ***Tobacco Cessation Counseling Programs --*** Members are eligible for two tobacco cessation attempts per calendar year. Each attempt may include a maximum of four intermediate or intensive sessions. The total number of sessions should not exceed eight sessions in a 12-month period. **Covered in full. Office visit copayment may apply.**

43. ***Vision Coverage—*** All SecurityBlue members are covered for *Medicare-covered* vision services and for *routine* vision care. Routine vision services are covered in full after a copayment per eye exam at participating Davis Vision providers and suppliers listed in the SecurityBlue *Provider Directory*. (More details about routine vision benefits and Davis Vision network providers are listed later in this section.) Or you can locate providers on our Web site at www.highmarkbcbs.com. You also may call Member Service at 1-800-935-2583 and select the "Blues On Call" option from the menu. Then choose the option to talk with a health coach. (TTY users may call 1-877-888-7834.) Routine services and supplies received from non-Davis Vision network providers and suppliers must be paid in full by you and will not be covered by SecurityBlue.

Routine Vision Care—

a. *Routine Eye Exam And Refraction—* You are eligible to receive one routine vision examination (eye examination with refraction) every calendar year, subject to a copayment. This examination includes: a case history; testing for visual acuity, near and far; external examination including pupils; refraction, subjective, objective; binocular vision testing when indicated; tonometry; slit lamp examination of anterior segment, fundus examination including dilation when indicated; assessment and plans.

b. *Eyeglass Frames—* You are eligible to receive one eyeglass frame every two calendar years. At many participating provider locations, you will have access to a collection of frames available as a paid-in-full option from the Davis Vision Tower collection of frames. If you prefer, a $60 allowance is available towards the purchase of any other frame at the participating Davis Vision provider location. Any pair of eyeglasses selected from the Davis Vision Tower collection will be covered by a one-year warranty against breakage.

c. *Contact Lens Exams*— In addition to coverage for a routine eye exam and refraction, your vision program also includes coverage for one contact lens evaluation and fitting every two calendar years. A contact lens evaluation and fitting is comprised of a keratometry or K reading; proper fitting of appropriate contact lenses, including the application of trial contact lenses to the patient's corneas; training of a new contact lens wearer; post-dispensing contact lens follow-up care, including the correction of any ill-fitting or unsuitable lenses. Davis Vision network providers will accept the program allowance as payment in full for the contact lens exam.

d. *Eyeglass Lenses Or Contact Lenses*— You are eligible to receive one pair of eyeglass lenses *or* contact lenses every two calendar years. Davis Vision network providers will accept the program allowance as payment in full when standard eyeglass lenses are selected. Standard lenses are single vision, bifocal, trifocal, aphakic and lenticular lenses. Non-standard lenses include, but are not limited to, polycarbonate lenses, occluder and balance lenses, prisms, special base curves and progressive no-line bifocals. If you choose non-standard lenses, you must pay 90% of the difference between the charge for standard lenses and the charge for non-standard lenses when you purchase the lenses. Instead of lenses for eyeglasses, you may elect to receive coverage for one pair of contact lenses every two calendar years. (You only may receive coverage for either eyeglass lenses or contact lenses in any two calendar year period.) You will receive full coverage for standard (hard or soft daily wear) contact lenses. Specialty contact lenses include, but are not limited to, hard or soft bifocal, toric, extended wear, gas permeable and disposable lenses. Specialty contact lenses priced up to $75 per pair are covered in full. Disposable contact lens wearers may purchase up to $75 worth of lenses within a two calendar year period. If you would like to purchase specialty contact lenses priced over $75, you must pay the difference between $75 and the charge.

e. *Limitations*— Benefits are limited to one pair of prescription eyeglass lenses *or* one pair of contact lenses, *and* one eyeglass frame, every two calendar years, when services are rendered by Davis Vision network providers. Routine eye exam and refractions are limited to one every calendar year. Contact lens exams are limited to one every two calendar years.

Non-Routine Vision Care—

Treatment for glaucoma, cataracts or other non-routine conditions affecting the eye are covered by SecurityBlue when a network specialist is used and it is medically necessary. See page 24 of this booklet for more details.

Routine cataract surgery includes the insertion of a conventional intraocular lens (IOL) prosthesis. In accordance with Medicare rules and regulations, you may request the insertion of a non-conventional IOL, called a presbyopia-correcting IOL. However, you will be financially responsible for payment of that portion of the charge for the presbyopia-correcting IOL and associated services that exceed the charge for insertion of a conventional IOL following cataract surgery. A single presbyopia-correcting IOL provides what would otherwise be achieved by two separate items: an implantable IOL that restores far vision, and eyeglasses or contact lenses that correct presbyopia.

Benefits For Cataract Surgery Patients—

SecurityBlue also provides benefits for cataract surgery patients. If you have had cataract surgery, the following services will be covered in full when you use providers and suppliers in the Davis Vision network:

1. Vision examinations and contact lens evaluation and fittings. One exam and one contact lens evaluation and fitting is eligible per operated eye, limit two per lifetime. Davis Vision network providers will accept the program allowance as payment in full for these services.

2. Standard prescription eyeglasses and contact lenses, limited to one pair of eyeglasses or contact lenses per operated eye. Plan coverage and limitations for eyeglass frames, eyeglass lenses and contact lenses would apply.

Promotional sales and discounts that are offered by your vision care professional may not be combined with your vision benefits available under SecurityBlue. Promotional offers include, but are not limited to, coupons, in-store discounts and sale items. You may choose to take advantage of a promotional offer instead of your SecurityBlue vision benefits. However, to effectively minimize your out-of-pocket expenses, you should ask your vision care professional to explain the cost savings between store promotions and your vision benefits.

SECTION 4
Summary Of Exclusions And Limitations

The following services and supplies are **not** covered by your SecurityBlue benefits plan:

1. Acupuncture.
2. Adaptive driving examinations
3. Any illness or injury eligible for, or covered by, any Federal, state or local government Workers' Compensation Act or Occupational Disease Law or other legislation of similar purpose.
4. Benefits and services not covered by Medicare unless specifically described as a covered service in this *Evidence of Coverage.*
5. Care for conditions that Federal, state or local law requires to be treated in a public facility.
6. Chiropractic services, except for manual manipulation to correct a subluxation of the spine when demonstrated by x-rays or other diagnostic tests obtained for diagnostic purposes.*
7. Christian Science practitioners' services.
8. Cosmetic surgery, unless it is needed because of prompt repair 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.
9. Court-ordered services when not medically necessary, as determined by the PCP.
10. Custodial care is not covered by SecurityBlue unless it is provided in conjunction with skilled nursing care and/or skilled rehabilitation services. "Custodial care" includes care that helps members in the activities of daily living, such as 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.
11. Dental care and dental services related to the care, treatment, removal or replacement of teeth or structures directly supporting the teeth, including dental implants, crowns, bridges and caps which are provided as the result of injury to sound natural teeth, except for routine dental benefits and oral surgery benefits as described in this *Evidence of Coverage* and inpatient hospital services related to such dental procedures that are covered when hospitalization is required because of the member's underlying medical condition, clinical status and the severity of the dental procedures.* Regardless of whether the inpatient hospital services are covered, the medical services of physicians furnished in connection with non-covered dental services are not covered. The services of an anesthesiologist, radiologist or pathologist whose services are performed in connection with the care, treatment, filling, removal or replacement of teeth or structures directly supporting teeth are not covered.

12. Durable medical equipment, prosthetic devices, supplies or footwear not covered by Medicare.
13. Emergency room services for non-authorized, routine conditions that do not appear to a prudent layperson to be based on an emergency medical condition, except for out-of-area urgently needed services or in extraordinary cases in which the SecurityBlue network is unavailable or inaccessible due to an unusual event.
14. Experimental/investigative procedures and items.
15. Eye surgery (radial keratotomy) to correct refraction errors, LASIK surgery, vision therapy and other low vision aids and services.
16. Homemaker services.
17. Hospice services in a Medicare-participating hospice are not covered under SecurityBlue, but are covered under Medicare when you enroll in a Medicare-certified hospice. SecurityBlue can assist you in locating a Medicare-participating hospice if you wish to elect such coverage. You may remain enrolled in SecurityBlue even though you have elected hospice coverage.
18. Immunizations for the purpose of travel.
19. Meals delivered to your home.
20. Naturopaths' services.
21. Nursing care on a full-time basis in your home.
22. Orthopedic shoes unless they are (1) part of a leg brace and are included in the orthopedist's charge; or (2) therapeutic shoes for those suffering from diabetic foot disease.
23. Personal convenience items in your home or room at a hospital or skilled nursing facility, including, but not limited to, telephones, televisions, air conditioners, humidifiers, barber or beauty services, guest services and similar incidental services and supplies which are not medically necessary.
24. Private duty nurses.
25. Private room in a hospital, unless medically necessary.
26. Remedial education, including services which are extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation or autism disabilities.
27. Routine examinations and preparation of reports or insurance forms for licensing, employment, pre-marital examinations, travel or other non-preventive care purposes.
28. Routine foot care, unless associated with disease affecting the lower limbs, such as diabetes, which requires care of a podiatrist or a physician.*
29. Services and items not reasonable and necessary for the diagnosis and treatment of the member's illness or injury, as determined by SecurityBlue

using Medicare standard guidelines and relying upon professionally recognized standards of practice.

30. Services not received from or prescribed by Keystone Health Plan West Medicare Advantage Network providers or SecurityBlue, except in the case of emergency and urgently needed care or out-of-area renal dialysis.
31. Services performed by immediate relatives or members of your household.
32. Services rendered prior to your beginning date of coverage or after the date your coverage terminates. Exception: If you are hospitalized at the time your disenrollment becomes effective, SecurityBlue will cover your Medicare Part A Hospital Insurance benefits until the date of discharge.
33. Services, supplies or charges for which a member would have no legal obligation to pay.
34. Reversal of sterilization procedures; sex change operations; and non-prescription contraceptive supplies and devices including voluntary sterilization; in vitro fertilization programs, the GIFT program, ZIFT program and any form of assisted fertilization, except for medically necessary services for infertility.
35. Smoking cessation aids or devices, such as the "patch."
36. Transportation services, unless medically necessary and necessitated by an emergency or authorized using Medicare guidelines by SecurityBlue. Non-emergent ambulance or other transportation services from outside the SecurityBlue service area back to the plan service area are not covered unless authorized in advance by SecurityBlue.
37. Travel oxygen services furnished by an airline.
38. Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law, including any medical benefits payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Act.
39. Vision training, subnormal vision aids, orthoptics and tonography.
40. Services provided to veterans in Veteran's Affairs (VA) facilities. The sole exception to this exclusion is that SecurityBlue will reimburse veteran members for the cost-sharing expenses assessed by the VA for emergency services. The cost sharing reimbursable by SecurityBlue is limited to the amount that SecurityBlue normally charges for emergency services under your SecurityBlue Plan.

* *Routine services covered by the Deluxe Plan are not excluded.*

SECTION 5
Support Services

Quality health care is more than helping you get better when you are sick or injured. It's also the many services that keep you informed and enlightened…that respond to your needs...and, most importantly, are designed to keep you healthy or help you lead a healthier lifestyle. As a SecurityBlue member, you enjoy all of these services and support.

SilverSneakers® Fitness Program Membership—

As a SecurityBlue member, you have access to a large network of fitness centers located throughout the SecurityBlue service area…*at no additional cost*. Each location offers different services, but at every location you'll find a friendly, safe environment where you can take part in a variety of exercise options through the SilverSneakers Fitness Program. It's a total health and fitness program designed just for Medicare beneficiaries...to improve your health and well-being no matter what your current fitness level may be. And if you live more than 15 miles from a participating fitness center, you can still take advantage of the SilverSneakers Steps self-directed walking and physical activity program. You can also take advantage of your membership while traveling or living temporarily outside of our service area by using participating facilities in your new location. You can locate participating SilverSneakers fitness centers by visiting www.silversneakers.com. See the separate SilverSneakers information you received for details or call Member Service at the number printed on your SecurityBlue membership card.

Member Newsletter—

Periodically, you will receive an informative newsletter featuring useful articles that can help you lead a healthier, more enjoyable life. Other important information about your SecurityBlue program is also included.

PALS People Able To Lend Support—

The PALS Program recruits and trains volunteers to lend a hand to others in the community who need help with everyday activities like grocery shopping, trips to the doctor, light meal preparation, running errands, or friendly phone calls and visits. Volunteers give the extra support a person may need to make everyday living a little easier and maintain their independence. In exchange for their time, PALS volunteers earn "service credits" which can be redeemed for help they may need at a later date or for items such as grocery store certificates. To volunteer to help or to request help, call PALS at 1-800-988-0706. TTY users, call 1-800-988-0668.

Advance Directives—

You have the right to make your own health care decisions. If you had an injury or illness so serious that you became unable to make these decisions for yourself, you might want the following to happen:

- You could have a particular person you trust make these decisions for you.
- You could let health care providers know the types of medical care you would want and not want if you were unable to make decisions for yourself.
- You could do both—appoint someone else to make decisions for you and let that person and your health care providers know the kinds of medical care you would want or not want if you were unable to make these decisions for yourself.

A legal form such as a "living will" or "power of health care attorney" can help you give directions in advance about your health care in case you become unable to speak for yourself or make your own health care decisions. These legal forms are often called an "advance directive."

It's your choice whether you fill out an advance directive. The law forbids any discrimination against you in your medical care based on whether you have or do not have an advance directive. However, it makes sense to have a legally binding document that allows you to keep control over whether your life will be prolonged by the use of artificial means. Your advance directive, if you wish, will allow you to authorize the withholding or withdrawal of treatment and procedures, such as artificial food and water (nutrition and hydration). You can change your advance directive at any time.

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 one and you believe that a doctor or a hospital has not followed the instructions in it, you may file a complaint by writing or calling the following agencies:

Complaints about Doctors:

Department of State
Bureau of Professional and
Occupational Affairs Complaints Office
P.O. Box 2649
Harrisburg, PA 17105-2649

1-800-822-2113

Complaints about Hospitals:

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

SecurityBlue members receive an advance directive form in their new member welcome kits. If you have questions about it or need an additional copy, please call Member Service at 1-800-935-2583, Monday through Sunday, between 8:00 a.m. and 8:00 p.m. TTY users, call 1-800-988-0668.

SECTION 6
Your Financial Liability As A SecurityBlue Member

Premiums And Other Financial Obligations

1. If you are enrolled in a SecurityBlue Plan that requires you to pay a premium, follow the instructions on your invoice. In general, your payments are due monthly or quarterly. If you pay by the quarter, your payment is due by the 1st day of the first month of each calendar year quarter. For example, payment for the second quarter of April-May-June is due by April 1. If you pay monthly, your payment is due by the 1st day of the month for which you are paying. If your monthly premium payment is automatically deducted from your checking account, it will be deducted on or about the 1st day of the month for which you are paying. For example, your payment for September coverage is due by September 1 if you receive a monthly bill. Your payment for September coverage will be deducted automatically from your checking account on or about September 1 if you have signed up for electronic bank payment of your monthly premium.

