Document Submitted By Bob Clarkin

PUBLIC COMMENTS FOR 8/10/2023 RHBAS MEETING - SUBMITTED BY ROBERT CLARKIN, 8/2/23

Funding, Eligibility, and Benefit Design Option Combination (Example 2) on Page 12 of the 7/20/2023 Options to Reduce OPED Liability Presentation

I believe that the most effective and efficient long term approach to fund quality health care and prescription plans for retirees is to model the OPEB Trust Fund after the successful and highly regarded Delaware Pension Trust Fund. It is an undeniable fact that the pension trust fund is maintained annually with reasonable State and active employee contributions, while actual pension costs are paid for with trust fund interest, dividends, and other capital gains. On the other hand, the OPEB trust fund is underfunded and the State is burdened with increasing annual Pay-Go costs.

Looking at the Funding, Eligibility, and Benefit Design Combination (Example 2) on page 12 of the 7/20/2023 Options to Reduce OPEB Liability Presentation (Attachment #1), I believe with a change to the OPEB liability rate percentage and a revised discount rate assumption, the model would reach ADC well prior to 2041. And, when the ADC is reached and the fund can then cover the pay-go costs from interest, dividends, and other capital gains, the State will be relieved from the pay-go contribution burden (which greatly reduces the overall OEC rate across all FTE's regardless of their funding).

Funding: As increasing the State OPEB rate of payroll has an adverse affect upon ASF, NSF, TFO, TFC, and Affiliated Entity funded positions, I propose an increase in the state funding rate of payroll to OPEB from 0.36% to 0.5% for **FTE's funded with General Funds** beginning July 1, 2024 and an additional 0.5% each fiscal year thereafter, and an increase in the state funding rate of payroll to OPEB from 0.36% to 0.5% **for FTE's funded with other than General Funds** beginning July 1, 2024 and an additional **0.25%** each fiscal year thereafter until reaching a 10% funding level, **respectively,** or the ADC, **in combination**.

Additional Assumption: During the 7/20/2023 RHBAS meeting, Dave Craik remarked that since the OPEB trust fund assets are commingled with Pension trust fund assets and the Pension trust fund enjoys a 7% discount rate, then the OPEB trust fund could also enjoy a 7% discount rate. The discount rate, in and of itself, is very significant when determining a current and future liability. On page 2 of the Cheiron Postretirement Health Plan Actuarial Valuation Report as of 7/1/2022 (Attachment #2), there is a table that summarizes key valuation results. The table indicates an increase in the discount rate from 2.16% as of 7/1/2021 to 3.54% as of 7/1/2022. This discount rate increase,

decreased the Unfunded Actuarial Liability from $10.1B to $8.4B. Page 12 (Attachment #3) of the report indicates that increasing the discount rate to 7%, in and of itself, produces an unfunded liability of $5.0B rather than $8.4B (a reduction of 40.5% without any funding, eligibility, or plan design changes). I propose recalculating this option, and all of the other options, based on a 7% discount rate.

General Funding, Eligibility, and Plan Design Options

Funding: While researching the establishment of the Pension trust fund, I have not been able to locate information regarding the initial investments in the fund. I believe there may have been significant investments in the fund during the initial start-up years above and beyond the required ADC. I would like to suggest that Dave Craik or Joanna Adams give a presentation to the Committee regarding the financial start-up and maintenance of the Pension trust fund as well as how the start-up and maintenance relates to the OPEB trust fund.

Eligibility and Plan Design: Looking at all of the Eligibility and Plan Design items contained in the Options to Reduce OPEB Liability presentation, it is apparent that these items do not apply to pre-65 retirees. During FY22, 47.3% of retiree healthcare costs were attributable to pre-65 retirees. Is it prudent or fair to address the liability and pay-go problems solely on the backs of Medicare eligible retirees?

Attachment #1

Recalculate
* additional 0.5% each fiscal year for General Fund Positions
* additional 0.25% each fiscal year for Other Than General Fund Positions

Options to Reduce OPEB Liability

- Funding, Eligibility and Benefit Design Option Combination (Example 2)

Option	Option Description	Additional Assumption Details	Approx. 2025 OPEB Liability Reduction[1,2]	Approx. 2052 OPEB Liability Reduction[1,2]	2052 Approx. Funded Ratio[1,2]
Funding: *	Assumes 1% of prior fiscal year state budget ($47.7M based on $4.7B budget for FY22); projected to grow at 3.6% AND Increase State funding rate of payroll to OPEB from 0.36% to 0.5% beginning July 1, 2024 and an additional 0.5% each fiscal year thereafter until reaching a 10% funding level or ADC.	▪ Model B: Hire date after 1/1/25 *	▪ Model B: $2.2B	▪ Model B: $14.7B	▪ Model B: 80.8% NOTE: ▪ Reach ADC in 2041 ▪ When ADC is reached, paygo contributions stop
Eligibility:	Reduce Spousal State Share Subsidy to 50% for Spouses for new hires on/after 1/1/25 AND Eliminate vested retirees from eligibility for healthcare for new hires on/after 1/1/25.				
Plan Design:	Reduce State Share from 95% to 85% and increase Pensioner share from 5% to 15% for retirees with 20+ years of service for new hires on/after 1/1/2025.				

[1] Includes 0.36% payroll contribution
[2] Estimated; modeling provided by Cheiron

Very Important

244.6M in FY22

Recalculate @ 7% Discount Rate

256.9M projected for FY23

Attachment #2

SECTION I – SUMMARY

Valuation Results

The table below presents the key results of the 2021 and 2022 valuations.

Table I-1
Summary of Key Valuation Results
($ In Millions)

Discount Rate	2.16%	3.54%
	July 1, 2021	**July 1, 2022**
Actuarial Liability (AL)	$ 10,773.3	$ 8,938.0
Assets	650.3	582.7
Unfunded Actuarial Liability (UAL)	$ 10,123.0	$ 8,355.3
Fiscal Year Ending	**June 30, 2022**	**June 30, 2023**
Annual Required Contribution (ARC)	$ 784.3	$ 646.3
Actual / *Expected* Contribution	273.4	*305.3*
Actual / *Expected* Net Benefit Payments	254.5	*248.9*

The figures provided in this report are highly sensitive to the assumptions used.

The expected increase in liability during the year was $470 million. The Plan experienced an increase in liability due to population changes of $5 million as well as a decrease due to updated health claims and trend assumptions of $159 million and a decrease due to the discount rate increase from 2.16% to 3.54% of $2,150 million. The total decrease in the actuarial liability was approximately $1,835 million. More detail on the effects of these changes can be found in the valuation results section of this report.

The expected contribution of $305.3 million for the period ending June 30, 2023 includes $47.7 million in one-time payments plus 0.36% of covered payroll plus $248.9 million of net benefit payments.

Attachment #3

SECTION V – ACTUARIAL FUNDING

To have a system where the assets will eventually accumulate to the actuarial liability, meaning that the entire liability is funded, the State of Delaware may wish to begin funding this program on an actuarial basis by contributing the ADC. For illustration purposes, the amortization period selected to pay off the unfunded liability was set to a 30-year closed amortization. If the State were to establish a funding policy of contributing the ADC, the discount rate could be increased. Using a discount rate of 7.0% (matching the pension assumption) produces an unfunded liability of $5.0 billion rather than $8.4 billion.

In addition to the change in overall liability, the ADC will also decrease. Thus, in order to fund on an actuarial basis, the State needs to contribute $478.2 million, or $168.1 million below the ARC under PAYGo. The $478.2 million is $229.3 million higher than the expected PAYGo cost of $248.9 million for FYE 2022.

If the State increases its contribution, but it is still less than the actuarially funded scenario, the discount rate will increase above the 3.54% discount rate, and the resulting liabilities and ADC payments will likely fall between the two discount rate scenarios presented in this report.

Table V-1
Actuarial Liability
Actuarial Funding
(7.0% assumed discount)
($ in millions)

	State Employees	Judges	Closed State Police	Open State Police	Total
Actives	$ 2,504.1	$ 1.7	$ -	$ 87.3	$ 2,593.1
Retirees	2,819.0	3.8	41.0	80.6	2,944.4
Total	**$ 5,323.1**	**$ 5.5**	**$ 41.0**	**$ 167.9**	**$ 5,537.5**
Assets*	559.7	1.0	4.0	18.0	582.7
UAL	**$ 4,763.4**	**$ 4.5**	**$ 37.0**	**$ 149.9**	**$ 4,954.8**

* Assets allocated in proportion to liabilities

Table V-2
Actuarially Determined Contributions – FY2023
Actuarial Funding
(7.0% assumed discount)
($ in millions)

	State Employees	Judges	Closed State Police	Open State Police	Total
Normal Cost	$ 141.9	$ 0.2	$ -	$ 5.8	$ 147.9
UAL Amortization	263.3	0.3	2.0	8.3	273.9
Total	**$ 405.2**	**$ 0.5**	**$ 2.0**	**$ 14.1**	**$ 421.8**

Documents Submitted By Joe Zilcosky

Dear SEBC and Subcommittees,

I would like to comment on the SEBC Retiree Healthcare Benefit Advisory Subcommittee presentation that was given on July 10th.

In the presentation, it had Model A, B and C and Model C suggested that anyone who retires after 1/1/25 will get greatly reduced benefits. I am opposed to this Model for a following reasons:

1. Many of us have worked at the state for many years and have begun to qualify for benefits that will then be taken away from us.
2. It could cause a mass retirement in 2024 so people don't lose those benefits and the state already has a couple thousand job openings that it can't fill.
3. Tenured employees have rights and we should not be given a bate and switch. The most ethical way would be to choose the model that only affects new hires as of 1/1/25.
4. The savings difference in the three models is not that significant to justify impacting such a large group of people.

Joe Zilcosky

Document Submitted
By
Dr. Joe Lucca

Some Thoughts on the State of Delaware's Plan to Transition to Highmark's Medicare's Advantage Plan

The following briefly discusses a serious problem with Highmark's Medicare Advantage Plans.

Besides the practice of Prior Authorization that Medicare Advantage Programs (MAP) impose on their members there is another, almost criminal, behavior common to MAPs and that is the alteration of MAP patient's Health Profiles by the MAPs. This fraudulent practice goes like this:

- MAPs get paid per patient based on the severity of their anticipated health needs ie: the amount of health care and the complexity of health care they will need.

- In other words, the sicker the patient appears on paper, the more money MAPs get from Medicare.

- In Medicare jargon, this practice is called 'Risk Adjustment', the process of predicting health care costs by assigning a risk score to beneficiaries based on their health status.

- So as you might imagine, the MAPs view this opportunity as a cash cow.

  MAPs have been falsifying their patients' Risk Adjustment profiles for decades and draining the Medicare Trust Fund.

- MAPs have been the focus of congressional hearings and reports from the U.S. Department of Health and Human Services Office of Inspector General (HHS OIG) and the Government Accountability Office for several years.

So, it should be of no surprise to you that Medicare and the OIG's office have been uncovering huge over payments to MAPs that were based on fraudulent Risk Assessments? I might add that Highmark is front and center in this activity. The OIG has assessed that Highmark owes Medicare over $6,000,000 from 2015-2016 alone for Risk Adjustment issues and probably much more as the OIG investigation continues. Needless to say that the OIG is finding that this behavior is endemic throughout the MAPs .

My question to you is, should we appeal to the Governor's, and the General Assembly's, responsibility to not do business with healthcare entities whose practices either teeter on the edge of criminality or are fully involved in criminal behavior, and who are obviously interested in getting as much money from Medicare as possible. Really, Governor John Carney has a duty to be a faithful steward of Delaware's finances and steer clear of business entities who practice fraudulently like Highmark does, and as most of the MAPS also do.

I have attached several PDFs with information on this general practice of Risk Adjustment modification in general, and Highmarks involvement in particular. Another reference speaks to the OIGs efforts to get to the bottom of it. I, for one, think the State of Delaware should get as far away as possible from any MAP involvement.

Thank you for your attention,

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#1

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE ADVANTAGE COMPLIANCE AUDIT OF SPECIFIC DIAGNOSIS CODES THAT HIGHMARK SENIOR HEALTH COMPANY (H3916) SUBMITTED TO CMS

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Amy J. Frontz
Deputy Inspector General
for Audit Services

September 2022
A-03-19-00001

Office of Inspector General

https://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief
Date: September 2022
Report No. A-03-19-00001

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Highmark Senior Health Company (H3916) Submitted to CMS

Why OIG Did This Audit

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) makes monthly payments to MA organizations according to a system of risk adjustment that depends on the health status of each enrollee. Accordingly, MA organizations are paid more for providing benefits to enrollees with diagnoses associated with more intensive use of health care resources than to healthier enrollees, who would be expected to require fewer health care resources. To determine the health status of enrollees, CMS relies on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS. Some diagnosis codes are at higher risk for being miscoded, which may result in overpayments from CMS. For this audit, we reviewed one MA organization, Highmark Senior Health Company.

Our objective was to determine whether selected diagnosis codes that Highmark submitted to CMS for use in CMS's risk adjustment program complied with Federal requirements.

How OIG Did This Audit

We sampled 226 unique enrollee condition and payment years (enrollee-years) with the high-risk diagnosis codes for which Highmark received higher payments for 2015 and 2016. We limited our review to the portion of the payments that were associated with these high-risk diagnosis codes, which totaled $801,166.

What OIG Found

With respect to the six high-risk groups covered by our audit, most of the selected diagnosis codes that Highmark submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 160 of the 226 sampled enrollee-years, the diagnosis codes were not supported in the medical records.

These errors occurred because the policies and procedures that Highmark had to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, could be improved. As a result, the Hierarchical Condition Categories (diagnosis code groupings based on similarity of clinical characteristics, severity, and cost implications) for these high-risk diagnosis codes were not validated. On the basis of our sample results, we estimated that Highmark received at least $6.2 million of net overpayments for 2015 and 2016.

What OIG Recommends and Highmark Comments

We recommend that Highmark: (1) refund to the Federal Government the $6.2 million of estimated net overpayments; (2) identify, for the high-risk diagnoses included in the report, similar instances of noncompliance that occurred before or after our audit period and refund any resulting overpayments to the Federal Government; and (3) continue its examination of its existing compliance procedures to identify areas where improvements can be made to ensure diagnosis codes that are at high risk for being miscoded comply with Federal requirements (when submitted to CMS for use in CMS's risk adjustment program) and take the necessary steps to enhance those procedures.

In written comments on our draft report, Highmark disagreed with our findings and recommendations. Highmark provided additional information for two medical records that it said substantiated specific Hierarchical Condition Categories. Highmark also questioned our audit and statistical sampling methodologies and stated that it had a robust compliance program. After reviewing Highmark's comments and the additional information provided, we revised our findings and recommendations as appropriate. We maintain that our methodologies were reasonable and properly executed.

The full report can be found at https://oig.hhs.gov/oas/reports/region3/31900001.asp.

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INTRODUCTION

WHY WE DID THIS AUDIT

Under the Medicare Advantage (MA) program, the Centers for Medicare & Medicaid Services (CMS) makes monthly payments to MA organizations based in part on the characteristics of the enrollees being covered. Using a system of risk adjustment, CMS pays MA organizations the anticipated cost of providing Medicare benefits to a given enrollee, depending on such risk factors as the age, sex, and health status of that individual. Accordingly, MA organizations are paid more for providing benefits to enrollees with diagnoses associated with more intensive use of health care resources relative to healthier enrollees, who would be expected to require fewer health care resources. To determine the health status of enrollees, CMS relies on MA organizations to collect diagnosis codes from their providers and submit these codes to CMS.[1] We are auditing MA organizations because some diagnoses are at higher risk for being miscoded, which may result in overpayments from CMS.

This audit is part of a series of audits in which we are reviewing the accuracy of diagnosis codes that MA organizations submitted to CMS.[2] Using data mining techniques and considering discussions with medical professionals, we identified diagnoses that were at higher risk for being miscoded and consolidated those diagnoses into specific groups. (For example, we consolidated 29 major depressive disorder diagnoses into 1 group.) This audit covered Highmark Senior Health Company (Highmark) for contract number H3916 and focused on six groups of high-risk diagnosis codes for payment years 2015 and 2016.[3]

OBJECTIVE

Our objective was to determine whether selected diagnosis codes that Highmark submitted to CMS for use in CMS's risk adjustment program complied with Federal requirements.

BACKGROUND

Medicare Advantage Program

The MA program offers beneficiaries managed care options by allowing them to enroll in private health care plans rather than having their care covered through Medicare's traditional

[1] Providers code diagnoses using the International Classification of Diseases (ICD), Clinical Modification (CM), *Official Guidelines for Coding and Reporting* (ICD Coding Guidelines). The ICD is a coding system that is used by physicians and other health care providers to classify and code all diagnoses, symptoms, and procedures. Effective October 1, 2015, CMS transitioned from the ninth revision of the ICD Coding Guidelines (which we refer to as "ICD-9" in this report) to the tenth revision (which we refer to as "ICD-10" in this report). Each revision includes different diagnosis code sets.

[2] See Appendix B for related Office of Inspector General reports.

[3] All subsequent references to "Highmark" in this report refer solely to contract number H3916.

fee-for-service (FFS) program.[4] Beneficiaries who enroll in these plans are known as enrollees. To provide benefits to enrollees, CMS contracts with MA organizations, which in turn contract with providers (including hospitals) and physicians.

Under the MA program, CMS makes advance payments each month to MA organizations for the expected costs of providing health care coverage to enrollees. These payments are not adjusted to reflect the actual costs that the organizations incurred for providing benefits and services. Thus, MA organizations will either realize profits if their actual costs of providing coverage are less than the CMS payments or incur losses if their costs exceed the CMS payments.

For 2020, CMS paid MA organizations $317.1 billion, which represented 34 percent of all Medicare payments for that year.

Risk Adjustment Program

Federal requirements mandate that payments to MA organizations be based on the anticipated cost of providing Medicare benefits to a given enrollee and, in doing so, also account for variations in the demographic characteristics and health status of each enrollee.[5]

CMS uses two principal components to calculate the risk-adjusted payment that it will make to an MA organization for an enrollee: a base rate that CMS sets using bid amounts received from the MA organization and the risk score for that enrollee. These are described as follows:

- *Base rate*: Before the start of each year, each MA organization submits bids to CMS that reflect the MA organization's estimate of the monthly revenue required to cover an enrollee with an average risk profile.[6] CMS compares each bid to a specific benchmark amount for each geographic area to determine the base rate that an MA organization is paid for each of its enrollees.[7]

- *Risk score*: A risk score is a relative measure that reflects the additional or reduced costs that each enrollee is expected to incur compared with the costs incurred by enrollees on average. CMS calculates risk scores based on an enrollee's health status (discussed below) and demographic characteristics (such as the enrollee's age and sex). This

[4] The Balanced Budget Act of 1997, P.L. No. 105-33, as modified by section 201 of the Medicare Prescription Drug, Improvement, and Modernization Act, P.L. No. 108-173, established the MA program.

[5] The Social Security Act (the Act) §§ 1853(a)(1)(C) and (a)(3); 42 CFR § 422.308(c).

[6] The Act § 1854(a)(6); 42 CFR § 422.254 *et seq*.

[7] CMS's bid-benchmark comparison also determines whether the MA organization must offer supplemental benefits or must charge a basic beneficiary premium for the benefits.

process results in an individualized risk score for each enrollee, which CMS calculates annually.

To determine an enrollee's health status for purposes of calculating the risk score, CMS uses diagnoses that the enrollee receives from acceptable data sources, including certain physicians and hospitals. MA organizations collect the diagnosis codes from providers based on information documented in the medical records and submit these codes to CMS. CMS then maps certain diagnosis codes, on the basis of similar clinical characteristics and severity and cost implications, into Hierarchical Condition Categories (HCCs).[8] Each HCC has a factor (which is a numerical value) assigned to it for use in each enrollee's risk score.

As a part of the risk adjustment program, CMS consolidates certain HCCs into related-disease groups. Within each of these groups, CMS assigns an HCC for only the most severe manifestation of a disease in a related-disease group. Thus, if MA organizations submit diagnosis codes for an enrollee that map to more than one of the HCCs in a related-disease group, only the most severe HCC will be used in determining the enrollee's risk score.

For enrollees who have certain combinations of HCCs (in either the Version 12 model or the Version 22 model), CMS assigns a separate factor that further increases the risk score. CMS refers to these combinations as disease interactions. For example, if MA organizations submit diagnosis codes (in the Version 12 model) for an enrollee that map to the HCCs for acute stroke, acute myocardial infarction, and chronic obstructive pulmonary disease, CMS assigns a separate factor for this disease interaction. By doing so, CMS increases the enrollee's risk score for each of the three HCC factors and by an additional factor for the disease interaction.

The risk adjustment program is prospective. Specifically, CMS uses the diagnosis codes that the enrollee received for one calendar year (known as the service year) to determine HCCs and calculate risk scores for the following calendar year (known as the payment year). Thus, an enrollee's risk score does not change for the year in which a diagnosis is made. Instead, the risk score changes for the entirety of the year after the diagnosis has been made. Further, the risk score calculation is an additive process – as HCC factors (and, when applicable, disease interaction factors) accumulate, an enrollee's risk score increases, and the monthly risk-adjusted payment to the MA organization also increases. In this way, the risk adjustment program compensates MA organizations for the additional risk for providing coverage to enrollees expected to require more health care resources.

CMS multiplies the risk scores by the base rates to calculate the total Medicare monthly payment that an MA organization receives for each enrollee before applying the budget

[8] CMS transitioned from one HCC payment model to another during our audit period. As part of this transition, for 2015, CMS calculated risk scores based on both payment models. CMS refers to these models as the Version 12 model and the Version 22 model, each of which has unique HCCs. CMS blended the two separate risk scores into a single risk score that it used to calculate a risk-adjusted payment. Accordingly, for 2015, an enrollee's blended risk score is based on the HCCs from both payment models. For 2016, CMS calculated risk scores based on the Version 22 model.

sequestration reduction.[9] CMS uses diagnosis codes that it receives from MA organizations to determine which HCCs should be used in calculating enrollee risk scores. If medical records do not support these diagnosis codes, the HCCs are not validated. Unvalidated HCCs cause enrollee risk scores to be overstated, which results in improper payments (overpayments) from CMS to MA organizations. Conversely, if medical records support diagnosis codes that MA organizations do not submit to CMS, enrollee risk scores may be understated, which may also result in improper payments (underpayments).

High-Risk Groups of Diagnoses

Using data mining techniques and discussions with medical professionals, we identified diagnoses that were at higher risk for being miscoded and consolidated those diagnoses into specific groups. For this audit, we focused on six high-risk groups:[10]

- *Acute stroke*: An enrollee received one acute stroke diagnosis (which maps to the HCC for Ischemic or Unspecified Stroke) on one physician claim during the service year but did not have that diagnosis on a corresponding inpatient hospital claim. A diagnosis of history of stroke (which does not map to an HCC) typically should have been used.

- *Acute heart attack*: An enrollee received one diagnosis that mapped to either the HCC for Acute Myocardial Infarction or to the HCC for Unstable Angina and Other Acute Ischemic Heart Disease (Acute Heart Attack HCCs) on only one physician claim during the service year but did not have that diagnosis on a corresponding inpatient hospital claim (either within 60 days before or 60 days after the physician's claim). A diagnosis for a less severe manifestation of a disease in the related-disease group typically should have been used.

- *Embolism*: An enrollee received one diagnosis that mapped to either the HCC for Vascular Disease or to the HCC for Vascular Disease With Complications (Embolism HCCs) during the service year but did not have an anticoagulant medication dispensed on his or her behalf. An anticoagulant medication is typically used to treat an embolism. A diagnosis of history of embolism (an indication that the provider is evaluating a prior acute embolism diagnosis, which does not map to an HCC) typically should have been used.

- *Vascular claudication*: An enrollee received one diagnosis related to vascular claudication (which maps to the HCC for Vascular Disease) during the service year but had medication dispensed on his or her behalf that is frequently dispensed for a

[9] Budget sequestration refers to automatic spending cuts that occurred through the withdrawal of funding for certain Federal Government programs, including the MA program, as provided in the Budget Control Act of 2011 (BCA) (P.L. No. 112-25 (8-2-2011)). Under the BCA, the sequestration of mandatory spending began in April 2013.

[10] Unless otherwise specified, the HCCs described in this report have the same name under both the Version 12 and Version 22 models.

diagnosis of neurogenic claudication.[11] In these instances, the vascular claudication diagnoses may not be supported in the medical records.

- *Major depressive disorder*: An enrollee received one major depressive disorder diagnosis (which maps to the HCC for Major Depressive, Bipolar, and Paranoid Disorders) during the service year but did not have an antidepressant medication dispensed on his or her behalf. In these instances, the major depressive disorder diagnoses may not be supported in the medical records.

- *Potentially mis-keyed diagnosis codes*: An enrollee received multiple diagnoses for a condition but received only one—potentially mis-keyed—diagnosis for an unrelated condition (which mapped to a possibly unvalidated HCC). For example, ICD-9 diagnosis code 250.00 (which maps to the HCC for Diabetes Without Complication) could be transposed as diagnosis code 205.00 (which maps to the HCC for Metastatic Cancer and Acute Leukemia and, in this example, would be unvalidated). Using an analytical tool that we developed, we identified 832 scenarios in which diagnosis codes mis-keyed because of data transposition or other data entry errors could have resulted in the assignment of an unvalidated HCC.

In this report, we refer to the diagnosis codes associated with these groups as "high-risk diagnosis codes."

Highmark Senior Health Company

Highmark is an MA organization based in Pittsburgh, Pennsylvania. As of December 31, 2016, Highmark provided coverage under contract number H3916 to approximately 208,600 enrollees. For the 2015 and 2016 payment years (audit period),[12] CMS paid Highmark approximately $3.6 billion to provide coverage to its enrollees.[13]

HOW WE CONDUCTED THIS AUDIT

Our audit included enrollees on whose behalf providers documented diagnosis codes that mapped to one of the six high-risk groups during the 2014 and 2015 service years, for which Highmark received increased risk-adjusted payments for payment years 2015 and 2016, respectively. Because enrollees could be classified in more than one high-risk group or have high-risk diagnosis codes documented in more than 1 year, we classified these individuals

[11] Vascular claudication and neurogenic claudication are different diagnoses. Vascular claudication is a condition that can result in leg pain while walking and is caused by insufficient blood flow. Neurogenic claudication is a condition that can also result in leg pain but is caused by damage to the neurological system, namely the spinal cord and nerves.

[12] The 2015 and 2016 payment year data were the most recent data available at the start of the audit.

[13] All of the payment amounts that CMS made to Highmark and the overpayment amounts that we identified in this report reflect the budget sequestration reduction.

according to the condition and the payment year, which we refer to as "enrollee-years." We identified 4,232 unique enrollee-years and limited our review to the portions of the payments that were associated with these high-risk diagnosis codes ($11.2 million). We selected for audit a sample of 226 enrollee-years, which comprised: (1) a stratified random sample of 150 (out of 4,156) enrollee-years for the first 5 high-risk groups and (2) 76 enrollee-years for the remaining high-risk group.

Table 1 details the number of sampled enrollee-years for each high-risk group.

Table 1: Sampled Enrollee-Years

High-Risk Group	Number of Sampled Enrollee-Years
1. Acute stroke	30
2. Acute heart attack	30
3. Embolism	30
4. Vascular claudication	30
5. Major depressive disorder	30
Total for Stratified Random Sample	**150**
6. Potentially mis-keyed diagnosis codes	76
Total for All High-Risk Groups	**226**

Highmark provided medical records as support for the selected diagnosis codes associated with the 218 of 226 enrollee-years.[14] We used an independent medical review contractor to review the medical records to determine whether the HCCs associated with the sampled enrollee-years were validated. If the contractor identified a diagnosis code that should have been submitted to CMS instead of the selected diagnosis code, we included the financial impact of the resulting HCC (if any) in our calculation of overpayments.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology, Appendix C contains our statistical sampling methodology, Appendix D contains our sample results and estimates, and Appendix E contains Federal regulations regarding compliance programs that MA organizations must follow.

[14] Highmark could not locate any medical records for 8 enrollee-years.

FINDINGS

With respect to the six high-risk groups covered by our audit, most of the selected diagnosis codes that Highmark submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. For 66 of the 226 sampled enrollee-years, either the medical records validated the reviewed HCCs, or we identified another diagnosis code (on CMS's systems) that mapped to the HCC under review. However, for the remaining 160 enrollee-years, the diagnosis codes were not supported in the medical records.

These errors occurred because the policies and procedures that Highmark had to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations, could be improved. As a result, the HCCs for these high-risk diagnosis codes were not validated. On the basis of our sample results, we estimated that Highmark received at least $6.2 million of net overpayments for 2015 and 2016.[15]

FEDERAL REQUIREMENTS

Payments to MA organizations are adjusted for risk factors, including the health status of each enrollee (the Social Security Act § 1853(a)). CMS applies a risk factor based on data obtained from the MA organizations (42 CFR § 422.308).

Federal regulations state that MA organizations must follow CMS's instructions and submit to CMS the data necessary to characterize the context and purposes of each service provided to a Medicare enrollee by a provider, supplier, physician, or other practitioner (42 CFR § 422.310(b)). MA organizations must obtain risk adjustment data required by CMS from the provider, supplier, physician, or other practitioner that furnished the item or service (42 CFR § 422.310(d)(3)).

Federal regulations also state that MA organizations are responsible for the accuracy, completeness, and truthfulness of the data submitted to CMS for payment purposes and that such data must conform to all relevant national standards (42 CFR §§ 422.504(l) and 422.310(d)(1)). In addition, MA organizations must contract with CMS and agree to follow CMS's instructions, including the *Medicare Managed Care Manual* (the Manual) (See 42 CFR § 422.504(a)).