2. SecurityBlue has the right to disenroll you for failure to pay your SecurityBlue premiums. However, before such action is taken, we will: (a) contact you regarding the payment due, (b) advise you that failure to pay the premiums within a 60-day grace period will result in termination

of your SecurityBlue coverage, and (c) include an explanation of your rights under the SecurityBlue grievance procedures.

Nonpayment of SecurityBlue premiums will automatically return you to Original Medicare after the 60-day grace period has expired. Until you are notified of your disenrollment, you are still a SecurityBlue member and must continue to use SecurityBlue contracting providers.

For more details on disenrollment, please see Section 8, "Leaving the Plan," page 68.

3. Pay any applicable copayments or coinsurance amount at the time of service.

4. Continue to pay Medicare Part B Medical Insurance premiums.

5. If you are not covered under Medicare Part A Hospital Insurance, you must purchase Part A coverage from Social Security or the Railroad Retirement Board office.

6. Be responsible for paying for services not covered by Medicare or SecurityBlue.

Changes In SecurityBlue Premiums

Increases in premiums and/or decreases in the levels of coverage are only permitted at the beginning of each calendar year and must be approved by CMS and the Pennsylvania Insurance Department. Increases in the level of coverage or benefit enhancements are permitted mid-year. You will receive written notice well in advance of the effective date of any change.

Medicare Premiums

As a SecurityBlue member, you must continue to pay your Medicare Part B Medical Insurance premium and Medicare Part A Hospital Insurance premium, if applicable. If you receive a Social Security or Railroad Retirement Board annuity check, the Part B premium is automatically deducted from your check. Otherwise, your premium is paid directly to Medicare by you or someone on your behalf (such as the state Medicaid agency).

Medicare Savings Programs For People With Low Incomes

Financial help is available to low income Medicare beneficiaries through the Medicare Savings Programs. These programs are available to people who qualify for both Medicare and Medicaid, a joint Federal and state medical assistance program. If you qualify, the Medicare Savings Programs may cover all or part of your Original Medicare premiums, deductibles and coinsurance. For details about how to qualify for Medicaid and about the Medicare Savings Programs, call your local state medical assistance office. You can find this number in the phone book under Medicaid, Social Services, Medical Assistance, Human Services or Community Service. Or call 1-800-633-4227 (TTY users, call 1-877-486-2048) for help finding the right office.

Member Liability

Except for certain copayments, coinsurance amounts and other limitations as specified in this contract, the member is not liable for any charges for covered services when (a) such services have been authorized by SecurityBlue, (b) urgently needed services are incurred (see definition on page 97), (c) emergency care services are incurred (see definition on page 92), or (d) post-stabilization care services are incurred (see definition on page 37).

Direct Pay Members Only: You can have your SecurityBlue Plan premium automatically deducted from your monthly Social Security check. To select this option, call 1-800-935-2583, Monday through Sunday, between 8:00 a.m. and 8:00 p.m., and a Member Service Representative will assist you. Hearing-impaired TTY users, call 1-800-988-0668. If you choose to have your premium deducted from your monthly Social Security check, you must stay with this option for the remainder of the plan year. If you don't choose this option, we will send you your normal invoice which you can pay by mail or through "Pay-It-Easy," automatic premium payment or electronic funds transfer (EFT).

SECTION 7
Claims, Appeals And Grievance Procedures

What To Do When You Receive A Bill Or If You Have Paid For Covered Services

If you receive any emergency or urgently needed care from a provider that is not part of the Keystone Health Plan West Medicare Advantage Network, be sure to ask the provider or facility to file a claim for you. Tell them to send their claims directly to SecurityBlue at one of the following addresses:

Hospital or Other Facility Claim Filing Address:

Keystone Health Plan West, Inc./
SecurityBlue
P.O. Box 358
Pittsburgh, PA 15230-0358

Professional Provider Claim Filing Address:

SecurityBlue
P.O. Box 890170
Camp Hill, PA 17089-0170

Alternatively, you could ask the provider to file the claim with their local Blue Cross and/or Blue Shield Plan, if applicable.

If you receive a bill from any provider, do not pay it until you first call Member Service at 1-800-935-2583, Monday through Sunday, between 8:00 a.m. and 8:00 p.m. TTY users, call 1-800-988-0668. A claim may be in our files already. If not, SecurityBlue Member Service will contact the provider and ask them to file a claim on your behalf if the service is eligible for coverage.

If the provider won't file the claim for you, or if you have already paid the provider in full for his charges, you'll want to file a claim for reimbursement. Please submit your bill(s) for reimbursement to SecurityBlue at the following address:

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

When you submit your bill to SecurityBlue, be sure to include:

- Your full name and address
- Your SecurityBlue Membership Number (from your ID card)
- Your date of birth
- Your sex
- An explanation of services itemized on the bill

– A note indicating when you paid the bill.

To receive prompt reimbursement for covered services, submit your claim as soon as possible. The length of time you have to file a claim depends on when the services were received:

– To be eligible for payment, most claims must be filed before the end of the calendar year immediately following the calendar year in which the service or item was received. For example, for services received between January 1, 2007 and September 30, 2007, claims must be filed before the end of 2008.

– The only exception is for services or items received in the fourth quarter of a calendar year. Claims for these services must be filed before the end of the second following year. For example, for services received between October 1, 2007 and December 31, 2007, claims must be filed before the end of 2009.

Important Note: For services received at non-contracted facilities or by non-contracted providers, SecurityBlue will reimburse you the Medicare-approved amount minus any applicable copayment or coinsurance.

Coordination Of Benefits

If you are covered under another insurance carrier's program in addition to SecurityBlue, duplicate coverage exists. If you have duplicate coverage, it must be determined which insurance company has primary liability—that is, which coverage will pay first for your eligible medical services. The process of determining this is called "coordination of benefits."

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

A special rule applies if you have or develop End Stage Renal Disease (ESRD) and you are covered under an employer group plan. In this case you must use the benefits of that plan for the first 30 months after becoming eligible for Medicare as a result of ESRD. Medicare is the primary payer after this coordination period. (However, if your employer group plan coverage was secondary to Medicare when you developed

ESRD because it was not based on current employment as described above, then Medicare continues to be the primary payer.)

If any no-fault liability insurance (or payment from a liable third party) is available to you, then benefits under that plan or from that third party must be applied to the costs of health care covered by SecurityBlue. When SecurityBlue has provided benefits and a judgment or settlement is made with a no-fault or liability insurer (or liable third party), you must reimburse SecurityBlue. However, our reimbursement may be reduced by a share of procurement costs (e.g., attorney fees and costs). Workers' compensation for treatment of work-related illness or injury should also pay first for eligible medical services. Because of this, we may ask you for information about other insurance you may have. If you have other insurance, you can help us obtain payment from the other insurer by promptly providing the information we request. Coordination of benefits protects you from higher premiums and helps to keep the cost of health care affordable.

Coordination Of Benefits With TRICARE For Life

To be eligible for TRICARE for Life, you must be a military retiree and/or dependent and have Medicare Parts A and B. TRICARE for Life covers out-of-pocket expenses for beneficiaries enrolled in a Medicare Advantage Organization such as Keystone Health Plan West, Inc., including copayments, deductibles and coinsurance (if applicable). Plan premiums are not covered.

If you are a SecurityBlue member who is also eligible for TRICARE for Life, you are responsible for paying the SecurityBlue out-of-pocket expenses at the time you receive the service. Then you should request reimbursement from the United States Department of Defense, the administrator of the TRICARE for Life program.

Subrogation

Subrogation means that if you incur health care expenses for injuries due to an accident caused by another person or organization, the person or organization causing the accident is responsible for paying these expenses.

As a SecurityBlue member, if you incur health expenses for injuries due to an accident caused by another person or organization, SecurityBlue has the right, through subrogation, to seek repayment from the other person or his/her insurance company for benefits paid.

SecurityBlue will provide eligible benefits when needed, but you may be asked to show documents or take other necessary actions to support SecurityBlue's subrogation efforts. Subrogation does not apply to an individual insurance policy you may have purchased for yourself or your dependents or where subrogation is specifically prohibited by law.

You Have A Right To Appeal Service Denials And Service Terminations

Note: Separate appeals and grievance procedures related to your Medicare Prescription Drug Coverage are found in the *Addendum to the Evidence of Coverage*.

As a SecurityBlue member, you have the right to appeal a decision you do not agree with made by SecurityBlue about your medical bills or health care.

You have the right to appeal if you believe:

- SecurityBlue has not paid a bill.
- SecurityBlue has not paid a bill in full.
- SecurityBlue will not approve or give you care it should cover.
- SecurityBlue is stopping care you still need.

SecurityBlue normally has 30-60 days to process your appeal. (Please see standard appeals procedure on the following pages.) In some cases, you have a right to a fast, 72-hour appeal decision if your health or ability to function could be seriously harmed by waiting the normal time frame for a standard appeal. If you ask for a fast appeal, SecurityBlue will decide whether or not you may have a fast, 72-hour decision. If you are denied a fast decision, your appeal will be processed in the standard 30 days. If any doctor asks SecurityBlue to give you a fast, 72-hour appeal or supports your request for a fast decision, we must give it to you.

If you disagree with the SecurityBlue decision to not process your appeal within 72 hours, you have the right to file a grievance. Also, you may resubmit your request for a 72-hour appeal with a physician's support.

Medicare Appeals Procedure

SecurityBlue provides a Medicare appeals procedure for all of its members. As a member of SecurityBlue, you have the right to appeal any decision about payment by SecurityBlue for, or failure of SecurityBlue to provide, what you believe are services covered by Original Medicare. You may appeal for:

1. Payment for emergency services, post-stabilization care or urgently needed care.
2. Any other health services furnished or denied that you believe are covered by Medicare and should have been furnished, including a delay in providing, arranging for, or approving health care services.
3. Reduction or termination of services you feel are medically necessary covered services.
4. The denial of claims or services that are included in the Value, Standard or Deluxe Plans.

You can have a friend, lawyer or someone else help you. There are groups that can help you find a lawyer or give you free legal services if you qualify. There are groups such as lawyer referral services that can help you find a lawyer. Some lawyers do not charge unless you win your appeal. There are also groups such as legal aid services who will give you free legal services if you qualify.

The Medicare Standard Appeals Procedure For Claim Denials Is As Follows—

1. Within 60 days of receipt of a request for payment, SecurityBlue will notify you of our decision. This notice will be in writing and will state the reasons for the decision. If the decision is a denial (partial or complete), SecurityBlue will state the reason for the denial, and will advise you of your right to request a reconsideration under the Medicare appeals process. If you have not received notice within 60 days, you may assume that your claim has been denied, and file for a reconsideration.

2. The initial determination rendered by SecurityBlue will be final and binding unless you request, in writing, a reconsideration within 180 days from the date of notice of the initial determination. You must submit this request within 180 days of the date of the notice of the initial decision from SecurityBlue. You may submit additional evidence in person or in writing.

3. A reconsideration decision will be reached by SecurityBlue based upon a review of the initial determination and any new evidence available. The reconsideration decision will be made by a person or persons not involved in making the initial determination.

4. If the initial determination is reversed by SecurityBlue, a written notice of favorable determination will be sent to you within 60 days of the date your reconsideration request was received.

5. If the reconsideration decision upholds wholly or partially the original decision which is unfavorable to you, SecurityBlue will forward within 60 days a written explanation of the decision to Maximus Federal Services and you will be notified that your request for reconsideration has been forwarded to Maximus Federal Services.

6. Maximus Federal Services will review the information provided and request any additional documentation needed from either you or SecurityBlue. They will send a written notice of their decision to you and SecurityBlue. If the decision is not favorable and the amount in question is $100 or more, Maximus Federal Services will inform you of your right to a hearing before an administrative law judge of the Social Security Administration. If the decision is in favor of the member, SecurityBlue must make payment within 30 calendar days for claims. We must authorize the service in dispute within 72 hours from the date we receive Maximus Federal Services' notice reversing our decision, or provide the service under dispute as expeditiously as your health condition requires, but no later than 14 calendar days from the date of Maximus Federal Services' notice.

7. A request for a hearing before an administrative law judge of the Social Security Administration must be filed in writing within 60 days from the date of the notice of the reconsideration determination.

8. The administrative law judge's decision can be reviewed by the Appeals Council of the Social Security Administration, either by its own action or as the result of a request from you or SecurityBlue.

9. If the amount involved is $1,050 or more, either you or SecurityBlue may request that a decision made by the Appeals Council or administrative law judge be reviewed by a Federal district court.

10. An initial, revised or reconsidered determination made by SecurityBlue, Maximus Federal Services, an administrative law judge or the Appeals Council may be reopened for any reason within 12 months, within four years for just cause, or at any time for clerical correction or in cases of fraud.

The Medicare Standard Appeals Procedure For Pre-Service Denials Is As Follows—

11. Within 14 days of receipt of a request for payment or provision of service, SecurityBlue will notify you of our decision. An extension of 14 calendar days is allowable if you or your representative need extra time to provide information to support your case, or if SecurityBlue needs additional time (such as to perform additional testing or obtain medical consultation). This notice will be in writing and will state the reasons for the decision. If the decision is a denial (partial or complete), SecurityBlue will state the reason for the denial, and will advise you of the right to request a reconsideration under the Medicare Appeals Process. If you have not received a notice within 14 days (or following the 14-calendar-day extension), you may assume the decision is negative and file for a reconsideration.

12. The initial determination rendered by SecurityBlue will be final and binding unless you request, in writing, a reconsideration within 180 days from the date of notice of the initial determination. You may submit additional evidence in person or in writing.

13. A reconsideration decision will be reached by SecurityBlue based upon a review of the initial determination and any new evidence available. The reconsideration decision will be made by a person or persons not involved in making the initial determination. Lack of medical necessity review must be made by a physician with appropriate expertise in the field of medicine appropriate for the service at issue.

14. If the initial determination is reversed by SecurityBlue, a written notice of favorable determination will be sent to you within 30 days of the date your reconsideration request is received. An extension of 14 calendar days is allowable if you or your representative need extra time to provide information to support your case, if medical records are needed from a non-participating provider, or if SecurityBlue needs additional time (such as to perform additional testing or obtain medical consultation). You may file a grievance with SecurityBlue if you disagree with the 14-calendar-day extension.

15. If the reconsideration decision upholds wholly or partially the original decision which is unfavorable to you, SecurityBlue will forward within 30 days a written explanation of the decision to Maximus Federal Services

and you will be notified that the request for reconsideration has been forwarded to Maximus Federal Services.

16. When a Maximus Federal Services decision is received, steps six through 10 will be followed.

To file either type of standard appeal mentioned above (claim denials and pre-service denials), do the following:

1. File your request in writing with SecurityBlue by mailing it to the following address:
Keystone Health Plan West, Inc./SecurityBlue
Appeals Department
P.O. Box 535047
Pittsburgh, PA 15253-5047

2. You may FAX your request to 1-412-544-1513, Attention: Appeals Dept.

3. You may hand deliver your request between 8:30 a.m. and 4:30 p.m., Monday through Friday, to one of the following Highmark Blue Cross Blue Shield Servicenters:
Erie Servicenter
717 State Street
Erie, PA 16501

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

Johnstown Servicenter
One Pasquerilla Square
Johnstown, PA 15901

4. File your request within 180 days of the date of notice of the initial decision you receive from Keystone Health Plan West, Inc./SecurityBlue, and be sure to include this date on your request.

5. Please also refer to the following sections which apply to both the standard appeal and the fast, 72-hour appeal: "Support for Your Appeal," "Who May File an Appeal," "Help with Your Appeal," and "Quality Improvement Organization Complaint Process."

Fast, 72-Hour Medicare Appeal Process

(This appeal process does not apply to claim denials. See the standard appeal process in the preceding section for information on how to appeal claim denials.)

1. ***Expedited Determinations—*** If you believe you need a service—but your health could be jeopardized by waiting 14 calendar days for a decision—you may request that the decision be expedited. If SecurityBlue decides that the time frame for the standard process could seriously jeopardize your life, health or ability to regain maximum functioning, the review of your request will be expedited. In these cases, the health plan will notify you of its decision within 72 hours of your request.

2. ***Expedited Reconsiderations—*** If you want to appeal a service denial by your doctor or health plan, or appeal a decision to discontinue a service you believe you need—and if your health could be seriously jeopardized by waiting 30 days for a standard reconsideration described earlier in this section—you may request an expedited appeal. If SecurityBlue decides that the time frame for the standard reconsideration process could seriously jeopardize your life, health or ability to regain maximum functioning, the appeal will be expedited. In these cases, SecurityBlue will notify you of its decision within 72 hours of your request. If you disagree with a decision to discharge you from the hospital, see that section on page 63.

3. ***To Request An Expedited Determination Or Reconsideration, Follow These Instructions For Oral And Written Requests—***

A. You may file an oral or written request for a fast, 72-hour decision. You should state one of the following:

– *"I want an expedited decision."*
– *"I want a fast, 72-hour decision."*
– *"I believe that my health could be seriously harmed by waiting the standard 14 days for a decision."*

B. You may file your oral request by calling 1-800-485-9610. TTY users, call 1-888-422-1226. Keystone Health Plan West, Inc./SecurityBlue will document your oral request in writing.

C. You may hand deliver your written request between 8:30 a.m. and 4:30 p.m., Monday through Friday, to one of the following Highmark Blue Cross Blue Shield Servicenters:

Erie Servicenter
717 State Street
Erie, PA 16501

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

Johnstown Servicenter
One Pasquerilla Square
Johnstown, PA 15901

D. You may FAX your written request to1-800-894-7947. If you are in a hospital or nursing facility, you may ask for help in having your written request for a service transmitted by fax machine to Keystone Health Plan West, Inc./SecurityBlue.

E. You may mail your written request to following address. Please note that the 72-hour review time does not begin until your request is received at our office:

Keystone Health Plan West, Inc./SecurityBlue
Expedited Review Department
P.O. Box 535073
Pittsburgh, PA 15253-5073

F. At any time during the review process, if you want to submit additional evidence supporting your position, you may use the same channels, i.e., you may call, fax, hand deliver or mail supporting evidence, using the procedures outlined above. Keystone Health Plan West, Inc./SecurityBlue will make a

decision about your request for a service and notify you of the decision within 72 hours after receiving your request.

4. **If a doctor requests or supports your request that the process be expedited,** then the plan must automatically expedite the review. No further proof of urgency is needed.

5. **If SecurityBlue decides that your request is not time-sensitive,** it will automatically begin processing your request under standard procedures. If you disagree and believe the review should be expedited, you may file an expedited grievance with SecurityBlue or resubmit a request for an expedited review with your physician's support.

6. **If you or your representative needs extra time** to provide information to support your case, if medical records are needed from a non-participating provider, or if SecurityBlue needs additional time (such as to perform additional testing or obtain medical consultation), an extension of up to 14 calendar days is allowable. If you disagree with this extension, you may file an expedited grievance with SecurityBlue.

Reconsidered Determinations Or Decisions

a). *Reversals By SecurityBlue*

1. ***Requests For Service—*** Upon reconsideration of a request for service, if SecurityBlue completely reverses its determination, then SecurityBlue must authorize or provide the service as expeditiously as the member's health condition requires, but no later than 30 calendar days after the date SecurityBlue receives the request for reconsideration.

2. ***Requests For Payment—*** Upon reconsideration of a request for payment, if SecurityBlue completely reverses its determination, then SecurityBlue must pay for the service no later than 60 calendar days after the date SecurityBlue receives the request for reconsideration.

b.) *Reversals By Other Than SecurityBlue*

If the SecurityBlue determination is reversed in whole or in part by Maximus Federal Services, then SecurityBlue must pay for, authorize or provide the service under dispute as expeditiously as the member's health condition requires, but no later than 30 calendar days from the date it receives notice reversing the determination for claim payment, or authorize/provide the service within 72 hours, but no later than 14 days for standard pre-service denials and 72 hours for expedited pre-service denials. For higher levels of appeal, SecurityBlue must authorize or provide the service under dispute as expeditiously as the member's health condition requires, but no later than 60 days from the date it receives notice reversing the determination. SecurityBlue also must inform the independent outside entity that it has carried out the decision.

The Following Information Applies To Both The Standard Appeal And 72-Hour Appeal

Support For Your Appeal—

You are not required to submit additional information to support your request for services or payment for services already received. Keystone Health Plan West, Inc./SecurityBlue is responsible for gathering all necessary medical information. However, it may be helpful to you to include additional information to clarify or support your position. For example, you may want to include in your appeal request information such as medical records or physician opinions in support of your appeal. To obtain medical records, send a written request to your physician.

If you want to submit additional evidence supporting your position, you may use the same procedures outlined in previous sections; that is, you may call, fax, hand deliver or mail the additional information to us at the numbers and addresses listed earlier.

Who May File An Appeal—

1. You may file an appeal.

2. You may choose someone to file an appeal for you:
   a) Give us your name, your Medicare number, and a statement which appoints an individual as your representative. (You may appoint any provider as your representative.) For example, state, "I (your name) appoint (name of representative) to act as my representative in requesting an appeal from Keystone Health Plan West,

Inc./SecurityBlue and/or CMS regarding Keystone Health Plan West, Inc./SecurityBlue's (denial of services or denial of payment for services).

b) You must sign and date the statement.
c) Your representative also must sign and date the statement unless he/she is an attorney.
d) Include this signed statement with your appeal.
e) For 72-hour appeals, a written statement is not required if you are appointing a physician as your representative.

3. A provider who is not participating in the SecurityBlue provider network may file a standard 60-day appeal of a denied claim if he/she completes a waiver of liability statement which says that he/she will not bill you regardless of the outcome of the appeal.
4. A court-appointed guardian or an agent under a health care proxy, to the extent provided under state law, may file an appeal for you.

Help With Your Appeal—

If you decide to appeal and want help with your appeal, you may have your doctor, lawyer, a friend or someone else help you. There also are groups that can help you. You may want to contact the Pennsylvania Department of Aging, APPRISE Health Insurance Counseling Program, at 1-800-783-7067, Monday through Friday, 9:00 a.m. to 4:00 p.m. Or call the Medicare Rights Center toll-free at 1-888-HMO-9050.

Hospital Discharges

When you are first admitted to the hospital, you will receive a booklet entitled "An Important Message From Medicare." Please read this document carefully. It will describe your rights if you believe you are being asked to leave the hospital too soon. If you believe you are being discharged too soon, ask the hospital or SecurityBlue for a written notice of explanation immediately, if you have not already received one. This notice is called a Notice of Discharge and Medicare Appeal Rights. You must have this if you wish to exercise your right to request a review by a Quality Improvement Organization. You do not have to pay for your hospital care until the Quality Improvement Organization makes its decision if you request the review by noon of the first workday after you receive the Notice of Discharge and Medicare Appeal Rights.

As a Medicare beneficiary, you have the right to receive all the hospital care that is necessary for the proper diagnosis and treatment of your illness or injury. You also

have the right to complain about the quality of medical services provided by SecurityBlue that do not meet professionally recognized standards of care by writing to the Quality Improvement Organization. The organization must review the complaint and inform you or your representative of the results of the investigation. They can provide information about its review time frames and the steps involved in the process.

The Quality Improvement Organization in your area is:

Quality Insights of Pennsylvania (QIP)
2601 Market Place Street, Suite 320
Harrisburg, PA 17110
1-800-322-1914

If you ask for immediate review by the Quality Improvement Organization, you will be entitled to this process instead of the Medicare appeals process. You can only use the Medicare appeals process if you fail to exercise your right to immediate review by the Quality Improvement Organization within the required period of time.

Skilled Nursing Facility, Home Health Or Certified Outpatient Rehabilitation Facility Discharges

If we decide to end our coverage for your skilled nursing facility (SNF) or certified outpatient rehabilitation facility (CORF) services, you will receive written notice from your provider at least two calendar days in advance of our ending our coverage. If we decide to end our coverage for your home health service, you will receive written notice from your provider no later than your next to the last visit at which home health services are provided. This notice is called the Notice of Medicare Non-Coverage. You (or someone you authorize) may be asked to sign and date this document, to show that you received the Notice of Medicare Non-Coverage.

As a Medicare beneficiary, you have the right to receive all the SNF, home health or CORF care that is necessary for the proper diagnosis and treatment of your illness or injury. You also have the right to ask for an appeal of our termination of your coverage by notifying the Quality Improvement Organization (QIO) in your area. See page 67 for your QIO's address and phone number.

If you want to appeal the termination of your coverage, you must make your request to the QIO no later than noon of the day after you received the Notice of Medicare Non-Coverage from your provider. The QIO will then notify SecurityBlue that you have requested an appeal. SecurityBlue must then issue a Detailed Explanation of

Non-Coverage to both of you and the QIO no later than the close of business the day SecurityBlue is notified by the QIO of your request.

The QIO must review the request and inform you or your authorized representative of the results of the investigation. If the QIO agrees with SecurityBlue's decision, you will be financially responsible for paying the SNF, home health or CORF charges after the termination date on the Notice of Medicare Non-Coverage you received from your provider. If the QIO agrees with you, then we will continue to cover your SNF, home health or CORF services for as long as medically necessary.

If you fail to exercise your right to an immediate review by the QIO within the required period of time, you may request an expedited appeal. Please refer to page 67 for more details on filing an expedited appeal.

If you ask for immediate review by the QIO, you will be entitled to this process instead of the Medicare appeals process. You can only use the Medicare appeals process if you fail to exercise your right to immediate review by the QIO within the required period of time.

SecurityBlue Grievance Procedure

If you have a complaint about your medical care, delivery of service, denial of a claim or service, or any other aspect of your SecurityBlue coverage, please call a Member Service Representative at 1-800-935-2583, Monday through Sunday, between 8:00 a.m. and 8:00 p.m. TTY users, call 1-800-988-0668. We'll try to resolve it to your satisfaction.

SecurityBlue grievance procedures are designed to resolve disputes you may have with network physicians or SecurityBlue regarding plan/benefits design, the delivery of services, the operation of SecurityBlue or the terms of this *Evidence of Coverage*, including the breach or termination of this *Evidence of Coverage*.

The SecurityBlue Standard Grievance Procedure Is As Follows—

The standard grievance procedures are used in the following instances:

a. Complaints regarding such issues as waiting times, physician behavior and demeanor, adequacy of facilities and other similar member concerns.

b. Involuntary disenrollment situations (though disenrollment for cause requires prior CMS approval).

c. Any other complaints not involving the denial of claims or services, as these situations will be handled through the Medicare appeals process.

1. Your initial inquiry should be directed to the SecurityBlue Member Service Department. If you are dissatisfied with the response to your inquiry, you can ask for a First Level Complaint Review. Presentation of your written complaint for review should be made within 180 days from the date you receive an adverse decision. Your written complaint may include written information from you or any other party of interest. Accommodations will be made for those members who cannot submit their requests in writing. Send your written grievance to:

   Keystone Health Plan West, Inc./SecurityBlue
   Appeals Department
   P.O. Box 535047
   Pittsburgh, PA 15253-5047
   Fax #: 1-412-544-1513

2. Keystone Health Plan West, Inc./SecurityBlue will review your written complaint. For complaints regarding such issues as waiting times, physician behavior and demeanor, quality of care, adequacy of facilities and other similar member concerns, Keystone Health Plan West, Inc./SecurityBlue will take the appropriate steps to investigate your complaint. These steps may include, but are not limited to, investigation with the provider, a review of the medical records or ongoing provider monitoring. Keystone Health Plan West, Inc./SecurityBlue will respond in writing within 30 days.

3. Complaints that do not involve providers or general dissatisfaction with the health plan will be forwarded to the First Level Complaint Committee for review. Examples of such complaints may include, but are not limited to, involuntary disenrollment situations or requests for premium reimbursement. You will receive a response from the First Level Complaint Committee in writing within 30 days. If you are dissatisfied with the response to your complaint, you may request to have the decision reviewed by a Second Level Complaint Committee. The request to have the decision reviewed must be submitted in writing within 45 days from the date the adverse decision is received and may include any written supporting material from you or any party of interest.

4. The Second Level Complaint Committee is comprised of three individuals who did not participate in the initial reviews. At least one Committee member will not be a Keystone Health Plan West, Inc./SecurityBlue employee. The Committee will hold an informal hearing to consider your complaint. When arranging the hearing, Keystone Health Plan West, Inc./SecurityBlue will notify you in writing of the hearing procedures and your rights at the hearing, including your right to appear before the committee. The hearing will be held within 30 days of the Committee's receipt of your request for review. The Committee will provide written notification of the decision within five business days of the hearing. The notification will specify the reasons for the decision.

   The decision of the Second Level Complaint Committee will be binding.

5. For further information regarding the purposes and operations of the grievance procedure, contact SecurityBlue Member Service at the number printed on your membership card.

The SecurityBlue Expedited Grievance Procedure Is As Follows—

The expedited grievance procedures are used in the following instances:

a. If you disagree with SecurityBlue invoking a 14-day extension on either an initial determination or a reconsideration.

b. If you disagree with the decision made by SecurityBlue not to grant you an expedited initial determination or reconsideration.

Your initial inquiry should be directed to the SecurityBlue Member Service Department.

1. You may file this request either orally or in writing. Your complaint may include information from you or any other party of interest. Accommodations will be made for those members who cannot submit their requests.

2. SecurityBlue will review your grievance and take the appropriate steps to investigate your complaint. SecurityBlue will respond in writing within

24 hours from the date the SecurityBlue Grievance Department receives your complaint.

If You Have A Complaint About Quality, Follow These Procedures

Quality Improvement Organization Complaint Process—

If you are concerned about the quality of the care you have received, you may file a complaint with the local Quality Improvement Organization (QIO):

Quality Insights of Pennsylvania (QIP)
2601 Market Place Street, Suite 320
Harrisburg, PA 17110
1-800-322-1914

Quality Improvement Organizations are groups of doctors and health professionals who monitor the quality of care provided to Medicare beneficiaries. The QIO review process is designed to help stop any improper practices.