CMS has provided instructions to MA organizations regarding the submission of data for risk scoring purposes (the Manual, chap. 7 (last rev. Sept. 19, 2014)). Specifically, CMS requires all submitted diagnosis codes to be documented in the medical record and to be documented as a result of a face-to-face encounter (the Manual, chap. 7, § 40). The diagnosis must be coded

[15] Specifically, we estimated that Highmark received at least $6,227,005 ($5,897,209 for the statistically sampled groups plus $329,796 for the group of potentially mis-keyed diagnosis codes) of net overpayments. To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

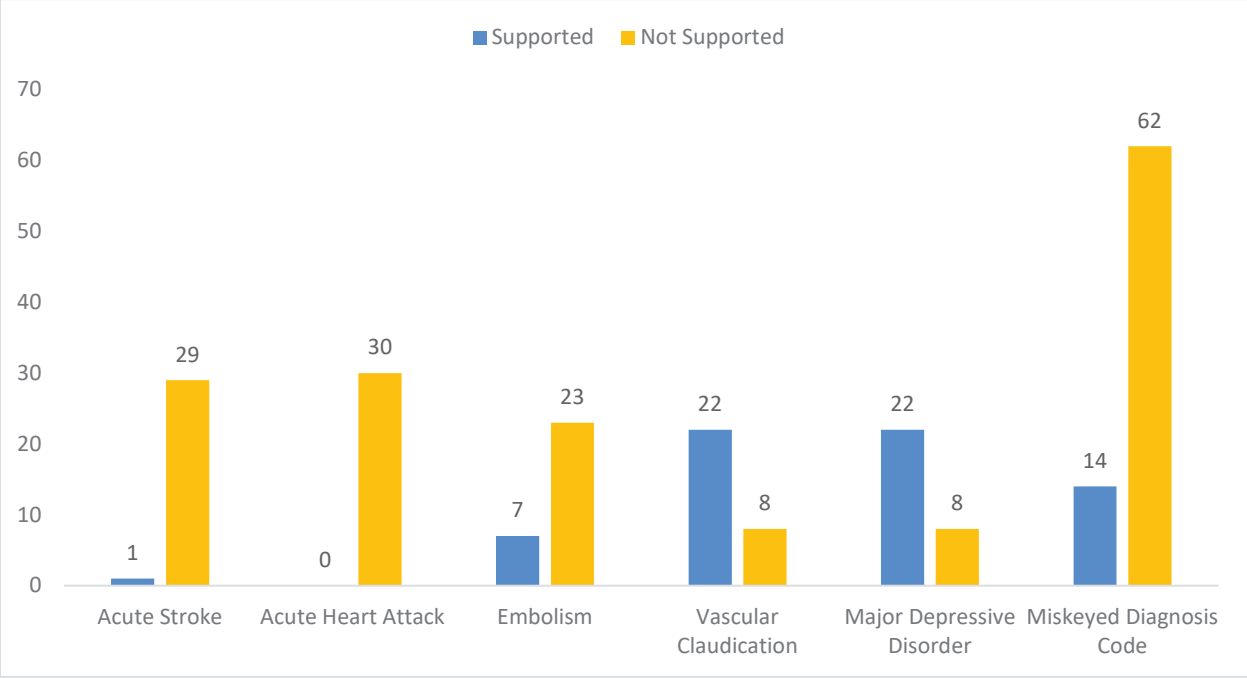
according to the ICD Coding Guidelines (42 CFR § 422.310(d)(1) and 45 CFR §§ 162.1002(b)(1) and (c)(2)-(3)). Further, the MA organizations must implement procedures to ensure that diagnoses come only from acceptable data sources, which include hospital inpatient facilities, hospital outpatient facilities, and physicians (the Manual, chap. 7, § 40).

Federal regulations state that MA organizations must monitor the data that they receive from providers and submit to CMS. Federal regulations also state that MA organizations must "adopt and implement an effective compliance program, which must include measures that prevent, detect, and correct non-compliance with CMS' program requirements . . . ." Further, MA organizations must establish and implement an effective system for routine monitoring and identification of compliance risks (42 CFR § 422.503(b)(4)(vi)).

MOST OF THE SELECTED HIGH-RISK DIAGNOSIS CODES THAT HIGHMARK SUBMITTED TO CMS DID NOT COMPLY WITH FEDERAL REQUIREMENTS

Most of the selected high-risk diagnosis codes that Highmark submitted to CMS for use in CMS's risk adjustment program did not comply with Federal requirements. As shown in the figure below, the medical records for 160 of the 226 sampled enrollee-years did not support the diagnosis codes. In these instances, Highmark should not have submitted the diagnosis codes to CMS and received the resulting net overpayments.

Figure: Analysis of High-Risk Groups



Incorrectly Submitted Diagnosis Codes for Acute Stroke

Highmark incorrectly submitted diagnosis codes for acute stroke for 29 of the 30 sampled enrollee-years. Specifically:

- For 27 enrollee-years, the medical records did not support an acute stroke diagnosis:

    - For 17 enrollee-years, the medical records indicated in each case that the individual had previously had a stroke, but the records did not justify an acute stroke diagnosis at the time of the physician's service.

      For example, for 1 enrollee-year, the independent medical review contractor stated that "there is no evidence of an acute stroke or any related condition that would result in an assignment of the [reviewed] HCC. There is mention of a history of a stroke [diagnosis] but no description of residuals or sequelae[16] that should be coded."

    - For 9 enrollee-years, the medical records did not contain sufficient information to support an acute stroke diagnosis.

      For example, for 1 enrollee-year, the independent medical review contractor stated that "Based on review of the medical record/s submitted, there is no evidence of an acute stroke or any related condition that would result in an assignment of the submitted HCC or a related HCC. The patient was seen in an office setting with no support that the condition occurred at the time of the visit."

    - For 1 enrollee-year, Highmark submitted an acute stroke diagnosis code (which was not supported in the medical records) instead of a diagnosis code for hemiplegia[17] (which was supported in the medical records). This error caused an underpayment.

      For this enrollee-year, the independent medical review contractor did not find support for an acute stroke but noted that "[t]here is mention of hemiplegia as a late effect of [a] cerebral vascular accident."

- For the remaining 2 enrollee-years, Highmark could not locate any medical records to support the acute stroke diagnosis; therefore, the HCC for Ischemic or Unspecified Stroke was not validated.

[16] Sequelae is a condition following or occurring as a consequence of another condition or event.

[17] Hemiplegia is defined as total or partial paralysis of one side of the body that results from disease of or injury to the motor centers of the brain.

As a result of these errors, the HCCs for Ischemic or Unspecified Stroke were not validated, and Highmark received $62,261 of net overpayments for these 29 sampled enrollee-years.

Incorrectly Submitted Diagnosis Codes for Acute Heart Attack

Highmark incorrectly submitted diagnosis codes for acute heart attack for all 30 of the sampled enrollee-years. Specifically:

- For 17 enrollee-years, the medical records did not support either an acute myocardial infarction diagnosis or a diagnosis of a less severe manifestation of the related-disease group.

    - For example, for 1 enrollee-year, the medical review contractor noted that "there is no documentation of any condition that will result in assignment of [a diagnosis] code that translates to the assignment of [the] HCC [for Acute Myocardial Infarction]. The diagnosis is not documented on this date of service."

- For 13 enrollee-years, the medical records did not support an acute myocardial infarction diagnosis. However, we identified support for a diagnosis of a less severe manifestation of the related-disease group:

    - For 8 enrollee-years, which occurred in payment year 2015, we identified support for an old myocardial infarction diagnosis,[18] which mapped to an HCC for a less severe manifestation of the related-disease group. Accordingly, Highmark should not have received an increased payment for the acute myocardial infarction diagnosis but should have received a lesser increased payment for the old myocardial infarction diagnosis.

      For example, for 1 enrollee-year, the independent medical review contractor stated that "there is no documentation of any condition that will result in assignment of [diagnosis] that translates to the assignment of [the] HCC [for Acute Heart Attack] however, there is documentation of old [myocardial infarction]."

    - For 4 enrollee-years, which occurred in payment year 2016, we identified support for an old myocardial infarction diagnosis which did not map to an

[18] An "old myocardial infarction" is a distinct diagnosis that represents a myocardial infarction that occurred more than 4 weeks previously, has no current symptoms directly associated with that myocardial infarction, and requires no current care.

HCC.[19] Accordingly, Highmark should not have received an increased payment for acute myocardial infarction.

- For the remaining 1 enrollee-year, the medical review contractor stated that "Based on review of the medical record/s submitted for this HCC, there is no documentation of a diagnosis that results in [the] HCC [for Unstable Angina and Other Acute Ischemic Heart Disease]. There is documentation of chronic stable angina[20] (diagnosis code) which results in [the] HCC [for Angina Pectoris] and should have been assigned instead of a diagnosis that maps to the submitted HCC." Accordingly, Highmark should have received a lesser increased payment for the chronic stable angina diagnosis.

As a result of these errors, the Acute Heart Attack HCCs were not validated, and Highmark received $51,208 of overpayments for these 30 sampled enrollee-years.

Incorrectly Submitted Diagnosis Codes for Embolism

Highmark incorrectly submitted diagnosis codes for embolism for 23 of 30 sampled enrollee-years. Specifically:

- For 12 enrollee-years, the medical records indicated in each case that the individual had previously had an embolism, but the records did not justify an embolism diagnosis at the time of the physician's service.
  - For example, for 1 enrollee-year, the independent medical review contractor noted that "Based on review of the medical record/s submitted for this HCC, there is no documentation of any condition that will result in assignment of an ICD-9-CM code that translates to the assignment of [the] HCC [for Vascular Disease]. There is documentation of a past medical history of deep venous thrombosis [diagnosis][21] which does not result in an HCC."
- For 10 enrollee-years, the medical records did not contain sufficient information to support an embolism diagnosis.
  - For example, for 1 enrollee-year, the independent medical review contractor noted that "there is no documentation of any condition that will result in assignment of [a diagnosis] code that translates to the assignment of [the] HCC

[19] In contrast to the enrollee-years that occurred in payment year 2015 (for which CMS used the Version 12 model), for payment year 2016, CMS used only the Version 22 model, which did not include an HCC for Old Myocardial Infarction, to calculate risk scores (footnote 8).

[20] Chronic stable angina is defined as discomfort in the chest region due to poor blood flow through the blood vessels in the heart.

[21] Deep vein thrombosis is a blood clot in a major vein that usually develops in the legs or pelvis.

[for Vascular Disease with Complications]. Condition is not documented with active/current support."

- For the remaining 1 enrollee-year, Highmark could not locate any medical records to support the embolism diagnosis; therefore, the Embolism HCC was not validated.

As a result of these errors, the Embolism HCCs were not validated, and Highmark received $70,372 of overpayments for these 23 sampled enrollee-years.

Incorrectly Submitted Diagnosis Codes for Vascular Claudication

Highmark incorrectly submitted diagnosis codes for vascular claudication for 8 of 30 sampled enrollee-years. Specifically:

- For 6 enrollee-years, the medical records did not support a vascular claudication diagnosis.
    - For example, for 1 enrollee-year, the independent medical review contractor stated that "Based on review of the medical record/s submitted for this HCC, there is no documentation of any condition that will result in assignment of an ICD-9-CM code that translates to the assignment of [the] HCC [for Vascular Disease]."
- For the remaining 2 enrollee-years, Highmark could not locate any medical records to support the vascular claudication diagnosis; therefore, the Vascular Claudication HCC was not validated.

As a result of these errors, the HCCs for Vascular Disease were not validated, and Highmark received $18,691 of overpayments for these 8 sampled enrollee-years.

Incorrectly Submitted Diagnosis Codes for Major Depressive Disorder

Highmark incorrectly submitted diagnosis codes for major depressive disorder for 8 of 30 sampled enrollee-years. Specifically:

- For 7 enrollee-years, the medical records did not support a major depressive disorder diagnosis.[22]
    - For example, for 1 enrollee-year, the independent medical review contractor noted that "there is no documentation of any condition that will result in

[22] The 7 enrollee-years include 1 enrollee-year that the independent medical review contractor classified as an illegible record. We requested additional information for this illegible record but did not receive any additional documentation. As stated in 42 CFR § 482.24(c)(1), all patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided.

assignment of [a diagnosis] code that translates to the assignment of [the] HCC [for Major Depressive, Bipolar, and Paranoid Disorders]. The provider has documented [a diagnosis of depressive disorder, not elsewhere classified] in the assessment section of the note which does not result in an HCC."

- For the remaining 1 enrollee-year, Highmark could not locate any medical records to support the major depressive disorder diagnoses; therefore, the HCC for Major Depressive, Bipolar, and Paranoid Disorders was not validated.

As a result of these errors, the HCCs for Major Depressive, Bipolar, and Paranoid Disorders were not validated, and Highmark received $24,138 of overpayments for these 8 sampled enrollee-years.

Potentially Mis-Keyed Diagnosis Codes

Highmark submitted potentially mis-keyed diagnosis codes for 62 of 76 enrollee-years. In each of these cases, the beneficiaries associated with these enrollee-years received multiple diagnoses for a condition but received only one—potentially mis-keyed—diagnosis for an unrelated condition. Specifically:

- For 48 enrollee-years, the medical records did not support the diagnosis for the unrelated condition; therefore, Highmark submitted to CMS unsupported diagnosis codes that mapped to unvalidated HCCs.

    - For example, for 1 enrollee-year, Highmark submitted to CMS 31 diagnosis codes for coronary artery disease (414.00) and only one diagnosis code for dissection of aorta (441.00). The independent medical review contractor noted "there is no documentation of any condition that would result in the assignment of [the] HCC [for Vascular Disease with Complications]. There is documentation of coronary artery disease [diagnosis] which does not result in an HCC and should have been assigned instead of a diagnosis that maps to the submitted HCC."

- For 12 enrollee-years, the medical records did not support the diagnosis code submitted to CMS; however, we found support for a different diagnosis code that mapped to an HCC for a less severe manifestation of the related-disease group.

    - For example, for 1 enrollee-year, the independent medical review contractor noted that "there is no documentation of a diagnosis that results in [the] HCC [for Vascular Disease with Complications]. There is documentation . . . which results in [the] HCC [for Vascular Disease] and should have been assigned instead of a diagnosis that maps to the submitted HCC." Accordingly, Highmark should not have received an increased payment for the Vascular Disease with Complications HCC but should have received a lesser increased payment for the Vascular Disease HCC.

- For the remaining 2 enrollee-years, Highmark could not locate any medical records to support the potentially mis-keyed diagnosis code; therefore, the HCCs associated with the potentially mis-keyed diagnosis codes were not validated.

Appendix F summarizes the 62 HCCs that were not validated (Table 5) and the additional HCCs that were supported for the 12 enrollee-years (Table 6).

As a result of these errors, the HCCs associated with the potentially mis-keyed diagnosis codes were not validated, and Highmark received $329,796 in overpayments for these 62 sampled enrollee-years.

THE POLICIES AND PROCEDURES THAT HIGHMARK USED TO PREVENT, DETECT, AND CORRECT NONCOMPLIANCE WITH FEDERAL REQUIREMENTS COULD BE IMPROVED

The errors we identified occurred because the policies and procedures that Highmark had to prevent, detect, and correct noncompliance with CMS's program requirements, as mandated by Federal regulations (42 CFR § 422.503(b)(4)(vi)), could be improved.

Highmark had compliance procedures in place during our audit period to determine whether the diagnosis codes that it submitted to CMS to calculate risk-adjusted payments were correct. These procedures included routine internal medical reviews to compare diagnosis codes from a sample of claims to the diagnosis codes that were documented on the associated medical records. These internal medical reviews targeted diagnosis codes from certain high-risk groups such as acute stroke, acute heart attack, and embolism. If Highmark detected compliance problems, it corrected the reviewed claims and expanded its review to other claims not initially selected. The results of these internal medical reviews were used to develop provider educational materials that informed providers of high-risk diagnosis areas. The educational materials highlighted coding errors identified during Highmark's internal reviews and provided additional guidance to providers on how to avoid these errors. Despite the internal medical reviews and educational materials, the diagnosis codes for 160 of the 226 sampled enrollee-years were not supported by the medical records; therefore, Highmark's compliance procedures, with regard to high-risk diagnosis areas, could be improved.

HIGHMARK RECEIVED NET OVERPAYMENTS

As a result of the errors we identified, the HCCs for these high-risk diagnosis codes were not validated. On the basis of our sample results, we estimated that Highmark received at least $6,227,005 of net overpayments ($5,897,209 for the statistically sampled high-risk groups plus $329,796 for the group of potentially mis-keyed diagnosis codes) in 2015 and 2016 (Appendix D).

RECOMMENDATIONS

We recommend that Highmark Senior Health Company:

- refund to the Federal Government the $6,227,005 of estimated net overpayments;
- identify, for the high-risk diagnoses included in this report, similar instances of noncompliance that occurred before or after our audit period and refund any resulting overpayments to the Federal Government; and
- continue its examination of existing compliance procedures to identify areas where improvements can be made to ensure diagnosis codes that are at high risk for being miscoded comply with Federal requirements (when submitted to CMS for use in CMS's risk adjustment program) and take the necessary steps to enhance those procedures.

HIGHMARK COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Highmark disagreed with our findings and recommendations. Although Highmark did not specifically disagree with 159 of the 161 enrollee-years identified in our draft report as not having medical records to support the associated diagnosis codes, Highmark disagreed with our findings for the remaining 2 enrollee-years and provided additional information explaining why it believed that either the associated HCC was validated or an HCC for a less severe manifestation of the related disease group was validated.

Highmark stated that we used an audit methodology that was inconsistent with the fundamentals of MA program payment, we incorrectly changed our audit methodology without going through a notice-and-comment process, and our methodology was unpredictable and could have a negative effect on the MA program. Highmark also stated that we do not have the authority to extrapolate and there is no adequate mechanism for repayment of extrapolated amounts. In addition, Highmark stated that our findings and recommendations effectively require providers to attain 100 percent accuracy and that it disagrees with our suggestion that its compliance program is inadequate. Highmark requested that we withdraw all of our recommendations.

After reviewing Highmark's comments and the additional information it provided, we reduced the number of enrollee-years in error from 161 to 160 and adjusted our calculation of estimated net overpayments. Accordingly, we reduced our first recommendation from $6,314,074 to $6,227,005 for this final report. We did not make any changes to our second and third recommendations.

A summary of Highmark's comments and our responses follows. Highmark's comments appear in their entirety as Appendix G.

HIGHMARK DISAGREED WITH OUR FINDINGS FOR 2 ENROLLEE-YEARS

Highmark Comments

Highmark did not agree with our findings for two of the sampled enrollee-years and stated that we "failed to recognize alternative [diagnosis] codes identified in the medical record that should have been submitted to CMS instead of the selected codes." Specifically:

- For one enrollee-year, Highmark explained why it believed it should receive credit for the HCC for Old Myocardial Infarction instead of an Acute Heart Attack HCC. Highmark stated that a previously provided medical record "clearly indicated the patient had 'recently' suffered from a myocardial infarction. ICD9 coding guidelines allowed the coding of an acute myocardial infarction (AMI) for up to eight weeks after the initial event.; [*sic*] ICD10 (effective October of 2015) permits coding four weeks after an AMI. Although the note did not explicitly state how 'recently' the infarction had occurred, [the Office of Inspector General (OIG)] should have credited Highmark for . . . (Old Myocardial Infarction)."

- For the other enrollee-year, Highmark explained why it believed a Vascular Claudication HCC should be validated. Highmark stated that a previously provided medical record supported a diagnosis of atherosclerosis.[23] Highmark stated that although it submitted a code for Peripheral Vascular Disease[24] and acknowledged that the code was not supported by the submitted medical record, "(Atherosclerosis), which maps to the same HCCs, was supported by the medical record. The diagnosis was noted in the abdominal CT scan image findings that were specifically 'reviewed and assessed' by the physician. Specifically, the note reads, 'Atherosclerotic calcifications, abdominal aorta and iliac arteries.' ICD coding guidelines permit diagnoses from diagnostic imaging as long as the provider has noted a review of the findings."

Office of Inspector General Response

Our independent medical review contractor reviewed the medical records that Highmark referred to in its comments as well as the explanations that Highmark provided for these two enrollee-years and agreed with Highmark's statements regarding the HCCs that should be validated:

- For the first enrollee-year, the independent medical review contractor found support for an old myocardial infarction diagnosis but did not find support for the HCC for Unstable Angina and Other Acute Ischemic Heart Disease. Thus, this enrollee-year remains classified as an error. However, Highmark should not have received an increased payment for the acute myocardial infarction diagnosis but should have

[23] Atherosclerosis is a disorder in which arteries become clogged or narrowed due to abnormal fat deposits.

[24] Peripheral Vascular Disease is a narrowing, blockage, or spasms in a blood vessel.

received a lesser increased payment for the old myocardial infarction. Accordingly, we updated the overpayment amount for this enrollee-year; this update did not change the number of errors in the Acute Heart Attack high-risk group section.

- For the second enrollee-year, the independent medical review contractor stated that "There is documentation of atherosclerotic calcification of abdominal aorta [diagnosis code] which results in the [HCC] for [Vascular Disease] on the additional noted date of service." We reclassified this HCC as validated and updated the Vascular Claudication high-risk group section.

Accordingly, we reduced the number of sampled enrollee-years in error from 161 (in our draft report) to 160 and reduced the associated monetary recommendation.

HIGHMARK STATED THAT OUR AUDIT METHODOLOGY IS INCONSISTENT WITH THE FUNDAMENTALS OF MEDICARE ADVANTAGE PAYMENT

Highmark Comments

Highmark stated that our audit methodology was not consistent with the fundamentals of MA program payment. Specifically, Highmark said that "any inquiry in MA designed to determine whether an improper payment has occurred must take into account all potential errors that affect payment, including undercoding and overcoding." Highmark stated that our audit methodology did not consider "instances of potential undercoding, or underpayments, in the [MA organization's] data" and the impact of errors in FFS data (that CMS used to determine payments). Highmark said that if we had taken these points into consideration, we "would not have had a basis upon which to calculate and extrapolate an overpayment."

Highmark stated that any audit of improper payments "must determine whether, on average, across all codes for all members, the plan received a larger (or smaller) payment than it should have." Highmark stated that we did not account for underpayments in a meaningful way in our methodology and did not establish an overall underpayment rate because we chose, and audited, codes for which there was a likely error in the Government's favor and not codes for which there was a likely error in the MA organization's favor. Highmark said that it conducted a limited analysis of unsubmitted codes for certain chronic conditions and "used a targeted approach, similar to OIG's, selecting conditions that, in its experience, are often undercoded by providers." Highmark stated that it calculated $11.1 million in underpayments from this limited exercise and also said that we "should allow [MA organizations] to offset any alleged overpayments with evidence of underpayments." Further, Highmark stated that its coders reviewed the medical records it provided to us for this audit and found 36 new, unique codes for the same patients in the same year. Highmark stated that in a typical Risk Adjustment Data Validation (RADV) audit, CMS would offset the overpayments with these underpayments and that "It is particularly unclear" why we did not do so for this audit.

Highmark also stated that we did not account for the fact that the same types of coding errors are present in the FFS data that CMS uses to calculate the payments that it makes to MA

organizations. Highmark stated that "It is widely recognized that individual providers often submit inaccurate and non-comprehensive diagnosis data." Highmark said that CMS has argued that the FFS data still leads to appropriate overall reimbursement for MA organizations because errors (overpayments and underpayments) tend to offset one another. Highmark noted that CMS has argued that an "FFS adjuster" is not needed in the context of a RADV audit, but Highmark also said that others have criticized this conclusion. Highmark also said that an FFS adjuster for this audit (of selected diagnosis codes) would have to be higher than that of a RADV audit. Highmark stated that we "selected coding patterns most likely to have high rates of overcoding and ignored the other side of the equation (underpayments)." Highmark also said that because we "did not consider the errors in the FFS data, [our] audit methodology and results are inaccurate."

Finally, Highmark said that the Social Security Act requires that CMS pay MA organizations "in a way that ensures 'actuarial equivalence' with what CMS would have paid to provide care for the same beneficiaries under traditional Medicare." Highmark stated that our "audit approach, which does not consider underpayments or errors in the FFS data, would result in an [MA organization] being paid less than it would have cost traditional Medicare to care for the same beneficiaries" and that our approach is "inconsistent with the actuarial equivalence requirement."

Office of Inspector General Response

We maintain that our audit methodology was appropriate for the audit objective, and our audit objective and methodology correctly addressed certain aspects unique to the MA program. We do not agree that we have to consider the impact of errors in FFS data when calculating estimated net overpayments. Further, we do not agree that we have to consider, in our calculation of estimated net overpayments, all potential overpayments and underpayments for every diagnosis code submitted for every enrollee. It was beyond the scope of our audit to identify: (1) all possible diagnosis codes that Highmark could have submitted on behalf of the sampled enrollee-years, and (2) enrollees for whom Highmark did not submit any risk-adjusted diagnosis codes.

With regard to Highmark's comment that we did not consider the impact of errors in FFS, our audit methodology correctly applied CMS requirements to properly identify the overpayment amount associated with unsubstantiated HCCs for each sample item. We used the results of the independent medical review contractor's coding review to determine which high-risk HCCs were not substantiated. Consistent with our methodology, if the contractor identified a diagnosis code that should have been submitted to CMS instead of the selected diagnosis code, we included the financial impact of the resulting HCC (if any) in our calculation of overpayments. We followed the requirements of CMS's risk adjustment program to determine the payment that CMS should have made for each sampled enrollee-year. We used the overpayments and underpayments identified for each enrollee-year to determine our estimated net overpayment amount.

Although our approach was generally consistent with the methodology CMS uses in its RADV audits, it did not mirror CMS's approach in all aspects, nor did it have to. We recognize that CMS is responsible for making operations and program payment determinations for the MA program, including the application of any FFS adjuster requirements. CMS has not issued any requirements that compel us to reduce our net overpayment calculations. If CMS deems it appropriate to apply an FFS adjuster, it will adjust our overpayment finding by whatever amount it determines necessary. Thus, we believe that the steps that we followed for this audit provide a reasonable basis for our findings and recommendations, including our estimation of net overpayments.

HIGHMARK STATED THAT OUR AUDIT APPROACH VIOLATED STATUTORY AND REGULATORY REQUIREMENTS

Highmark Comments

Highmark stated that our approach violated statutory and regulatory requirements. Specifically, Highmark stated that our audit methodology is new and materially different from the CMS methodology that was in place when MA organizations submitted bids for the years covered by our audit. According to Highmark, this difference is a "substantive change" that demands 100-percent "accuracy of [MA organizations] and has a significant potential impact on the reimbursement received by those [MA organizations] for past years." According to Highmark, the Social Security Act "prohibits the retroactive application of rules absent a significant public safety concern or other critical need" and "prohibits OIG's retroactive application of this approach."

Highmark also said that "[i]n adopting a new audit approach, OIG did not engage the requisite notice and comment process." In this regard, Highmark cited a decision from the Supreme Court case *Azar v. Allina Health Services* that provides the public with advance notice to comment on any rule, requirement, or other statement of policy. Highmark stated that we "adopted new substantive legal standards by performing audits that impose different standards from one audit to the next and different standards than those that CMS has historically utilized in the context if its RADV audits. This is inappropriate given that these new standards did not go through the notice and comment process."

Office of Inspector General Response

Our audit did not violate statutory or regulatory requirements. The Inspector General Act of 1978 (IG Act), 5 U.S.C. App., provides OIG with independent authority to provide oversight of the Department's programs through audits and investigations. As such, we conduct our audits in accordance with generally accepted government auditing standards, which require that audits be planned and performed so as to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions. As a result, OIG's audits do not represent a "retroactive application of rules absent a significant public safety concern or other critical need." Instead, these audits represent OIG's exercise of its central statutory authorities under the IG Act as an independent oversight entity. Accordingly, we are not recommending the

application of any new statutory or regulatory or other type of requirements; thus, the criteria cited by Highmark that prohibit retroactivity are not applicable to this audit.

In addition, we disagree that our audit methodology represents a change in substantive legal standard and should not have been adopted without notice and comment. Our audit approach was generally consistent with the methodology used by CMS in its RADV audits; however, it did not mirror CMS's approach in all aspects, nor did it have to. Moreover, the criteria that we used for this audit does not represent a substantive change, or retroactive application of rules; these are the Federal requirements that CMS has put in place to govern the MA program.

HIGHMARK STATED THAT OUR APPROACH WAS UNPREDICTABLE AND COULD HAVE A NEGATIVE EFFECT ON THE MEDICARE ADVANTAGE PROGRAM

Highmark Comments

Highmark stated that our methodology is unpredictable and could have a negative effect on the MA program. Specifically, Highmark stated that our "audit approach is arbitrary and capricious for numerous reasons," including "its inconsistent application of approaches over time and from one [MA organization] to the next without explanation."

Highmark stated that "In submitting its bids for services to be provided in 2014 and 2015, Highmark reasonably considered financial risk associated with repayment obligations that might result from CMS's standard RADV audit process." Because our current audit process was applied to closed contract years, Highmark stated that "Unpredictable contract adjustments caused by these audits may, over time, increase premiums, decrease benefits, and harm the breadth and scope of the MA program. This could have a negative impact on both the overall cost of the Medicare program and the overall health of the Medicare population."

Highmark also stated that our audit approach continues to change and noted the differences in what our audits targeted in seven other audits of MA organizations. Highmark stated that the "uncertainty of additional future one-sided contract adjustments may inject unwarranted uncertainty into the benefit design process."

Finally, Highmark stated that our audit methodology "may unknowingly harm risk-bearing entities including primary care physician practices. . . . Depending on the particulars of the contract, if OIG attempts to retroactively recoup large sums from [MA organizations], these recoveries may impact, through recoupment, the providers themselves. This could present a significant financial challenge to provider practices, who do not carry or are [not] capable of booking large reserves."

Office of Inspector General Response

We do not agree that our audit methodology was arbitrary and capricious. Our audit is intended to provide an independent assessment of Department of Health and Human Services (HHS) programs and operations in accordance with the IG Act. Our mission is to provide

objective oversight to promote the economy, efficiency, effectiveness, and integrity of HHS programs, as well as the health and welfare of the people they serve. By identifying errors, we strive to ensure the efficiency and integrity of the MA program and promote the effective delivery of services to Highmark and its affiliated providers' members. With regard to Highmark's comment that our methodology may harm risk-bearing entities, including primary care physician practices, the interactions that Highmark has with downstream entities is beyond the scope of our audit.

HIGHMARK STATED THAT WE DO NOT HAVE THE AUTHORITY TO EXTRAPOLATE

Highmark Comments

Highmark stated that, "While OIG has the independent authority to conduct audits to ensure accurate payment, it does not have the authority to extrapolate its findings under Medicare Part C." Highmark further stated that, "The [Social Security Act] provides qualified authority to extrapolate only to Medicare contractors conducting audits on behalf of CMS under Medicare Parts A and B (traditional Medicare). The statute permits contractors to extrapolate error rates identified so long as there is evidence to show that there is: (1) a sustained or high level of payment error; and (2) documented evidence that educational interventions (by the government) failed to correct the payment error." In addition, Highmark noted that CMS does not use extrapolation in its RADV audits and that CMS has proposed but not implemented the use of extrapolation. Highmark quoted CMS as saying in 2018 that its proposed rule would "***establish*** that extrapolation would be utilized as a valid part of audit authority in Part C, as it has been historically a normal part of auditing practice throughout the Medicare program." According to Highmark, this statement is "a clear acknowledgement that there is currently no authority to extrapolate under MA even for CMS, let alone OIG." Further, Highmark stated that "even if extrapolation were appropriate (which it is not), OIG's use of a two-sided 90% confidence interval to calculate the extrapolated repayment amount was not appropriate. A better approach would be to use a lower bound of a 99% confidence interval, which is what CMS does in its RADV audits."

Expanding on this point, Highmark stated that "OIG is not a Medicare contractor" and "OIG never calculated an actual 'improper' payment error because it did not consider overall payments made to Highmark for its MA population or take into account FFS errors." In addition, Highmark stated that it "is aware of no means by which it could refund extrapolated amounts to CMS."

Office of Inspector General Response

We do not agree with Highmark's comments regarding extrapolation. Extrapolation has long been recognized as a permissible method of calculating overpayments in Medicare. Highmark relied on 42 U.S.C. section 1395ddd(f)(3) to say that we do not have the authority to extrapolate. However, no statutory or other authority limits our ability to recommend a recovery to CMS based on sampling and extrapolation. Further, Federal courts have consistently upheld statistical sampling and extrapolation as a valid means to determine

overpayment amounts in Medicare and Medicaid.[25] The legal standard for use of sampling and extrapolation is that it must be based on a statistically valid methodology, not the most precise methodology.[26] We properly executed our statistical sampling methodology in that we defined our sampling frame and sample unit, randomly selected our sample, applied relevant criteria in evaluating the sample, and used statistical sampling software (i.e., RAT-STATS) to apply the correct formulas for the extrapolation.