SecurityBlue Quality Complaint Process—

You also may file a quality complaint directly with SecurityBlue. Please follow the grievance procedure given in this section of this booklet. SecurityBlue will review your complaint and notify you in writing of its investigation. If you need more information about the grievance procedure, call a SecurityBlue Member Service Representative at 1-800-935-2583, Monday through Sunday, between 8:00 a.m. and 8:00 p.m. TTY users, call 1-800-988-0668.

SECTION 8
Leaving The Plan

Moves Or Extended Absences From The Service Area

If you *permanently* move or will be absent from your SecurityBlue service area of record (see Section 12, Appendix D for your service area) for *more than six months in a row*, you must call SecurityBlue Member Service before you leave. Call Monday through Sunday, between 8:00 a.m. and 8:00 p.m., at 1-800-935-2583 (TTY users, please call 1-800-988-0668). A Member Service Representative will help you disenroll from SecurityBlue.

If you are *permanently* moving or plan an extended absence of more than six months in a row from your SecurityBlue service area of record to live in one of the other western Pennsylvania counties where SecurityBlue is offered, and you want to remain a SecurityBlue member, you must change your enrollment to your new county of residence and pay the SecurityBlue Plan premium for that service area. If you do not change, you will be disenrolled from SecurityBlue. Please call a Member Service Representative for help *before* you move. Call 1-800-935-2583, Monday through Sunday, between 8:00 a.m. and 8:00 p.m. (TTY users, please call 1-800-988-0668).

If you are planning to travel or be away from your SecurityBlue service area of record (see Section 12, Appendix D on page 98 for your service area) for *up to six months in a row*, you must call SecurityBlue Member Service *before you leave* **and** *when you return home*. **This is to ensure that you understand what services will be covered by SecurityBlue while you are temporarily away. It will also ensure that once you return, you are not disenrolled from SecurityBlue for remaining outside the service area longer than six months**. Call Monday through Sunday, between 8:00 a.m. and 8:00 p.m., at 1-800-935-2583 (TTY users, please call 1-800-988-0668).

While you are traveling for up to six months in a row outside the SecurityBlue service area, SecurityBlue will cover emergency care, urgent care and renal dialysis treatment. Neither SecurityBlue nor Medicare will pay for any other services not provided or authorized by SecurityBlue while you are outside the service area.

If you fail to notify SecurityBlue of an extended absence or a permanent move, you may be responsible for paying for services you receive while out of the service area. **That is, if you leave the SecurityBlue service area for more than six consecutive months and do not notify SecurityBlue and/or do not disenroll, you are still a member of SecurityBlue and you must continue to obtain all covered services through SecurityBlue.**

Voluntary Disenrollment

You may end your membership in SecurityBlue for any reason. All you need to do is send a signed letter to SecurityBlue at this address:

SecurityBlue Enrollment Department
P.O. Box 535049
Pittsburgh, PA 15253-5049

You may also end your SecurityBlue membership by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Medicare Customer Service Representatives are available 24 hours a day, seven days a week.

For direct payment members, in general, your disenrollment from SecurityBlue will be effective the first day of the month after the month your completed written request to disenroll is received by SecurityBlue/Keystone Health Plan West, Inc. For example, if SecurityBlue receives your completed request to disenroll on February 28, your disenrollment will be effective on March 1. It is important to clearly state in your letter that you want to disenroll. We also ask that you include your member ID number as well as the reason you are disenrolling. Your letter must be signed. If you are married and both you and your spouse wish to disenroll, you can send in one letter, but both of you must sign.

There is one exception to this general rule. If we receive your written request to leave the plan between November 15 and November 30, your disenrollment will be effective January 1.

Leaving SecurityBlue And Your Choices For Continuing Medicare After You Leave

What are your choices for continuing Medicare if you leave the *SecurityBlue Standard Plan or Deluxe Plan:*

- If you leave the SecurityBlue Standard Plan or the SecurityBlue Deluxe Plan, one choice for continuing with Medicare is to join a **Medicare Advantage 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 the **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 **Medicare 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, 2007 and March 31, 2007 (see "When and how often can you change your Medicare choices?" on the next page), you may be required to join one of these plans if you join Original Medicare.

– **Other Medicare Advantage Plans** (including HMOs such as SecurityBlue 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 provider 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 prescription drugs, as part of the Medicare Part D (Prescription Drug) benefit.

– **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 pays and what you pay—for the services you will get. You may pay more for Medicare-covered benefits. You may get extra benefits that Original Medicare does not cover, like prescription drugs, as part of the Medicare Part D (Prescription Drug) benefit. (See "When and how often can you change your Medicare choices?") Private Fee-for-Service plans are *not* the same as Medigap (Medicare supplement insurance) policies.

What are your choices for continuing Medicare if you leave the *SecurityBlue Value Plan?*

If you leave the SecurityBlue Value Plan, one choice for continuing with Medicare is to join another **Medicare Advantage Plan** or a **Medicare Private Fee-for-Service plan** *if* any of these types of plans are available in your area, and are accepting new members. You can also choose to go to **Original Medicare**.

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

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, 2006 through December 31, 2006, anyone with Medicare will have an opportunity to switch from one way of getting Medicare to another.
2. From January 1, 2007 through March 31, 2007, anyone with Medicare has another chance to make one change in the way they get Medicare.

   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 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 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 information. Later in the year, from November 15, 2007 through December 31, 2007, anyone with Medicare can switch their way of getting Medicare to another way for the following year.

   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.

If you are a member of an employer group plan, follow the disenrollment guidelines of your former employer or trust fund regarding open enrollment or special election periods.

Remember: You are still a SecurityBlue member until the effective date of your disenrollment and you must obtain all covered services through SecurityBlue. Neither SecurityBlue nor Medicare will pay for services that are not provided or authorized by SecurityBlue, except for emergency care, urgently needed care or out-of-area renal dialysis services. You will receive written confirmation of your disenrollment from SecurityBlue.

Involuntary Disenrollment

SecurityBlue may end your coverage for any of the following reasons:

1. If you permanently move out of your SecurityBlue service area of record and do not voluntarily disenroll. A permanent move means an uninterrupted absence of more than six months in a row from the service area. You are required to notify SecurityBlue if you are moving out of the service area.

2. If you lose your entitlement to Medicare Part A Hospital Insurance.

3. If you fail to pay your Medicare Part B Medical Insurance premiums.

4. If you fail to pay your plan premiums to SecurityBlue within the 60-day grace period.

5. If you supply fraudulent information or misrepresentation on the membership application form which materially affects your eligibility to enroll in SecurityBlue.

6. If you knowingly permit abuse or misuse of the SecurityBlue membership (identification) card, including the use of your membership card by another person to obtain services.

7. If you are disruptive, abusive, unruly or uncooperative to the extent that SecurityBlue's ability to provide services is impaired. Termination for this reason is subject to the review and pre-approval of Medicare (CMS).

8. If the contract between Keystone Health Plan West, Inc. and CMS is not renewed by either party. In either case, you would receive written notice at least 90 days before the end of the contract. The notice would describe the alternatives available to you for obtaining Medicare services within your service area, including alternative Medicare Advantage Plans, Medicare supplement plan options, and Original (regular) Medicare.

9. If the contract between Keystone Health Plan West, Inc. and CMS is terminated by CMS. You would receive written notice by mail at least 30 days before the end of the contract.

10. If the contract between Keystone Health Plan West, Inc. and CMS is terminated by SecurityBlue. You would receive notice at least 60 days before the end of the contract. The notice would describe the alternatives available to you for obtaining Medicare services within your service area,

including alternative Medicare Advantage Plans, Medicare supplement plan options, and Original Medicare.

If your enrollment in SecurityBlue is terminated for any of the above reasons, you will be notified in writing by SecurityBlue of the reason for the termination as well as your right to appeal the termination through the SecurityBlue grievance procedure. If you fail to make any required premium payment to CMS (Medicare Part B), you do not have the right to appeal. If you are automatically terminated for loss of Medicare Part A or Part B, you should contact your local Social Security office if you believe this is an error. The termination will become effective on the first day of the month specified in the termination notice. Until you are notified in writing that a disenrollment is effective, you are a member of SecurityBlue and you must continue to obtain all covered services through SecurityBlue until the effective date of disenrollment. No member will be terminated from enrollment due to health status or for any other reason than stated above.

Conversion

When your coverage with SecurityBlue is ended, you will have the option of enrolling in a Medicare supplement insurance policy (also called Medigap coverage). If this is the first time you ever joined a Medicare Advantage Plan or a Medicare managed care plan, and if your disenrollment from SecurityBlue is within 12 months of your effective date of enrolling in SecurityBlue, then you are guaranteed the right to buy any Medigap coverage you had before your enrollment in SecurityBlue, if that policy is still sold by the same insurance company in Pennsylvania. If your previous policy is no longer available, you are still guaranteed the right to buy a Medigap policy designated Plan A, B, C or F that is offered in Pennsylvania. You have 63 days after your last day of coverage under SecurityBlue to apply for a Medigap policy.

In addition, if you joined SecurityBlue when you were first eligible for Medicare Part B at age 65, and your disenrollment from SecurityBlue is within 12 months of your effective date of enrollment in SecurityBlue, then you are guaranteed issuance of any Medigap policy that is sold in Pennsylvania, as long as you apply within 63 days after your last day of coverage under SecurityBlue. Contact the Pennsylvania Department of Aging, APPRISE Health Insurance Counseling Program, at 1-800-783-7067, Monday through Friday, 9:00 a.m. to 4:00 p.m., for more information about the availability of Medigap coverage in Pennsylvania.

You are also guaranteed acceptance into certain Highmark Blue Cross Blue Shield Medicare Supplement Programs without any waiting period for pre-existing conditions. Complete enrollment information will automatically be sent to you if you disenroll from SecurityBlue. Call a Member Service Representative at 1-800-935-2583,

Monday through Sunday, between 8:00 a.m. and 8:00 p.m., for more information about the programs for which you may be eligible. TTY users, call 1-800-988-0668.

SECTION 9

Quality Improvement Program

Making Your Health Plan The Best It Can Be

It's a priority of Highmark Blue Cross Blue Shield/Keystone Health Plan West, Inc. that you receive high-quality health care and services. In fact, we have an entire division devoted to corporate quality improvement.

Our quality improvement efforts are designed to ensure quality care and member satisfaction with your plan. To do this, we constantly review the things that affect your care and satisfaction and look for ways to improve them.

In addition, we work closely with physicians on mutual quality concerns, such as finding the most effective treatments for health problems.

Our quality efforts also address our internal areas, such as Member Service and claims processing. In both clinical and administrative areas, we use member surveys and other tools to get feedback on how we're doing. We use these results to guide our future quality efforts.

For a detailed description of our Quality Management Program, an update on our progress toward meeting our goals, information on our clinical practice/preventive health guidelines or to provide input, please write to:

Quality Management Department
Highmark Blue Cross Blue Shield
Fifth Avenue Place
120 Fifth Avenue
Suite P4501
Pittsburgh, PA 15222

The clinical practice and preventive health guidelines can be found on our Web site at www.highmarkbcbs.com.

SecurityBlue clinical quality improvement initiatives include:

1. ***Condition Management Programs—***
   For members with certain chronic diseases, SecurityBlue works with you, your family and all doctors involved to control the disease and improve your quality of life.
2. ***Preventive Care Initiatives—***
   To encourage you to get regular preventive care appropriate for your age and health status. Examples include sending yearly reminders to members and their doctors if members are overdue for PAP tests, mammograms and diabetic retinal examinations.

Network Quality

Keystone Health Plan West, Inc. follows a provider credentialing process to ensure that every participating physician is highly qualified in his or her field. In addition, registered nurses regularly visit doctors' offices to document, on an ongoing basis, the quality of care and service provided to SecurityBlue members at these offices.

Surveying Your Needs

SecurityBlue is committed to continuously improving the services we provide and our responsiveness to your needs. To help us determine the best ways to do this, we occasionally conduct surveys of our members. Subjects may include:

- Your level of satisfaction with SecurityBlue.

- A survey of your health, called the "Senior Health Risk Questionnaire," mailed to you within 90 days of your SecurityBlue effective date. The survey includes questions about your recent health history, your use of tobacco, alcohol and prescription drugs, and your general behavior. Your answers are kept confidential and may only be shared with your PCP. SecurityBlue uses your responses and those of all other SecurityBlue members to learn about your health concerns and develop educational programs and activities to help you address these concerns.

- Information about other health insurance you may have, including a survey about you or your spouse's employment status, if applicable. This "Working Beneficiary Survey," required by the Centers for Medicare and Medicaid Services (CMS), is mailed between March and May of every year. Be sure to complete and return your survey.

– Other subjects as required by CMS. These surveys may be mailed to you or carried out through a telephone call. In all cases, we will try to be brief and guarantee that any information you share with us will be kept strictly confidential. If you are asked to participate in a survey or other research, we ask for your cooperation and thank you in advance.

How We Evaluate New Technologies

SecurityBlue is always looking into new ways to treat health problems. Sometimes we evaluate totally new methods to treat a disease. Or we may look at a new use for an existing technology. We may review new treatments and/or benefits because a doctor or member asks us to.

Highmark believes that decisions for evaluating new technologies, as well as new applications of existing technologies, for medical and behavioral health procedures, pharmaceuticals and devices should be made by medical professionals. That is why a panel of more than 400 medical professionals works with our nationally recognized Medical Affairs Committee to review new technologies and new applications of existing technologies for medical and behavioral health procedures and devices. To stay current and patient-responsive, these reviews are ongoing and all encompassing, considering factors such as product efficiency, safety and effectiveness.

When we do our review, we look at medical reports about the new technology. We find out what regulatory agencies have decided about it. We also get expert opinions from doctors and other health care practitioners.

These are the questions we try to answer:

1. Has the U.S. Food and Drug Administration approved the new technology for the condition(s) it is supposed to treat?
2. Is there scientific proof that people treated with this new technology have good results?
3. Has the new way been proved as safe or effective as older ways, and do patients get equally good or better results?
4. Does the technology improve results?
5. Is there proof that the technology works well outside of a research setting?

If the answer to each question is "yes," the Highmark Medical Affairs Committee may recommend that the treatment be considered as acceptable medical practice. If that happens, we may decide to cover it in our health plans.

But if the answers are "no," then the new technology may still be considered experimental or investigative. Most of the time, such technology is not covered by health plans because it doesn't meet the criteria for standard medical practice. However, if things change and more data comes to light, the Highmark Medical Affairs Committee may review it again.

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

If you have questions about coverage for services involving recent medical technology, refer to Section 3 of this book, page 17, "All About Your Benefits" or call Member Service at 1-800-935-2583, Monday through Sunday, between 8:00 a.m. and 8:00 p.m. TTY users, call 1-800-988-0668.

SECTION 10
Care Or Case Management Program

Identify Members With Complex Medical Conditions

The Senior Health Risk Questionnaire is also used to identify SecurityBlue members with complex or serious medical conditions. SecurityBlue works with your

physician whenever possible to assess the condition and to provide medical procedures to diagnose and monitor the condition on an ongoing basis. Most importantly, SecurityBlue continues to work with your physician to establish and implement a treatment plan appropriate to the condition. If appropriate to your medical condition, you also will be invited to participate in a condition management program.