OIG is an independent and objective oversight unit of HHS. Our policy is to recommend recovery at the lower limit of a two-sided 90-percent confidence interval. We believe that the lower limit of a two-sided 90-percent confidence interval provided a reasonably conservative estimate of the total amount overpaid to Highmark for the enrollee-years and time period covered in our sampling frame. This approach, which is routinely used by HHS for recovery calculations,[27] results in a lower limit (the estimated overpayment amount to refund) that is designed to be less than the actual overpayment total 95 percent of the time. Action officials at CMS will determine whether an overpayment exists and will recoup any overpayments consistent with CMS's policies and procedures.

HIGHMARK STATED THAT WE ARE EFFECTIVELY REQUIRING PROVIDERS TO ATTAIN 100 PERCENT ACCURACY AND THAT IT HAS AN EFFECTIVE COMPLIANCE PROGRAM

Highmark Comments

Highmark stated that OIG's audit approach would hold MA organizations to a "standard of perfection" which is "inconsistent with previous acknowledgments by both CMS and OIG that 100% accuracy in the data [MA organizations] submit to CMS is not possible or required." Highmark further stated that "CMS regulations require that an [MA organization] take reasonable steps to ensure the 'accuracy, completeness, and truthfulness' of the data it submits to CMS based on its 'best knowledge, information, and belief'." Highmark concluded

[25] *See Yorktown Med. Lab., Inc. v. Perales*, 948 F.2d 84 (2d Cir. 1991); *Illinois Physicians Union v. Miller*, 675 F.2d 151 (7th Cir. 1982); *Momentum EMS, Inc. v. Sebelius*, 2013 U.S. Dist. LEXIS 183591 at *26-28 (S.D. Tex. 2013), *adopted by* 2014 U.S. Dist. LEXIS 4474 (S.D. Tex. 2014); *Anghel v. Sebelius*, 912 F. Supp. 2d 4 (E.D.N.Y. 2012); *Miniet v. Sebelius*, 2012 U.S. Dist. LEXIS 99517 at *17 (S.D. Fla. 2012); *Bend v. Sebelius*, 2010 U.S. Dist. LEXIS 127673 (C.D. Cal. 2010).

[26] *See John Balko & Assoc. v. Sebelius*, 2012 U.S. Dist. LEXIS 183052 at *34-35 (W.D. Pa. 2012), *aff'd* 555 F. App'x 188 (3d Cir. 2014); *Maxmed Healthcare, Inc. v. Burwell*, 152 F. Supp. 3d 619, 634–37 (W.D. Tex. 2016), *aff'd*, 860 F.3d 335 (5th Cir. 2017); *Anghel v. Sebelius*, 912 F. Supp. 2d 4, 18 (E.D.N.Y. 2012); *Miniet v. Sebelius*, 2012 U.S. Dist. LEXIS 99517 at *17 (S.D. Fla. 2012); *Transyd Enters., LLC v. Sebelius*, 2012 U.S. Dist. LEXIS 42491 at *13 (S.D. Tex. 2012).

[27] For example, HHS has used the two-sided 90-percent percent confidence interval when calculating recoveries in both the Administration for Child and Families and Medicaid programs. See e.g., *New York State Department of Social Services*, HHS Departmental Appeals Board (DAB) No. 1358, 13 (1992); *Arizona Health Care Cost Containment System*, DAB No. 2981, 4-5 (2019). In addition, HHS contractors rely on the one-sided 90-percent confidence interval, which is less conservative than the two-sided interval, for recoveries arising from Medicare FFS overpayments. See e.g., *Maxmed Healthcare, Inc. v. Burwell*, 152 F. Supp. 3d 619, 634–37 (W.D. Tex. 2016), aff'd, 860 F.3d 335 (5th Cir. 2017); *Anghel v. Sebelius*, 912 F. Supp. 2d 4, 17-18 (E.D.N.Y. 2012).

that "It is unreasonable for OIG to effectively hold [MA organizations] to a standard of 100% accuracy by constructing an audit consisting solely of a heavily data-mined sample designed to highlight only overpayments and not underpayments."

Further, Highmark stated it has a "robust compliance program," which it continually refines. Highmark stated that we acknowledged Highmark's compliance program, and, while we indicated that the program could be improved, did not offer specific improvement recommendations. Highmark further stated that CMS provided broad discretion to MA organizations "to design their compliance plan structure to meet the unique aspects of each organization." Highmark stated that MA organizations "could only achieve OIG's requirement of 100% accuracy if [MA organizations] undertook chart review for all submitted encounters. Highmark submits over 7.5 million claims to CMS annually for its MA members. Given this, reviewing every chart is simply not feasible. In fact, the cost and burden of reviewing all risk adjusted encounters would be prohibitive and would eliminate any efficiencies or savings under the MA program." Highmark concluded that its current compliance policies and auditing and monitoring activities more than comply with MA statutory and regulatory requirements and that it therefore believes that our third recommendation should be withdrawn.

Office of Inspector General Response

We do not agree with Highmark's interpretation of our audit approach as requiring MA organizations to have 100 percent data accuracy. Our objective was developed to review specific diagnoses. We recognize that MA organizations have the latitude to design their own compliance programs and recognize that CMS applies a best "knowledge, information, and belief" standard when MA organizations certify the volume of data submitted for the CMS risk adjustment program.

However, Federal regulations at 42 CFR section 422.503(b)(4(vi) state that MA organizations must "implement effective measures that prevent, detect, and correct noncompliance with CMS' program requirements." Further, these regulations specify that an MA organization "must at a minimum, include [certain] core requirements," which include "an effective system for routine monitoring and identification of compliance risks [including] internal monitoring and audit and, as appropriate, external audits to evaluate . . . compliance with CMS requirements and the overall effectiveness of the compliance program."

While we acknowledge Highmark had compliance procedures in place during our audit period to determine whether the diagnosis codes that it submitted to CMS to calculate risk-adjusted payments were correct, the diagnosis codes for 160 of the 226 sampled enrollee-years were not supported by the medical records. In addition, three of the areas we reviewed (Acute Stroke, Acute Heart Attack, and Embolism) accounted for 51 percent (82 of 160 sample errors) of the errors we found. Improving compliance program procedures to monitor provider record submissions, with a focus on diagnosis codes at risk for being miscoded, may have prevented these errors.

Accordingly, we maintain that our third recommendation is valid.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

CMS paid Highmark $3,551,632,114 to provide coverage to its enrollees for 2015 and 2016. We identified a sampling frame of 4,232 unique enrollee-years on whose behalf providers documented high-risk diagnosis codes during the 2014 and 2015 service years. Highmark received $68,663,268 in payments from CMS for these enrollee-years for 2015 and 2016. We selected for audit 226 enrollee-years with payments totaling $4,413,571.

The 226 enrollee-years included 30 acute stroke diagnoses, 30 acute heart attack diagnoses, 30 embolism diagnoses, 30 vascular claudication diagnoses, 30 major depressive disorder diagnoses, and 76 potentially mis-keyed diagnoses. We limited our review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled $801,166 for our sample.

We reviewed internal controls directly related to our audit objective. Specifically, we reviewed Highmark's internal controls for ensuring that the diagnosis codes it submitted to CMS were coded in accordance with Federal requirements. We performed our audit from April 2019 through January 2022.

METHODOLOGY

To accomplish our objective, we performed the following steps:

- We reviewed applicable Federal laws, regulations, and guidance.
- We discussed with CMS program officials the Federal requirements that MA organizations should follow when submitting diagnosis codes to CMS.
- We identified, through data mining and discussions with medical professionals at a Medicare administrative contractor, diagnosis codes and HCCs that were at high risk for noncompliance. We also identified the diagnosis codes that potentially should have been used for cases in which the high-risk diagnoses were miscoded.
- We consolidated the high-risk diagnosis codes into specific groups, which included:
    - 6 diagnosis codes for acute stroke,
    - 35 diagnosis codes for acute heart attack,
    - 58 diagnosis codes for embolism,
    - 4 diagnosis codes for vascular claudication, and
    - 29 diagnosis codes for major depressive disorder.

- We developed an analytical tool that identified 832 scenarios in which either ICD-9 or ICD-10 diagnosis codes, when mis-keyed into an electronic claim because of a data transposition or other data entry error, could result in the assignment of an incorrect HCC to an enrollee's risk score. For each of the 832 occurrences, the tool identified a potentially mis-keyed diagnosis code and the likely correct diagnosis code. Accordingly, we considered the potentially mis-keyed diagnosis codes to be high risk.

- We used CMS's systems to identify the enrollee-years on behalf of which providers documented the high-risk diagnosis codes. Specifically, we used extracts from CMS's:

    - Risk Adjustment Processing System (RAPS)[28] to identify enrollees who received high-risk diagnosis codes from a physician during the service years,

    - Risk Adjustment System (RAS)[29] to identify enrollees who received an HCC for the high-risk diagnosis codes,

    - Medicare Advantage Prescription Drug System (MARx)[30] to identify enrollees for whom CMS made monthly Medicare payments to Highmark before applying the budget sequestration reduction for the relevant portions of the service and payment years (Appendix C),

    - Encounter Data System (EDS)[31] to identify enrollees who received specific procedures, and

    - Prescription Drug Event (PDE) file[32] to identify enrollees who had Medicare claims with certain medications dispensed on their behalf.

- We interviewed Highmark officials to gain an understanding of: (1) the policies and procedures that Highmark followed to submit diagnosis codes to CMS for use in the risk adjustment program and (2) Highmark's monitoring of those diagnosis codes to identify and detect noncompliance with Federal requirements.

- We selected for audit a sample of 226 enrollee-years that included: (1) a stratified random sample of 150 enrollee-years and (2) 76 enrollee-years as identified by our analytical tool.

[28] MA organizations use the RAPS to submit diagnosis codes to CMS.

[29] The RAS identifies the HCCs that CMS factors into each enrollee's risk score calculation.

[30] The MARx identifies the payments made to MA organizations.

[31] The EDS contains information on each item (including procedures) and service provided to an enrollee.

[32] The PDE file contains claims with prescription drugs that have been dispensed to enrollees through the Medicare Part D (prescription drug coverage) program.

- We used an independent medical review contractor to perform a coding review for 218 of the 226 enrollee-years to determine whether the high-risk diagnosis codes submitted to CMS complied with Federal requirements.[33, 34]

- The independent medical review contractor's coding review followed a specific process to determine whether there was support for a diagnosis code and the associated HCC:

    - If the first senior coder found support for the diagnosis code on the medical record, the HCC was considered validated.

    - If the first senior coder did not find support on the medical record, a second senior coder performed a separate review of the same medical record:

        - If the second senior coder also did not find support, the HCC was considered to be not validated.

        - If the second senior coder found support, then a physician independently reviewed the medical record to make the final determination.

    - If either the first or second senior coder asked a physician for assistance, the physician's decision became the final determination.

- We used the results of the independent medical review contractor to calculate overpayments or underpayments for each enrollee-year. Specifically, we calculated:

    - a revised risk score in accordance with CMS's risk adjustment program and

    - the payment that CMS should have made for each enrollee-year.

- We estimated the total net overpayment made to Highmark during the audit period.

- We discussed the results of our audit with Highmark officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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[33] Our independent medical review contractor used senior coders all of whom possessed one or more of the following qualifications and certifications: Registered Health Information Technician (RHIT), Certified Coding Specialist (CCS), Certified Coding Specialist – Physician-Based (CCS-P), Certified Professional Coder (CPC), and Certified Risk Coder (CRC). RHITs have completed a 2-year degree program and have passed an American Health Information Management Association (AHIMA) certification exam. The AHIMA also credentials individuals with CCS and CCS-P certifications and the American Academy of Professional Coders credentials both CPCs and CRCs.

[34] Highmark could not locate any medical records for 8 enrollee-years.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Medicare Advantage Compliance Audit of Diagnosis Codes That Regence BlueCross BlueShield of Oregon (Contract H3917)	A-09-20-03009	9/13/2022
Medicare Advantage Compliance Audit of Diagnosis Codes That WellCare of Florida, Inc. (Contact H1032) Submitted to CMS	A-04-19-07084	8/29/2022
Medicare Advantage Compliance Audit of Diagnosis Codes That Cigna HealthSpring of Florida, Inc. (Contract H5410) Submitted to CMS	A-03-18-00002	8/19/2022
Medicare Advantage Compliance Audit of Diagnosis Codes That Cariten Health Plan, Inc., (Contract H4461) Submitted to CMS	A-02-20-01009	7/18/2022
Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Peoples Health Network (Contract H1961) Submitted to CMS	A-06-18-05002	5/25/2022
Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Tufts Health Plan (Contract H2256) Submitted to CMS	A-01-19-00500	2/14/2022
Medicare Advantage Compliance Audit of Diagnosis Codes That SCAN Health Plan (Contract H5425) Submitted to CMS	A-07-17-01169	2/3/2022
Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Healthfirst Health Plan, Inc., (Contract H3359) Submitted to CMS	A-02-18-01029	1/5/2022
Medicare Advantage Compliance Audit of Specific Diagnosis Codes That UPMC Health Plan, Inc. (Contract H3907) Submitted to CMS	A-07-19-01188	11/5/2021
Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Coventry Health Care of Missouri, Inc. (Contract H2663) Submitted to CMS	A-07-17-01173	10/28/2021
Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Anthem Community Insurance Company, Inc. (Contract H3655) Submitted to CMS	A-07-19-01187	5/21/2021
Medicare Advantage Compliance Audit of Diagnosis Codes That Humana, Inc., (Contract H1036) Submitted to CMS	A-07-16-01165	4/19/2021
Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Blue Cross Blue Shield of Michigan (Contract H9572) Submitted to CMS	A-02-18-01028	2/24/2021

Some Diagnosis Codes That Essence Healthcare, Inc., Submitted to CMS Did Not Comply With Federal Requirements	A-07-17-01170	4/30/2019

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

We identified Highmark enrollees who: (1) were continuously enrolled in Highmark throughout all of the 2014 or 2015 service year and January of the following year, (2) were not classified as being enrolled in hospice or as having end-stage renal disease status at any time during 2014 or 2015 or in January of the following year, and (3) received a high-risk diagnosis during 2014 or 2015 that caused an increased payment to Highmark for 2015 or 2016, respectively.

We presented the data for these enrollees to Highmark for verification and performed an analysis of the data included on CMS's systems to ensure that the high-risk diagnosis codes increased CMS's payments to Highmark. After we performed these steps, our finalized sampling frame consisted of 4,232 enrollee-years.

SAMPLE UNIT

The sample unit was an enrollee-year, which covered either payment year 2015 or 2016.

SAMPLE DESIGN

The design for our statistical sample comprised of five strata of enrollee-years that had:

- an acute stroke diagnosis (which maps to the HCC for Ischemic or Unspecified Stroke) on one physician claim during the service year but did not have that diagnosis on a corresponding inpatient hospital claim (1,362 enrollee-years),

- a diagnosis that mapped to an Acute Heart Attack HCC on only one physician claim during the service year but did not have that diagnosis on a corresponding inpatient hospital claim either 60 days before or 60 days after the physician claim (1,012 enrollee-years),

- a diagnosis that mapped to an Embolism HCC on one claim during the service year but for which an anticoagulant medication was not dispensed (498 enrollee-years),

- a vascular claudication diagnosis (which maps to the HCC for Vascular Disease) on one claim during the service year but for which medication was dispensed for neurogenic claudication (646 enrollee-years), or

- a major depressive disorder diagnosis (which maps to the HCC for Major Depressive, Bipolar, and Paranoid Disorders) on one claim during the service year but for which antidepressant medication was not dispensed (638 enrollee-years).

The specific strata are shown in Table 2 on the following page.

Table 2: Sample Design for Audited High-Risk Groups

Stratum (High-Risk Groups)	Frame Count of Enrollee-Years	CMS Payment for HCCs in Audited High-Risk Groups*	Sample Size
1 – Acute stroke	1,362	$3,572,730	30
2 – Acute heart attack	1,012	2,311,468	30
3 – Embolism	498	1,537,107	30
4 – Vascular claudication	646	1,585,493	30
5 – Major depressive disorder	638	1,798,997	30
Total – First Five Strata	**4,156**	**$10,805,795**	**150**

*Rounded to the nearest whole dollar amount.

After we selected the 150 enrollee-years, we identified an additional group of 76 enrollee-years that represented individuals who received 1 of the 832 potentially mis-keyed diagnosis codes (which mapped to a potentially unvalidated HCC) and multiple instances of diagnosis codes that were likely keyed correctly. Thus, we selected for audit a total of 226 enrollee-years.

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the OIG, Office of Audit Services (OAS), statistical software.

METHOD FOR SELECTING SAMPLE ITEMS

We sorted the items in each stratum by enrollee identifier and payment year and then consecutively numbered the items in each stratum in the stratified sampling frame. After generating 150 random numbers according to our sample design, we then selected the corresponding frame items for review. We also selected all 76 items from the potentially mis-keyed group.

ESTIMATION METHODOLOGY

We used the OIG, OAS, statistical software to estimate the total amount of net overpayments to Highmark at the lower limit of the two-sided 90-percent confidence interval (Appendix D). Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time. We also identified the net overpayment associated with each of the 76 potentially mis-keyed diagnosis codes and added the sum of those amounts to the estimate for the statistical sample to obtain the total net overpayments.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 3: Sample Results

Audited High-Risk Groups	Frame Size	CMS Payment for HCCs in Audited High-Risk Groups (for Enrollee-Years in Frame)	Sample Size	CMS Payment for HCCs in Audited High-Risk Groups (for Sampled Enrollee-Years)	Number of Sampled Enrollee-Years With Unvalidated HCCs	Net Overpayment for Unvalidated HCCs (for Sampled Enrollee-Years)
1 – Acute Stroke	1,362	$3,572,730	30	$71,630	29	$62,261
2 – Acute Heart Attack	1,012	2,311,468	30	66,321	30	51,208
3 – Embolism	498	1,537,107	30	88,055	23	70,372
4 – Vascular Claudication	646	1,585,493	30	71,425	8	18,691
5 – Major Depressive Disorder	638	1,798,997	30	77,952	8	24,138
Total – First Five Strata	**4,156**	**$10,805,795**	**150**	**375,383**	**98**	**$226,670**
6 – Potentially Mis-Keyed Diagnoses	76	$425,783	76	$425,783	62	$329,796
Totals – All Strata	**4,232**	**$11,231,578**	**226**	**$801,166**	**160**	**$556,466**

Table 4: Estimated Net Overpayments in the Sampling Frame
(*Limits Calculated at the 90-Percent Confidence Level)*

	Estimated Net Overpayment for Statistical Sample	Overpayment for Potentially Mis-Keyed Diagnosis Group	Total Estimated Net Overpayments
Point Estimate	$6,638,029	$329,796	$6,967,825
Lower Limit	5,897,209	329,796	6,227,005
Upper Limit	7,378,849	329,796	7,708,645

APPENDIX E: FEDERAL REGULATIONS REGARDING COMPLIANCE PROGRAMS THAT MEDICARE ADVANTAGE ORGANIZATIONS MUST FOLLOW

Federal regulations (42 CFR § 422.503(b)) state:

> Any entity seeking to contract as an MA organization must . . . .
>
> (4) Have administrative and management arrangements satisfactory to CMS, as demonstrated by at least the following . . . .
>
> (vi) Adopt and implement an effective compliance program, which must include measures that prevent, detect, and correct non-compliance with CMS' program requirements as well as measures that prevent, detect, and correct fraud, waste, and abuse. The compliance program must, at a minimum, include the following core requirements:
>
> (A) Written policies, procedures, and standards of conduct that—
>
> (1) Articulate the organization's commitment to comply with all applicable Federal and State standards;
>
> (2) Describe compliance expectations as embodied in the standards of conduct;
>
> (3) Implement the operation of the compliance program;
>
> (4) Provide guidance to employees and others on dealing with potential compliance issues;
>
> (5) Identify how to communicate compliance issues to appropriate compliance personnel;
>
> (6) Describe how potential compliance issues are investigated and resolved by the organization; and
>
> (7) Include a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials. . . .
>
> (F) Establishment and implementation of an effective system for routine monitoring and identification of compliance risks. The system should include internal monitoring and audits and, as appropriate, external audits, to evaluate the MA organization,

including first tier entities', compliance with CMS requirements and the overall effectiveness of the compliance program.

(G) Establishment and implementation of procedures and a system for promptly responding to compliance issues as they are raised, investigating potential compliance problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensure ongoing compliance with CMS requirements.

(1) If the MA organization discovers evidence of misconduct related to payment or delivery of items or services under the contract, it must conduct a timely, reasonable inquiry into that conduct.

(2) The MA organization must conduct appropriate corrective actions (for example, repayment of overpayments, disciplinary actions against responsible employees) in response to the potential violation referenced in paragraph (b)(4)(vi)(G)(1) of this section.

(3) The MA organization should have procedures to voluntarily self-report potential fraud or misconduct related to the MA program to CMS or its designee.

APPENDIX F: DETAILS OF POTENTIALLY MIS-KEYED DIAGNOSIS CODES

Table 5: Potentially Mis-Keyed Diagnosis Codes and Associated Overpayments

Number of Enrollee-Years	One Diagnosis for a Condition (Determined To Be Incorrect)		Multiple Diagnoses for a Condition (Not Reviewed)		Overpayment
	Diagnosis Code	Diagnosis Code Description	Diagnosis Code	Diagnosis Code Description	
9	205.00	Acute myeloid leukemia, without mention of having achieved remission	250.00	Diabetes mellitus without mention of complications, type II or unspecified type	$153,129
9	441.00	Dissection of aorta, unspecified site	414.00	Coronary atherosclerosis of unspecified type of vessel, native or graft	19,570
8	441.01	Dissection of aorta, thoracic	414.01	Coronary atherosclerosis of native coronary artery	19,878
7	482.0	Pneumonia due to Klebsiella pneumonia	428.0	Congestive heart failure, unspecified	37,121
5	E32.9	Disease of thymus, unspecified	F32.9	Major depressive disorder, single episode	11,490
3	433.01	Occlusion and stenosis of basilar artery with cerebral infarction	433.10	Occlusion and stenosis of carotid artery without mention of cerebral infarction	8,812
3	714.9	Unspecified inflammatory polyarthropathy	174.9	Malignant neoplasm of breast (female), unspecified	9,872
3	850.2	Concussion with moderate loss of consciousness	805.2	Closed fracture of thoracic vertebra without mention of spinal cord injury	4,527
2	174.9	Malignant neoplasm of breast (female), unspecified	714.9	Unspecified inflammatory polyarthropathy	3,322
2	200.00	Reticulosarcoma, unspecified site, extranodal and solid organ sites	250.00	Diabetes mellitus without mention of complications, type II or unspecified type	7,898

Number of Enrollee-Years	One Diagnosis for a Condition (Determined To Be Incorrect)		Multiple Diagnoses for a Condition (Not Reviewed)		Overpayment
	Diagnosis Code	Diagnosis Code Description	Diagnosis Code	Diagnosis Code Description	
2	250.00	Diabetes mellitus without mention of complications, type II or unspecified type	205.00	Acute myeloid leukemia, without mention of having achieved remission	1,873
2	250.10	Other specified diabetes mellitus with ketoacidosis without coma	205.10	Chronic myeloid leukemia, without mention of having achieved remission	4,139
2	402.01	Malignant hypertensive heart disease with heart failure	402.10	Benign hypertensive heart disease without heart failure	7,476
1	205.02	Acute myeloid leukemia, in relapse	250.02	Diabetes mellitus without mention of complication, type II or unspecified, uncontrolled	20,623
1	249.20	Secondary diabetes mellitus with hyperosmolarity, not stated as uncontrolled, or unspecified	294.20	Dementia, unspecified, without behavioral disturbance	3,027
1	441.2	Thoracic aneurysm without mention of rupture	414.2	Chronic total occlusion of coronary artery	2,847
1	710.3	Dermatomyositis	170.3	Malignant neoplasm of ribs, sternum, and clavicle	1,628
1	996.56	Mechanical complication due to peritoneal dialysis catheter	996.65	Infection and inflammatory reaction due to other genitourinary device, implant, and graft	12,564
62					**$329,796**

Table 6: Hierarchical Condition Categories That Were Not Validated and Hierarchical Condition Categories for a Less Severe Manifestation of the Related-Disease Group That Were Supported

Count of Enrollee-Years	More Severe Hierarchical Condition Category That Was Not Validated	Less Severe Hierarchical Conditional Category That Was Supported*
11	Vascular Disease with Complications	Vascular Disease
1	Diabetes with Acute Complications	Diabetes without Complication

*Unless otherwise indicated, the definitions were the same in both Version 12 and Version 22.

APPENDIX G: HIGHMARK COMMENTS

April 1, 2022

BY EMAIL

Nicole Freda, Regional Inspector General for Audit Services
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Re: **Response to OIG Draft Audit Report Number: A-03-19-00001 of Highmark Senior Health Company (H3916)**

Dear Ms. Freda and Mr. Cohen,

Highmark Senior Health Company ("**Highmark**") writes this letter in response to the draft report issued by the United States Department of Health and Human Services, Office of Inspector General ("**OIG**") in February 2022 entitled *Medicare Advantage Compliance Audit of Specific Diagnosis Codes that Highmark Senior Health Company (H3916) Submitted to CMS* (the "**Draft Report**"). Highmark and its affiliated companies are non-profit licensees of the Blue Cross Blue Shield Association. Highmark offers HMO and PPO Medicare Advantage (**"MA"**) products in Pennsylvania, New York, West Virginia, and Delaware. In the most recent Medicare Star Ratings, all of Highmark's plans scored either 4.5 or 5 out of a possible 5 stars. In the J.D. Power study of overall customer satisfaction with MA plans, Highmark ranked first in 2020 and second in 2021.

Highmark respectfully disagrees with OIG's findings and requests that OIG withdraw its recommendations that Highmark refund the government $6.3 million in extrapolated "overpayments" for the years covered by the audit; identify similar instances of "overpayments" in other years and refund the corresponding amounts; and enhance its compliance procedures.

As discussed in more detail below, Highmark requests that OIG withdraw its recommendations for several reasons. First, OIG did not take into consideration all elements of an "improper payment," focusing only on alleged overpayments to Highmark and ignoring underpayments to Highmark and errors in the fee-for-service (**"FFS"**) data on which MA payment rates are based. Second, extrapolation is not appropriate because OIG does not have the authority to extrapolate and there is no adequate mechanism for repayment of extrapolated amounts. Moreover, OIG's imposition of its new audit approach retroactively and without the proper notice and comment process violates statutory and regulatory requirements. Additionally, these unpredictable and inconsistent audits have potential devastating effects to the MA program ranging from plan participation to, most importantly, beneficiary harm. Lastly, Highmark has a robust compliance program, which it continually refines. Highmark disagrees with OIG's suggestion that the findings of this audit demonstrate that Highmark's compliance program is inadequate.

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I. OIG'S AUDIT METHODOLOGY IS INCONSISTENT WITH THE FUNDAMENTALS OF MEDICARE ADVANTAGE PAYMENT.

A. In a Capitated System Such as MA, an Audit Should Be Designed to Determine Not Only Whether Individual Coding Errors Occurred, But Also Whether the Overall Payment to the MAO Was Too High.

The MA program uses a global capitated payment model developed by the Centers for Medicare & Medicaid Services (**"CMS"**) that relies on FFS data from the traditional Medicare program to determine the value of coefficients used for payment. Because the model is population-based, any inquiry in MA designed to determine whether an improper payment has occurred must take into account all potential errors that affect payment, including undercoding and overcoding, as well as errors in the FFS data, and the resultant effect on CMS's total *overall* payment to the MA Organization (**"MAO"**). OIG's findings, upon which it bases the extrapolated demand, do not take into account: (i) instances of potential undercoding, or underpayments, in the MAO's data; and (ii) the impact of errors in FFS data on payment. If OIG had taken these into consideration in defining the purported improper payment amount, it would not have had a basis upon which to calculate and extrapolate an overpayment.

B. OIG Did Not Account for Underpayments, Which, When Evaluated, More Than Offset the Alleged Overpayments.

An audit seeking to determine whether an MAO was improperly paid must determine whether, on average, across all codes for all members, the plan received a larger (or smaller) payment than it should have. OIG acknowledges this itself, stating in the Draft Report: "Unvalidated HCCs cause enrollee risk scores to be overstated, which results in improper payments (overpayments) from CMS to MA organizations. Conversely, if medical records support diagnoses codes that MA organizations do not submit to CMS, enrollee risk scores may be understated, which may also result in improper payments (underpayments)."[1] While OIG acknowledges that underpayments also constitute an improper payment, it does not account for them in any meaningful way in its methodology.[2] OIG's current audit approach does not establish that there were actual overall *improper payments* because OIG chose, and audited, codes for which there was a likely error in the government's favor while ignoring the inverse.

To demonstrate the potential error in OIG's approach, Highmark performed a limited analysis of certain chronic conditions that were likely to have existed during 2014 and 2015 but not submitted to CMS. Highmark used a targeted approach, similar to OIG's, selecting conditions that, in its experience, are often undercoded by providers – diabetes mellitus with complications (**"DM"**), chronic kidney disease (**"CKD"**), and chronic obstructive pulmonary disease

[1] Draft Report at 4.

[2] Where OIG found that the HCC in question was not supported but that a different HCC should have been assigned, that change was incorporated into the calculation. This was the only way in which OIG accounted for codes that should have been submitted but were not.

("**COPD**").[3] Highmark focused on members who had one of these diagnoses submitted in a prior and/or subsequent year but not in either 2014 or 2015. Highmark selected a random sample from the universe identified for which medical records were readily available. Experienced coders reviewed the associated medical records.[4]

After a quality assurance process that included two levels of review, Highmark identified an undercoding rate between 7% and 10%, depending on the diagnosis code. This resulted in an underpayment amount of approximately $18,100 identified in the samples reviewed. To replicate OIG's approach, Highmark then extrapolated from this amount, using OIG's methodology. Highmark calculated $11.1 million in underpayments from this limited exercise. This amount more than offsets the $6.3 million in alleged overpayments. Significantly, Highmark reviewed only three conditions. If Highmark had evaluated the undercoding associated with additional conditions, the underpayments found, presumably, would have been even more significant.

To be clear, Highmark is not suggesting that CMS now pay Highmark for these missed codes. However, if OIG elects to effectively re-open a long since closed contract period, it should allow MAOs to offset any alleged overpayments with evidence of underpayments.[5]

C. OIG Did Not Fully Account for Undercoding Evident in the Medical Records Provided to OIG.

As noted above, the appropriate approach to this type of audit would be to consider all potential offsetting underpayments. This should include consideration of underpayments related to all patients and all medical records, and not be limited to those patients and records that are the subject of the audit. OIG did not do this, and in fact, did not even consider underpayments in the medical records submitted in connection with the audit. This approach departs from CMS Risk Adjustment Data Validation ("**RADV**") audits. OIG disregarded all instances of undercoding shown in the medical records reviewed unless the code replaced the targeted diagnosis code.

Highmark coders reviewed the medical records submitted to OIG and identified a total of 36 new, unique codes for the same patient in the same year, with a value of $82,486. Of these codes, 19 were associated with a medical record that validated a targeted condition. These 19 codes

[3] The following table shows the Hierarchical Condition Categories (**"HCCs"**) and International Classification of Disease (**"ICD"**) codes for these conditions. Version 12 (**"V12"**) of the HCCs was used through 2014. Version 22 (**"V22"**) was incorporated into the risk adjustment model beginning in 2014. The ICD system of diagnoses codes switched from version 9 (**"ICD9"**) to version 10 (**"ICD10"**) on October 1, 2015.

Condition	V12 HCC	V22 HCC	ICD9	ICD10
DM	18	18	250.1x- 250.9x	E11.1x-E11.8
CKD	n/a	136 and 137	585.3-585.5	N18.3-N18.5
COPD	108	111	496	J44.x

[4] The Highmark coders who conducted this review all had American Academy of Professional Coders (**"AAPC"**) Certified Professional Coder (**"CPC"**) and/or AAPC Certified Risk Adjustment Coder (**"CRC"**) certifications. All had at least five years (and most had at least ten years) of risk adjustment coding experience.

[5] CMS allows correction of underpayments only during a specified period (typically until January 31 of the year following the payment year), although it allows correction of overpayments during a much longer period. Although CMS does not allow MAOs to "add" missing codes after the deadline, there does not appear to be anything that would prevent OIG from allowing an MAO to submit evidence of underpayments to offset the alleged overpayments in the context of this audit.

have a value of $39,026, which CMS would offset in a typical RADV. As noted above, the appropriate approach would be to fully credit *any* offsetting underpayments. It is particularly unclear why OIG would not credit underpayments to the same extent that CMS does in its RADV audits.

D. OIG Made Two Errors in Applying its Own Methodology for Accounting for Codes That Could Have Been Submitted.

In its audit, OIG stated that it accounted for undercoding only to a very limited extent: "[i]f the contractor identified a diagnosis code that should have been submitted to CMS instead of the selected diagnosis code, we included a financial impact of the resulting HCC (if any) in our calculation of overpayments." For instance, OIG noted, "Highmark submitted an acute stroke diagnosis code (which was not supported in the medical records) instead of a diagnosis code for hemiplegia (which was supported by the medical records). This error caused an underpayment."[6]

However, there were two instances in which OIG failed to recognize alternative codes identified in the medical record that should have been submitted to CMS instead of the selected codes. In Sample 82, Highmark submitted ICD-9 410.72 (Sub endocardial Infarction, Subsequent), which triggered V12HCC 82. The medical record provided in support of the code was a cardiac catheterization procedure note, which clearly indicated the patient had "recently" suffered from a myocardial infarction. ICD9 coding guidelines allowed coding of an acute myocardial infarction (AMI) for up to eight weeks after the initial event.; ICD10 (effective October of 2015) permits coding four weeks after an AMI. Although the note did not explicitly state how "recently" the infarction had occurred, OIG should have credited Highmark for ICD-9 412 (Old Myocardial Infarction), which, in 2014, mapped to HCC 83.

In Sample 128, one of the codes submitted was ICD-9 443.9 (Peripheral Vascular Disease ("**PVD**")), which maps to V12HCC 105/ V22HCC 108. While PVD was not supported by the medical record provided to OIG, ICD-9 440.0 (Atherosclerosis), which maps to the same HCCs, was supported by the medical record. The diagnosis was noted in the abdominal CT scan image findings that were specifically "reviewed and assessed" by the physician. Specifically, the note reads, "Atherosclerotic calcifications, abdominal aorta and iliac arteries." ICD coding guidelines permit diagnoses from diagnostic imaging as long as the provider has noted a review of the findings.

E. OIG Did Not Account for the Fact That the Same Errors Are Present in the FFS Data Upon Which MA Reimbursement Rates Are Based.

It is widely recognized that individual providers often submit inaccurate and non-comprehensive diagnosis data. Although coding continues to improve, FFS providers often do not code comprehensively and may include only diagnosis codes necessary to support a service. Given the substantial number of ICD codes, providers may also select the wrong diagnosis code or not include documentation in the medical record that is sufficient to support the code they select. In fact, a CMS analysis of Medicare FFS data showed that the claim-level error rate in diagnoses supporting each HCC ranged from 21 to 46%.[7]

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[6] Draft Report at 9.

[7] CMS, *Fee for Service Adjuster and Payment Recovery for Contract Level Risk Adjustment Data Validation Audits* (Oct. 26, 2018) at 3 ("A claim level discrepancy rate was derived for each HCC. The discrepancy rates ranged from 21 to 46 percent.").

CMS has argued that the traditional Medicare data still leads to appropriate *overall* reimbursement for MAOs because, when the data is considered as a whole, errors tend to "offset" one another.[8] Thus, CMS has argued that there is no need for an "FFS Adjuster" in the context of RADV audits. Notably, others have criticized this conclusion. For instance, a Milliman white paper concluded that CMS's analysis was faulty and that, in fact, a FFS Adjuster is necessary.[9]

Even if CMS was correct, in that underpayments and overpayments cancel one another *overall*, this would not negate the need for OIG to take the error rate in the FFS data into account in the present audit. Here, OIG selected coding patterns most likely to have high rates of overcoding and ignored the other side of the equation (underpayments), which, CMS acknowledges, cancels out overpayments. Individual providers submitted the vast majority of codes in the OIG sample. These providers make the same coding errors when treating FFS Medicare patients. CMS then uses the same FFS data to set the co-efficient values for specific HCCs, which factor into MAO payments. Thus, the payments to MAOs already take into account the fact that a large number of the codes submitted in these situations are likely to be unsupported.[10] Further, the amount of a FFS Adjuster in this type of audit would have to be much higher than in a RADV audit, as the relevant measure here is not the overall error rate in the FFS data, but, rather, the error rate in the FFS data for the same situations targeted in OIG's audit.[11]

In this audit, OIG searched for specific coding patterns in which the diagnosis was unlikely to be supported. If OIG is going to use this approach, the results must, at a minimum, be compared to the same coding patterns in the FFS data. Because OIG did not consider the errors in the FFS data, its audit methodology and results are inaccurate.[12]

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[8] *Id.* at 5 ("while a particular HCC's relative factor may have inaccuracy attached to it, the fact that the relative factors are summed across each enrollee's HCCs and then across a plan's enrollment, leads the inaccuracies to mitigate each other due to offsetting effects"); *id.* at n.9 ("As a statistical phenomenon, certain individual HCCs with measurement error may be subject to downward biases. However, this will result in upward biases to other HCCs and demographic factors. Across HCCs, these biases are likely to offset.").

[9] Pipich, R., *Medicare Advantage RADV FFS adjuster: White paper*, Milliman (August 23, 2019).

[10] For instance, as OIG has discovered, when the code for an acute myocardial infarction ("MI") is submitted from a physician's office with no accompanying hospital admission, that code is often an error (and the physician typically meant to capture a history of an acute MI). But this same coding error likely occurs just as frequently in the FFS data. Thus, the value of the co-efficient for the related HCC, which is based on what Medicare FFS pays to care for patients with particular conditions, already takes this rate of error into account in the payment. Removing those codes from the MA data without also removing them from the FFS data on which the HCC values are based is likely to result to underpayment to the MAOs.

[11] For example, OIG identified members diagnosed with Major Depressive Disorder who had no related medication. OIG found that in these instances, the diagnosis was not supported by the medical record in 22 of 30 instances (or 73% of the time). However, to determine whether this actually represents an improper payment, FFS data for the same set of conditions should be reviewed to determine whether it differs from Highmark's data. If the errors occur with the same frequency in both the FFS and the MA data, then Highmark would be underpaid if it were required to remit these amounts back to CMS.

[12] The failure to account for the error rate in the FFS data is also inconsistent with OIG's previous acknowledgment of the need to take this into account. During its 2012 OIG audit, PacifiCare argued that OIG's results did not account for error rates in Medicare FFS data. OIG withdrew its recommendation that PacifiCare repay an extrapolated amount and recommended instead that PacifiCare "work with CMS to determine the correct contract-level adjustments for the estimated overpayments." OIG, *Risk Adjustment Data Validation of Payments Made to PacifiCare of California for Calendar Year 2007* (Contract Number H0543), A-09-09-00045, ii-iii (Nov. 2012).

F. OIG Is Effectively Requiring that Providers Performing Services under Medicare Advantage Code 100% Accurately Which Both OIG and CMS Have Acknowledged Is Not Required Under Medicare Advantage.

OIG's audit approach effectively requires MAOs to have a 0% coding error rate for all of its encounter data. Holding MAOs to a standard of perfection is inconsistent with previous acknowledgements by both CMS and OIG that 100% accuracy in the data MAOs submit to CMS is not possible or required.[13] CMS regulations require that an MAO take reasonable steps to ensure the "accuracy, completeness, and truthfulness" of the data it submits to CMS based on its "best knowledge, information, and belief."[14] At the time it implemented the current regulatory scheme, CMS acknowledged that 100% accuracy could not be expected and was not required, stating, "M+C organizations cannot reasonably be expected to know that every piece of data is correct, nor is that the standard that HCFA, the **OIG,** and DOJ believe is reasonable to enforce."[15] Similarly, OIG has stated that the requirement that an MAO certify the accuracy of data "does not constitute an absolute guarantee of accuracy."[16]

It is unreasonable for OIG to effectively hold MAOs to a standard of 100% accuracy by constructing an audit consisting solely of a heavily data-mined sample designed to highlight only overpayments and not underpayments. This is particularly true given that both CMS and OIG have previously stated that 100% accuracy is not expected.

G. OIG's Audit Approach Would Result in a Violation of the Actuarial Equivalence Requirement.

The Social Security Act ("**SSA**") provides that CMS must compensate MAOs in a way that ensures "actuarial equivalence" with what CMS would have paid to provide care for the same beneficiaries under traditional Medicare.[17] This means that CMS's overall payment to MAOs must be equivalent to what CMS would have paid to cover the same individuals under traditional Medicare. Application of OIG's audit approach, which does not consider underpayments or errors

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[13] Similarly, in *UnitedHealthcare Ins. Co. v. Becerra*, 16 F.4th 867 (D.C. Cir. Nov. 1, 2021), the D.C. Circuit recently held that: "***Nothing in the Overpayment Rule obligates insurers to audit their reported data***...the Rule only requires insurers to refund amounts they know were overpayments, i.e., payments they are aware lack support in a beneficiary's medical records. That limited scope does not impose a self-auditing mandate." *Id.* at 884 (emphasis added).

[14] 42 C.F.R. § 422.504(l) ("As a condition for receiving a monthly payment under subpart G of this part, the MA organization agrees that its chief executive officer (CEO), chief financial officer (CFO), or an individual delegated the authority to sign on behalf of one of these officers, and who reports directly to such officer, must request payment under the contract on a document that certifies (based on best knowledge, information, and belief) the accuracy, completeness, and truthfulness of relevant data that CMS requests.").

[15] Health Care Financing Administration ("**HCFA**"), Department of Health and Human Services ("**HHS**"), *Medicare Program, Medicare+Choice Program*, 65 Fed. Reg. 40,170, 40,268 (June 29, 2000) (emphasis added).

[16] HHS, OIG, *Publication of the OIG's Compliance Program Guidance for Medicare+Choice Organizations Offering Coordinated Care Plans*, 64 Fed. Reg. 61,893, 61,900 (Nov. 15, 1999) (emphasis added).

[17] 42 U.S.C. § 1395w-23(a)(1)(C)(i)) ("[T]he Secretary shall adjust the payment amount [of fixed monthly payments to Medicare Advantage insurers] for such risk factors as age, disability status, gender, institutional status, and such other factors as the Secretary determines to be appropriate, including adjustment for health status ..., ***so as to ensure actuarial equivalence***.") (emphasis added); Actuarial Standards Board, *Actuarial Standard of Practice No. 45* § 3.2 (January 2012) ("The type of input data . . . used in the application of risk adjustment should be reasonably consistent with the type of data used to develop the model.").

in the FFS data, would result in an MAO being paid less than it would have cost traditional Medicare to care for the same beneficiaries. This is inconsistent with the actuarial equivalence requirement.

II. EVEN IF THE AUDIT HAD IDENTIFIED IMPROPER PAYMENTS, EXTRAPOLATION FROM OIG'S FINDINGS WOULD BE INAPPROPRIATE.

A. OIG Lacks the Authority to Extrapolate.

While OIG has the independent authority to conduct audits to ensure accurate payment, it does not have the authority to extrapolate its findings under Medicare Part C. The SSA provides qualified authority to extrapolate only to ***Medicare contractors*** conducting audits on behalf of CMS ***under Medicare Parts A and B*** (traditional Medicare). The statute permits contractors to extrapolate error rates identified so long as there is evidence to show that there is: (1) a sustained or high level of payment error; and (2) documented evidence that educational interventions (by the government) failed to correct the payment error.[18]

First, OIG is not a Medicare contractor. Moreover, there is no comparable statutory authority provided to OIG under Medicare Part C. Similarly, we are not aware of any rulemaking or public notice that purports to grant OIG the ability to adjust payment via extrapolation under MA.

Second, although OIG might argue that there is a high level of payment error revealed by its sample, this is untrue for the reasons discussed above. OIG never calculated an actual "improper" payment error because it did not consider overall payments made to Highmark for its MA population or take into account FFS errors.

Third, CMS has yet to impose extrapolation in its own RADV audits. In 2012, CMS attempted to incorporate extrapolation into its methodology for payment recoveries related to RADV audits but, as CMS has noted, "it has never been implemented." . . In 2018, CMS proposed a revised RADV audit methodology, which included the use of extrapolation.[19] CMS stated: "In this proposed rule, we would, based on longstanding case law and best practice from HHS and other federal agencies, ***establish*** that extrapolation would be utilized as a valid part of audit authority in Part C, as it has been historically a normal part of auditing practice throughout the Medicare program."[20] This is a clear acknowledgement that there is currently no authority to extrapolate under MA even for CMS, let alone OIG. CMS has yet to issue a final rule regarding RADV methodology and extrapolation. However, CMS continues with RADV audits, most recently for payment years 2014 and 2015, and has explicitly stated that it would "not seek to recover on any extrapolated basis until the rule is final."[21]

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[18] 42 U.S.C. § 1395ddd(f)(3).

[19] HHS, CMS, *Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-for-Service, and Medicaid Managed Care Programs for Years 2020 and 2021*, 83 Fed. Reg. 54,982 (Nov. 1, 2018).

[20] *Id.* at 54,984 (emphasis added).

[21] *Id.* at 55,039 n.26.

It may be OIG's position that its results are not final and that OIG itself is not "requiring" extrapolation or a repayment. We note that OIG is careful not to suggest that its audits are a final agency determination and instead suggests that MAOs work with CMS on remediation. This sidesteps the practical implications for MAOs that receive a letter from an enforcement agency instructing them to re-open a closed contract period and make payment adjustments to CMS.[22]

B. There Is No Mechanism for Correcting Diagnostic Data Associated With Extrapolated Amounts.

Highmark is aware of no means by which it could refund extrapolated amounts to CMS. Currently, CMS requires MAOs to correct diagnostic data by issuing "delete files" to CMS. The financial amount associated with the diagnosis codes deleted is then reconciled against future payments for that contract. It is impossible to issue delete files based on an extrapolated number, as OIG proposes. CMS has yet to provide any guidance on how an MAO, in response to an OIG audit, is supposed to reconcile extrapolated amounts with the government. Further, there is currently no CMS settlement process, of which Highmark is aware, for which an MAO that refunded an extrapolated amount would obtain a release from liability for errors relating to the same codes in subsequent audits, investigations, or other disputes.

III. OIG'S APPROACH VIOLATES STATUTORY AND REGULATORY REQUIREMENTS.

A. The SSA Prohibits OIG From Imposing Its New Approach Retroactively.

The SSA prohibits the retroactive application of rules absent a significant public safety concern or other critical need.[23] OIG has argued in another audit report that because its new audit methodology is not a "statutory or regulatory requirement," it is not subject to this prohibition.[24] However, the prohibition is broader than that:

> *A **substantive change in regulations, manual instructions, interpretive rules, statements of policy, or guidelines of general applicability*** under this subchapter ***shall not be applied*** (by extrapolation or otherwise) ***retroactively*** to items and services furnished before the effective date of the change, unless the Secretary determines that (i) such retroactive application is necessary to comply with statutory requirements; or (ii) failure to apply the change retroactively would be contrary to the public interest.[25]

OIG's new methodology for conducting MA audits is materially different from the CMS methodology that was in place when the MAOs submitted bids for the years in question. Regardless of how OIG chooses to label this new approach, it clearly represents a "substantive

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[22] Moreover, even if extrapolation were appropriate (which it is not), OIG's use of a two sided 90% confidence interval to calculate the extrapolated repayment amount was not appropriate. A better approach would be to use a lower bound of a 99% confidence interval, which is what CMS does in its RADV audits. Had OIG used the same confidence interval that CMS uses, the extrapolated repayment amounts would have been lower.

[23] 42 U.S.C. §139hh(e)(1)(A).

[24] Healthfirst Audit at 18.

[25] 42 U.S.C. §139hh(e)(1)(A).

change." The change effectively demands 100% accuracy of MAOs and has a significant potential impact on the reimbursement received by those plans for past years. Moreover, retroactive application is neither necessary to comply with statutory requirements nor in the public interest. Given this, the SSA prohibits OIG's retroactive application of the approach.

B. OIG's Audit Methodology Represents a Change in a Substantive Legal Standard and Should Not Have Been Adopted without Notice and Comment.

In adopting a new audit approach, OIG did not engage the requisite notice and comment process. The "notice and comment" provision of the Administrative Procedures Act ("**APA**") does not apply to the Medicare Act. However, in 1987, Congress enacted a notice and comment statute specifically for Medicare. As the Supreme Court explained in *Azar v. Allina Health Services*:

> [T]he law requires the government to provide the public with advance notice and a chance to comment on any "rule, requirement, or other statement of policy" that "establishes or changes a substantive legal standard governing … the payment for services."[26]

The Court further noted that "[n]otice and comment gives affected parties fair warning of potential changes in the law and an opportunity to be heard on those changes—and it affords the agency a chance to avoid errors and make a more informed decision."[27]

In the present case, OIG has adopted new substantive legal standards by performing audits that impose different standards from one audit to the next and different standards than those that CMS has historically utilized in the context of its RADV audits. This is inappropriate given that these new standards did not go through the notice and comment process.

C. OIG's Audit Methodology Is Arbitrary and Capricious.

Agency actions can generally be set aside if they are "arbitrary and capricious."[28] OIG's audit approach is arbitrary and capricious for numerous reasons discussed above: OIG's failure to consider underpayments or to account for errors in the FFS data and actuarial equivalence; its effective insistence on 100% accuracy despite the fact that both OIG and CMS have acknowledged that this is neither possible nor required; its extrapolation of results despite a lack of authority to do so; its retroactive application of a new audit methodology in violation of the SSA; its adoption of a new audit methodology without the opportunity for notice and comment; and its inconsistent application of approaches over time and from one MAO to the next without explanation.

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[26] *Azar v. Allina Health Services*, 139 S.Ct. 1804 (2019) (quoting 42 U.S.C. § 1395hh(a)(2)). In *Azar v. Allina*, the government noted that, under the APA, "interpretive rules" do not require notice and comment and argued that the same should be true under the Medicare Act's notice and comment provision. But the Court rejected this argument, holding that the notice and comment requirement under the Medicare Act was broader than under the APA and siding with the defendants, which argued that (i) under the Medicare Act, a "substantive legal standard" subject to the notice and comment requirement is one that "creates duties, rights and obligations," and (ii) CMS's adoption of a new approach required notice and comment (even though, in that case, the change was merely noted in a spreadsheet on the CMS website).

[27] *Id.* at 1816.

[28] *See, e.g., Lead Indus. Ass'n, Inc. v. Env't Prot. Agency*, 647 F.2d 1130, 1146 (D.C. Cir. 1980).

IV. OIG'S APPROACH TO RISK ADJUSTMENT AUDITS COULD NEGATIVELY IMPACT THE MEDICARE ADVANTAGE PROGRAM.

A. The MA Program Results in Improved Quality and Reduced Costs.

The Congressional Budget Office has forecast that by 2029, 47% of Medicare beneficiaries will be enrolled in MA plans.[29] MA plans are attractive to many beneficiaries because they are generally more affordable and offer more benefits than traditional Medicare. MA plans also manage chronic conditions better than traditional Medicare. A 2015 paper found that MA plans did better than traditional Medicare in managing diabetes.[30] Similarly, a 2017 study found that MA plans outperformed traditional Medicare on all 16 quality measures and four out of six patient experience measures.[31] In addition, a 2018 study showed that MA enrollees with certain chronic conditions had 23% fewer inpatient stays and 33% fewer emergency department visits than equivalent traditional Medicare beneficiaries.[32] There is also evidence of a spillover effect from MA that saves money on traditional Medicare because physicians tend to implement the same disease management and population health practices with all of their patients.[33]

B. OIG's Unpredictable Approach and Resulting Contract Offsets May Complicate the MA Bidding Process and Negatively Impact Benefit Packages and Premiums.

Each year an MAO must present a bid to CMS for each contracted health plan. The bid contains the essential cost and design elements necessary for the MAO to deliver the Parts A and B benefits, plus supplemental benefits to its members. In setting the bid prices and creating benefit packages, an MAO makes informed assumptions about the payments it will receive and retain from CMS.[34] In submitting its bids for services to be provided in 2014 and 2015, Highmark reasonably considered financial risk associated with repayment obligations that might result from CMS's standard RADV audit process. OIG adopted a completely new approach to audits and has applied it retroactively to long closed contract years. Highmark could not have predicted this or

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[29] *See* KFF, *Medicare Advantage* (June 6, 2019).

[30] Landon et al., *A Comparison of Relative Resource Use and Quality in Medicare Advantage Health Plans Versus Traditional Medicare*, AJMC (August 18, 2015).

[31] Timbie et al., *Medicare Advantage and Fee-for-Service Performance on Clinical Quality and Patient Experience Measures*, 52 Health Services Research 2038 (2017).

[32] Avalere Health, *Medicare Advantage Achieves Cost-Effective Care and Better Outcomes for Beneficiaries with Chronic Conditions Relative to Fee-for-Service Medicare* (July 2018).

[33] Johnson et al., *Recent Growth In Medicare Advantage Enrollment Associated With Decreased Fee-For-Service Spending In Certain US Counties*, Health Affairs Vol. 35, No. 9 (Sept. 2016); Timbie et al., *Medicare Advantage and Fee-for-Service Performance on Clinical Quality and Patient Experience Measures*, 52 Health Services Research 2038 (2017).

[34] Significantly, under the Affordable Care Act ("**ACA**"), MAOs are required to spend at least 85% of the money they receive from the Medicare program on medical care – a percentage known as the Medical Loss Ratio ("**MLR**"). Plans that do not meet this MLR standard must return the difference between 85% and their MLR to the government. 42 CFR § 422.2410(b) provides: "If CMS determines for a contract year that an MA organization has an MLR for a contract that is less than 0.85, the MA organization has not met the MLR requirement and must remit to CMS an amount equal to the product of the following: (1) The total revenue of the MA contract for the contract year. (2) The difference between 0.85 and the MLR for the contract year." MAOs design their benefits to ensure that at least 85% of the money they receive from the government is spent on patient care.

taken it into account when it submitted bids and determined what benefits it could offer to its members for the years at issue in this audit.

Importantly, OIG's audit approach continues to change.[35] The uncertainty of additional future one-sided contract adjustments may inject unwarranted uncertainty into the benefit design process. OIG has conducted both beneficiary level and specific code-targeted audits; it has chosen different codes for different plans; it has recommended extrapolation in some audits but not others; and it has defined the categories audited differently in different audits.[36] For instance, in the Essence audit, OIG defined the high-risk category for Major Depressive Disorder as consisting of a diagnosis of Major Depressive Disorder on only one or two claims in a year, rather than several claims in a year.[37] In other audits, it has defined this same high-risk category as consisting of a diagnosis of Major Depressive Disorder without an anti-depressant medication dispensed.

Unpredictable contract adjustments caused by these audits may, over time, increase premiums, decrease benefits, and harm the breadth and scope of the MA program. This could have a negative impact on both the overall cost of the Medicare program and the overall health of the Medicare population.

[35] See summaries of OIG audits, below:

Plan	Date of Plan's Response to Draft Audit	Date of Final OIG Audit Report	What the Audit Targeted	Errors Found (thousands)	Extrapolated Amounts (millions)	Service Years
Essence	2019 (Mar. 11)	2019 (Apr.)	2 categories	$159	***None***	2012, 2013, 2014
Humana	2019 (Dec. 6)	2021 (Apr.)	200 ***enrollees***	$249	$197.7	2014
Coventry	2020 (Aug. 20)	2021 (Oct.)	6 categories	$549	***None***	2013, 2014, 2015
Anthem	2020 (Oct. 16)	2021 (May)	7 categories	$354	$3.47	2014, 2015
BCBSM	2021 (Feb. 1)	2021 (Feb.)	7 categories	$668	$14.5	2014, 2015
UPMC	2021 (May 26)	2021 (Nov.)	10 categories	$681	$6.4	2014, 2015
Tufts	2021 (Sept. 16)	2022 (Feb.)	7 categories	$536	$3.8	2014, 2015
Healthfirst	2021 (Oct. 18)	2022 (Jan.)	7 categories	$517	$5.2	2014, 2015
Highmark	Draft report - Feb. 1, 2022		6 categories	$560	$6.3	2014, 2015

[36] OIG's approach differs not only from one audit to the next but also from CMS's approach. Most obviously, CMS's RADV audits use a more representative sample of diagnosis codes rather than targeting just codes with a high risk of error. Additionally, as noted above, when extrapolating, CMS uses a lower bound of a 99% confidence interval instead of the two sided 90% confidence interval used by OIG. Further, in the coding review, CMS uses a two level review process, whereas OIG uses a three level review process in which a physician makes the determination if the second level reviewer disagrees with the first level reviewer. This raises concerns not only because it differs from CMS's approach, but also because the physician is unlikely to be a certified coder and because it suggests that the review process may be taking into account whether the clinical diagnosis was appropriate, which CMS has indicated is not to play any role in determining the appropriateness of a diagnosis code. *See* CMS, *ICD-10-CM Official Guidelines for Coding and Reporting FY 2019*, at 13 (effective Oct. 1, 2018) ("The assignment of a diagnosis code is based on the provider's diagnostic statement that the condition exists. The provider's statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.").

[37] Essence Audit at 3.

C. OIG's Methodology Could Destabilize Value Based Contracting with Downstream Physician Practices.

OIG's methodology may unknowingly harm risk-bearing entities including primary care physician practices. MAOs increasingly contract with physicians and other clinicians through value- and risk-based contracts, which CMS has encouraged. In many of these arrangements, most operating margins, including risk-adjusted revenue, are paid directly to the providers. Depending on the particulars of the contract, if OIG attempts to retroactively recoup large sums from MAOs, these recoveries may impact, through recoupment, the providers themselves. This could present a significant financial challenge to provider practices, who do not carry or are capable of booking large reserves.

V. HIGHMARK MAINTAINS AN EFFECTIVE COMPLIANCE AND MONITORING PROGRAM BUT CANNOT REASONABLY BE EXPECTED TO VALIDATE ALL PROVIDER DIAGNOSTIC CODES IN ENCOUNTER DATA.

OIG recommended that Highmark (1) continue its examination of its existing compliance procedures to identify areas where improvements can be made to ensure that diagnosis codes that are at high risk for being miscoded comply with federal requirements (when submitted to CMS for use in CMS's risk adjustment program) and (2) take the necessary steps to enhance these procedures. Notably though, Highmark already has a robust compliance program. OIG acknowledges as much, stating:

> Highmark had compliance procedures in place during our audit period to determine whether the diagnosis codes that it submitted to CMS to calculate risk-adjusted payments were correct. These procedures included routine internal medical reviews to compare diagnosis codes from a sample of claims to the diagnosis codes that were documented on the associated medical records. These internal medical reviews targeted diagnosis codes from certain high-risk groups such as acute stroke, acute heart attack, and embolism. If Highmark detected compliance problems, it corrected the reviewed claims and expanded its review to other claims not initially selected. The results of these internal medical reviews were used to develop provider educational materials that informed providers of high-risk diagnosis areas. The educational materials highlighted coding errors identified during Highmark's internal reviews and provided additional guidance to providers on how to avoid these errors.[38]

Notwithstanding these strong controls, OIG states that because errors were found, Highmark's policies and procedures "could be improved." Notably, though, OIG does not offer specific improvement recommendations. OIG cannot reasonably expect MAOs to achieve perfection, especially when measured by an audit specifically designed to identify one-sided errors. CMS provides MAOs broad discretion "to design their compliance plan structure to meet the unique aspects of each organization."[39] Highmark believes that its current compliance policies and auditing and monitoring activities more than comply with MA statutory and regulatory requirements. Moreover, OIG's audit included only data from 2014 and 2015 and, thus, has limited

[38] Draft Report at 14.

[39] Health Care Financing Administration ("**HCFA**"), Department of Health and Human Services ("**HHS**"), Medicare Program, *Medicare+Choice Program*, 65 Fed. Reg. 40,170, 40,265.

applicability to Highmark's current compliance policies. Further, MAOs could only achieve OIG's requirement of 100% accuracy if MAOs undertook chart review for all submitted encounters. Highmark submits over 7.5 million claims to CMS annually for its MA members. Given this, reviewing every chart is simply not feasible. In fact, the cost and burden of reviewing all risk adjusted encounters would be prohibitive and would eliminate any efficiencies or savings under the MA program.

VI. CONCLUSION

For the reasons stated above, Highmark requests that OIG withdraw its recommendations that Highmark "(1) refund to the Federal Government the $6.3 million … (2) identify … similar instances of noncompliance that occurred before or after our audit period and refund any resulting overpayments … and (3) continue its examination of its existing compliance procedures … and take the necessary steps to enhance those procedures." Highmark will work with CMS to delete individual codes that Highmark determines were unsupported in the audit.

Highmark welcomes the opportunity to discuss OIG's methodology and findings, as well as its proposed recommendations, and reserves all rights to challenge any current or revised recommendations.