Medical Necessity Criteria Policy

Highmark Blue Cross Blue Shield/Keystone Health Plan West, Inc. and its delegates use written criteria to evaluate the necessity of medical and behavioral health services. These criteria include nationally developed clinical care guidelines, medical policy, Medicare guidelines and locally developed criteria that have been reviewed and approved by appropriate medical and clinical specialists. These guidelines and policies are used to promote consistent review decisions by our clinical reviewers.

If the care or service that is requested cannot be approved by a nurse reviewer, the nurse will refer the request to a physician. This physician may contact the treating physician to discuss the request and/or to obtain additional clinical information. A decision relative to the care or service request will be made by the physician based on the clinical information provided.

The member or the treating physician has the right to request the source of the care guideline/policy used to make the review decision at any time during or following the review process. Members may request a copy of the care guideline/policy used to make the review decision by contacting SecurityBlue at 1-800-935-2583, Monday through Sunday, between 8:00 a.m. and 8:00 p.m. TTY users, call 1-800-988-0668.

SECTION 11
Summary Of Your Financial Responsibilities

The information contained in this section is for *direct payment* SecurityBlue Plan members only.

If you are a member of a SecurityBlue Plan that is provided to you through an employer group or trust fund, you will receive your "Schedule of Copayments" separately. To request a copy of your employer group plan information, contact your group or retiree benefits office or call SecurityBlue Member Service at the number printed on your SecurityBlue membership card.

See page 90, Appendix C, "Definitions," for an explanation of terms used in the chart.

Schedule Of Copayments For The Direct Payment Standard Plan

***Note*: This information is for direct payment members only. If you are a member of an employer group plan, please refer to your separate Schedule of Copayments.**

Certain covered services you receive as a SecurityBlue member require that you pay a fee, called your "copayment" or "coinsurance," at the time you receive the service. You are responsible for paying the following copayments/coinsurance under your SecurityBlue Plan:

SERVICE	COPAYMENT/COINSURANCE
Primary Care Physician office visit*	$10 per visit
Specialist physician office visit	$20 per visit
Annual routine pelvic exam office visit	$10 per visit to PCP; $20 per visit to gynecologist
Routine vision exam office visit	$20 per visit
Routine hearing exam office visit	$20 per visit
Medicare-covered eye exam office visit	$20 per visit
Medicare-covered hearing exam office visit	$20 per visit
Emergency room visit	$50 per visit, waived if admitted to hospital for same condition within 3 days and the admission is authorized by SecurityBlue
Observation room visit+	$50 per visit, waived if admitted to hospital for same condition within 3 days and the admission is authorized by SecurityBlue
Durable medical equipment, medical supplies, foot orthotics or prosthetics, and diabetic testing devices (excludes oxygen supplies/equipment)	15% coinsurance up to an out-of-pocket maximum of $500 per calendar year, then SecurityBlue pays 100%
Out-of-area urgent care from any provider other than emergency room	$20 per visit
Medically necessary ambulance services (including wheelchair vans)	$25 per one-way trip
Physical and occupational therapy, cardiac rehabilitation, respiratory therapy, speech pathology services	$20 per outpatient visit or therapy session
Mental health services	$20 per outpatient visit or therapy session

Medicare-covered chiropractic services	$10 per office visit to PCP; $20 per office visit to specialist
Medicare-covered podiatry services	$10 per office visit to PCP; $20 per office visit to specialist
Medicare-covered Part B drugs	$10 generic, $31 brand name for up to a 34-day supply; 3 times the 34-day supply copayment for up to a 90-day supply
Inpatient Services (Acute, Mental Health, Substance Abuse, Rehab)	$150 per admission/$300 maximum per year
Long Term Acute Care	$50 per day/$500 maximum per year
Skilled Nursing Facility	$25 per day for days 21-40, per benefit period/$500 maximum per year
Outpatient Surgery	$50 per visit, per day, per provider

*** If you receive services from a PCP other than your PCP or PCP group practice on record with SecurityBlue, your copayment will be $20 per visit.**

+ The copayment applies if you are in the hospital for up to a 72-hour observation or rapid treatment status, as these are not considered hospital admissions.

Please refer to the Prescription Drug Benefits Information in the *Addendum to the Evidence of Coverage* for your plan's copayments, and other information about your prescription drug benefits.

Schedule Of Copayments For The Direct Payment Deluxe Plan

***Note*: This information is for direct payment members only. If you are a member of an employer group plan, please refer to your separate Schedule of Copayments.**

Certain covered services you receive as a SecurityBlue member require that you pay a fee, called your "copayment" or "coinsurance," at the time you receive the service. You are responsible for paying the following copayments/coinsurance under your SecurityBlue Plan:

SERVICE	**COPAYMENT/COINSURANCE**
Primary Care Physician office visit*****	$10 per visit
Specialist physician office visit	$20 per visit
Annual routine pelvic exam office visit	$10 per visit to PCP; $20 per visit to gynecologist

Routine vision exam office visit	$20 per visit
Routine hearing exam office visit	$20 per visit
Medicare-covered eye exam office visit	$20 per visit
Medicare-covered hearing exam office visit	$20 per visit
Emergency room visit	$50 per visit, waived if admitted to hospital for same condition within 3 days and the admission is authorized by SecurityBlue
Observation room visit+	$50 per visit, waived if admitted to hospital for same condition within 3 days and the admission is authorized by SecurityBlue
Durable medical equipment, medical supplies, foot orthotics or prosthetics and diabetic testing devices (excludes oxygen supplies/equipment)	15% coinsurance up to an out-of-pocket maximum of $500 per calendar year, then SecurityBlue pays 100%
Out-of-area urgent care from any provider other than emergency room	$20 per visit
Medically necessary ambulance services (including wheelchair vans)	$25 per one-way trip
Physical and occupational therapy, cardiac rehabilitation, respiratory therapy, speech pathology services	$20 per outpatient visit or therapy session
Mental health services	$20 per outpatient visit or therapy session
6 routine chiropractic office visits for manual manipulation of the spine per calendar year and 8 routine podiatrist office visits per calendar year	$20 per visit
Routine dental care: 1 oral exam and cleaning every 6 months; bitewing x-rays every 12 months; full-mouth x-rays every 5 years; fillings as needed	40% coinsurance of plan's established fee schedule
Medicare-covered chiropractic services	$10 per office visit to PCP; $20 per office visit to specialist
Medicare-covered podiatry services	$10 per office visit to PCP; $20 per office visit to specialist
Medicare-covered Part B Drugs	$8 generic, $25 brand name for up to a 34-day supply; 3 times the 34-day supply copayment for up to a 90-day supply
Inpatient Services (Acute, Mental Health, Substance Abuse, Rehab)	$100 per admission/$200 maximum per year

*** If you receive services from a PCP other than your PCP or PCP group practice on record with SecurityBlue, your copayment will be $20 per visit.**

+ The copayment applies if you are in the hospital for up to a 72-hour observation or rapid treatment status, as these are not considered hospital admissions.

Please refer to the Prescription Drug Benefits Information in the *Addendum to the Evidence of Coverage* for your plan's copayments, and other information about your prescription drug benefits.

Schedule Of Copayments For The Direct Payment Value Plan

Note: **This information is for direct payment members only. If you are a member of an employer group plan, please refer to your separate Schedule of Copayments.**

Certain covered services you receive as a SecurityBlue member require that you pay a fee, called your "copayment" or "coinsurance," at the time you receive the service. You are responsible for paying the following copayments/coinsurance under your SecurityBlue Plan:

SERVICE	COPAYMENT/COINSURANCE
Primary Care Physician office visit*	$10 per visit
Specialist physician office visit	$20 per visit
Annual routine pelvic exam office visit	$10 per visit to PCP; $20 per visit to specialist
Routine vision exam office visit	$20 per visit
Routine hearing exam office visit	$20 per visit
Medicare-covered eye exam office visit	$20 per visit
Medicare-covered hearing exam office visit	$20 per visit
Emergency room visit	$50 per visit, waived if admitted to hospital for same condition within 3 days and the admission is authorized by SecurityBlue
Observation room visit+	$50 per visit, waived if admitted to hospital for same condition within 3 days and the admission is authorized by SecurityBlue
Inpatient Services (Acute, Mental Health, Substance Abuse, Rehab)	$175 per admission/$350 maximum per year
Long Term Acute Care	$50 per day/$500 maximum per year
Skilled Nursing Facility	$25 per day for days 21-40, per benefit period/$500 maximum per year

Outpatient Surgery	$100 per visit, per day, per provider
Diagnostic, Laboratory and X-ray services**	$20 per provider, per service type, per day
MRI, PET and CT Procedures	$50 per provider, per service type, per day
Durable medical equipment, medical supplies, foot orthotics or prosthetics, and diabetic testing devices (excludes oxygen supplies/equipment)	15% coinsurance up to an out-of-pocket maximum of $500 per calendar year, then SecurityBlue pays 100%
Out-of-area urgent care from any provider other than emergency room	$20 per visit
Medically necessary ambulance services (including wheelchair vans)	$25 per one-way trip
Outpatient physical and occupational therapy, cardiac rehabilitation, respiratory therapy, speech pathology services	$20 per therapy type, per day, per provider
Mental health services	$20 per outpatient visit or therapy session
Medicare-covered chiropractic services	$10 per office visit to PCP; $20 per office visit to specialist
Medicare-covered podiatry services	$10 per office visit to PCP; $20 per office visit to specialist
Medicare-covered Part B Drugs	$10 generic, $31 brand name for up to a 34-day supply; 3 times the 34-day supply copayment for up to a 90-day supply

*** If you receive services from a PCP other than your PCP or PCP group practice on record with SecurityBlue, your copayment will be $20 per visit.**

+ The copayment applies if you are in the hospital for up to a 72-hour observation or rapid treatment status, as these are not considered hospital admissions.

****Under the terms of the Value Plan, copayments are required for diagnostic, laboratory and X-ray services performed per provider, per service type, per day, when not performed as part of your one-time physical exam within 6 months of your first coverage under SecurityBlue.**

SECTION 12
Appendices

Appendix A.

General Provisions

Limitations—

In the event that the rendering of services provided under this *Evidence of Coverage* is delayed or rendered impractical due to circumstances not within the control of SecurityBlue, including but not limited to a major disaster, epidemic, civil insurrection or similar causes, SecurityBlue will make a good faith effort to arrange for an alternative method of providing coverage. In such event, SecurityBlue will provide services covered under this agreement insofar as practical, and according to its best judgment; but neither SecurityBlue nor providers will incur liability or obligation for delay or failure to provide or arrange for services if such failure or delay is caused by such event(s).

Relationship Of Parties—

1. Provider-Patient Relationship—

Participating physicians maintain the physician-patient relationship with SecurityBlue members and are solely responsible to members for all medical services. The relationship between Keystone Health Plan West, Inc. and contracting providers of health services is an independent contract relationship. Participating network physicians are not agents or employees of Keystone Health Plan West, Inc., nor is any employee of Keystone Health Plan West, Inc. an employee or agent of participating physicians. SecurityBlue will not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the member while receiving care from any Keystone Health Plan West, Inc. participating physician.

Keystone Health Plan West, Inc./SecurityBlue is prohibited by the Centers for Medicare & Medicaid Services (CMS) from restricting health care professionals from advising you or advocating on your behalf about any of the following:

- Your health status, medical care or treatment options (including any alternative treatments that may be self-administered), including providing you with sufficient information to have the opportunity to decide among all relevant treatment options.

- The risks, benefits and consequences of treatment or non-treatment.

- The opportunity for you to refuse treatment and to express your preferences about future treatment decisions.

Furthermore, SecurityBlue health care professionals will make every effort to provide information to you regarding your treatment options (or non-treatment option) in clear, easy to understand communications with you or your representative, so that you can make informed decisions regarding your treatment options.

2. Non-Compliance With Treatment Plan—
Certain members may, for reasons personal to themselves, refuse to accept procedures or courses of treatment recommended by a network provider. Providers will use their best efforts to render all necessary and appropriate professional services in a manner compatible with the member's wishes, insofar as this can be done consistently with the provider's judgment as to the requirements of proper medical practice.

Disclosure Of Information—

SecurityBlue is required by the Centers for Medicare & Medicaid Services (CMS) to provide members with the following information upon request:

- How Keystone Health Plan West, Inc. controls the use of medical services.
- The number of appeals and grievances SecurityBlue has received and how those cases were resolved.
- How SecurityBlue pays its participating physicians.
- The financial condition of Keystone Health Plan West, Inc./SecurityBlue.

Please contact SecurityBlue Member Service at P.O. Box 1068, Pittsburgh, PA 15230-1068 to request this information. If you prefer, you may call 1-800-935-2583, Monday through Sunday, 8:00 a.m. to 8:00 p.m. TTY users, call 1-800-988-0668.

Payment Of Benefits—

1. Assignment— Any rights of a member to receive services or payments under this agreement are personal to the member and may not be assigned to any person, provider or entity without the written consent of SecurityBlue.

2. Erroneous Payment— If SecurityBlue pays for any excluded services or supplies through inadvertence or error, the member will be responsible for payment.

Member Agreement—

1. ***Entire Contract—*** This *Evidence of Coverage*, together with the enrollment application of the member, will constitute the entire agreement between the parties. No statements or representations may be used in any legal dispute regarding the terms of coverage or any exclusions or limitations hereunder unless contained in such documents. No alteration of this agreement and no waiver of any of its provisions will be valid unless evidenced by a written endorsement or amendment signed by a duly authorized officer of Keystone Health Plan West, Inc. Any insurance agent or broker licensed through Keystone Health Plan West, Inc. who may have assisted in the contract for this plan is not an authorized officer of Keystone Health Plan West, Inc. for this or any other purpose.

None of the terms or provisions of the Articles of Incorporation or Bylaws of Keystone Health Plan West, Inc. will form a part of this agreement or be used in any suit hereunder unless the same is set forth in full herein.

2. ***Severability—*** In the event that any provision of the *Evidence of Coverage* detailing the terms and conditions of your SecurityBlue policy is hereafter found by a court or governmental agency to be invalid or unenforceable for any reason, such court finding will be limited to such provision. The other provisions of the *Evidence of Coverage* which are not subject to the court/agency finding will remain binding and enforceable regardless of such court finding and the member's SecurityBlue policy will continue in effect as a valid insurance contract between the parties.

3. ***Policies And Procedures—*** SecurityBlue may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this agreement, with which members will comply.

4. ***Keystone Health Plan West, Inc. Liability Waiver Of Liability—*** Keystone Health Plan West, Inc. will not be liable for injuries resulting from negligence, misfeasance, nonfeasance or malpractice on the part of any provider in the course of performing services for SecurityBlue members.

Notice Of 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 Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the Commonwealth of Pennsylvania may apply.