Sincerely,

/ Melissa Anderson /

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Executive Vice President, Chief Auditor & Compliance Officer, Highmark Health

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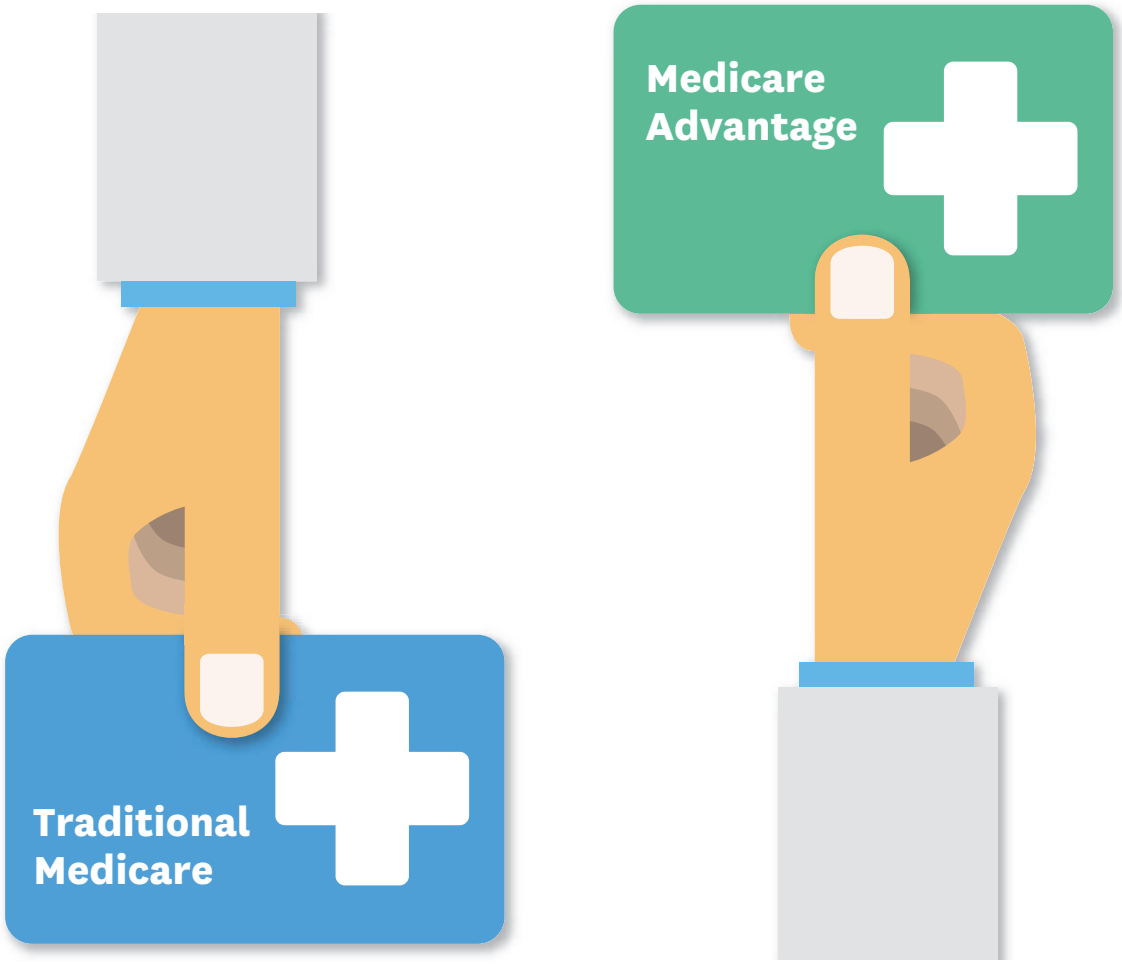
Medicare Advantage Enrolls Lower-Spending People, Leading to Large Overpayments



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Leonard D. Schaeffer Center
for Health Policy & Economics

Schaeffer Center White Paper Series

Medicare Advantage Enrolls Lower-Spending People, Leading to Large Overpayments

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POLICY CONTEXT

Rapid growth in Medicare Advantage (MA) has led to almost equal numbers of Medicare beneficiaries in 2023 receiving benefits from MA plans and from traditional fee-for-service (FFS). But MA rates paid to plans are based on spending by FFS beneficiaries, resulting in Medicare overpaying MA plans by 6% ($27 billion) in 2023 alone, according to the Medicare Payment Advisory Commission (MedPAC). Overpayments were due primarily to "coding intensity" ($23 billion) and Star Rating (quality) bonuses. Importantly, the MedPAC overpayment estimate does not include the effects of favorable selection into MA, but favorable selection likely generates a larger magnitude of overpayment.

This paper analyzes the degree of biased selection associated with beneficiaries choosing to switch from FFS to an MA plan by studying MA enrollees in 2020 who switched from FFS during annual open-enrollment periods (which come late in the year) in 2006-2019 and comparing them with those who remained in FFS. Applying the CMS risk adjustment model to the differing diagnoses and demographics of the 402 million FFS beneficiary years in 2006-2019, we found that switchers had substantially lower risk-score-adjusted expenditures in the year that they made the election to switch than beneficiaries who remained in FFS. For each of the 14 years, the odds of switching to MA were consistently higher for FFS beneficiaries with lower risk-score-adjusted expenditures, with the likelihood of switching diminishing as expenditures increase.

The persistent migration of FFS beneficiaries with below-average, risk-score-adjusted expenditures to MA generates overpayments because the capitation amounts paid to MA plans assume these FFS beneficiaries have average expenditures. Focusing on those who switched from FFS to MA plans from 2015 through 2019, we estimate that these distortions in payment rates led to overpayments on the order of 14.4%, with sensitivity analysis suggesting the estimate remains relatively stable under alternative assumptions. This favorable selection into MA makes the current approach of basing MA payments on FFS increasingly problematic and costly to the government, increasing annual overpayments in 2023 from the $27 billion estimated by MedPAC to $75 billion or more. Reform options can attempt to substantially improve the relationship between FFS expenditures and MA payments or delink MA payments from FFS spending, potentially through competitive bidding limited to MA.

KEY TAKEAWAYS

- **Beneficiaries with lower-than-average expenditures than those with similar risk factors were significantly more likely to switch from Fee-for-Service (FFS) to Medicare Advantage (MA).**
- **As a result, risk-score-adjusted expenditures for the 16.9 million beneficiaries who switched from FFS to MA between 2006–2019 were substantially below average. Plans were overpaid because MA rates are intended for beneficiaries with average—not systematically below average—expenditures.**
- **MA plans in 2020 were overpaid by 14.4% due to this favorable selection phenomenon; when combined with the 6% overpayment reported by MedPAC for coding intensity and other factors, total MA overpayments were on the order of 20%.**
- **Basing MA payment benchmarks on FFS expenditures is increasingly problematic as FFS enrollment continues to decline – underscoring the need for reforming how MA payments are set such as by decoupling MA payments from FFS benchmarks or instituting competitive bidding.**

ABSTRACT

This study contributes to understanding of how the explosive growth in Medicare Advantage (MA) affects overall federal Medicare spending by comparing expenditures of fee-for-service (FFS) beneficiaries electing to switch to MA at the end of a year with beneficiaries who remain in FFS. Analysis of 2006-2019 data indicate a significantly greater propensity to switch to MA among FFS beneficiaries whose expenditures are low in relation to others with the same risk score. In 2019, beneficiaries with low expenditures compared to their peers (in the first to 15th percentile) were twice as likely to switch to MA as those in the middle (45th to 55th percentile), and beneficiaries above the 85th percentile were less likely to switch than the middle group. Almost half of MA beneficiaries in 2020 had switched from FFS in 2006-2019, and their below-average expenditures generated significant overpayments to MA plans. We estimate that favorable selection led to MA overpayments on the order of 14.4%. Our findings underscore the need for reforming how MA payments are set. Adding our favorable selection estimate to the Medicare Payment Advisory Commission's 6% estimate of overpayment from differing coding intensity and quality bonuses, overpayments increase to about 20% ($75 billion) of Medicare payments to MA plans.

INTRODUCTION

While the Medicare Payment Advisory Commission (MedPAC) and others have estimated that factors such as differences in coding intensity between MA plans and FFS Medicare and easy-to-achieve quality bonuses in MA have led to substantial overpayment to MA plans (MedPAC's estimate is 6% or $27 billion), we are not aware of any estimates of the effects of favorable selection on MA overpayment.[a] In this study, we estimate favorable selection by comparing the expenditures of beneficiaries switching to MA with those staying in FFS in 2006-2019. We investigate two questions: (a) What is the relationship between beneficiary expenditures and the odds of switching from FFS Medicare to MA during annual open-enrollment periods and (b) what are the implications for government costs if beneficiaries switching to MA have below-average, risk-score-adjusted expenditures?

After providing background on MA, risk adjustment and the skewed distribution of expenditures, the paper details our methodology and findings that the likelihood of switching to MA increases as beneficiaries' expenditures decrease and the annual cohorts of switching beneficiaries consistently had below-average, risk-score-adjusted expenditures. We conclude by discussing potential options for reforming the role of FFS expenditures in setting MA payments.

BACKGROUND ON MEDICARE ADVANTAGE

Medicare offers beneficiaries a choice of either participating in traditional fee for service (FFS) or enrolling in private Medicare Advantage (MA) plans. For existing beneficiaries, change is generally restricted to annual open-enrollment periods running from October 15 to December 7, with enrollment in MA starting on January 1 of the next year.[b] In FFS, the Centers for Medicare and Medicaid Services (CMS) is the insurer, processing claims for services received by FFS beneficiaries and directly reimbursing providers such as hospitals and physicians. In MA, CMS transfers risk to private insurers and pays plans set monthly capitation amounts to finance services utilized by their enrollees, with plans earning profits or losses depending on whether these payments and any enrollee premiums exceed expenditures.[c]

a. Multiple studies have estimated the cost of more aggressive coding in MA than FFS, although the extent of upcoding varies by MA plans.

b. Get Started With Medicare, Joining a Plan. https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan.

c. MedPAC Payment Basics, Medicare Advantage Program Payment System. https://www.medpac.gov/wp-content/uploads/2021/11/MedPAC_Payment_Basics_22_MA_FINAL_SEC.pdf.

During a calendar year, CMS pays plans based on their bids, submitted for specific counties in the prior June. The monthly MA rate per beneficiary for a plan combines its bid with other plan characteristics (such as its "Star Rating") and the benchmark for a county with bidding targets for plans reflecting the expenditures of FFS beneficiaries living in that county. The statute assigns counties to quartiles that increase benchmarks for counties with low average FFS spending and decrease them in counties with high FFS spending.[d] MA rates (with the 5% bonus) in 2023, generated by combining the variation in average FFS expenditures among states and the District of Columbia at the county level and the quartile system, varied by 220%, ranging from a low of $863.58 in Mora County, New Mexico, to $1,878.96 in Niobrara County, Wyoming.[e,1]

The expenditures of beneficiaries living in a county and remaining in FFS that provide the basis for MA rates are impacted by biased selection and other distortions, especially if a large share of beneficiaries switch to MA and relatively few remain in FFS. Our order-of-magnitude estimate does not account for the delay when future MA benchmarks reflect increases in average expenditures from having higher spending beneficiaries stay in FFS and the absence of low-spending beneficiaries who switch to MA. Expenditures incurred by MA beneficiaries play no role in setting MA payment rates, although MA beneficiary expenditures in one year can indirectly affect—with a lag of several years—Medicare spending if they influence the future bids of a plan, which are subject to the market discipline of competing with other MA plans as well as with FFS.

Among beneficiaries in April 2023 with both Part A and Part B (a requirement to join MA), 31.2 million (52.6%) participated in private plans versus 28.0 million in FFS, a vast change from 2006, when MA enrollment totaled 1 in 6 (6.6 million) and FFS had 32.4 million beneficiaries. From 2006 to 2023, private plan enrollment grew by 24.6 million (373%) but FFS beneficiaries *decreased* by 4.3 million (-13.3%)[f]. The decline in FFS enrollment left 16.5% of counties in January 2023 with 1,000 or fewer FFS beneficiaries with both Part A and Part B, 49.4% of counties with 3,000 or fewer, and 65.1% of counties with 5,000 or fewer—the minimum risk-pool size established for accountable care organizations.[2] Between 2006 (the first year in which MA plans implemented reforms enacted in the Medicare Modernization Act) through 2019 (the last year for which we have detailed claims data unaffected by COVID-related distortions in healthcare spending), 16.9 million FFS beneficiaries switched to MA during annual open-enrollment periods. Notably, 11.3 million of these switchers remained in MA in 2020, comprising 46.9% of private plan enrollment.

BACKGROUND ON RISK ADJUSTMENT

Published research findings on risk adjustment do not fully address the relationship between biased selection into MA, MA rates and the highly skewed distribution of FFS expenditures, in part because they preceded rapid MA growth and switching by millions of FFS beneficiaries to MA. Prior research provides conflicting conclusions about the efficacy of CMS' approach to risk adjustment, which makes use of hierarchical condition categories (HCC) and demographic information. Some research indicates that CMS' HCC approach considerably reduced the extent to which MA plans enrolled beneficiaries with lower-than-average risk.[3,4,5] Other research suggests that MA plans responded strategically to the introduction of the HCC model by selectively enrolling beneficiaries with below-average risk score costs.[6] Yet other research examining HCC risk adjustment when the system was fully implemented concluded that the amount of selection in 2006-2010 was approximately the same as before the HCC system was implemented.[7]

CMS uses the expenditures and utilization of FFS beneficiaries to calibrate the increasingly sophisticated versions of its risk-adjustment model, which adjusts MA payments by accounting statistically for expected differences in expenditures associated with specific groups of beneficiaries based on their diagnosed conditions and demographics.[g,8] The HCC model incorporates specific diagnoses (e.g., diabetes or congestive heart failure) and/or beneficiary characteristics (e.g., age, gender, institutional status, disability and dual eligibility for Medicaid) to create risk scores that adjust payments to MA plans.

d. MA payment rates result from multiplying benchmarks times a statutorily set percentage based on the quartile in which the costs fall. Payment rates for plans enrolling 98.4% of MA beneficiaries reflect county costs, with the remainder in plans that use regional rates. CMS, Monthly Contract Summary Report – May 2023, accessed 6/2/23, https://www.cms.gov/files/zip/monthly-contract-summary-report-may-2023.zip. MedPAC, Medicare Advantage program payment system. https://www.medpac.gov/wp-content/uploads/2021/11/MedPAC_Payment_Basics_22_MA_FINAL_SEC.pdf. MA Ratebook2023, https://www.cms.gov/files/zip/2023-ma-rate-book-zip.zip.

e. CMS, 2023 MA Ratebook (zip), April 4, 2022, accessed 5/17/23 https://www.cms.gov/files/zip/2023-ma-rate-book-zip.zip. These rates exclude Alaska.

f. Medicare Monthly Enrollment (Jan. 2023) accessed 5/17/23 https://catalog.data.gov/dataset/medicare-monthly-enrollment; MA State Penetration 2023 04, accessed 4/20/23, https://www.cms.gov/files/zip/monthly-enrollment-state-april-2023.zip.

g. A separate potential issue related to biased selection arises because the CMS HCC system of risk adjustment is developed based on FFS expenditures and utilization; if the migration of less expensive beneficiaries to MA increases the level and alters the distribution of expenditures in FFS, the risk adjustments imputed from FFS beneficiaries might similarly overcompensate MA beneficiaries (a topic beyond the scope of this paper).

The CMS risk-adjustment model identifies for each beneficiary a risk score and applicable HCCs. HCCs represent clinically meaningful categories but beneficiaries grouped together can have additional HCCs, varying demographic characteristics and different risk scores, as well as differing expenditures. Grouping beneficiaries by risk scores facilitates analyzing the role of expenditures in switching to MA or staying in FFS because variations other than expenditures are statistically controlled when beneficiaries have similar risk scores (which incorporate HCCs and demographics).

MA risk adjustment corrects for group-level differences in expenditures but not those associated with specific individuals, as CMS explained in a 2021 Report to Congress:

> *At the individual level, predicted medical expenditures can be lower or higher than actual medical costs, but at the group level, below-average predicted costs balance out above-average predicted costs.*[9]

Only neutral selection avoids changing average expenditures at the group level, maintaining the balance between below- and above-average expenditures. As detailed later, the switching to MA by 16.9 million beneficiaries in 2006-2019 demonstrated a consistent pattern of biased selection with below-average, risk-score-adjusted expenditures in each annual cohort changing the FFS population and increasing both FFS average expenditures and MA rates.[10]

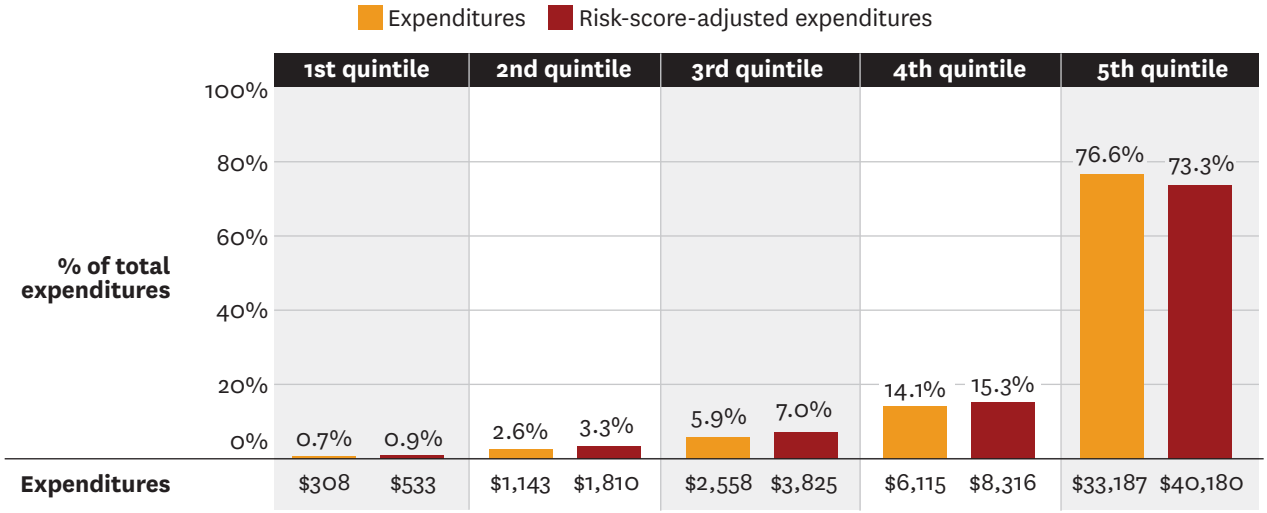
HIGHLY SKEWED DISTRIBUTION OF EXPENDITURES AND RISK ADJUSTMENT

A highly skewed distribution of health spending magnifies the financial effects of favorable selection if a disproportionately large share of the 16.9 million FFS beneficiaries who switched to MA in 2006-2019 have significantly below-average expenditures (or if disproportionately few have significantly above-average expenditures). Having 2019 mean expenditures of $8,663 exceed by 347% the median of $2,494 illustrates the skewed distribution of FFS expenditures, a conclusion amplified by comparing expenditures of beneficiaries in the lowest and highest quintiles—averages of $308 versus $33,187 and 0.7% versus 76.6% of total spending. Converting 2019 FFS beneficiary expenditures to risk-score-adjusted expenditures does not materially alter the highly skewed distribution: The mean risk-score-adjusted expenditure of $11,439 exceeded by 427% the median of $3,742; beneficiaries in the lowest quintile averaged $533 and 0.9% of total spending compared to expenditures of beneficiaries in the highest quintile averaging $40,180 and 73.3% of total spending. On both a nominal and risk-score-adjusted basis, Exhibit 1 displays for each quintile the average and share of total 2019 FFS spending. The distribution of risk-score-adjusted expenditures by quintiles remains similar when 2019 risk scores are disaggregated into low-risk, medium-risk and high-risk categories (Appendix Exhibit A1).

STUDY DATA AND METHODS

We used logistic regressions to estimate the odds of switching to MA based on risk-score-adjusted spending and analyzed descriptive statistics comparing the risk-score-adjusted expenditures of FFS beneficiaries switching to MA and staying in FFS. We also used our results regarding risk-score-adjusted expenditures to approximate CMS overpayments to MA from favorable selection in 2020. The next two

Exhibit 1. FFS distribution of expenditures by quintile, with and without risk-score adjustment, 2019



Source: Authors' analysis of expenditures is derived from 100% fee-for-service claims data, 2019, and the Master Beneficiary Summary File, March 2019-2020.

paragraphs explain risk-score-adjusted expenditures, which refers to the relationship of a beneficiary's expenditures to the mean for all beneficiaries with the same risk score in a year.

We computed risk scores for each beneficiary for each year using the most current risk-adjustment model with CMS-provided software that accepts both ICD-9 and ICD-10 as input diagnostic codes (2016 v21 HCC).[h] With an annual average of 28.7 million FFS beneficiaries, we assigned beneficiaries in each year to 183 risk-score cells, grouping into separate cells risk scores below 1.0 that had the same single-digit decimal (e.g., 0.7), risk scores greater than one and less than 10 based on having the same two digits (e.g., 1.7), and risk scores greater than 10 into cells based on having the same three digits (e.g., 10.7). For ease of exposition, we refer to beneficiaries assigned to each of these risk-score cells as having the same risk score.

For each year for each risk-score cell, we constructed expenditure percentiles to measure spending variation. Arraying expenditures from lowest to highest among beneficiaries with the same risk score in a year, we mapped expenditures to percentiles, assigned beneficiaries to percentiles based on their expenditures and calculated the average (mean) expenditure for each percentile. We generated the ratio of spending in each percentile to the mean for that risk score by dividing the average amount for each percentile by the risk-score mean, repeating the process of assigning ratios to percentiles for each risk score.

The migration of switchers with below-average, risk-score-adjusted expenditures overpays MA in two ways. First, CMS pays MA plans capitation calibrated for beneficiaries with average (mean) risk-score-adjusted expenditures despite switchers consistently having below-average expenditures. To the extent switchers' lower risk-score-adjusted expenditures persist over time, the migration of successive cohorts to MA increases the number of switchers with below-average, risk-score-adjusted expenditures for whom plans are being paid average rates. Second, favorable selection increases the rates paid to plans for all MA enrollees by overstating average FFS expenditures, which result from including expenditures of more expensive stayers but excluding those of less expensive switchers.

Study Sample: The 100% Medicare Master Beneficiary Summary Files, accessed through the CMS Virtual Research Data Center, constituted our primary source of enrollment, demographic, diagnostic and expenditure data for 2006-2019. Beneficiaries in the 50 states and the District of Columbia who participated in both Part A and Part B generated 402 million beneficiary-year observations, with beneficiaries classified as either FFS or MA based on their enrollment status in March of each year. FFS beneficiaries ineligible for MA (because they lacked both Part A and Part B) or who died during the year (because most deaths would have occurred before the annual mid-October to December open-enrollment period) were excluded from our analysis. After linking enrollment and expenditure data, we standardized each year's expenditures to 2019 by updating nominal year dollars by the annual changes in Medicare average expenditures per beneficiary.[i]

Measures: We analyzed FFS beneficiary propensity to switch to MA using a binary indicator variable, with one for electing to enroll in an MA plan in the annual October to December open-enrollment period or zero when remaining in FFS. Our primary independent variable of interest is beneficiaries' risk-score-adjusted expenditures in that year.[j] After assigning expenditure percentiles to FFS beneficiaries for each risk score for each year, we placed each beneficiary in one of seven categories reflecting whether their expenditures were below the 15th percentile, between the 15th and 30th percentile, between the 30th and 45th percentile, between the 45th and 55th percentile (the median category), between the 55th and 70th percentile, between the 70th and 85th percentile, or above the 85th percentile.

MA Overpayments from Favorable Selection: Favorable selection generates overpayments from paying average MA rates for switchers with below-average expenditures and paying overstated rates to plans for all MA. We computed overpayments from favorable selection as a percentage of base-case 2020 payments to MA plans and in 2020 dollars. After separately computing each source of overpayments, we combined the two components after adjusting for interactions that reduce the total.

As the first step, we computed a base case of total MA payments in 2020, multiplying at the county level the number of MA beneficiaries times the average risk score times the monthly 2020 MA rates times 12, summed nationally. Our $285 billion base case is within 10% of 2020 actual MA expenditures, despite our stylized calculations making important simplifying assumptions, such as using CMS-published MA rates rather than actual rates reflecting

h. Claims data in the earlier years of this period only reported ICD-9 diagnostic codes but in later years converted to reporting only ICD-10 diagnostic codes. In subsequent HCC model versions, CMS differentiates between the aged and disabled, with three population segments for the disabled and three for the aged. We replicated our analysis of the disabled and aged using only the aged, and the results were completely consistent and almost unchanged.

i. For Part B non-institutional services, expenditure equals the sum of all the line item-level Medicare payments. For non-hospital services and for other non-institutional services, expenditure equals the total actual Medicare payment amount. Finally, for inpatient services, expenditures include the claim pass-through per diem payments made by Medicare, which is equal to the total amount paid by Medicare for the claim, the pass-through amount multiplied by the number of Medicare-covered days, and then added to the claim payment amount.

j. The 2016 model was applied to all of the years of data. https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors-Items/Risk2016.

plan bids (along with other plan-specific factors) and not incorporating the time lag between when FFS expenditures occur and when they factor into MA rates.[k] When computing switchers' expenditures, we also assumed the ratio of each expenditure percentile to the mean, derived from national data, applies at the county level.

We computed overpayments from paying MA rates appropriate for beneficiaries with average risk-score-adjusted expenditures for switchers with below-average, risk-score-adjusted expenditures in three steps. First, we computed annual payments to MA plans for all switchers by multiplying the monthly MA rates in their counties of residence times their risk scores times 12. Second, we computed the expected spending of switchers based on their expenditure percentiles—the ratios of beneficiaries' expenditure to the means for their risk scores—times the monthly 2020 MA rates in their counties of residence times 12, summed nationally. Third, we subtracted the expected expenditures for switchers (if they had remained in FFS) from the revenue paid to MA plans for them.

We computed overpayments from paying MA rates overstated by no longer factoring into FFS the below-average expenditures of switchers. After computing FFS average expenditures for both switchers and stayers, we calculated the percentage by which the FFS average for stayers exceeds the average for all FFS beneficiaries. We multiplied the percentage by which the average for stayers exceeds the average for all beneficiaries times the national base case of total MA payments to generate the associated overpayment.

Since many who switch to MA remain in the program for many years, the decision to switch will affect Medicare spending for multiple years. So, in addition to calculating how their first year in MA affects Medicare spending, we calculated up to five years of potential impact from switching. But calculating these multiyear impacts involves grappling with the phenomenon of "regression to the mean," a statistical tendency for those whose spending is above or below a population mean in one year to be closer to the mean in subsequent years.

We explored how many annual cohorts of switchers to include when estimating overpayments and how to adjust the risk-score-adjusted expenditures of switchers over time. While generally observing little difference in our logistic regressions when we substituted an earlier year's spending to predict expenditures of in the year of switching, we felt that it would be an appropriately conservative approach to use a range of assumptions about the magnitude of regression to the mean. We annually reduced the gap between the mean and switchers' expenditures to 85% of the previous year's gap and only included the five most recent cohorts of switchers, assuming the expenditures of earlier cohorts of switchers had fully regressed to the mean. These assumptions included only overpayments associated with 7.1 million 2020 MA enrollees who had switched from FFS in the 2015-2019 cohorts, excluding any overpayments associated with the 4.2 million switchers from the 2006-2014 cohorts also enrolled in MA in 2020 and the 5.6 million switchers to MA in 2006-2019 who were not enrolled in 2020.

In 2020, the risk-score-adjusted gap between the mean and expenditures of 2019 switchers would be 85% of the gap in 2019, while the gap in 2020 between the mean and expenditures of 2015 switchers would be 37.7%. Choosing a more rapid regression to the mean factor—multiplying the previous year's difference by 75%—generated a relatively modest decrease in the estimate even though the gap in 2020 between the mean and expenditures for 2015 switchers would fall by 19.9 percentage points to 17.8%.

Statistical Analysis: First, we generated descriptive statistics on the key characteristics of switchers and stayers for each year in 2006-2019, which consistently showed that the risk-score-adjusted expenditures of switchers were substantially below those of stayers. Next, we estimated a logistic regression model with fixed effects for each year, while also exploring a second model with a covariate control for county-level MA penetration.

Limitations: CMS files contain extensive data on FFS expenditures and utilization, but lack comparable data on MA, which precludes directly comparing risk-score-adjusted expenditures of beneficiaries in FFS with those in MA. Despite recent progress after years of CMS prodding MA plans to improve reporting, MA encounter data are not yet comparable to FFS claims data, do not reliably capture all services provided, and reflect differences in reporting diagnoses and resulting risk scores. In its June 2019 Report to Congress, MedPAC explained the substantial usefulness that complete encounter data would have and recommended a series of strong actions to achieve it. These included stricter penalties for plans with poor performance in accurately reporting encounter data, implementing a payment withhold to introduce a direct financial incentive for plans to submit complete and accurate data, and requiring direct submission of providers' claims to Medicare Administrative Contractors.[11] Accordingly, we did not investigate the expenditures of beneficiaries who switched from MA to FFS; however, published studies report that higher-cost MA patients have an above-average rate of disenrolling from plans, suggesting another potential source of biased selection.[12, 13, 14]

Focusing on when beneficiaries elect to switch to MA

k. 2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. https://www.cms.gov/oact/tr/2023.

permits comparing their risk-score-adjusted FFS expenditures with those of stayers in that year as well as in prior years, but raises the question of how well switchers' FFS expenditures predict subsequent years' expenditures had they remained in FFS. A beneficiary with either a significantly above- or below-average expenditure in one year is statistically likely over time to become less of an outlier. However, it is unclear how the general phenomenon of beneficiary expenditures regressing to the mean applies to risk-score-adjusted expenditures and, more specifically, changes in expenditure percentiles. As detailed later, we computed multiyear effects based on the experience of 2019 switchers in combination with their change in risk-score-adjusted expenditures over time, adopting regression to the mean factors after exploring several alternative approaches.

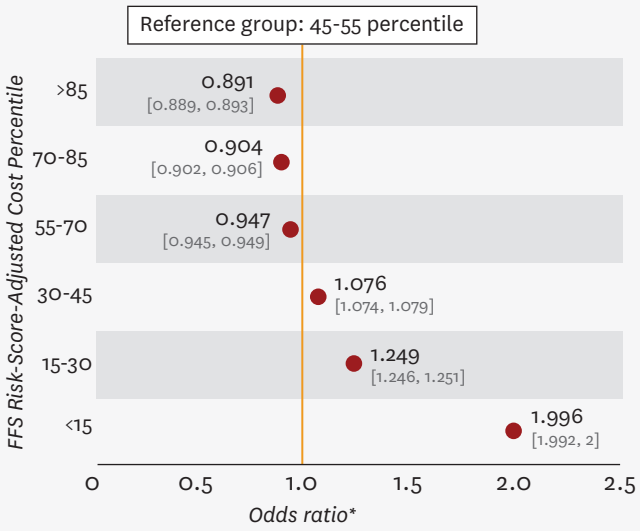
Our analysis did not include investigating what motivates beneficiaries with lower risk-score-adjusted expenditures to be more likely to switch to MA. We do not have insight into the role of either beneficiaries' assessments that MA would work better for them (adverse selection) or MA plan actions such as marketing, network composition, or designing benefits, cost-sharing and formularies (preferred-risk selection). Similarly, we did not study beneficiary switching among plans or from plans to FFS, newly eligible beneficiaries who bypassed FFS when joining MA, plan exit,[15,16,17] or the extent and cost implications of coding differences.[18, 19]

STUDY RESULTS

Each annual cohort of beneficiaries electing to switch to MA during open enrollment had below-average, risk-score-adjusted expenditures. Of the 29.0 million FFS beneficiaries in 2019, 1.7 million (6.0%) switched to an MA plan. Without risk-score adjustment, expenditures for all FFS beneficiaries in 2019 averaged $8,663, but switchers had expenditures of $6,631, compared to $8,793 for stayers. With risk-score adjustment, 2019 expenditures for all FFS beneficiaries averaged $11,439, but switchers had expenditures of $9,094, compared to $11,589 for stayers. Removing the expenditures of switchers results in average risk-score-adjusted expenditures of stayers 1.3% higher than a risk pool that included both stayers and switchers. As detailed in Appendix Exhibit A2, 2006 and 2012 had similar results.