Notice Of Non-Discrimination—

SecurityBlue and each of its contracting network providers are committed to complying with all aspects of the Americans with Disabilities Act, Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and all other laws that apply to organizations that receive Federal funding, and any other laws and rules that apply for any other reason. Furthermore, they are committed to providing health care to all members, regardless of a person's race, disability, age, sex, sexual orientation, health, creed, socioeconomic status, education or ethnic or cultural origin without discrimination. SecurityBlue has mandated that each contracting provider will make an effort to ensure that members with limited proficiency in English, limited education or other socioeconomic disadvantages receive the health care to which they are entitled. If you have a question or concern about these provisions, please call SecurityBlue Member Service at the toll-free number printed on your membership card.

Upon payment in advance of the applicable SecurityBlue premium, Keystone Health Plan West, Inc. agrees to make payment for those services performed as set forth in this agreement. The SecurityBlue agreement is renewable subject to the consent of Keystone Health Plan West, Inc., a company operating under the supervision of the Pennsylvania Insurance Department and the Department of Health of the Commonwealth of Pennsylvania.

Appendix B.
Confidentiality And Release Of Information

Information from your medical records and from providers or hospitals will be kept confidential. Except as is necessary in connection with administering this contract, fulfilling state and Federal requirements (including review programs to achieve quality and cost-effective medical care), and performing normal business operations, such information will not be disclosed without your written permission.

1. ***Disclosure Of Information—*** Data about you in our files is private. We will not give this data to anyone unless: (a) you have authorized it; or (b) it is needed for conducting our business. We can give out certain data shown below without your authorization. We may give it to:

a. Insurers, agents, or insurance support organizations. Data must be reasonably needed for them or us: (1) to detect or prevent a crime, fraud, or material misrepresentation or nondisclosure; or (2) to perform our or their function relating to your insurance.

b. A medical care institution or medical professional for the purpose of informing you of a medical problem of which you may not be aware.

c. A state or Federal insurance regulatory authority or health care oversight agency.

d. A law enforcement authority or other government authority to prevent or prosecute fraud or other unlawful activities.

e. Others as required in response to administrative or judicial order or subpoena.

f. A government authority in order to determine eligibility for health benefits for which it may be liable.

g. Providers, including your personal physician, if applicable, and other entities as required to treat, manage care and administer the provisions of this contract. Our contracts with doctors, hospitals and other health care providers contain language designed to protect the confidentiality of your personal health information.

h. Others as permitted or required by law.

i. When medical information is gathered for CMS-approved and/or authorized purposes, including measurement reports and bona fide research, unless we have your authorization to send identifiable data, the data collected and passed on excludes or scrambles any personally identifiable information.

2. Your Rights Of Access To Information—

a. You have the right to request timely access to data about you in our files. Your request must be sent to us in writing clearly describing the data you want and the purpose for which you want

the data. Your request must be for data which we can reasonably locate and retrieve.

b. We are committed to safeguarding and maintaining the confidentiality and accuracy of your medical documents and SecurityBlue enrollment information. We abide by Federal and state laws regarding confidentiality and disclosure for mental health records, medical records, other health information and enrollee information.

c. We will have 30 workdays to respond, or 60 days to respond if the information is offsite.

d. We may charge a reasonable cost-based fee for providing copies of data in our files.

e. Some data you request may not be in our files. If not, we will arrange for you to get the data from the source. For example, medical records can be obtained from the SecurityBlue network participating provider.

3. How We Protect Your Right To Confidentiality—

a. At Keystone Health Plan West, we have established policies and procedures to protect the privacy of protected health information from unauthorized or improper use. As permitted by law, Keystone Health Plan West may use or disclose protected health information for treatment, payment and health care operations, such as: claims management, routine audits, coordination of care, quality assessment and measurement, case management, utilization review, performance measurement, customer service, credentialing, medical review and underwriting.

b. As a condition of employment, all Keystone Health Plan West employees must sign a statement agreeing to hold member information in strict confidence.

c. Our Privacy Department reviews and approves policies regarding the handling of confidential information.

Appendix C.

Definitions

Following is a list of definitions for important words and phrases that we use in this booklet:

1. ***Additional Benefits—*** Those benefits, services and supplies not covered by Medicare which SecurityBlue has agreed to cover and which are described in this *Evidence of Coverage* and any applicable riders.

2. ***Annual Election Period—*** The Annual Election Period is the period of time during which Medicare Advantage eligible individuals may elect a Medicare Advantage Plan or change his or her election. For Medicare Advantage Plans effective January 1, 2007, the Annual Election Period is November 15 through December 31, 2006. The Centers for Medicare and Medicaid Services has established this period as the Annual Election Period.

3. ***Basic Benefit Package—*** All health care services that are covered under Original Medicare Part A Hospital Insurance and Part B Medical Insurance and available to beneficiaries residing in the geographic area in which services are covered under the plan, national coverage decisions, as well as specific written policies of the Medicare carrier or intermediary with jurisdiction for claims, additional services funded from savings, and mandatory supplemental services, except hospice services.

4. ***Benefit Period—*** A benefit period begins on the first day of a Medicare-covered inpatient hospital stay and ends with the close of a period of 60 consecutive days during which you were receiving neither inpatient hospital nor inpatient skilled nursing care.

5. ***CMS—*** The Centers for Medicare and Medicaid Services (CMS), the Federal government agency responsible for administering Medicare and Federal participation in Medicaid.

6. ***Coinsurance—*** The percentage of eligible expenses you and SecurityBlue share for services. For example, SecurityBlue pays 85% coinsurance for eligible durable medical equipment, such as a wheelchair, while you pay 15% coinsurance.

7. ***Contracting Provider—*** A health professional, a supplier of health care items, or a health care facility having an agreement with Keystone Health

Plan West, Inc. or its affiliate organizations to provide medical services to SecurityBlue members. Also see "Provider Network."

8. ***Copayment—*** The fixed, up-front dollar amount you pay for certain covered services you receive. For example, the $50 you must pay for a visit to the emergency room. Copayments for direct payment plan members are listed in the "Summary of Your Financial Responsibilities" on pages 79-84 of this booklet. Employer group plan members, see your separate "Schedule of Copayments."

9. ***Covered Services—*** Those benefits, services and supplies for which SecurityBlue will pay while you are a member.

10. ***Custodial Care—*** Care furnished for the purpose of meeting personal needs, such as assistance in moving about, dressing, bathing, eating, preparation of special diets and taking medication which could be provided by persons without professional skills or training. Custodial care is not covered under this *Evidence of Coverage*.

11. ***Disenrollment—*** The process of ending membership in SecurityBlue. The procedure for this is described in Section 8, "Leaving the Plan," on page 68.

12. ***Durable Medical Equipment—*** Equipment which can withstand repeated use, is primarily and usually used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in the home. Durable medical equipment includes, but is not limited to, the following: hospital beds, crutches, canes, wheelchairs, walkers, trusses, support stockings, peripheral circulatory aids, elastic bandages, cervical collars, back supports, traction equipment, physiotherapy equipment, and oxygen equipment.

13. ***Effective Date—*** The date, as shown in SecurityBlue records, on which SecurityBlue coverage begins for you under this contract.

14. ***Emergency Services—*** Covered inpatient and outpatient services that are: a) furnished by a qualified provider and b) needed to evaluate or stabilize an emergency medical condition. Emergency medical condition means a medical condition that is revealed by acute symptoms of sufficient severity (including severe pain) that a prudent layperson with an average knowledge of health and medicine could expect the absence of immediate

attention to result in (1) serious jeopardy to health of the individual (or an unborn child); (2) serious impairment to bodily functions; or (3) serious dysfunction of bodily organ or part.

15. ***Evidence Of Coverage—*** This document that explains the services and benefits covered by SecurityBlue and defines the rights and responsibilities of the member and SecurityBlue.

16. ***Exclusions—*** Items or services which are not covered under this contract.

17. ***Experimental Procedures And Items—*** Items and procedures determined by Medicare not to be generally accepted by the medical community. When making a determination as to whether a service is experimental, SecurityBlue will use Medicare guidelines or rely upon determinations already made by Medicare. Experimental procedures and items are not covered under this contract.

18. ***Group—*** An employer or other group entity, if any, through which this SecurityBlue coverage is provided.

19. ***Health Plan Provider—*** A physician, specialist, hospital or other health care provider or facility that has signed an agreement with Keystone Health Plan West/SecurityBlue to participate in the credentialing process, member satisfaction evaluations, office and medical records reviews, and to accept the SecurityBlue allowable charge as payment in full. Health plan or network providers file claims for the member and handle all hospital inpatient admission authorizations.

20. ***Home Health Agency—*** A Medicare-certified agency which provides intermittent skilled nursing services and other therapeutic services in your home, when you are confined to your home and when medically necessary.

21. ***Hospice—*** An organization or agency, certified by Medicare, that is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

22. ***Hospital—*** A Medicare-certified institution which provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term "Hospital" does **not** include a convalescent nursing home, rest facility or

facility for the aged which furnishes primarily custodial care, including training in activities of daily living.

23. ***Inpatient—*** A member who is admitted as a bed patient in a hospital, a rehabilitation hospital, a skilled nursing facility or a substance abuse treatment facility.

24. ***Keystone Health Plan West, Inc. (KHPW)—*** Keystone Health Plan West, Inc. is a company operating under the supervision of the Pennsylvania Insurance Department and the Department of Health of the Commonwealth of Pennsylvania. Keystone Health Plan West, Inc. is a Medicare Advantage Organization that offers the Medicare Advantage Plan called SecurityBlue in accordance with a contract with CMS.

25. ***Long-Term Acute Care (LTAC)—*** A LTAC is a provider that is certified by Medicare as an acute care hospital, but provides long-term patient care resulting in average lengths of stay of at least 25 days or longer.

26. ***Medically Necessary And Appropriate—***
Services or supplies determined by SecurityBlue to be (1) appropriate for the symptoms and diagnosis or treatment of your condition, illness, disease or injury; (2) provided for your diagnosis or the direct care and treatment of your condition, illness, disease or injury; (3) not primarily for the convenience of you, your physician, hospital or health care provider; (4) in accordance with standards of good medical practice; and (5) the most appropriate supply or level of service that can safely be provided.

27. ***Medicare—*** The Federal government health insurance program established by Title XVIII of the Social Security Act. This is also known as Original Medicare.

28. ***Medicare Advantage Organization—*** A public or private entity (such as Keystone Health Plan West, Inc.) organized and licensed under state law as a risk-bearing entity that is certified by CMS as meeting Medicare Advantage contract requirements, and which contracts with CMS to offer a Medicare Advantage Plan (such as SecurityBlue).

29. ***Medicare Advantage Plan—*** The specific health benefits, terms of coverage and pricing structure that the Medicare Advantage Organization offers to beneficiaries. The plan may include all Medicare-covered

benefits and additional benefits combined with mandatory and/or optional supplemental benefits.

30. ***Member—*** You, the Medicare beneficiary entitled to receive health care services under the terms of this SecurityBlue *Evidence of Coverage*, who has voluntarily chosen to enroll and whose enrollment in SecurityBlue has been confirmed by CMS.

31. ***Non-Plan Provider Or Non-Plan Facility—*** Any professional person, organization, health facility, hospital or other person or institution licensed and/or certified by the state or Medicare to deliver or furnish health care services which does not have a signed agreement with Keystone Health Plan West/SecurityBlue to provide covered services or supplies to SecurityBlue members.

32. ***Observation Services—*** Those services, including all ancillary services, furnished on a hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for possible admission to the hospital as an inpatient.

33. ***Out-Of-Pocket Maximum—*** The amount of money you pay out of your pocket for example, eligible Durable Medical Equipment expenses before SecurityBlue begins to pay 100 percent for additional eligible expenses.

34. ***Outpatient—*** A member who receives covered services while not an inpatient such as from a provider's office, in the member's home, at freestanding radiology facilities, physical therapy facilities or substance abuse treatment facilities.

35. ***Part A Premium—*** A monthly premium paid to cover care received in a hospital or skilled nursing facility and some home health care and hospice care. This premium is usually financed by the Social Security payroll withholding tax paid by workers and their employers or by the self-employment tax paid by self-employed persons. If you are required to pay a mandatory premium for Part A equivalent services and you became a SecurityBlue member before 1/1/99, you pay this premium to SecurityBlue. Members of Medicare Advantage Plans such as SecurityBlue must be entitled to Medicare Part A to be eligible to join and remain a member.

36. ***Part B Premium—*** A monthly premium paid (usually deducted from a person's Social Security check) to cover Part B services in fee-for-service Medicare. Members of Medicare Advantage Plans such as SecurityBlue must also pay this premium to receive full coverage and be eligible to join and stay in the plan.

37. ***Pharmacist—*** An individual, duly licensed as a pharmacist by the State Board of Pharmacy or other governing body having jurisdiction, who is employed by or associated with a pharmacy.

38. ***Plan—*** SecurityBlue.

39. ***Premium—*** The payment that you, the member, make to SecurityBlue, usually every month or calendar year quarter. Along with the Medicare Part B Medical Insurance premium (and Part A Hospital Insurance premium, if applicable) you pay to Medicare, your SecurityBlue premium entitles you to the benefits outlined in this *Evidence of Coverage.*

40. ***Primary Care Physician (PCP)—*** A SecurityBlue contracting physician who is selected by you, the member, at enrollment in SecurityBlue to be responsible for providing routine physical exams covered under this contract and to provide or coordinate other covered services as you, the member, deem appropriate. The PCP may be a family practitioner, general practitioner, internist or other specialist.

41. ***Prior Authorization—*** A system whereby a provider must receive approval from a staff member of SecurityBlue, such as the SecurityBlue Medical Director, before you, the member, can receive certain health care services.

42. ***Provider Network—*** The network of health care providers SecurityBlue is required to maintain in the SecurityBlue service area to meet access standards of CMS. The Keystone Health Plan West Medicare Advantage Network encompasses all 17 counties in the Commonwealth of Pennsylvania in which SecurityBlue Plans are offered, including Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Crawford, Erie, Fayette, Greene, Indiana, Lawrence, Mercer, Somerset, Washington and Westmoreland counties.

43. ***Quality Improvement Organization—*** Entities paid by CMS to review medical necessity, appropriateness and quality of medical care and services provided to Medicare beneficiaries.

44. ***SecurityBlue—*** A Medicare Advantage Plan offered by Keystone Health Plan West, Inc., a Medicare Advantage Organization, which offers this program of benefits in accordance with a contract with the Centers for Medicare & Medicaid Services of the United States Department of Health and Human Services. SecurityBlue is a Medicare Advantage HMO with benefits as described in this *Evidence of Coverage.*

45. ***Service Area—*** The designated geographic area of a Medicare Advantage Organization where the Medicare Advantage Plan (SecurityBlue) is offered. The plan is required to maintain a network of providers in the service area to meet access standards of CMS. Please see Section 12, Appendix D, page 97, for details of your particular service area.

46. ***Skilled Nursing Care—*** Services that can only be performed by, or under the supervision of, licensed nursing personnel.

47. ***Skilled Nursing Facility—*** A facility which provides inpatient skilled nursing care, rehabilitation services or other related health services, and is certified by Medicare. The term "skilled nursing facility" does not include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily custodial care, including training in routines of daily living.

48. ***Specialty Care Physician—*** A SecurityBlue contracting physician who provides certain specialty medical care; also called a specialist.