Beneficiaries with low risk-score-adjusted expenditures were more likely to switch relative to median-expenditure beneficiaries, while beneficiaries with high risk-score-adjusted expenditures were less likely to switch (Exhibit 2). FFS beneficiaries assigned to the least expensive grouping of risk-score-adjusted expenditures were twice as likely to switch to an MA plan compared to the median group of beneficiaries (those with expenditures falling between the 45th and 55th percentiles). Relative to the median group (in the 45th to 55th

Exhibit 2. Odds of switching to an MA plan among FFS beneficiaries, by risk-score-adjusted expenditure, 2006-2019

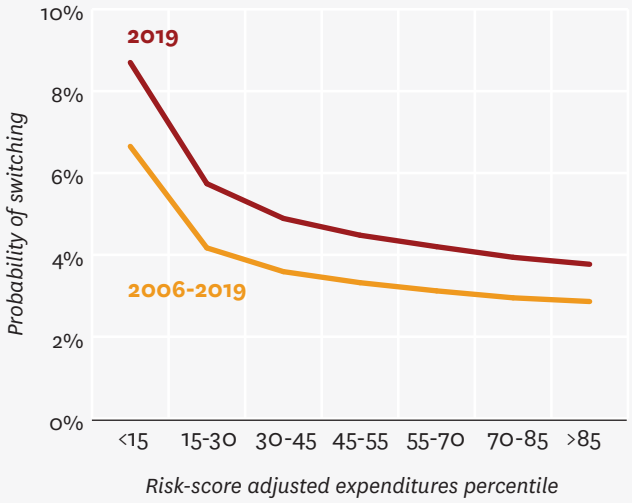


[ ] 95% Wald Confidence Limits

**p < 0.01. The reference value is 1.00. Reference categories are listed for categorical variables; for binary variables the reference category is the complement of the category shown. All analyses include year-fixed effects. The models are described in the main text.*

Source: Authors' analysis of expenditures, hierarchical condition categories assignment and risk score measures.

Exhibit 3. Probability of switching to an MA plan among FFS beneficiaries, by risk-score-adjusted expenditures percentiles, all years analyzed and 2019 only



Notes: The probabilities are calculated for a mean individual in the sample. Point estimates from Exhibit 1 are used with year-fixed effects controls. The model is run separately for the full 2006 to 2019 sample and the 2019 subsample, respectively.

Source: Authors' analysis of expenditures, hierarchical condition categories assignment and risk score measures.

percentiles), the likelihood of switching diminished as the category reflecting risk-score-adjusted expenditures increased (significant at the 1% level).

To investigate the influence of MA penetration on switching to MA, we constructed an alternative logistic regression model that interacted county MA penetration with the regression underlying Exhibit 2. The results show that the odds of switching to MA increase with county MA penetration (Appendix Exhibit A3), which implies that the substantial amount of switching seen in recent years is likely to continue. Interactions between the groupings of beneficiaries by percentile range and county MA penetration did not show appreciable differences in the odds of switching.

To assess risk-score-adjusted FFS expenditures over time as a proxy for switching to MA, we first re-estimated the regression underlying Exhibit 2 using only 2019 FFS beneficiaries to estimate the probabilities of switching to an MA plan. Comparing the results from regressions using 2006-2019 and 2019-only data shows higher odds of switching in 2019, but a similar pattern (Exhibit 3). The probabilities of switching remained quite similar when the 2006-2009, 2010-2014 and 2015-2019 cohorts were modeled separately.

Exhibits 4 and 5 detail the results of our overpayment analysis. To help explain our methodology, Exhibit 4 presents a simplified single-year approach that assumes no change in risk-score-adjusted expenditures between 2019 and 2020. Exhibit 5 incorporates the effects of the 2015-2019 annual cohorts of switchers, with expenditures progressively regressing to the mean over time, which lessens the amount by which risk-score-adjusted expenditures vary from average. The four panels in each exhibit present similar information and the national base case of MA payments (Panel A) is the same in both exhibits. Panel B displays the revenue paid to MA plans in 2020 for switchers (which is a subset of the national base case revenue) and the projected expenditures of switchers; the difference between switcher revenue and switcher expenditures is the amount of overpayment from paying average rates for switchers with expected below-average expenditures. Panel C shows the overpayment from recalculating MA rates to include the expenditures of both stayers and switchers, presenting the average risk-score-adjusted expenditures for all FFS beneficiaries by to reflect both FFS stayers and FFS switchers. Panel D combines into a single estimate the increased government cost resulting from paying average capitation for switchers with below-average expenditures and overstated rates for all MA enrollees, after adjusting for the interaction that somewhat reduces the amount by which rates are overstated. Amounts are expressed both in dollars and as a percent of the national base-case amount.

We estimate that national base-case revenue paid to MA plans in 2020 totals $285 billion, which benchmarks reasonably well to actual 2020 MA expenditures reported by the CMS actuary. Under our stylized approach to approximating MA overpayments—which includes only the 2015-2019 cohorts of switchers and assumes risk-score-adjusted expenditures progressively regress to the mean—the combined overpayment from favorable selection is 14.4% of MA revenue. Expressed in dollars, MA favorable selection approximates $40.9 billion in 2020, which would grow to $59.3 billion in 2023 if increased by the ratio of MA spending in 2023 to 2020.

Disaggregating the sources of overpayment, the larger component—$38.9 billion—arises from paying average 2020 MA rates for switchers with below-average, risk-score-adjusted expenditures. Regression to the mean lowers average overpayments per switcher for earlier cohorts, but the increased number of switchers increases total overpayments. The overpayment amounts to 41.2% of plan revenues for switchers, for an average overpayment per switcher of $5,456 in 2020. Overpayments from overstated MA rates based on skewed average FFS expenditures total $2.4 billion in 2020, or 1.0% of national base-case revenue.

DISCUSSION AND CONCLUSIONS

Our analysis showed substantial differences in risk-score-adjusted expenditures between those who switched to MA and those remaining in FFS. Results were consistent over the 14 years studied. This persistent effect pays average MA rates for millions of beneficiaries with below-average, risk-score-adjusted expenditures, and overstated per-beneficiary FFS expenditures translate into higher county benchmarks and MA rates. Studies have shown that higher MA rates result in higher plan profit margins along with enrollees receiving additional extra benefits.[20]

Despite Medicare beneficiaries with both Part A and Part B increasing by 20.3 million—from 39.0 million in 2006 to 59.3 million in April 2023—the number in FFS declined by 4.3 million (-13.3%), falling from 32.4 million in 2006 to 28.1 million in April 2023. Basing MA payment rates on FFS expenditure becomes more problematic as FFS beneficiaries with both Part A and Part B are a shrinking minority (47.4%), and their spending becomes increasingly skewed by the selection process outlined in this paper. The differentials in diagnostic coding in MA versus FFS compound concerns about using FFS to set MA rates, in part because CMS' current 5.9% reduction to MA rates is substantially below the 9.5% reduction recommended by MedPAC, with academic literature suggesting even larger coding adjustments.[21]

Identifying substantial favorable selection into MA does not shed light on the factors behind it. Favorable selection could be driven mostly by individual beneficiaries choosing which model is most suited to them given their preferences and medical conditions. Or it could be driven mostly by actions by plans, some of which are designed to improve

Exhibit 4. Projected excess payments in 2020, assuming only 2019 switchers affect spending and no change in their risk-score-adjusted expenditures

Panel A	National base case revenues	National baseline revenue amount*	$285 billion
Panel B	Effects of paying average revenue for beneficiaries with below average risk-score-adjusted expenditures on revenues, expenditures and overpayments	National switcher revenue amount**	$24.1 billion
		National switcher expenditure amount***	$15.2 billion
		Overpayments	$8.9 billion
		▪ Percentage of national switcher revenue	37.0%
		▪ Annual average per switcher	$5,126
Panel C	Overstatement of MA rates due to skewed risk pool	National average annual risk-score-adjusted expenditures:	
		▪ All FFS beneficiaries	$11,439
		▪ FFS stayers	$11,589
		MA capitation overpayment	
		▪ Percentage	1.3%
		▪ Total	$3.7 billion
Panel D	Combined overpayment****	Percentage national base case revenue	4.4%
		Total	$12.5 billion

Notes: FFS stayers = 27.3M; switchers = 1.7M.
** National base case revenue equals sum of multiplying risk scores by 2020 MA rates by number of aged and disabled MA beneficiaries at county level.*
*** National switcher revenue equals sum of multiplying beneficiary-level risk scores by 2020 MA rates for beneficiaries' county of residence.*
**** Expenditures are a function of switcher percentiles relative to national mean expenditures for a given risk score. Applying the 2019 percentiles to 2020 county-level MA rates generates dollar amounts that are summed to the national level, assuming each county-level distribution of risk-score-adjusted percentiles parallels the national distribution.*
***** Combined overpayment equals overpayments of switchers due to paying average revenue for beneficiaries with below-average expenditures (Panel B) plus overpayment of MA rates due to skewed risk pool (Panel C), after adjusting the MA capitation reduction for interactions.*

Exhibit 5. Projected excess payments in 2020 from 2015 to 2019 switcher cohorts whose risk-score-adjusted expenditures are updated by regression to the mean factors

Panel A	National base case revenues	National baseline revenue amount*	$285 billion
Panel B	Effects of paying average revenue for beneficiaries with below average risk-score-adjusted expenditures on revenues, expenditures and overpayments	National switcher revenue amount, 2015-2019**	$94.3 billion
		National switcher expenditure amount, 2015-2019***	$55.5 billion
		Overpayments	$38.8 billion
		▪ Percentage of national switcher revenue	41.2%
		▪ Annual average per switcher	$5,456
Panel C	Overstatement of MA rates due to skewed risk pool	National average risk-score-adjusted expenditures:	
		▪ 2019 FFS stayers and 2015-2019 switchers	$10,865
		▪ 2019 FFS stayers	$10,956
		MA capitation overpayment:	
		▪ Percentage	1.0%
		▪ Total	$2.4 billion
Panel D	Combined overpayment****	Percentage national base case revenue	14.4%
		Total	$40.9 billion

Notes: 2019 FFS Stayers = 27.3M; 2015-2019 Switchers = 7.1M.
** National base case revenue equals sum of multiplying risk scores by 2020 MA rates by number of aged and disabled MA beneficiaries at county level.*
*** National switcher revenue equals sum of multiplying beneficiary-level risk scores by 2020 MA rates for beneficiaries' county of residence.*
**** Expenditures are a function of switcher percentiles relative to national mean expenditures for a given risk score in year beneficiaries switched to MA, which are then adjusted by the regression to the mean factor applicable to year of switching. Applying the percentiles to 2020 county-level MA rates generates dollar amounts that are summed to the national level, assuming each county-level distribution of risk-score-adjusted percentiles parallels the national distribution.*
***** Combined overpayment equals overpayments of switchers due to paying average revenue for beneficiaries with below-average expenditures (Panel B) plus overpayment of MA rates due to skewed risk pool (Panel C), after adjusting the MA capitation reduction for interactions.*

care, that attract relatively low-spending enrollees. FFS beneficiaries with chronic conditions being actively treated and using a substantial amount of specialized care may be reluctant to switch to MA and change from unrestricted provider networks or to incur more aggressive use of utilization management tools, such as prior authorization. Health plans' substantial investment in primary care, intended to improve care and member satisfaction, as well as save money, may be more appealing to relatively healthy beneficiaries than to those accustomed to needing care from many subspecialists.

Policies to improve the accuracy of MA rate setting can follow two fundamentally different directions. One strategy would pursue proposals to reform the current administered payment approach, either by setting MA rates without regard to their relationship to FFS or by assuring equity between FFS and MA. For example, overpayments from aggressive coding by plans could be significantly diminished, such as by increasing the statutory minimum for the across-the-board reduction that CMS applies to all MA plans, eliminating the influence of codes with little connection to treatment, or precluding plans from incorporating into risk adjustment codes generated by health risk assessments or during annual physicals.[22] Over time, MA rates could be updated based on policy and budgetary considerations without regard to FFS.

Maintaining the relationship between FFS and MA would require making MA encounter data comparable to FFS claims data, which would require mandating a major effort by MA plans to markedly improve the accuracy, completeness and comparability of their data, but could help address the selection effects estimated by this study.

Significant obstacles constrain generating MA data comparable to FFS claims data that would permit reliably comparing MA and FFS data to address equity. MA encounter reporting lacks the detailed, lengthy payment-system regulations that govern paying FFS claims and assure the comparability of claims data. Implementing uniform, detailed MA data reporting standards would entail significant behavioral change and investments. The lengthy history of managed care companies having limited success with getting complete and accurate data reporting when encounters are not directly connected to payments illustrates some of these obstacles. The lack of uniform reporting by states of Medicaid expenditure data to CMS may be indicative of challenges associated with imposing uniform coding and reporting requirements on organizations with differing practices, policies and incentives. Differences in coding both between FFS and MA and among MA plans pose similar issues for reliably gaining comparable data on diagnoses, an objective complicated by differences in practice patterns between FFS and managed care such as greater reliance on primary rather than specialist care or substituting enhanced skilled nursing facility care for inpatient hospital care.

A starkly different strategy would abandon administered pricing for setting MA rates in favor of competitive bidding. One version, often called premium support, would include setting premiums to both MA and FFS based on bids, where the "bid" for FFS would be risk-score-adjusted expenditures in FFS. Premium support would likely disrupt significantly the FFS system relied upon by 28 million seniors, with coding differences and biased selection contributing to MA plans bidding below FFS. The prospect of charging significantly higher premiums for FFS beneficiaries would be unfair and effectively undermines the viability of premium support.

An alternative approach would restrict competitive bidding to setting payment rates for MA, using market forces to determine what Medicare pays MA plans.[23] To the degree that MA plans are more efficient, such competition would lead to some of this efficiency being captured by taxpayers instead of extra benefits for enrollees and overly large MA plan profits. The Senate version of the 2010 Affordable Care Act (ACA) included a competitive-bidding provision but the final (Reconciliation) version of the ACA replaced competitive bidding with the current quartile payment system. Despite having similar budget savings, House leaders and MA plan sponsors opposed competitive bidding and instead developed the quartile system.

The prospects for competitive bidding will involve three broad questions: What are the likely policy alternatives, how much more generous would MA benefits be than FFS, and what are the transition rules and timing? Fiscal considerations (large MA overpayments, the looming insolvency of the Federal Hospital Insurance Trust Fund and federal deficits) and programmatic concerns (favorable selection, tying MA payments to the extent of upcoding and problems with linking MA payments to FFS expenditures) will shape reform proposals and industry preferences.

Decoupling MA plan payments from FFS recognizes that Medicare is currently bifurcated. An increasing majority of beneficiaries eligible for MA choose private plans offering richer benefits and lower out-of-pocket expenditures despite restrictions associated with utilization management and contracted provider networks. Somewhat less than half of beneficiaries participate in the government-run FFS system offering fewer benefits and fewer restrictions.

Without fundamental reform, payments to MA plans will grow more excessive with the increasing shift from FFS to MA of beneficiaries with below-average, risk-score-adjusted expenditures. As the number and share of beneficiaries in FFS continues to decline, using their expenditures as the basis for setting MA payment rates becomes increasingly problematic and expensive, even before considering coding differences.

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#3 Is a couple of interesting OIG & Forbes web pages.

- 4a Is the OIG Page listing Targeted Risk-Adjustment investigations These are damning…
    - https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000422.asp
- 4b-2022 Forbes piece piece entitled 'The Coming Explosion Of Medicare Advantage Fraud And Penalties'
    - https://www.forbes.com/sites/forbestechcouncil/2022/08/19/the-coming-explosion-of-medicare-advantage-fraud-and-penalties/?sh=109bb35e3ed2)

Document Submitted
By
Lynda Hastings

Please accept these as my comments on Medicare "Advantage" for today's meeting

It was one year ago
When the State let us know
You intended to change Medicare.
Silver Sneakers.. One card..
Only hid just how hard
Our life would be. It just wasn't fair.

Most surely, by now
Most of you will know how
Bad it is to deny and delay…our care
But still too often are heard
These discouraging words
"Medicare Advantage"; it just won't go away.

How much more will it take
For this group to make
The decision to table MA?
We've been tortured enough.
You've looked through this stuff.
Close the book on it this very day.

Document Submitted
By
Tom Pledgie

RHBAS Public Comments August 10, 2023

My name is Thomas Pledgie and I am a State Retiree. I wish to first thank the Committee members for their vote today to 'grandfather in' all current age 65 and above Retirees into whatever system is developed to replace Medicfill.

In responsed to Paul B's interest in focusing efforts on developing a future RFP.

- I fully endorsed the concept that the work of the RHBAS should drive any future RPF Plan design concepts.

- I defined for the Committee and have attached above what is meant by Medicfill: It is guided by 2 documents:
    - a. A Guide to Your Benefits --attachment 1 above.

      b. The Account Contract with BCBSD Highmark --attachment 2 above.

      c. And thankfully no ware is Medicfill impacted by the 40+ pages of prior approval procedures found in the rejected Medicare Advantage Plan - - attachment 3 above.

- I suggested that Retirees are not looking to replace current Medicfill with something called "the same", or "a mirror". We want an **identical** replacement.

- After listening to Trinidad and Faith answer my earlier question as to what is the difference between Medicfill and Medigap Plan G coverage, I believe a Plan G is quite close. Faith indicated that the only 2 differences were some extended nursing coverage and out of country coverage.

- I referenced the $3,320 cost number that the State is now paying Highmark for each Retiree under Medicfill. Then discussed how any Retiree could simply go to the Medicare.gov website and Select Delaware, Plan G and then simply fill in their age, gender, and smoker status and up pops estimated rates from 36 vendors including BCBS of DE (Highmark). When I did this, I got the following numbers from BCBS DE.

Age 65 Male non-smoker= $1620, Female=$1500
Age 80 Male non-smoker= 2374, Female= $2195
Age 90 Male non-smoker= $3192, Female= $2952
Age 100 Male non-smoker= $3192, Female= $2952

Then I asked, “How can these cost all be under $3,300?” Is it a bait-and-switch? That’s a question that still needs to be addressed by the Insurance Commissioner. I do realize these rates are for an individual contract. BUT could not a State Group contract be lower? Especially one with not 2 bidders like last time, but now upward of 36 bidders.

My point is that Retirees are satisfied with what we call Medicfill and with the provider. The program that appears to be **identical** is a Medigap Plan G. IF, the numbers provided by BCBS of DE to Medicare.Gov are correct, then utilizing a TPA to provide age 65 and + Retirees with State funded prepaid Medigap Plan G’s should be considered.

Thank you for your time.

Tom Pledgie

MASTER HEALTH SERVICES AGREEMENT (MHSA)

Name of Plan Sponsor (Sponsor):	State of Delaware
Address:	Statewide Benefits Office
	Attn: Director, Statewide Benefits and Insurance Coverage
	Enterprise Business Park
	97 Commerce Way, Suite 201
	Dover, DE 19904
Highmark BCBSD Inc. (Highmark) Address:	Highmark Blue Cross Blue Shield Delaware
	Attn: Margaret Eitl, Regional Vice President
	800 Delaware Avenue, Suite 900
	Wilmington, DE 19801
MHSA Effective Date:	July 1, 2017

Section **Page**

IN WITNESS WHEREOF, the parties have entered into the Master Health Services Agreement and Statements of Work listed above and as attached hereto as of the effective date noted by signature of their duly authorized representatives.

FOR: HIGHMARK BCBSD INC.	FOR: STATE OF DELAWARE
BY: Margaret Eitl Signature	BY: Signature
NAME: Margaret Eitl	NAME: Brenda L. Lakeman
TITLE: Regional Vice President Sales	TITLE: Director, Statewide Benefits and Insurance Coverage
DATE: 8/2/17	DATE: 7/28/17

Unredacted material.

DESIGNATION OF PLAN REPRESENTATIVES

Sponsor, as plan administrator, hereby designates the following employees as "Plan Representatives" for purposes of receiving Confidential and Proprietary Information, as well as protected health information. These Plan Representatives will also be "Users" of eDelivery as more fully described in the Agreement.

1 Name: **Susan Zeller** Phone: 302-672-5120

Job Title: Accounting Technician

Address: Financial Operations, 122 Martin Luther King, Jr. Blvd. South, Dover DE 19901

Email Address: susan.zeller@state.de.us

Information To Be Shared:	□ Health Plan[1]	**X** Spending Account[2]	□ Enrollment	**X** Billing System (eBill)

2 Name: **Georgia Moore** Phone: 302-672-5120

Job Title: Sr. FAO

Address: Financial Operations, 122 Martin Luther King, Jr. Blvd. South, Dover DE 19901

Email Address: georgia.moore@state.de.us

Information To Be Shared:	□ Health Plan[1]	**X** Spending Account[2]	□ Enrollment	**X** Billing System (eBill)

3 Name: **Heather Bailey** Phone: 302-672-5120

Job Title: Accountant

Address: Financial Operations, 122 Martin Luther King, Jr. Blvd. South, Dover DE 19901

Email Address: heather.bailey@state.de.us

Information To Be Shared:	□ Health Plan[1]	**X** Spending Account[2]	□ Enrollment	**X** Billing System (eBill)

4 Name: **Faith Rentz** Phone: 302-739-8331

Job Title: Deputy Director, Statewide Benefits Office

Address: Statewide Benefits Office, 97 Commerce Way, Suite 201, Dover, DE 19904

Email Address: faith.rentz@state.de.us

Information To Be Shared:	**X** Health Plan[1]	**X** Spending Account[2]	**X** Enrollment	**X** Billing System (eBill)

[1] By selecting "Health Plan," the recipient will receive claims detail reports

[2] By selecting "Spending Account," the recipient for HRA and FSA (if applicable) will receive claims detail reports.

5 Name: **Leighann Hinkle** Phone: 302-739-8331

Job Title: Policy Advisor (Program Lead)

Address: Statewide Benefits Office, 97 Commerce Way, Suite 201, Dover, DE 19904

Email Address: leighann.hinkle@state.de.us

Information To Be Shared:	**X** Health Plan[1]	**X** Spending Account[2]	**X** Enrollment	**X** Billing System (eBill)

Name: **Marie Hartigan** Phone: 302-739-8331

Job Title: HR Manager I

Address: Statewide Benefits Office, 97 Commerce Way, Suite 201, Dover, DE 19904

Email Address: marie.hartigan@state.de.us

Information To Be Shared:	**X** Health Plan[1]	**X** Spending Account[2]	**X** Enrollment	**X** Billing System (eBill)

Name: **Larry Frank** Phone: 302-739-8331

Job Title: HR Specialist III

Address: Statewide Benefits Office, 97 Commerce Way, Suite 201, Dover, DE 19904

Email Address: larry.frank@state.de.us

Information To Be Shared:	**X** Health Plan[1]	**X** Spending Account[2]	**X** Enrollment	**X** Billing System (eBill)

Name: **Roxanne Eutsey-Shaw** Phone: 302-739-8331

Job Title: HR Specialist I

Address: Statewide Benefits Office, 97 Commerce Way, Suite 201, Dover, DE 19904

Email Address: Roxanne.eutsey-shaw@state.de.us

Information To Be Shared:	**X** Health Plan[1]	**X** Spending Account[2]	**X** Enrollment	**X** Billing System (eBill)

Name: **Arlene Bentley-Graham** Phone: 302-739-8331

Job Title: HR Specialist I

Address: Statewide Benefits Office, 97 Commerce Way, Suite 201, Dover, DE 19904

Email Address: Arlene.bentley-graham@state.de.us

Information To Be Shared:	**X** Health Plan[1]	**X** Spending Account[2]	**X** Enrollment	**X** Billing System (eBill)

Unredacted material.

Name: **Samantha Mountz** Phone: 302-739-8331

Job Title: HR Specialist II

Address: Statewide Benefits Office, 97 Commerce Way, Suite 201, Dover, DE 19904

Email Address: Samantha.mountz@state.de.us

Information To Be Shared:	X Health Plan[1]	X Spending Account[2]	X Enrollment	X Billing System (eBill)

By: BLLK

Name: Brenda L. Lakeman

Title: Director, Statewide Benefits and Insurance Coverage

Date: 7/28/17

MASTER HEALTH SERVICES AGREEMENT
General Terms and Conditions

This agreement (Agreement) is made between Highmark, an independent licensee of BCBSA, licensed in Delaware as a Health Service Corporation under 18 Del. C. Chapter 63, and Sponsor, the State of Delaware (Sponsor), acting on its own behalf and on behalf of its health plans, and/or wellness programs (collectively, Plan). The main body of this Agreement is called the "Master Health Services Agreement," and contains general terms and conditions applicable to all Services (as defined below). The respective statements of work (SOW) contain the terms and conditions of specific Services. The Master Health Services Agreement, and the SOWs and Exhibits attached hereto constitute the entire Agreement. The parties hereto shall collectively be referred to as the "Parties" and individually referred to as a "Party."

By making payment of fees and/or claim costs, Sponsor accepts the terms and conditions of this Agreement, as well as the financial arrangements of the SOWs and Exhibits as set forth herein. Accordingly, Highmark may administer the Plan in accordance with this Agreement, its SOWs and Exhibits, and each shall be controlling in all respects unless and until such time as they are later amended by the Parties with fully-executed final documents.

RECITALS:

WHEREAS, Sponsor requested that Highmark furnish certain services for the Plan; and

WHEREAS, Highmark is willing to perform the Services for the fees set forth in each of the SOWs hereto.

NOW, THEREFORE, the Parties agree to the following terms and conditions:

A. Provision of Services and Payment Terms

1. Sponsor agrees to buy from Highmark and Highmark agrees to provide Sponsor with the Services described in the SOWs attached to this Agreement and any other services, responsibilities or tasks that are not specifically described but that are required for the proper performance and delivery or are an inherent part of the services (collectively, the Services).

2. The Parties may, from time to time, agree that Highmark will provide additional Services, as evidenced by additional SOWs.

3. Pricing for the Services shall be in accordance with the fee Appendix included in each SOW.

4. The terms and conditions for invoicing and payment for Services, as well as payment for the cost of Claims (if applicable) shall be set forth below and in each SOW.

5. Notwithstanding any provision contained herein to the contrary and for the purpose of complying with the provisions of any law, lawful order of court or regulatory authority, Highmark, upon giving not less than sixty (60) days prior written notice to Sponsor, shall have the right to amend this Agreement or an SOW to the extent necessary to accomplish such purpose. Sponsor also agrees to pay for any change in costs and/or expenses which result from such amendment. If the Parties cannot agree to any such change or amendment, notwithstanding any provision of this Agreement or an SOW to the contrary, Sponsor or Highmark may terminate this Agreement or the applicable SOW as of the end of any month by giving sixty (60) days written notice prior thereto. Highmark shall administer the Plan to conform to such amendments, which shall be deemed to be incorporated by reference into this Agreement and the applicable SOW. Sponsor assumes all responsibility for communication of the amendments to the Plan participants and for other notices that may be required by applicable state and federal laws and regulations.

B. Term and Termination

1. Term

The initial term of this Agreement shall be for three (3) years commencing July 1, 2017 (the Effective Date). Thereafter, this Agreement shall renew for up to two (2) successive twelve (12)

month periods upon the mutual written consent of the parties unless terminated as provided in this Agreement or otherwise amended.

2. Termination

a. Termination at Will

This Agreement may be terminated in whole or in part prior to the end of the Agreement by the Sponsor, but only after Highmark is given not less than ninety (90) days' written notice of intent to terminate. Highmark revokes the right to terminate for convenience.

b. Termination for Cause

i. In the event Highmark materially breaches this Agreement, the Sponsor shall provide thirty (30) days' written notice to Highmark of its intent to terminate this Agreement. In the event of a material breach, Highmark shall have thirty (30) days to cure the breach (the Cure Period) and avoid termination. Otherwise, termination shall become effective as of the expiration of the Cure Period. In the event Sponsor materially breaches this Agreement, Highmark shall provide one hundred and eighty (180) days' written notice to Sponsor of its intent to terminate this Agreement.

ii. Notwithstanding anything to the contrary herein, in the event Sponsor fails to honor a request for payment or fails to timely satisfy a payment obligation, then Highmark, at its sole discretion, may terminate the Agreement (or, at its discretion, the relevant SOW) by giving written notice to Sponsor stating the reason for termination; provided however, that Sponsor shall have eight (8) business days to cure any failure to pay an invoice for the cost of Paid Claims and ten (10) business days to cure any fee payment deficiency. Highmark may, at its sole discretion, suspend all or a portion of the relevant Services during any period that an invoice remains unpaid.

Either Party may terminate this Agreement if: (a) the other Party is declared insolvent or adjudged bankrupt by any court of competent jurisdiction or makes an assignment for the benefit of creditors; or (b) if a petition in bankruptcy or reorganization or an arrangement with creditors is filed by or against a Party and not dismissed within sixty (60) days.

c. Rights and Responsibilities Upon Termination

i. In the event of termination of this Agreement, the Sponsor will immediately notify each covered group member of the termination date.

ii. Termination of this Agreement for any reason shall not affect the rights or obligations of either party which arise prior to the date of termination.

iii. Except as may otherwise be provided in the relevant SOW, in the event a Service has been selected but not performed or completed at the time notice of termination is provided, Highmark reserves the right, in its sole discretion, to cancel the Service. Payment of any outstanding amounts due and owing will be accelerated and payment in full will be due immediately, unless otherwise agreed to in writing by the Parties.

iv. Upon termination of this Agreement or completion of any selected Service, a receiving Party may retain the disclosing Party's Confidential and Proprietary Information (as defined below) for only for purposes of administering this Agreement and no longer than reasonably necessary. Except as otherwise provided in Appendix 4, Technology and Security Requirements, a receiving Party shall dispose of all State of Delaware data in its systems or otherwise in its possession or under its control in all of its forms, for example: disk, CD/DVD, backup tape, and paper. Data shall be permanently deleted and shall not be recoverable according to the National Institute of Standards and Technology's standards.

v. A receiving Party shall not disclose or otherwise provide such information to any third party not covered by the terms of this Agreement without the express written consent of the disclosing Party.

vi. To the extent feasible, and subject to Highmark privacy policies (which may require execution of non-disclosure agreements), upon expiration or any termination of this Agreement or any of the SOWs, Highmark shall provide Sponsor with all information, files, documents, data and other assistance reasonably necessary to facilitate the orderly transition of the Services to Sponsor or its designee. Additional fees may apply to non-standard data extracts/file feeds. The foregoing shall not apply if termination of the Agreement is due to non-payment of fees or Paid Claims costs.

C. Relationship

1. Highmark and Sponsor shall not be deemed partners, engaged in a joint venture or governed by any legal relationship other than that of independent contractor. Highmark and any subcontractors, agents or employees employed by Highmark shall not, under any circumstances, be considered employees of the Sponsor and be entitled to any of the benefits or rights afforded employees of the Sponsor.

2. Except as may be explicitly set forth in this Agreement, nothing herein shall be construed as an implied license by a Party to use the other Party's name, trademarks, domain names, or other intellectual property. Neither Party shall use the name, trademarks, domain names, or any other name or mark of the other Party in any press release, printed form, advertising or promotional materials or otherwise (Document[s]), without the prior written consent of the other Party. In addition, Sponsor has no license to use the Blue Cross and/or Blue Shield trademarks or derivative marks (the Brands), and nothing in the Agreement shall be deemed to grant a license to Sponsor to use the Brands. Sponsor agrees not to use the Brands in any Document without Highmark's prior written approval. Additionally, any new or advertising releases pertaining to the solicitation and this contract shall require the prior express written permission of the Sponsor.

3. Highmark's obligations to Sponsor and Plan are expressly limited to the terms of this Agreement. Accordingly, any function not specifically delegated to Highmark pursuant to this Agreement shall remain the sole responsibility of Sponsor.

4. Highmark shall provide only administrative services under this Agreement. Accordingly, Highmark assumes no financial risk or obligation with respect to Claims for benefits under the Plan. Benefits shall be funded entirely by Sponsor. Highmark shall not be considered an insurer, stop-loss insurer, re-insurer, guarantor or underwriter of any Plan benefit. Sponsor agrees to disclose the foregoing terms of its relationship with Highmark in and benefits booklet and/or summary plan description it may distribute to individuals enrolled in or covered by the Plan.