49. ***Surgery—*** Operating and cutting procedures including specialized instrumentation, endoscopic examinations or other invasive or non-invasive procedures required in the diagnosis of a condition due to disease or injury. Fractures and dislocations are also considered surgery.

50. ***Urgently Needed Care—*** Covered services which are needed to treat an unforeseen condition while temporarily outside the plan's service area, or in extraordinary cases within the SecurityBlue service area, when the plan's network is unavailable or inaccessible due to an unusual event. The services must be needed to prevent a serious deterioration of the member's

health. See Section 3, "All About Your Benefits," for information on emergency and urgently needed care.

Appendix D.
Service Area

This appendix defines the SecurityBlue service area in which you reside. Your service area is determined by the western Pennsylvania county you list as your county of residence on your most current Enrollment Application on record with SecurityBlue and verified by the Federal Centers for Medicare & Medicaid Services (CMS). Find the county in which you reside in one of the three service areas described below. That is your "service area of record."

For more information related to your service area, see Section 1 of this book, "Getting Started With SecurityBlue," and Section 8, "Leaving The Plan."

Definition—
Service Area— The designated geographic area of Keystone Health Plan West, Inc. where SecurityBlue Medicare Advantage Plans are offered.

Your service area determines the particular plans in which you may enroll and the monthly premium (if applicable) you pay. Each SecurityBlue service area includes those counties in the Commonwealth of Pennsylvania listed for each area:

1. **Southwestern Pennsylvania Service Area**
   Allegheny, Armstrong, Beaver, Butler, Cambria, Fayette, Greene, Indiana, Lawrence, Washington and Westmoreland

2. **Bedford/Blair/Somerset Service Area**
   Bedford, Blair and Somerset

3. **Crawford/Erie/Mercer Service Area**
   Crawford, Erie and Mercer

Out Of Service Area—
You may travel or live temporarily outside your SecurityBlue service area of record for up to six months in a row and continue to be a member of SecurityBlue. While out of your service area of record, your SecurityBlue Plan will provide coverage only for emergency care, urgently needed care and renal dialysis services.

If you move permanently or are absent from your SecurityBlue service area of record for more than six months in a row, you must notify SecurityBlue. If you do not notify SecurityBlue and you do not disenroll from SecurityBlue, your SecurityBlue coverage will be ended and you will be involuntarily disenrolled. If you fail to notify SecurityBlue of a permanent or extended absence, you may have to pay for services you receive while out of the service area.

If you plan to move permanently outside your SecurityBlue service area of record, but within one of the other 17 counties where SecurityBlue Plans are offered, and you wish to remain a SecurityBlue member, please call SecurityBlue Member Service at 1-800-935-2583, Monday through Sunday, 8:00 a.m. to 8:00 p.m. Hearing-impaired TTY users, please call 1-800-988-0668. A Member Service Representative will help you identify the specific SecurityBlue Plans and monthly plan premiums available to you in your location, as well as the procedure you need to follow to change your enrollment to one of these plans and remain a SecurityBlue member. If you do not notify SecurityBlue and change your enrollment, your SecurityBlue coverage will be ended and you will be involuntarily disenrolled.

SECURITYBLUE℠ HIGHMARK BLUE CROSS BLUE SHIELD
A Medicare Advantage HMO from Keystone Health Plan West

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

Keystone Health Plan West has a contract with the Federal government to administer Medicare Prescription Drug Coverage in the SecurityBlue service area.

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ADDENDUM

to the SecurityBlue Evidence of Coverage

2007

General information about
Medicare Prescription Drug Coverage
for members of SecurityBlue Standard Plan,
Deluxe Plan and employer group plans.

Note:
Cost-sharing information for employer group plan members and low income subsidy (LIS) members can be found in the separate Rider.

HIGHMARK. SECURITYBLUE

A Medicare Advantage HMO
from Keystone Health Plan West

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Table of Contents

SECTION 1
Coverage For Outpatient Prescription Drugs

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

- What a formulary is and how to use it.
- Drug Management Programs.
- 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 outpatient 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 outpatient prescription drugs covered.**

What is a "network pharmacy"? A network pharmacy is a pharmacy where you can get your outpatient prescription drug through your prescription drug coverage. We call them "network pharmacies" because they contract with SecurityBlue. Your prescriptions are covered at a higher level 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.

We have a list of preferred network pharmacies. Our pharmacy network is called the Premier Network. If you have your prescriptions filled at non-network pharmacies, you *must* pay your copayment or coinsurance plus the difference in cost between the network pharmacy and non-network pharmacy charges for the drug.

What are "covered drugs"? "Covered drugs" is the general term we use to mean all of the outpatient prescription drugs that are covered by SecurityBlue. 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 SecurityBlue prescription drug membership card at one of our network pharmacies. If you do not have your SecurityBlue drug 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 copayment). If this happens, you can ask us to reimburse you for our share of the cost by submitting a claim to us. Please call Member Service at 1-800-935-2583, Monday through Sunday, between 8:00 a.m. and 8:00 p.m. to request a paper claim form. TTY users, please call 1-800-988-0668. Then follow the instructions on the form.

The SecurityBlue Provider Directory gives you a list of network pharmacies

As a member of our plan, you received a SecurityBlue *Provider Directory* when you enrolled. This directory includes a section that lists all of the chain and independent pharmacies in the SecurityBlue network. You can use it to find a network pharmacy closest to you. If you don't have the *Provider Directory*, you can get a copy from Member Service. They can also give you the most up-to-date information about changes in our pharmacy network. In addition, you can find this information on our Web site at www.highmarkbcbs.com.

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

Sometimes a pharmacy might leave the SecurityBlue network. If this happens, you will have to get your prescriptions filled at another SecurityBlue network pharmacy. Please refer to the pharmacy section of your SecurityBlue *Provider Directory* or call Member Service to find another network pharmacy in your area. You can also locate a participating network pharmacy on our Web site at www.highmarkbcbs.com.

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

You can use our network mail order pharmacy service to fill prescriptions for what we call "maintenance drugs." These are drugs that you take on a regular basis for a chronic or long-term medical condition. Please be sure to read the separate packet of information you received for details of the mail order service.

When you order prescription drugs through our network mail order pharmacy service, you can order up to a 90-day supply of the drug. You will be responsible for paying two-and-a-half (2.5) times the copayment you pay for up to a 34-day supply you buy at a retail pharmacy. The maximum expected turnaround time for processing and shipment of all mail orders is 6-10 days for first-time orders and 5-8 days for refills. If your mail order shipment is delayed, please call Medco Health Solutions 24 hours a day, seven days a week at 1-800-903-6228. TTY users call 1-800-871-7138.

You are not required to use our mail order services to get an extended supply of maintenance medications. You can also obtain an extended supply (up to a 90-day supply) through the SecurityBlue network of retail pharmacies. You will be responsible for paying three (3) times the copayment you pay for up to a 34-day supply you buy at a retail pharmacy.

FILLING PRESCRIPTIONS OUTSIDE THE NETWORK

We cover prescriptions that are filled at an out-of-network pharmacy; however, you will be responsible for paying the full cost of the drug when you fill your prescription. When you use an out-of-network pharmacy, your share of the cost will be your applicable copayment *plus* the difference in cost between the network and non-network pharmacy charges. 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 United States, but outside of our 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 copayment) when you fill your prescription. Your share of the cost will be your applicable copayment *plus* the difference in cost between the network and non-network pharmacy charges. 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 in the next section.

Prior to filling your prescription at an out-of-network pharmacy, call SecurityBlue Member Service to find out if there is a network pharmacy in the area where you are traveling. SecurityBlue features a large network of more than 60,000 chain and independent drug stores located throughout the United States, so you should be able to locate a participating pharmacy wherever you travel. We cannot pay for any prescriptions that are filled by pharmacies outside the United States, even for a medical emergency.

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, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. Call Member Service at 1-800-935-2583, Monday through Sunday, between 8:00 a.m. and 8:00 p.m. and ask for a paper claim form. TTY users, please call 1-800-988-0668. Then follow the instructions on the form for filing your claim.

SPECIALTY PHARMACIES

Home infusion pharmacies

SecurityBlue will cover home infusion therapy if:

- Your prescription drug is on our plan's formulary,

- You have followed all required coverage rules and SecurityBlue has approved your prescription for home infusion therapy,

- Your prescription is written by a doctor, and

- You get your home infusion services from a network home infusion therapy provider.

Please refer to the pharmacy section of the SecurityBlue *Provider Directory* to find a home infusion therapy provider in your area. For more information, please contact Member Service.

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.

WHAT DRUGS ARE COVERED BY SECURITYBLUE?

What is a formulary?

A formulary is a list of all the drugs we cover. We have a formulary that lists all drugs that we cover. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a network pharmacy or through our network mail order pharmacy service and other coverage rules are followed. For certain prescription drugs, we have additional requirements for coverage or limits on our coverage.

The drugs on the formulary are selected by SecurityBlue 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 as effective as brand name drugs.

Important: SecurityBlue requires network pharmacies to fill your prescription with a generic drug whenever a generic is available. If you or your SecurityBlue physician request a brand name drug when a generic equivalent is available, you

will be charged the difference in cost between the brand name and the generic drug in addition to your applicable copayment.

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.

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

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

The direct pay Standard Plan and certain employer group plans utilize the Highmark Medicare-approved Select Formulary. This formulary is comprised of generic and preferred brand name drugs.

The direct pay Deluxe Plan and certain employer group plans utilize the Highmark Medicare-approved Choice Formulary. All drugs covered by Medicare are listed on this formulary. This formulary is comprised of generic, preferred brand name and non-preferred brand name drugs.

Members of employer group sponsored plans should refer to their separate Prescription Drug Amendment for information on which formulary their specific plan uses.

Can the formulary change?

Generally, if you are taking a drug on our 2007 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2007 coverage year except when a new, less expensive generic drug becomes available, or when new information about the safety or effectiveness of a drug is released. Other types of formulary changes, such as removing a drug from our formulary, will not affect members who are currently taking the drug. It will remain available at the same cost sharing for those members taking it for the remainder of the coverage year. We feel it is important that you have continued access for the remainder of the coverage year to the formulary drugs that were available when you chose our plan, except for cases in which you can save additional money or improve the safety of your drugs.

If we remove drugs from our formulary, or add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 60 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a 60-day supply of the drug. If the Food and Drug Administration

deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug. However, if the drug is removed from our formulary because the drug has been recalled from the market we will not give affected members 60 days notice before removing the drug or provide a 60-day supply of the drug. To get updated information about the drugs covered by SecurityBlue, please visit our Web site at www.highmarkbcbs.com, you may call Member Service at 1-800-935-2583, Monday through Sunday, 8:00 a.m. to 8:00 p.m. TTYusers should call 1-800-988-0668.

What if your drug is not on the formulary?

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

If Member Service 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. All participating SecurityBlue physicians have a copy of our formulary which includes covered drugs that are used to treat similar medical conditions. Non-participating physicians can view the formulary on our Web site at www.highmarkbcbs.com.

- You can ask us to make an exception for us to cover your drug. See the section, "How Can You Request an Exception to the Plan's Formulary?" for more information.

- You can pay out of pocket for the drug and request that SecurityBlue reimburse you by means of an exceptions request. This does not obligate us to reimburse you if the exception request is not approved. If the exception is not approved, you may appeal the plan's denial. See Section 2, "Appeals and Grievances," for more information on how to request an appeal.

As a new or continuing member in our plan, you may be taking drugs that are not on our formulary. Or you may be taking a drug that is on our formulary, but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception, so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or in situations where your ability to get your drugs is limited, we will cover a temporary 34-day supply (unless you have a prescription written for fewer days) when you go to a network pharmacy. After your first

34-day supply, we will not pay for these drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility, we will cover a temporary 34-day transition supply (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days you are a member of our plan. If you need a drug that is not on our formulary or your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 34-day emergency supply of that drug (unless you have a prescription for fewer days) while you pursue a formulary exception. This process will be implemented to accommodate you if you have an immediate need for a non-formulary drug or a drug that requires prior authorization due to a change in your level of care while you are waiting for an exception request to be processed.

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.

- For members of the direct pay Standard Plan and certain employer group plans, you can ask us to cover your drug even if it is not on our formulary.
- For members of the direct pay Deluxe Plan and certain employer group plans, you can ask us to provide a higher level of coverage for your drug. If your drug is contained in our Non-Preferred Brand tier, you can ask us to cover it at the cost-sharing amount that applies to drugs in the Preferred Brand tier instead.
- 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.

Please see the section, "Detailed Information About How to Request a Coverage Determination and an Appeal," 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 deny your exception request, you can appeal our decision. Please see Section 2, "Appeals and Grievances" for more information about how to request an appeal.

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:

- Non-prescription 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
- Erectile dysfunction drugs

In addition, a Medicare 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 the Drugs Covered Under Medicare Part A or Part B?"

For more information about catastrophic coverage and out-of-pocket costs, see the following pages.

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 you or your doctor 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 eight patches per prescription for Estraderm.

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 the section, "How Can You Request an Exception to the Formulary?" described earlier for more information.

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 indicated that you must take the brand name drug. If you or your doctor requests a brand name drug when a generic equivalent is available, you will have to pay the difference in cost between the brand name and the generic drug in addition to the applicable copayment.

Drug utilization review

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

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

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

Medication therapy management programs

We offer medication therapy management programs at no additional cost for members who have multiple medical conditions, who are taking many prescription drugs, or who have high drug costs. These programs were developed for us by a team of pharmacists and doctors. We use these medication therapy management programs to help us provide better coverage for our members.

For example, these programs help us make sure that our members are using appropriate drugs to treat their medical conditions and help us identify possible medication errors. We offer a medication therapy management program for members that meet specific criteria. We may contact members who qualify for these programs. If we contact you, we hope you will join so that we can help you manage your medications. Remember, you 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 Prescription Drug Plan (Part D).

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

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

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 in the following charts. See the section, "Extra Help with Drug Plan Costs for People with Limited Income and Resources," and the separate "Low Income Subsidy Rider" for those who get extra help paying for their prescription drugs.

Also, if you are a PACE or PACENET member, you will not have to pay any more for your drugs than your PACE or PACENET copayment amounts, as long as you remain a PACE or PACENET member and you purchase your prescription drugs within Pennsylvania.

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 a network or out-of network pharmacy. Your drug costs for each coverage level are described in the following charts.

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 copayment. Your copayment will vary depending on the drug and where the prescription is filled, as well as the SecurityBlue Plan you are enrolled in.

Important: SecurityBlue requires network pharmacies to fill your prescription with a generic drug whenever a generic is available. If you or your SecurityBlue physician request a brand name drug when a generic equivalent is available, you will be charged the difference in cost between the brand name and the generic drug in addition to your applicable copayment.