5. This Agreement is between Highmark and Sponsor only. Highmark is an independent corporation operating under licenses from the Blue Cross Blue Shield Association (BCBSA), which is a national association of independent Blue Cross and Blue Shield Plans throughout the United States. Although all of these independent Blue Cross and Blue Shield Plans operate from a license with the BCBSA, each of them is a separate and distinct corporation. BCBSA allows Highmark to use the familiar Blue Cross and/or Blue Shield words and symbols. Sponsor acknowledges that it has not entered into this Agreement based upon representations by any person other than Highmark employees and/or its agents, and Highmark is not contracting as an agent of BCBSA. Only Highmark shall be liable to Sponsor for any of the obligations arising from this Agreement. This paragraph shall not add any obligations to this Agreement.

6. Highmark agrees to neither appoint, nor authorize or make payment to, any agent, general agent, broker, or any party acting in like capacity, with respect to this Agreement without written approval by Sponsor.

7. An activity central to the Statement of Work for Health Plan Administrative Services cannot take place at a physical location outside of the United States. Only support activities may be performed at satellite facilities such as a foreign office or division. Subcontractors are also subject to this provision.

D. File and Data Exchange

1. Highmark shall provide Sponsor with reports as specified in an SOW; which, upon agreement of the Parties, may be provided by electronic medium.

2. Any electronic exchange and/or retrieval of reports and other data via Highmark information systems are subject to the terms of the eDelivery Exhibit attached hereto or as agreed to between the Parties in an implementation agreement.

E. Data Security and Privacy. Highmark acknowledges that, in furtherance of its rendering of Services, it may prepare, obtain and disclose personal and confidential records and information related to employees and/or Plan members that may be subject to various statutory privacy standards; including, without limitation, state laws governing the privacy of personal financial and health information and "protected health information" (PHI) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Accordingly, where applicable, Highmark shall treat all such information in accordance with those standards and its obligations as a "Business Associate" of the relevant Plan (as that term is defined in 45 C.F.R. §160.103) under the terms of the Business Associate Agreement Exhibit included in this Agreement or as previously agreed to by the Parties in an implementation agreement and any amendment.

F. **Audit Rights.** Unless otherwise agreed, Sponsor's audit rights shall apply to the annual review of Paid Claims in accordance with the terms of the Audit Exhibit to this Agreement and Highmark external audit policies and procedures.

G. **Standard of Care.** Highmark will discharge all obligations under the Agreement with that level of care, skill, prudence and diligence under the circumstances then prevailing that a prudent service provider acting in a like capacity and familiar with such matters would have used.

H. **Overpayment of Benefits**. With the full cooperation of Sponsor, Highmark will make reasonable best efforts under the circumstances, considering the chances of successful recovery and the costs thereof, to recover any payment made is in excess of the amount provided under the Plan (Overpayments). Sponsor assigns to Highmark the authority to pursue recovery of Overpayments and Highmark will pursue all reasonable means of recovery of Overpayments under the circumstances but will not be obligated to commence litigation, unless otherwise specifically agreed to by the Parties. Highmark will assume liability up to the amount of an unrecovered Overpayment only if and at such time as it is determined that: (a) the Overpayment was caused by Highmark's fraudulent or criminal activity, or was caused by Highmark's act or omission which was an intentional disregard of Highmark's obligations under this Agreement or inconsistent with the Standard of Care; (b) all reasonable means of recovery under the circumstances have been exhausted; and (c) Highmark's acts or omissions were not undertaken at the express direction of Sponsor.

I. **Sponsor Responsibilities**

1. Sponsor shall comply each of its obligations described in this Agreement.

2. Unless otherwise specifically delegated to and accepted by Highmark, it shall be Sponsor's sole responsibility and duty to ensure compliance with applicable federal and state employment and employee benefit laws as each may relate to the Services.

3. Sponsor will furnish Highmark with written notice of any modification or amendment of the Plan prior to the proposed effective date of the change. The final effective date for modification or amendment, as well as any cost associated therewith, will be subject to mutual agreement by Sponsor and Highmark.

4. Sponsor understands and agrees that certain of the services may require prior execution of a Highmark-approved consent or authorization on the part of employees and/or Plan members. The Parties shall mutually agree as to whether Highmark or Sponsor is responsible to obtain such consents or authorizations prior to the initiation of such service. Sponsor further understands and agrees that Highmark shall be excused from its obligation to perform a service

to the extent the responsible Party was unable to procure the required consents and/or authorizations.

5. Sponsor understands and agrees that certain of the services may, in whole or in part, require information from the Sponsor or a vendor of the Sponsor (e.g., pharmacy benefits manager, dental insurer or vision insurer); and, further, that the disclosure of such information may require the execution of agreed-upon nondisclosure agreements between Highmark and one or more of the Sponsor's vendors. Sponsor further understands and agrees that Highmark shall be excused from its obligation to perform a Service to the extent it was unable to procure the required nondisclosure agreements; provided, however, that Highmark (a) exercised reasonable best efforts in procuring the agreement; and (b) did not unreasonably withhold its consent to the terms of the agreement.

6. Unless otherwise specifically delegated to Highmark, Sponsor remains responsible for the distribution of information required to be provided to Plan enrollees under applicable laws and regulations, and for maintaining and operating the Plan in accordance with applicable laws and regulations.

J. **Determination of Eligibility.** Sponsor shall be responsible for: (a) establishing standards governing the eligibility of individuals to participate in the Plan in conformity with applicable state and federal laws and regulations; (b) notifying individuals of their eligibility to participate in the Plan (c) determining the eligibility of each individual who seeks to enroll in the Plan; (d) enrolling eligible individuals; and, to the extent applicable; and (e) resolving all disputes relating to Plan eligibility in conformity with applicable state and federal laws and regulations.

K. **Accuracy and Completeness.** Sponsor shall furnish data requested by Highmark as determined necessary to perform Highmark's functions hereunder, including information concerning the Plan and the eligibility of individuals to participate in and receive Plan benefits. Such information shall be provided to Highmark in the time and in the manner agreed to by Plan and Highmark. Highmark shall have no responsibility with regard to benefits paid in error due to Sponsor's failure to timely update such information. Moreover, Highmark shall not be responsible for verifying the completeness or accuracy of any data provided by Sponsor (or its designee) or a vendor of Sponsor (e.g., pharmacy benefits manager, dental insurer or vision insurer), or re-keying any incorrect data.

L. **Acts and Omissions by Others.** Highmark shall not be liable for any acts or omissions of the Sponsor, Plan, or any other person or organization with which the Sponsor has made, or makes, arrangements for the performance of services related to this Agreement.

M. **No Tax or Legal Advice.** Highmark does not provide legal or tax advice to Sponsor or its employees and Plan enrollees. Sponsor should retain its own legal counsel to review any communication, documents or written materials created in connection with the Plan to determine whether the same comply with applicable federal, state and local laws.

N. **No Reporting/Withholding of Income or Employment Taxes.** Unless required by court order or by direct request for a government agency or otherwise agreed to in writing, Highmark shall not be responsible for reporting any information to any government agencies or withholding from any benefit amounts necessary to cover income or employment taxes.

O. **Confidentiality**

1. Highmark represents that the terms and conditions set forth in this Agreement are not confidential except for those sections identified in the Confidential and Proprietary Information Listing accompanying Highmark's letter dated 06/30/17.

2. The Parties hereby acknowledge, agree and stipulate that the provisions of this Section are made for the benefit of both parties and shall survive termination of this Agreement, and that monetary damages would be inadequate to compensate a party for any breach of this Section. The foregoing notwithstanding, in the event of such breach or threatened breach, the Parties agree and stipulate that they shall be entitled to damages to be determined at the time and

based upon the facts and circumstances of the Parties at the time of said breach or threatened breach of this Section.

3. Except as provided above, nothing in this Section shall affect the rights of either Party to use for any purpose or to disclose to third parties any Confidential and Proprietary Information (as defined below) not otherwise containing PHI received from the other Party if such information: (a) was already legally available to the public prior to receipt thereof; (b) becomes generally available to the public through no act by a Party nor through any breach of this Agreement; (c) corresponds in substance to information furnished to a Party without restriction by any third party having a legal and *bona fide* right to do so; or (d) is developed independently by the receiving Party solely through employees who have not been exposed directly or indirectly to the other Party's Confidential or Proprietary Information.

4. The Parties acknowledge that in fulfilling their obligations in connection with this Agreement, they may disclose or make available to each other statistical and other information which is commercially valuable, confidential and/or proprietary.

5. Highmark represents that all provider information, including but not limited to provider contracts, pricing, utilization data, reports, software Plans, processing techniques, procedures of operation and trade secrets; including written materials pertaining to the same, developed in whole or in part, or provided by either Party (collectively referred to herein as Confidential and Proprietary Information) shall not be used or disclosed except as necessary to implement the terms of this Agreement and then only on a need-to-know basis, nor used or disclosed to any third party, except its legal counsel, without the prior express, written consent of the other Party and except as necessary to implement the terms of this Agreement and then only on a need-to-know basis and except as may be required by law or regulation.

6. Confidential and Proprietary Information of Highmark may be given to the Sponsor's accountant or consultant (the Third Party for the purposes of this subsection) to enable them to perform their responsibilities to the Sponsor in regard to this Agreement; provided, however, that the Sponsor first obtain Highmark's written consent; which, among other things, may require execution of an appropriate non-disclosure agreement between Highmark and the Third Party.

7. Sponsor and Highmark each agree as follows: (a) to fully protect and preserve the confidential nature of the other's Confidential and Proprietary Information; and (b) to not use, distribute, or exploit each other's Confidential and Proprietary Information, in whole or in part, for its own benefit or that of any third party without the other's prior written consent, unless legally compelled to do so, in which case the Party so compelled shall provide, to the extent practicable, the other Party with prompt notice so that it may seek a protective order or other appropriate remedy and/or waive compliance with the provisions of this Section and except as may be required by law or regulation.

8. Each Party shall take all reasonable steps to safeguard the other Party's Confidential and Proprietary Information and to preserve it in confidence. Sponsor and Highmark each shall be deemed to have discharged its entire obligation hereunder if, in safeguarding the Confidential and Proprietary Information, it gives at least as careful treatment to the other's Confidential and Proprietary Information as it gives to its own.

9. Notwithstanding anything in this Agreement to the contrary, Highmark's disclosure of Confidential and Proprietary Information shall be subject to the terms of such confidentiality and indemnification agreements, authorizations, consents, designations, certifications, or other understandings as Highmark deems necessary and appropriate to comply with applicable Highmark policies and procedures, laws and regulations.

P. **Interpretation**

Except as otherwise specifically provided, common definitions for SOWs shall be set forth in the Common Definitions Exhibit.

Q. **Indemnification**

Highmark shall indemnify and hold harmless the Sponsor, its agents and employees, from any and all liability, suits, actions or claims, together with all reasonable costs and expenses (including attorneys' fees) directly arising out of (a) the negligence or other wrongful conduct of Highmark, its agents or employees, or (b) Highmark's breach of any material provision of this Agreement not cured after due notice and opportunity to cure, provided as to (a) or (b) that (i) Highmark shall have been notified in writing by the Sponsor of any notice of such claim; and (ii) Highmark shall have the sole control of the defense of any action on such claim and all negotiations for its settlement or compromise, and provided further that this section shall not apply to claims related to a determination made by the Sponsor or with the Sponsor's explicit consent, provided that when obtaining the Sponsor's explicit consent Highmark shall disclose in writing the negligence or other wrongful conduct or breach of any material provision of this Agreement.

Sponsor shall not indemnify Highmark under this Agreement or any related contract. Highmark shall not request the Sponsor to indemnify or provide quasi-indemnification under any contract. An example of an unacceptable quasi-indemnification provision is:

> The State asserting it is without legal authority to agree to such indemnification, acknowledge that Vendor, on behalf of itself and any affiliate, reserves such rights as it may have to obtain reasonable compensation from the State, against any loss, damage, costs of suit or other expenses resulting from the improper use or disclosure of data or any breach of this Agreement by State.

R. **Litigation**

1. Each Party will select and retain its own defense counsel to represent its interests if a Claim or demand arising from or out of this Agreement (and the Services described herein) is asserted by a Participant or third party in litigation, arbitration or administrative proceedings (Litigation). Notwithstanding the preceding and when applicable, the Parties may agree to joint defense counsel in connection with Litigation; provided, however, that no conflict of interest arises among each of them.

2. A Party named as a defendant in Litigation shall notify the other Party as promptly as is reasonably practicable upon receiving notice or knowledge of the Litigation.

3. A Party named in Litigation (including an intervening Party) shall have sole discretion to resolve the legal or administrative proceeding in a reasonable manner and for a reasonable amount under the circumstances.

4. In all events Sponsor remains responsible for the full amount of any benefits paid as a result of Plan benefits Litigation.

S. **Assignment.**

1. With the prior written consent of Sponsor, which consent shall not be unreasonably withheld, Highmark may assign or delegate any or all of its rights or obligations under this Agreement to a subsidiary, affiliate or successor of Highmark. Benefits described in this Agreement are not assignable by any Plan enrollee.

2. Any attempt by Highmark to assign or otherwise transfer any interest in this Agreement without the prior written consent of the Plan Sponsor shall be void.

T. **Subcontractors.** Highmark will use commercially reasonable efforts to identify any services specified by this Agreement that may be performed by a subcontractor and is willing to discontinue

use of any subcontractor that does not meet with Sponsor's approval. Approval by the Sponsor of Highmark's request to subcontract or acceptance of or payment for subcontracted work by the Sponsor shall not in any way relieve Highmark of responsibility for the professional and technical accuracy and adequacy of the work. All subcontractors shall adhere to all applicable provisions of this Agreement. The compensation due shall not be affected by the Sponsor's approval of the Highmark's request to subcontract.

U. **Benefit of the Parties.** This Agreement is for the sole and exclusive benefit of the Parties and is not intended to, nor does it, confer any benefit upon any third party.

V. **Entire Agreement.** This Agreement (including the Agreement's Exhibits, SOWs and Appendices) and the State of Delaware's Request for Proposal (RFP), constitute the entire agreement between the Parties and, as of the Effective Date hereof, supersedes all other oral or written agreements or understandings between the Parties regarding the subject matter hereof. In the event there is any discrepancy between any of these documents, the following order of documents governs so that the former prevails over the latter: Agreement, RFP. No other documents will be considered.

W. **Modification of Agreement.** This Agreement shall be subject to amendment, modification or termination in accordance with any provisions hereof or by signed written agreement between Highmark and Sponsor and without the consent or concurrence of employees and/or Plan enrollees. The Parties further agree to amend this Agreement as necessary to maintain its compliance with applicable law.

X. **Force Majeure.** No failure, delay, or default in performance of any obligation of Highmark under this Agreement shall constitute an event of default or breach of the Agreement to the extent that such failure to perform, delay or default arises out of a cause, existing or future, that is beyond the control and without negligence of Highmark including, by way of illustration and not limitation, Acts of God, war (declared or undeclared), government regulation, acts or inaction of governmental agency, civil or military authority, unforeseen disruptions caused by suppliers, subcontractors, vendors, or carriers, terrorism, disaster, strikes, civil disorder, curtailment of transportation facilities, fire, floods, blizzards, epidemics and/or any other cause beyond the reasonable control of Highmark (Force Majeure Event), making it impossible, illegal, or commercially impracticable for Highmark to perform its obligations under this Agreement, in whole or in part. Upon the occurrence of a Force Majeure Event, Highmark shall take action to minimize the consequences of any Force Majeure Event. If Highmark relies on any of the foregoing as an excuse for failure, default or delay in performance, it shall give prompt written notice of the facts that constitute such Force Majeure Event, when it arose, and when it is expected to cease.

Y. **Insurance.**

Highmark shall maintain the following insurance during the term of this Agreement:

1. Worker's Compensation and Employer's Liability Insurance in accordance with applicable law;

2. Comprehensive General Liability - $1,000,000.00 per person / $3,000,000 per occurrence;

3. Medical/Professional Liability - $1,000,000.00 per person / $3,000,000 per occurrence; and/or

4. Miscellaneous Errors and Omissions - $1,000,000.00 per person / $3,000,000 per occurrence.

Highmark shall provide forty-five (45) days written notice of cancellation or material change of any policies. Within thirty (30) days of renewal, Highmark shall provide the Plan Sponsor a copy of renewal certificates throughout the term of this Agreement. In no event shall the State of Delaware be named as an additional insured.

Z. **Notice of Adverse Judgement.** Highmark shall provide a written report no later than forty-five (45) days following the close of each quarter which shall describe any judgment or settlement or pending

litigation involving Highmark that could result in judgments or settlements in excess of five hundred thousand dollars ($500,000).

AA. **Damages.** In no event will Highmark or its subcontractors or assigns be liable to Sponsor (including the successors and/or assigns of each) for any consequential, incidental, indirect, punitive or special damages (including, but not limited to, loss of profits, data, business or goodwill) in connection with the performance of services under this Agreement.

BB. **Governing Law.** Except as otherwise governed by federal laws, this Agreement is entered into pursuant to the laws of the State of Delaware and shall be interpreted pursuant to Delaware law, without regard to its conflict of law principles.

CC. **Severability.** In the event of the unenforceability or invalidity of any Section or provision of this Agreement (including an SOW), such Section or provision shall be enforceable in part to the fullest extent permitted by law, and such unenforceability or invalidity shall not otherwise affect any other Section or provision of this Agreement and this Agreement shall otherwise remain in full force and effect.

DD. **Non-waiver.** The failure of either Party, in any one or more instances, to demand strict performance or compliance with any of the terms or conditions of this Agreement or to take advantage of any of its rights shall not operate or be construed as a waiver of any such terms or conditions or the relinquishment of any such rights. All such terms or conditions and rights shall continue and remain in full force and effect.

EE. **Notices.** All notices under this Agreement shall be in writing and may be served on each Party's representative by email, facsimile, regular mail, by hand or courier; addressed to such designated representative at the address indicated on the first page of this Agreement. The address of either Party or their designated representative may be changed at any time by written notice of such change to the other Party. Any such notice shall be effective upon delivery to the intended recipient or seven (7) days after being placed in the ordinary course of the U.S. mail, postage paid and properly addressed, whichever occurs first.

FF. **Suspension or Debarment.** Highmark affirms that within the past five (5) years Highmark or any officer, controlling stockholder, partner, principal, or other person substantially involved in the contracting activities of Highmark's business is not currently suspended or debarred and is not a successor, subsidiary, or affiliate of a suspended or debarred business.

GG. **Notice of Regulatory Action.** Highmark will provide Sponsor notice of material regulatory matters related to performance of this Agreement and will provide copies of relevant material correspondence to regulatory agencies that apply to services or products of this Agreement.

COMMON DEFINITIONS EXHIBIT

Administrative Fees means the amount(s) specified in an SOW that Sponsor agrees to pay Highmark in exchange for Highmark's performance of its obligations under the SOW. The Parties may agree in writing to amend the Administrative Fees specified in the SOW from time to time, and each such amendment shall be incorporated into the SOW as if fully set forth therein.

BCBSA means the Blue Cross and Blue Shield Association, a national association of independent licensees.

Benefits means the care, treatment, services and supplies described in the Benefits Booklet which are eligible for payment or reimbursement by the Plan.

Benefits Booklet refers to the document under which Benefits will be administered pursuant to an SOW, and is incorporated herein by reference.

Claim means the amount a Provider, Member or vendor requests from the Plan for payment or reimbursement of a treatment, service or supply. "Claim" does not include any of the following: casual inquiries; requests for advance information on coverage when prior authorization is not required; benefits or services received directly from a Network Provider, including a pharmacy, until and unless the Claim has been received for processing; transactions between Highmark and a Network Provider where the Member is not liable for any charges.

Contractholder or Contract means an employee or retiree covered under this MHSA: (a) collectively, if each is enrolled under the same Group number; and (b) individually, if the employee or retiree and his/her dependents are enrolled under separate group numbers.

Contract Year means the initial 12-month period commencing on the effective date of a given SOW, and each succeeding 12-month period thereafter.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended, and regulations implemented thereunder; including, but not limited to, HIPAA privacy standards (Privacy Rule), transaction standards (Transactions Rule) and security standards (Security Rule).

Host Blue means a Licensee operating in a Service Area outside of the Highmark Service Area.

Licensee means a licensee of BCBSA.

Member means any individual who is enrolled in the Plan. Members shall be deemed to be Highmark subscribers, and any reference to "subscribers" in any SOW, regulation or policy adopted by Highmark shall be deemed to apply to Members.

Network Provider means any Provider that is included within the network of Providers described in the Benefits Booklet.

Paid Claim refers to the amount charged to Sponsor for Benefits provided to Members during the term of an SOW. [redacted]

[redacted]

Participating Provider means any Provider with whom Highmark and/or any Blue Cross and/or Blue Shield licensee has a contract with respect to payment for services performed for persons enrolled in any Blue Cross or Blue Shield health care program or a health care program administered by a Blue Cross and/or Blue Shield licensee.

Payment Innovation Program. A program under which Highmark pays providers for reaching agreed-upon cost/quality goals through retrospective financial settlements, Provider Incentives, a share of target savings, care coordinator fees and/or other allowed amounts.

PHI means "Protected Health Information," as that term is defined in the Privacy Rule.

Plan means the provisions of the health plan, program of benefits (including spending account benefits) or wellness program established by Sponsor, including any amendments thereto, administered by Highmark under this Agreement.

Sponsor refers to the entity identified on the signature page of this Agreement. Unless otherwise indicated in an SOW, the Sponsor shall be deemed to be the Plan administrator. Highmark shall not be considered to be the Plan administrator except to the extent that Highmark has accepted fiduciary responsibility for a Plan administrative function under an SOW.

PPACA means the Patient Protection and Affordable Health Care Act of 2010 and implementing regulations thereunder; including, but not limited to, rules relating to internal Claims and appeals and external review processes under PPACA (PPACA Claim Rule).

Provider refers to any duly licensed and approved health care facility, pharmacy or health care professional for whose services the Sponsor is obligated to pay under the terms of the Benefits Booklet.

Service Area refers to the geographic area in which a Licensee may operate under its agreement with BCBSA.

Summary Plan Description means a document furnished by Sponsor or its designee.

EDELIVERY EXHIBIT

1. **In General.** "eDelivery" means a service allowing for the electronic presentment and retrieval of reports and other agreed-upon data, and may include the ability to electronically view and pay bills owed to Highmark via Highmark's System (known as "eBill").

2. **Users of eDelivery.** Plan Representatives designated by the Sponsor are "Users" of eDelivery. Unless otherwise agreed, each Plan Representative shall be deemed to be a User of eDelivery for purposes of this Exhibit.

3. **Authorization/Application for Access.** Following receipt and review of this Agreement and the completed User Forms, Highmark shall assign a logon ID and password to each User, along with the date on which it will be authorized to utilize eDelivery. Users of eBill may also be required to complete an on-line application for access before obtaining an on-line User ID and password.

4. **Logon IDs and Passwords.** Each User shall not disclose or otherwise make logon IDs or passwords available to any third party. If a User ceases to be a User for any reason, including termination from employment or contractual obligation, or the User otherwise discloses his or her intent to resign; Sponsor shall notify Highmark within three (3) days so that Highmark can disable the applicable logon ID and password. Sponsor and Plan are responsible for any breaches of security relating to use of any User's logon ID and password until Highmark has disabled that logon ID and password. If a breach or suspected breach of this provision occurs, Sponsor or a User must notify Highmark immediately by telephone.

5. **Security.** Sponsor and Plan shall maintain reasonable and appropriate security procedures to prevent unauthorized access to Data in their office(s) or system(s). Further, and to the extent applicable, such procedures shall comply with the Privacy and Security Rules and any other applicable rule governing data imposed by state or federal laws and regulations.

6. **Liability.** The materials, information and services provided through eDelivery are provided "as is" without warranty of any kind, either express or implied, including, but not limited to, the implied warranties of merchantability and fitness for a particular purpose. There is no warranty against interference with one's enjoyment of any materials, information, or services (including, but not limited to, any data, text, images, sounds or computer programs (including collections and compilations of them)).

   Highmark, its officers, directors, employees or agents shall not be liable for any direct, indirect, special, consequential, punitive, exemplary and/or incidental damages of any kind whatsoever (including, but not limited to, lost profits or attorneys' fees or disbursements) in any way due to, resulting from or arising in connection with user's/Sponsor's/plan's access to, inability to access, or use of eDelivery, or from user's/Sponsor's/plan's reliance on any information provided through eDelivery, even if Highmark has been advised of the possibility of such damages. This limitation applies to all causes of action in the aggregate including, but not limited to, breach of contract, breach of warranty, negligence, strict liability, misrepresentation and any other tort.

7. **Use of eDelivery.** Use of eDelivery is subject to all applicable local, state, national and international laws and regulations, and Sponsor agrees not to use eDelivery for purposes that violate such laws and regulations. In addition, Sponsor agrees that it , the Plan and its Users: (a) will not interfere with another person's use and enjoyment of eDelivery; (b) will not upload, download, transmit or otherwise distribute any viruses or other harmful, disruptive or destructive files; (c) will not upload, download, transmit or otherwise distribute any Content that would constitute or encourage a criminal offense, violate the rights of any party or that would otherwise create liability or violate any local, state, national or international law; (d) will not use or attempt to use another's eDelivery account without authorization from Highmark, or create or use a false identity on this Site; (e) will not interfere with or disrupt networks, systems and/or computers connected to eDelivery; (f) will comply with all regulations, policies and procedures of such networks and systems; and (g) will comply with all United States laws regarding the transmission of technical data exported from the United States.

8. **Further Assurances.** Highmark may require Sponsor to make further amendment to this eDelivery Exhibit as necessary to keep the eDelivery service compliant with applicable laws and regulations. By its execution of the User Form, each User automatically agrees to be bound by any such amendment.

9. **Intellectual Property Restrictions.** Nothing within any of the material and content of the eDelivery service shall be construed as conferring any license under Highmark's or any third party's intellectual property rights, whether by estoppel, implication, waiver or otherwise. Except as expressly provided to the contrary, Sponsor, Plan and Users agree not to modify, alter, or deface any trademarks, service marks, or other intellectual property of Highmark made available through the eDelivery service. Sponsor, Plan and Agents further agree not to: (a) use any of the trademarks, service marks or other content accessible through the eDelivery service by Highmark; or (b) adapt, translate, modify, decompile, disassemble, or reverse engineer the eDelivery service or any software or Plans used in connection with the eDelivery service.

10. **Confidentiality.** Each User shall comply with the confidentiality provisions of the Agreement shall likewise apply to this eDelivery Exhibit as if fully set forth herein.

11. **Standard Transactions.** To the extent applicable, each User shall comply with the requirements of the Transactions Rule. Highmark EDI reference guides and companion documents shall apply in connection with any transaction contemplated herein.

12. **Termination.** Highmark reserves the right to terminate a User's use of eDelivery at any time with or without cause. Highmark may immediately terminate a User's use of eDelivery if the User breached any agreement with Highmark (including a breach of the Agreement) or Highmark has reason to believe that there has been or may be an unauthorized use or disclosure of a logon ID or password or the eDelivery service.

BUSINESS ASSOCIATE AGREEMENT EXHIBIT

This Business Associate Agreement ("BA Agreement") is undertaken pursuant to the parties' performance of a certain contract ("Contract") effective July 1, 2017, by and between the State of Delaware by and through the State Employee Benefits Committee ("Plan Sponsor"), on its own behalf and on behalf of the group health plan it sponsors for employees or other covered persons (the "Plan"), and Highmark BCBSD Inc. ("Contractor").

In the performance of services on behalf of the Plan pursuant to the Contract, and in order for Contractor to use, disclose or create certain information pursuant to the terms of the Contract, some of which may constitute Protected Health Information ("PHI") (defined below), Contractor is a Business Associate of the Plan as that term is defined by the Health Insurance Portability and Accountability Act of 1996, including the modifications required under the American Recovery and Reinvestment Act of 2009 ("ARRA"), and its implementing Administrative Simplification regulations (45 C.F.R. §§142, 160, 162 and 164) ("HIPAA"). Accordingly, Contractor, the Plan and Plan Sponsor mutually agree to modify the Contract to incorporate the terms of this BA Agreement to comply with the requirements of HIPAA, and to include additional provisions that Plan Sponsor, the Plan and Contractor desire to have as part of the Contract.

Therefore, in consideration of the mutual covenants contained herein and for other good and valuable consideration, the parties agree as follows:

I. DEFINITIONS

The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

A. Specific Definitions

1. Business Associate. "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean Contractor.

2. Covered Entity. "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean the Plan.

3. HIPAA Rules. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

II. PERMITTED USES AND DISCLOSURES BY CONTRACTOR

A. During the continuance of the Contract, Contractor will perform services necessary in connection with the Plan as outlined in the Contract. These services may include Payment activities, Health Care Operations, and Data Aggregation as these terms are defined in 45 CFR §164.501. In connection with the services to be performed pursuant to the Contract, Contractor is permitted or required to use or disclose PHI it creates or receives for or from the Plan or to request PHI on the Plan's behalf as provided below.

B. Functions and Activities on the Plan's Behalf. Unless otherwise limited in this BA Agreement, Contractor may use or disclose PHI to perform functions, activities, or services for, or on behalf of, the Plan as specified in the Contract. Contractor may decide in its own reasonable discretion what uses and disclosures of PHI are required for it to perform administrative services for the Plan as outlined in this BA Agreement and in the Contract as well as in accordance with the law.

1. Use for Contractor's Operations. Contractor may use PHI it creates or receives for or from the Plan for Contractor's proper management and administration or to carry out Contractor's legal responsibilities in connection with services to be provided under the Contract.

2. Disclosures for Contractor's Operations. Contractor may disclose the minimum necessary of such PHI for Contractor's proper management and administration or to carry out Contractor's legal responsibilities, but only if the following conditions are met:

   a. The disclosure is required by law; or

   b. Contractor obtains reasonable assurance, evidenced by written contract, from any person or organization to which Contractor will disclose such PHI that the person or organization will:

      i) Hold such PHI in confidence and use or further disclose it only for the purpose for which Contractor disclosed it to the person or organization or as required by law; and

      ii) Promptly notify Contractor (who will in turn promptly notify the Plan) of any instance of which the person or organization becomes aware in which the confidentiality of such PHI was breached.

3. Other Uses and Disclosures. Contractor may make any Use and/or Disclosure of Protected Health Information permitted under 45 C.F.R. §§ 164.506(c), 164.508 and 164.510, as well as under Contractor's Notice of Privacy Practices ("NPP").

4. Creation of Limited Data Sets and De-Identified Health Information
Contractor may use Group Health Plan's PHI to create (or have created on its behalf) Limited Data Sets, in conformance with 45 C.F.R. § 164.514(e) (2), and De-Identified Health Information, in conformance with 45 C.F.R. § 164.514(b). Contractor may use such Limited Data Sets for public health, research and health care operations purposes permitted by the Privacy Rule.

5. Additional Uses and Disclosures. In addition to uses and disclosures authorized by Sections II. A. and B hereof, Contractor may use or disclose data collected in the performance of services under Benefits Contract or any other Agreement between the Parties, so long as: (i) the data is de-identified in a manner consistent with the requirements of HIPAA; or (ii) the data is used or disclosed for research, health oversight activities or other purposes permitted by law; or (iii) a Member has consented to the release of his or her individually identifiable data. The data used or disclosed shall be used for a variety of lawful purposes, including, but not limited to, research, monitoring, and benchmarking of industry and health care trends.