SECURITYBLUE STANDARD PLAN

Drug Type	Retail Copayment Up to 34-day supply	Retail Copayment Up to 90-day supply	Mail Order Copayment Up to 90-day supply
Generic	$10 copayment	$30 copayment	$25 copayment
Preferred Brand Name	$31 copayment	$93 copayment	$77.50 copayment

<CHART FORMAT HERE>

SECURITYBLUE DELUXE PLAN

Drug Type	Retail Copayment Up to 34-day supply	Retail Copayment Up to 90-day supply	Mail Order Copayment Up to 90-day supply
Generic	$8 copayment	$24 copayment	$20 copayment
Preferred Brand Name	$25 copayment	$75 copayment	$62.50 copayment
Non-Preferred Brand Name	$60 copayment	$180 copayment	$150 copayment

EMPLOYER GROUP PLANS

Please refer to the separate prescription drug coverage information you received with this *Addendum to the Evidence of Coverage* for details of your initial coverage period benefits.

Once your total drug costs reach $2,400, you will reach your **initial coverage limit**. Your initial coverage limit is calculated by adding payments made by SecurityBlue 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 drug costs reach $2,400, you will reach the **coverage gap**.

Coverage gap (after you reach your initial coverage limit and before you qualify for catastrophic coverage)

Standard Plan: After your total drug expenditures reach $2,400, you, or others on your behalf, will pay 100% for your drugs until your total out-of-pocket expenditures reach $3,850 and you qualify for catastrophic coverage. However, when you buy your prescription drugs at network pharmacies or through the mail order service during this period, you will pay the Highmark discounted price.

Deluxe Plan: After your total drug expenditures reach $2,400, we will continue to provide prescription drug coverage until your total out-of-pocket expenditures reach $3,850. You or others on your behalf will pay: $8 for generic drugs. You will pay 100% of the Highmark discounted price for all other drugs during this period. Once your total out-of-pocket expenditures reach $3,850, you will qualify for catastrophic coverage.

Employer Group Plans: Please refer to the separate prescription drug coverage information you received with this *Addendum to the Evidence of Coverage* for details of your benefits during the coverage gap.

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 $3,850 out of pocket for the year. When the total amount you have paid toward your copayments, and the cost for covered Part D drugs after you reach the initial coverage limit reaches $3,850, you will qualify for catastrophic coverage. During catastrophic coverage, you will pay:

The greater of $2.15 for generics or brand name drugs that are multi-source drugs and $5.35 for all other drugs or 5% coinsurance. 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:

- Your copayments made on drugs normally covered in a Medicare Drug Plan that are:
    - Covered by the plan up to the initial coverage level;
    - Not on SecurityBlue'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 out-of-network access rules.
- Any payments you make for prescription drugs after the initial coverage limit that would otherwise be covered by the plan.

When you have spent a total of $3,850 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 (Pennsylvania's PACE Program);
- 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 SecurityBlue. 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:

    - ***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 and 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 copayments and coinsurance, 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.

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, SecurityBlue 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.

IF YOU HAVE OTHER PRESCRIPTION DRUG COVERAGE

We will send you a questionnaire 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 SecurityBlue Member Service to update your membership records.

If you have Medicare and Medicaid

SecurityBlue, not Medicaid, will pay for most of your prescription drugs.

If you are a member of Pennsylvania's Pharmaceutical Assistance Contract for the Elderly (PACE) Program

If you are currently enrolled in PACE or PACENET, you may get help paying your prescription drug copayments. Also, direct pay SecurityBlue members who are also members of PACE may receive help paying for the prescription drug coverage portion of their SecurityBlue premium. Please contact PACE to determine what benefits are available to you by calling 1-800-225-7223, Monday through Friday, 8:30 a.m. to 5:00 p.m.

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 2006 from your Medigap issuer explaining your options and how the removal of drug coverage from your Medigap policy will affect your premiums. If you did 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 (other than SecurityBlue), 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 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 SecurityBlue can count towards your out-of-pocket expenses. Call Member Service to request a claim form, then follow the instructions on the form for filing your claim for reimbursement.

EXTRA HELP WITH DRUG PLAN COSTS FOR PEOPLE WITH LIMITED INCOME AND RESOURCES

What extra help is available?

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 copayments.

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 $14,700 (or $19,800 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 2006. If you pay more than half of the living expenses of dependent family members, income limits are higher. Please call Member Service 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?

If you think you may qualify for extra help from the Federal government to pay for your prescription drug costs, call the Social Security Administration at 1-800-772-1213 (TTY/TDD 1-800-325-0778), visit www.socialsecurity.gov on the Web, or apply at your State Medical Assistance office. After you apply, you will receive 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 2007 *Medicare & You* Handbook, visit www.medicare.gov on the Web, or call 1-800-MEDICARE (1-800-633-4227). You can call 24 hours a day, seven days a week. TTY/TDD users should call 1-877-486-2048.

If you are receiving extra help with your Medicare prescription drug coverage, please refer to the separate "Low Income Subsidy Rider" for your specific premium and cost-sharing information.

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 2
Appeals And Grievances: What To Do If You Have Complaints About Your Part D Prescription Drug Benefits

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 Service at the number printed on your SecurityBlue membership card.

Please note that this section addresses complaints about your Part D prescription drug benefits. If you have complaints about your SecurityBlue medical benefits, you must follow the rules outlined in Section 7 of your SecurityBlue *Evidence of Coverage*.

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 SecurityBlue 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 SecurityBlue 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 exceptions 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).

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 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 in the upcoming section).

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

- You feel that you are being encouraged to leave (disenroll from) SecurityBlue.
- Problems with the Member Service 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 timeframe.
- Failure to forward your case to the independent review entity if we do not give you a decision within the required timeframe.
- 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 in the following sections.

If you have a grievance, we encourage you to first call Member Service at the number on your SecurityBlue membership card. 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 the Medicare Prescription Drug Grievance Procedure.**

The Fast-Track Grievance Procedure is as follows:
The expedited grievance procedures are used in the following instance:

If you disagree with the decision made by SecurityBlue not to grant you an expedited initial determination or reconsideration.

Your initial inquiry should be directed to the SecurityBlue Member Service Department.

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

The Standard Grievance Procedure is as follows:

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

  SecurityBlue Medicare Prescription Drug
  Appeals Department
  P.O. Box 535047
  Pittsburgh, PA 15253-5047
  Fax # 1-412-544-1513

- SecurityBlue will review your written complaint. For complaints regarding such issues as waiting times, pharmacy staff behavior and demeanor, quality of care, adequacy of or access to facilities, fraud or abuse concerns, and other similar member concerns, SecurityBlue will take the appropriate steps to investigate your complaint. These steps may include, but are not limited to, investigating the pharmacy provider, a review of the medical records or ongoing provider monitoring. SecurityBlue will respond in writing within 30 days or as expeditiously as the case requires.

- Complaints that do not involve pharmacy providers or general dissatisfaction with the Part D Plan will be forwarded to the First Level Complaint Committee for review. Examples of such complaints may include, but are not limited to, involuntary disenrollment situations or requests for premium reimbursement. You will receive a response from the First Level Complaint Committee in writing within 30 days or as expeditiously as the case requires. If you are dissatisfied with the response to your complaint, you may request to have the decision reviewed by a Second Level Complaint Committee. The request to have the decision reviewed must be submitted in writing within 45 days from the date the decision is received and may include any written supporting material from you or any party of interest.

- The Second Level Complaint Committee is comprised of three individuals who did not participate in the initial reviews. At least one Committee

member will not be a Highmark Inc. employee, but they must be a member of a Highmark health care plan. The Committee will hold an informal hearing to consider your complaint. When arranging the hearing, SecurityBlue will notify you in writing of the hearing procedures and your rights at the hearing, including your right to appear before the Committee. The hearing will be held within 30 days of the Committee's receipt of your request for review. The Committee will provide written notification of the decision within five business days of the hearing. The notification will specify the reasons for the decision.

- The decision of the Second Level Complaint Committee will be binding.

- For further information regarding the purposes and operations of the grievance procedure, contact SecurityBlue Member Service.

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 timeframe 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 Section 7 in the SecurityBlue *Evidence of Coverage* for more information about how to file a quality of care complaint with the QIO.

HOW TO REQUEST A COVERAGE DETERMINATION

This part 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 SecurityBlue 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 SecurityBlue.

- If you have received a Part D prescription drug you believe may be covered by SecurityBlue 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 "What is a Coverage Determination" on page 31 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 "What is a Coverage Determination" on page 31 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 "What is a Coverage Determination" on page 31 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 in the following section titled, "Detailed Information About How to Request a Coverage Determination and an Appeal."

HOW TO REQUEST AN APPEAL

This part 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 also 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, you can appeal. A coverage determination, which includes those described on the following pages, 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 copayment 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 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 SecurityBlue, 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: SECURITYBLUE 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 SecurityBlue 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 SecurityBlue 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. 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).

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 the Member Service number printed on your SecurityBlue membership card 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 the Member Service number printed on your SecurityBlue membership card to ask for this type of decision.

- You ask for a non-preferred brand name drug at the preferred brand cost-sharing level. This is a request for a "tiering exception." You can call us at the Member Service number printed on your SecurityBlue membership card 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 the Member Service number printed on your SecurityBlue membership card 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 section, "Filling Prescriptions Outside the Network," for a description of these circumstances. You can call us at the Member Service number printed on your SecurityBlue membership card 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 SecurityBlue apply to your specific situation. This booklet and any amendments you may receive describe the Part D prescription drug benefits covered by SecurityBlue, including any limitations that may apply to these benefits. This booklet also lists exclusions (benefits that are "not covered" by SecurityBlue).

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 SecurityBlue, P.O. Box 1068, Pittsburgh, PA 15222. You can call SecurityBlue Member Service at the number printed on your SecurityBlue membership card 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 timeframe?

A decision about whether we will cover a Part D prescription drug can be a "standard" coverage determination that is made within the standard timeframe (typically within 72 hours), or it can be a "fast" coverage determination that is made more quickly (typically within 24 hours). 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 the Member Service number printed on your SecurityBlue membership card. Or, you can send a written request to Highmark Inc. Pharmacy Affairs, P.O. Box 279, Pittsburgh, PA 15230 or fax it to 1-412-544-7546.

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 the Member Service number printed on your SecurityBlue membership card. Or, you can send a written request to SecurityBlue at Highmark Inc. Pharmacy Affairs, P.O. Box 279, Pittsburgh, PA 15230 or fax it to 1-412-544-7546. 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 timeframe.

What happens when you request a coverage determination?

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

1. 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, a tiering exception, or an exception from utilization management rules—such as dosage or quantity limits), 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.

2. For a fast 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 (formulary or tiering), 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 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 timeframe 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 standard 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 fast 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 after 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 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 the SecurityBlue Member Service number printed on your SecurityBlue membership card 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 Timeframe?" and "Asking for a Fast Decision." While the process for deciding on a standard or fast appeal is the same as in the case of a coverage determination, the place where the appeal is sent is different—please refer to "What If You Want a Fast Appeal" later in this section for more information.

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: SecurityBlue Medicare Prescription Drug Appeals and Grievance Department, P.O. Box 535047, Pittsburgh, PA 15253-5047.

- By fax, at 1-412-544-1513.

- By telephone—if it is a fast appeal—at 1-800-485-9610; TTY users—1-888-422-1226.

- In person, at any of the following walk-in centers:
  Penn Avenue Place, 501 Penn Avenue, Ground Floor, Pittsburgh, PA 15222

  One Pasquerilla Plaza, Johnstown, PA 15901

  717 State Street, Erie, PA 16501.

You also have the right to ask us for a copy of information regarding your appeal. You can call at 1-800-935-2583 (TTY users, call 1-800-988-0668) or write us at SecurityBlue Medicare Prescription Drug Appeals and Grievance Department, P.O. Box 535047, Pittsburgh, PA 15253-5047.

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 SecurityBlue Medicare Prescription Drug Appeals and Grievance Department, P.O. Box 535047, Pittsburgh, PA 15253-5047.

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 1-800-485-9610. Or you can send a written request to SecurityBlue Medicare Prescription Drug Expedited Review Department, P.O. Box 535073, Pittsburgh, PA 15253-5073 or fax it to 1-800-894-7947. For requests that are made outside of regular weekday business hours, call Expedited Review at 1-800-485-9610 (TTY users, call 1-888-422-1226). 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 seven 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 seven 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 seven 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 SecurityBlue.

APPEAL LEVEL 2: IF WE DENY ANY PART OF YOUR FIRST APPEAL, YOU MAY ASK FOR A REVIEW BY A GOVERNMENT-CONTRACTED INDEPENDENT REVIEW ORGANIZATION

What independent review organization does this review?

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

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 SecurityBlue.

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 independent review organization 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 seven 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 $110.00 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. You must send your written request to:

Department of Health and Human Services
Office of Medicare Hearing & Appeals
200 Public Square, Suite 1300
Cleveland, OH 44114-2316

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 $110.00. If the dollar value is less than $110.00, 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 copayments, 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 your 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 3:
Definitions Of Some Words Used In This Prescription Drug Coverage *Addendum To The SecurityBlue Evidence Of Coverage*

For the terms listed below, this section either gives a definition or directs you to a place in this *Addendum to the Evidence of Coverage* that explains the term. Please also refer to the definitions in Section 12 of your *Evidence of Coverage*.

Appeal– A type of complaint you make when you want a reconsideration and a change to a decision we have made about what drugs are covered for you or what we will pay for a drug.

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 sometimes not available until after the patent on the brand name drug has expired.

Coverage Determination– The decision the plan makes about the prescription drug benefits you are entitled to get under the plan, and the amount that you are required to pay for a drug.

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

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

Evidence of Coverage and Disclosure Information– This document, along with your enrollment form and any other attachments, which explains your coverage, defines our obligations, and explains your rights and responsibilities as a member of our plan.

Exception– A type of coverage determination that, if approved, allows you to get a drug that is not on your plan's formulary (a formulary exception) or a non-preferred brand name drug covered at the preferred brand cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

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

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

Grievance– A type of complaint you make about us or one of our providers, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Late Enrollment Penalty– If you do not have creditable prescription drug coverage, you will have to pay a late enrollment penalty in addition to your monthly plan premium.

Medicare Advantage Plan with Prescription Drug Coverage– A benefit package offered by a Medicare Advantage Organization that offers a specific set of health benefits at a uniform premium and 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.

Medicare Health Plan– A benefit package offered by an insurance company that contracts with Medicare. The plan is available to anyone who lives in the plan service area and who has Medicare Parts A and B, except those who have End Stage Renal Disease (unless certain exceptions apply).

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

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

Out-of-Network Pharmacy– A pharmacy that we have not arranged with to coordinate or provide covered drugs to members of our plan.

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 unless it is covered under Part A or Part B.

Prior Authorization– Approval in advance to get certain drugs that may or may not be on our formulary. Some services are covered only if your doctor or other provider gets "prior authorization" from us. Covered services that need prior authorization are marked in the formulary.

Service Area– A geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a particular plan offered by a Medicare Health Plan.

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

This Addendum is available in audio tape or CD format. Call Member Service at the number on your membership card to request a copy.

SECURITYBLUE℠ HIGHMARK BLUE CROSS BLUE SHIELD
A Medicare Advantage HMO from Keystone Health Plan West

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

Keystone Health Plan West has a contract with the Federal government to administer Medicare Prescription Drug Coverage in the SecurityBlue service area.

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