C. Minimum Necessary and Limited Data Set. Contractor will apply policies and procedures intended to assure that it will Use, Disclose, or request only the minimum necessary amount of Protected Health Information to accomplish the intended purpose as required under 45 C.F.R. §§ 164.502(b) and 164.514(d) , and will use a Limited Data Set, as defined by the Privacy Rule, if practicable.

D. Sale of PHI. Contractor shall not directly or indirectly receive remuneration in exchange for PHI except where permitted by the Contract and consistent with applicable law.

E. Use of PHI for Marketing Purposes. Contractor shall not directly or indirectly receive payment for any use or disclosure of PHI for marketing purposes except where permitted by the Agreement and consistent with applicable law.

F. Disclosure to Contractor's Subcontractors and Agents. Contractor shall require any of its agents or subcontractors to provide reasonable assurance, evidenced by written contract that the agent or subcontractor will comply with the same privacy and security obligations as Contractor with respect to Protected Health Information of GHP.

G. Data Aggregation Services. The Plan agrees and recognizes that Contractor performs Data Aggregation services for the Plan, as defined by the HIPAA Rules. In the course of performing normal and customary services under the Contract, this data aggregation is an essential part of Contractor's work on behalf of the Plan under the Contract. Accordingly, Contractor can perform

these data aggregation services in its own discretion, subject to any limitations imposed by the Contract. The term "Data Aggregation" is defined under the HIPAA Rules to mean, with respect to PHI created or received by a Business Associate in its capacity as the Business Associate of a covered entity, the combining of such PHI by the Business Associate with the PHI received by the Business Associate in its capacity as a Business Associate of another covered entity, to permit data analyses that relate to the health care operations of the respective covered entities.

H. Prohibition on Unauthorized Use or Disclosure

1. Non-permitted Use and Disclosure of PHI. Contractor will neither use nor disclose PHI it creates or receives for or from the Plan or from another Business Associate of the Plan, except as permitted or required by the Contract and this BA Agreement, as required by law, as otherwise permitted in writing by the Plan, or as authorized by a Covered Person.

2. Disclosure to the Plan and the Plan Business Associates. To the extent permitted or required by the Contract and this BA Agreement, Contractor will disclose PHI to other Business Associates of the Plan which the Plan has identified in a writing provided to Contractor. Contractor shall only disclose such PHI to such Business Associates, in their capacity as Business Associates of the Plan. Other than disclosures permitted by this Section II or as otherwise specifically identified in the Contract, Contractor will not disclose Covered Persons' PHI to the Plan or to a Business Associate of the Plan except as directed by the Plan in writing.

3. No Disclosure to Plan Sponsor. Contractor will not disclose any Covered Persons' PHI to Plan Sponsor, except as permitted by and in accordance with Section VII or as otherwise specifically identified in the Contract.

III. OBLIGATIONS AND ACTIVITIES OF CONTRACTOR

A. Contractor will develop, document, implement, maintain and use appropriate administrative, technical and physical safeguards to preserve the integrity and confidentiality of, and to prevent non-permitted use or disclosure of, PHI created or received for or from the Plan.

B. Contractor agrees to mitigate, to the extent practicable, any harmful effect that is known to Contractor of a use or disclosure of PHI by Contractor in violation of the requirements of this BA Agreement.

C. Contractor agrees to report to Covered Entity, without unreasonable delay and in any event within thirty (30) days, any use or disclosure of the PHI not provided for by this BA Agreement or otherwise in writing by the Plan. Contractor shall maintain a written log recording the date, name of Covered Person and description of PHI for all such unauthorized use or disclosure and shall submit such log to the Plan Sponsor semiannually and by request. Contractor agrees to directly provide notice to any effected participants in the event of a Breach and to send a written log each such Breach and notice to participants to the Covered Entity within thirty (30) days of notification. Contractor agrees to notify participants in accordance with the guidelines and standards set forth by the Department of Health and Human Services under the American Reinvestment & Recovery Act and the HITECH Act.

D. Contractor will require that any agent, including a subcontractor, to whom it provides PHI as permitted by this BA Agreement (or as otherwise permitted with the Plan's prior written approval), agrees to the same restrictions and conditions that apply through this BA Agreement to Contractor with respect to such information.

E. Contractor agrees to make internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by Contractor on behalf of, Covered Entity available to the Covered Entity, or at the request of the Covered Entity to the Secretary, in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the HIPAA Rules.

F. Contractor agrees to implement administrative, physical, and technical safeguards (as set forth in the Security Rule) that reasonably and appropriately protect the confidentiality and integrity (as set forth in the Security Rule), and the availability of Electronic PHI, if any, that Contractor creates, receives, maintains, or transmits electronically on behalf of Covered Entity. Contractor agrees to establish and maintain security measures sufficient to meet the safe harbor requirements established pursuant to ARRA by making data unreadable, indecipherable, and unusable upon receipt by an unauthorized person. Contractor agrees to provide adequate training to its staff concerning HIPAA and Contractors responsibilities under HIPAA.

G. Contractor agrees to report to Covered Entity any Security Incident of which Contractor becomes aware.

H. Contractor agrees to ensure that any agent, including a subcontractor, to whom it provides Electronic PHI, agrees to implement reasonable and appropriate safeguards to protect such information.

IV. INDIVIDUAL RIGHTS OBLIGATIONS

A. **Access**. Contractor and the Plan agree that, wherever feasible, and to the extent that responsive information is in the possession of Contractor, Contractor will provide access to PHI as required by 45 CFR §164.524 on the Plan's behalf. Contractor will provide such access according to its own procedures for such access. Contractor represents that its procedures for such access comply with the requirements of 45 CFR §164.524. Such provision of access will not relieve the Plan of any additional and independent obligations to provide access where requested by an individual. Accordingly, upon the Plan's written or electronic request or the direct request of a Covered Person or the Covered Person's Personal Representative, Contractor will make available for inspection and obtaining copies by the Plan, or at the Plan's direction by the Covered Person (or the Covered Person's personal representative), any PHI about the Covered Person created or received for or from the Plan in Contractor's custody or control contained in a Designated Record Set, so that the Plan may meet its access obligations under 45 CFR §164.524. All fees related to this access, as determined by Contractor, shall be borne by Covered Persons seeking access to PHI.

B. **Amendment**. Contractor and the Plan agree that, wherever feasible, and to the extent that responsive information is in the possession of Contractor, Contractor will amend PHI as required by 45 CFR §164.526 on the Plan's behalf. Contractor will amend such PHI according to its own procedures for such amendment. Contractor represents that its procedures for such amendment comply with the requirements of 45 CFR §164.526. Such amendment will not relieve the Plan of any additional and independent obligations to amend PHI where requested by an individual. Accordingly, upon the Plan's written or electronic request or the direct request of a Covered Person or the Covered Person's Personal Representative, Contractor will amend such PHI contained in a Designated Record Set, in accordance with the requirements of 45 CFR §164.526. Upon receipt of written or electronic notice from the Plan, Contractor will amend or permit the Plan access to amend any portion of the PHI created or received for or from the Plan in Contractor's custody or control, so that the Plan may meet its amendment obligations under 45 CFR §164.526.

C. **Disclosure Accounting**. So that the Plan may meet its disclosure accounting obligations under 45 CFR §164.528, Contractor and the Plan agree that, wherever feasible and to the extent that disclosures have been made by Contractor, Contractor will provide the accounting that is required under 45 CFR §164.528 on the Plan's behalf. Contractor will provide such accounting according to its own procedures for such accounting. Contractor represents that its procedures for such accounting comply with the requirements of 45 CFR §164.528. Such provision of disclosure accounting will not relieve the Plan of any additional and independent obligations to provide disclosure accounting where requested by an individual. Accordingly, upon the Plan's written or electronic request or the direct request of a Covered Person or the Covered Person's Personal Representative, Contractor will provide an accounting as set forth below.

1. Disclosure Tracking

Starting as of the Effective Date of the Contract, Contractor will record each disclosure of Covered Persons' PHI, which is not exempted from disclosure accounting that Contractor makes to the Plan or to a third party.

The information about each disclosure that Contractor must record ("Disclosure Information") is (a) the disclosure date, (b) the name and (if known) address of the person or entity to whom Contractor made the disclosure, (c) a brief description of the PHI disclosed, and (d) a brief statement of the purpose of the disclosure.

For repetitive disclosures of Covered Persons' PHI that Contractor makes for a single purpose to the same person or entity (including the Plan), Contractor may record (a) the Disclosure Information for the first of these repetitive disclosures, (b) the frequency, periodicity or number of these repetitive disclosures, and (c) the date of the last of these repetitive disclosures.

2. Exceptions from Disclosure Tracking

Contractor is not required to record disclosure information or otherwise account for disclosures of PHI that this BA Agreement or the Plan in writing permits or requires: (i) for the purpose of the Plan's payment activities or health care operations, (ii) to the individual who is the subject of the PHI disclosed, or to that individual's personal representative; (iii) to persons involved in that individual's health care or payment for health care; (iv) for notification for disaster relief purposes, (v) for national security or intelligence purposes, (vi) to law enforcement officials or correctional institutions regarding inmates; (vii) pursuant to an authorization; (viii) for disclosures of certain PHI made as part of a limited data set; (ix) for certain incidental disclosures that may occur where reasonable safeguards have been implemented; (x) for disclosures prior to April 14, 2003; or (xi) as otherwise excepted under 45 CFR §164.528.

3. Disclosure Tracking Time Periods

Contractor will have available for the Plan or for Covered Persons the Disclosure Information required for the six (6) years immediately preceding the date of the Plan's request for the Disclosure Information (except Contractor will not be required to have Disclosure Information for disclosures occurring before April 14, 2003).

D. Right to Request Restrictions and Confidential Communications

So that the Plan may meet its obligations to evaluate requests for restrictions and confidential communications in connection with the disclosure of PHI under 45 CFR §164.522, Contractor and the Plan agree that, wherever feasible and to the extent that communications are within the control of Contractor, Contractor will perform these evaluations on behalf of the Plan. Contractor will evaluate such requests according to its own procedures for such requests, and shall implement such appropriate operational steps as are required by its own procedures. Contractor represents that its procedures for evaluating such requests comply with the requirements of 45 CFR §164.522. Such evaluation will not relieve the Plan of any additional and independent obligations to evaluate restrictions or implement confidential communications where requested by an individual. Accordingly, upon the Plan's written or electronic request or the direct request of a Covered Person or the Covered Person's Personal Representative, Contractor will evaluate requests for restrictions and requests for confidential communications, and will respond to these requests as appropriate under Contractor's procedures.

V. OBLIGATIONS OF THE COVERED ENTITY

A. Covered Entity shall provide Contractor with any changes in, or revocation of, permission by Individual to use or disclose PHI, if such changes affect Contractor's permitted or required uses and disclosures.

B. Covered Entity shall notify Contractor of any requested restriction to Contractor's use or disclosure of PHI in accordance with 45 CFR 164.522, and Contractor shall implement such restrictions that

are (i) required by 45 CFR 164.522, or (ii) otherwise mutually agreed to by Covered Entity and Contractor.

C. Covered Entity shall not request Contractor to use or disclose PHI in any manner that would not be permissible under the HIPAA Rules if done by Covered Entity except as provided in this BA Agreement. In no event shall Covered Entity request Contractor to disclose to Covered Entity or agents of Covered Entity any PHI unless such disclosure is the minimum necessary disclosure that satisfies the request and that such disclosure is solely for the purpose of treatment, payment or plan operations.

VI. BREACH OF PRIVACY OBLIGATIONS

Without limiting the rights of the parties under the Contract, the Plan will have the right to terminate the Contract if Contractor has engaged in a pattern of activity or practice that constitutes a material breach or violation of Contractor's obligations regarding PHI under this BA Agreement and, on notice of such material breach or violation from the Plan, fails to take reasonable steps to cure the breach or end the violation.

If Contractor fails to cure the material breach or end the violation after the Plan's notice, the Plan may terminate the Contract by providing Contractor written notice of termination, stating the uncured material breach or violation that provides the basis for the termination and specifying the effective date of the termination. Such termination shall be effective sixty (60) days from this termination notice.

A. Effect of Termination.

1. Return or Destruction upon Contract End

   Upon cancellation, termination, expiration or other conclusion of the Contract, Contractor will if feasible return to the Plan or destroy all PHI, in whatever form or medium (including in any electronic medium under Contractor's custody or control), that Contractor created or received for or from the Plan, including all copies of such PHI that allow identification of any Covered Person who is a subject of the PHI. Contractor will complete such return or destruction as promptly as practical after the effective date of the cancellation, termination, expiration or other conclusion of the Contract.

   Following notice, Contractor shall pay the costs incurred in returning or destroying such PHI unless Plan Sponsor agrees to reimburse Contractor for reasonable costs following good faith negotiation between Contractor and Plan Sponsor subject to the requisite appropriation by the Delaware General Assembly as required by Title 29 Delaware Code Chapter 65 and Article 8, Section III of the Delaware Constitution.

2. Disposition When Return or Destruction Not Feasible

   The Plan recognizes that in many situations, particularly those involving data aggregation services performed by Contractor for the Plan and others, that it will be infeasible for Contractor to return or destroy PHI. Accordingly, where in Contractor's discretion such return or destruction is infeasible, for any such PHI, upon cancellation, termination, expiration or other conclusion of the Contract, Contractor will limit its further use or disclosure of the PHI to those purposes that make their return to the Plan or destruction infeasible.

VII. PLAN SPONSOR'S PERFORMANCE OF PLAN ADMINISTRATION FUNCTIONS

A. Communication of PHI. Except as specifically agreed upon by Contractor, the Plan and Plan Sponsor, and in compliance with any requirements imposed by this Agreement, all disclosures of PHI from Contractor pursuant to the Contract shall be made to the Designated Plan Representatives identified in the Contract, except for disclosures related to enrollment or disenrollment in the Plan.

B. Summary Health Information. Upon Plan Sponsor's written request for the purpose either to, (a) obtain premium bids for providing health insurance coverage for the Plan, or (b) modify, amend or

terminate the Plan, Contractor is authorized to provide Summary Health Information regarding the Covered Persons in the Plan to Plan Sponsor.

C. **Disclosure to Plan Sponsor**. Contractor will not disclose Covered Persons' PHI to Plan Sponsor, unless Contractor has first ensured: (i) that its Plan Document has been amended as required by 45 C.F.R. § 164.504(f)(2), and (ii) that the Plan Sponsor has delivered the certification required by 45 C.F.R. § 164.504(f)(2)(ii). If GHP should require Claims Administrator to Disclose Protected Health Information directly to the Plan Sponsor, GHP shall authorize such disclosure by written instruction, accompanied by the Plan Sponsor's certification required by 45 C.F.R. § 164.504(f)(2)(ii). Claims Administrator may rely on Plan Sponsor's certification and GHP's written instruction, and will have no obligation to verify that the Plan Documents have been amended to comply with 45 C.F.R. § 164.504(f)(2) or that Plan Sponsor is complying with such amendments.

D. **Contractor Reliance**. Contractor may rely on Plan Sponsor's certification and the Plan's written authorization, and will have no obligation to verify that the Plan complies with the requirements of 45 CFR §164.504 or this BA Agreement or that Plan Sponsor is complying with the Plan.

VIII. MISCELLANEOUS

A. **Regulatory References**. A reference in this BA Agreement to a section in the HIPAA Rules means the section as in effect or as amended, and for which compliance is required.

B. **Survival**. The respective rights and obligations of Contractor under Section IV of this BA Agreement shall survive the termination of this BA Agreement.

C. **Interpretation**. Any ambiguity in this BA Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with the HIPAA Rules. Except to the extent specified by this BA Agreement, all of the terms and conditions of the Contract shall be and remain in full force and effect. In the event of any inconsistency or conflict between this BA Agreement and the Contract, the terms and provisions and conditions of this BA Agreement shall govern and control. Nothing express or implied in this BA Agreement and/or in the Contract is intended to confer, nor shall anything herein confer, upon any person other than the parties and the respective successors or assigns of the parties, any rights, remedies, obligations, or liabilities whatsoever. This BA Agreement shall be governed by and construed in accordance with the same internal laws that are applicable to the Contract.

D. **Term**. The Term of this BA Agreement shall be effective as of the date appearing on the signature page, and shall terminate when all of the PHI provided by Covered Entity to Contractor, or created or received by Contractor on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions of this BA Agreement.

E. **Amendment**. Upon the effective date of any final regulation or amendment to final regulations with respect to the HIPAA Rules, this BA Agreement will automatically amend such that the obligations imposed on Plan Sponsor, the Plan and Contractor remain in compliance with such regulations, unless (1) Contractor elects to terminate the Contract by providing Plan Sponsor and the Plan notice of termination in accordance with the Contract at least thirty (30) days before the effective date of such final regulation or amendment to final regulations; or (2) Contractor notifies the Plan of its objections to any such amendment. In the event of such an objection, the parties will negotiate in good faith in connection with such changes or amendment to the relevant final regulation.

F. **Conflicts**. The provisions of this BA Agreement will override and control any conflicting provision of the Contract. All nonconflicting provisions of the Contract will remain in full force and effect.

G. **Independent Relationship**. None of the provisions of this BA Agreement are intended to create, nor will they be deemed to create any relationship between the parties other than that of independent parties contracting with each other as independent parties solely for the purposes of effecting the provisions of this BA Agreement and the Contract.

H. **Rights of Third Parties**. This BA Agreement is between Contractor and the Plan and the Plan Sponsor and shall not be construed, interpreted, or deemed to confer any rights whatsoever to any third party or parties.

I. **Notices**. All notices and notifications under this BA Agreement shall be sent in writing by traceable carrier to the listed persons on behalf of Contractor, the Plan and Plan Sponsor at the addresses indicated on the signature page hereof, or such other address as a party may indicate by at least ten (10) days' prior written notice to the other parties. Notices will be effective upon receipt.

J. **Expenses**. Unless otherwise stated in this BA Agreement or the Contract, each party shall bear its own costs and expenses related to compliance with the above provisions. Any additional expenses incurred by Contractor in connection with services to be provided pursuant to this BA Agreement shall be included in the Contract.

K. **Documentation**. All documentation that is required by this BA Agreement or by the HIPAA Rules must be retained by Contractor for six (6) years from the date of creation or when it was last in effect, whichever is longer.

AUDIT EXHIBIT

A. Audit Agreement

Prior to commencement of any audit, Sponsor and its audit vendor, if any, shall execute a written audit agreement with Highmark's External Audit Services Department setting forth the terms and conditions of the audit. The audit agreement shall provide for the protection of Confidential and Proprietary Information, as well as PHI. Highmark shall in no event be required to disclose any information in violation of applicable law. The Sponsor's right to audit shall survive the termination of this Agreement between the Parties for a period of three (3) years.

B. Access to Provider Contracts

With regard to its contracts with hospitals or other providers that are not otherwise publicly available, Highmark reserves the right to not provide access to the contracts or to provide access only in a manner that Highmark deems would protect the Confidential and Proprietary information contained therein. This reservation of right pertains not only to the actual contracts but also to any data, reports or other information generated, and from which the terms of the contracts could be determined.

C. Procedure

In any audit under the Agreement, Sponsor shall give Highmark notice in writing of its desire to conduct an audit. Audits are limited to the most recently completed Contract Year and must be completed no later than eleven (11) months after the end of that Contract Year. Sponsor shall not request more than one audit per Contract Year for each of the following: (1) Paid Claims (2) financial audit, (3) pre-implementation, or (4) data security. Sponsor understands and agrees that: (a) due to timely filing requirements, Highmark will be limited in its ability to make any needed adjustments to Paid Claims, including Medicare and BlueCard Paid Claims (as more fully described in the SOW for Health Plan Administrative Services) that were incurred more than twenty-four (24) months prior to notice to Highmark of any need for adjustment; and (b) Highmark's ability to obtain BlueCard Paid Claims from Host Blues for audit is limited, as the provision of such Paid Claims is subject to the approval/discretion of the Host Blue responsible for paying a given Paid Claim. Unless otherwise agreed, audits shall be conducted during normal working business hours at the offices of Highmark. Audits shall be conducted by an auditor that is mutually acceptable to both Highmark and Sponsor. Such acceptance shall not to be unreasonably withheld. Sponsor and Highmark shall mutually agree on the scope and terms of the audit prior to its initiation. Highmark shall provide appropriate records and documents for Sponsor to evaluate the administration of the Plan benefits pursuant to this Agreement. Audits shall not be conducted for the same scope and time frame or portion of time of a previously conducted audit unless one of the following occurs: (a) Sponsor is required by a governmental agency to audit a certain period; (b) reasonable evidence of fraud exists; or (c) the audit identifies a systemic discrepancy, acknowledged as such by Highmark and strongly suspected of having preexisted the audit period. In this event an audit or re-audit may be conducted of a period no greater than the three (3) most recently completed Contract Years (including the current audit period) solely for the purpose of examining such systemic discrepancy.

D. Types of Audits

1. Paid Claims Audit.

    a. Subject to the requirements of this Exhibit, applicable laws and regulations, and Highmark's corporate policies, the Sponsor shall have the right to conduct an audit of Paid Claims for Plan benefits that were processed and paid under the terms of this Agreement. The audit shall be coordinated with Highmark's External Audit Services Department and will be limited to reviews of Paid Claim records, membership data, benefit file summaries and other documents considered relevant and applicable by Highmark. Audit sampling methodology shall be mutually agreed to by the parties and must be based on the universe of Paid Claims under review. A preliminary draft of the audit report shall be submitted to Highmark at least fifteen (15) days prior to issuance of the final report. Highmark shall be provided with the opportunity to respond to the draft audit report within a reasonable period of time prior to its finalization.

b. Provided the Sponsor has one thousand (1,000) or more enrolled Contractholders at the beginning of the Contract Year, the Sponsor may audit two hundred (200) Paid Claims at no cost to Sponsor. To the extent Sponsor has less than one thousand (1,000) enrolled Contract holders at the beginning of the Contract Year, Sponsor may audit up to one hundred (100) Paid Claims at no cost to Sponsor. The foregoing shall apply to all SOWs and Exhibits of this Agreement in the aggregate. If Sponsor elects to audit additional Paid Claims, Sponsor shall reimburse Highmark for each additional Paid Claim at a rate of fifty dollars ($50) per Paid Claim.

c. Highmark shall make no adjustment or refund on the basis of statistical projections or extrapolations of actual errors. To that end, Highmark reimbursement of any overpayments found during the course of an audit will be made on an individual case basis and under the Overpayment of Benefits provision of this SOW. Processing of adjustments will be subject to the limitations of this Section. However, in the event a systemic discrepancy is identified and acknowledged by Highmark, Highmark will perform a review to identify the impact on the overall population of Sponsor claims and report its findings to the Sponsor. The review will identify claims impacted from the inception of the discrepancy until its correction.

2. Financial Audits. For purposes of this section, financial audits are audits performed by a public accounting firm to certify Sponsor's financial statements. Subject to the requirements of this Section, applicable laws and regulations, and Highmark's policies, financial audits shall be limited to an examination of Highmark's records of provider charges, reimbursements and amounts invoiced to the Plan under this Agreement. The foregoing shall apply to all SOWs and Exhibits of this Agreement in the aggregate. If any financial audit requires more than fifty (50) hours of Highmark's time, Sponsor shall reimburse Highmark for personnel time in excess of such hours at the rate of fifty dollars ($50) per hour. Sponsor shall reimburse Highmark for the actual cost of any specialized reporting requested of Highmark as part of the audit.

3. Pre-Implementation Audit. Highmark shall conduct a pre-implementation testing process to ensure accuracy of the plan administration and any plan design changes prior to the effective date and share the results of the testing process with the Plan Sponsor. The process shall include claim scenarios in dedicated test environments with subscribers and groups. After reviewing the results and any discrepancies, retest the system defects until corrections are complete.

4. Data Security Audit: Highmark shall allow the Sponsor to audit conformance with the terms set forth in Appendix 4, Technology and Security Requirements, system security and data centers once annually as appropriate. The Sponsor may perform this audit or contract with a third party at its discretion at the Sponsor expense, provided however, that the party performing the audit is HITRUST/SOC2 certified at the commencement of the audit. Such reviews shall be subject to the conditions described in Section C, Procedures, of this Exhibit.

STATEMENT OF WORK
HEALTH PLAN ADMINISTRATIVE SERVICES

Sponsor desires to retain Highmark for health plan administrative services described in this SOW for the Administrative Fees set forth in Appendix 2 to this SOW (as may be amended by renewal letters in accordance with the terms thereof).

Section 1 – Plan Design and Benefits

1.1 **Plan Benefit Design.** Sponsor understands and agrees that it retains full responsibility for ensuring that the Plan's design and its governing documents conform to applicable federal and state laws and regulations; including, but not limited to, all matters involving such design. In this regard, Sponsor shall select and specify to Highmark the services for which Benefits are payable under the Plan, which may be modified by Sponsor from time to time during the term of the contract with reasonable notice to Highmark. It is understood and agreed by the parties hereto that Highmark shall not be required to conform the Benefits Booklet to any Summary Plan Description derived therefrom or review the same for compliance with applicable requirements of State or Federal law; and, further, that any such review and compliance shall be the sole responsibility of Sponsor. Until Sponsor has approved the Benefits Booklet, Highmark will administer the selected Benefits in accordance with the standard Benefits Booklet language for self-funded accounts.

1.2 **Benefits**. The Benefits available to Members under the Plan shall vary with respect to copayments, deductibles, coinsurance, and levels of payment for specific Benefits depending on whether Members use Network Providers (including Network Providers that participate in a Payment Innovation Program) or use non-network Providers as described in the Benefits Booklet.

Section 2 - Eligibility and Enrollment

2.1 **Eligibility and Enrollment Information.**

(a) Sponsor shall maintain current and accurate Plan eligibility and enrollment records. Sponsor shall periodically provide Highmark with a current list of Members with related Social Security Numbers and employee/retiree/newborn/foreign national identification numbers. Sponsor and Highmark shall jointly determine the medium and timing for providing such information. Highmark shall not be responsible for any non-performance or delay in the performance of this SOW that is caused or contributed to by the failure of Sponsor to provide any of the eligibility and enrollment information required by Highmark.

(b) Sponsor shall provide Highmark with notice of changes in Member eligibility as they occur (or for a future date not to exceed 120 days beyond the then current date,) and Highmark will post such changes not later than five (5) business days after receipt thereof from Sponsor. Changes involving the termination of an individual from the Plan as administered by Highmark shall be effective on the last day of the month except for:

i. The day after the effective date of a divorce; and

ii. Coverage for the ex-spouse of a retiree covered by a Medicare Supplement plan will terminate on the last day of the month in which the divorce is final.

Notwithstanding anything in the preceding to the contrary, and except as otherwise provided in Section 4.23, Claim Reprocessing, upon request of the Sponsor, Highmark will process a retroactively dated termination of coverage for up to one year; provided, however that Sponsor shall be responsible for the cost of any Claims incurred up to and including the posting date of such retroactive termination. Highmark will support retroactive enrollments and terminations of up to one year for members in situations allowable under PPACA. Highmark shall not adjust Paid Claims or refund Administrative Fees for services provided in reliance on eligibility information in effect at the time authorization was granted or services were rendered. Furthermore, Sponsor assumes responsibility for the erroneous disbursement of Benefits by Highmark in the event of error or neglect on Sponsor's part in providing eligibility information.

2.2 **Open Enrollment Period.** If requested by Sponsor, Highmark shall facilitate Plan open enrollment periods at least once during each twelve (12) month period that this SOW is in effect. Sponsor will determine the timing of the open enrollment period and work with Highmark to establish procedures and a process for the enrollment and disenrollment of individuals.

Section 3 – Sponsor/Plan Administrator Responsibilities

3.1 **Claims and Administrative Fees.** In exchange for the obligations undertaken by Highmark in this SOW, Sponsor agrees to pay Administrative Fees and the cost of Paid Claims in the amounts and in the manner specified in Appendix 2.

3.2 **Taxes.** Sponsor agrees to reimburse Highmark for taxes that are assessed against Highmark or that Highmark is required to pay, now or in the future, relating to Benefit payments but not Highmark's fees or services or taxes on Highmark's net income. Highmark has the authority and discretion to determine whether any such tax should be paid or disputed. Highmark will act reasonably when making that determination.

3.3 **Tax and PPACA Reporting.** Sponsor assumes all tax reporting obligations relative to the reimbursement of any Benefit to a Member in connection with the Plan and this SOW. Sponsor further assumes all reporting responsibilities relative to its obligations (or those of the Plan) arising under PPACA; including, but not limited to: (a) the filing of a form 720 (or any successor form) for payment of the Patient Centered outcomes Research Institute (PCORI) fee under Section 4376 of the Internal Revenue Code; (b) the information reporting requirements applicable to self-insuring employers, and certain other providers of minimum essential coverage under Section 6055 of the Internal Revenue Code; and (c) the information reporting requirements applicable to large employers under Section 6056 of the Internal Revenue Code. Notwithstanding the preceding, for an additional fee, Highmark may agree to file the transitional reinsurance program contribution (Reinsurance Fee) to the U.S. Department of Health and Human Services; provided, however, that (d) Sponsor agrees to the calculation methodology chosen by Highmark; and (e) Sponsor conveys payment for the Reinsurance Fee within five (5) business days of the date on which it receives Highmark's invoice for the same.

3.4 **Continuation Coverage.** Sponsor shall retain full responsibility for notifying Members (or former Members) of their termination of coverage and their rights to continuation of coverage, whether such coverage is pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985, other applicable law (including the Uniformed Services Employment and Reemployment Rights Act of 1994) or by contract (hereinafter collectively referred to as "COBRA"), and for the maintenance of records relating to the same. Highmark shall have no obligation to ensure that any instructions received by Members (or former Members) or the Sponsor comply with the requirements of COBRA; and, further, Highmark shall be indemnified by Sponsor from any and all liability arising from the failure of Sponsor to provide required COBRA notices.

3.5 **Financial Settlements.** [redacted]

3.6 **Medicare Secondary Payer Information.** Sponsor shall furnish Highmark with all information reasonably required by Highmark for purposes of proper coordination with Medicare in accordance with applicable Medicare secondary payer rules, including the reporting requirements of the Medicare, Medicaid and SCHIP Extension Act of 2007.

3.7 **Internal Revenue Code Requirements.** Unless otherwise specifically delegated herein, compliance with any requirement of the Internal Revenue Code applicable to the Plan shall be the sole responsibility of the Sponsor.

3.8 **Qualified Medical Child Support Orders.** Sponsor shall have the sole responsibility, in accordance with state and federal law, to develop procedures for determining whether a medical child support order is a "qualified" medical child support order. Sponsor shall provide notice to Highmark once it has made such determination.

Section 4 – Highmark Responsibilities

4.1 **Claims Administration**. To the extent applicable, Highmark shall administer and determine initial Claims and related appeals in accordance with: (a) the Benefits Booklet; (b) Highmark's administrative policies, practices, and network rules; (c) this SOW; and, to (d) the extent applicable: (1) the PPACA Claims Rule (taking into account sub-regulatory guidance and administrative relief); and (2) the U.S. Department of Labor Claims Procedure Rule [29 CFR 2560.503-1 et. seq.].

4.2 **Appeals of Claims.** Sponsor reserves the right to review Highmark's determination of a valid appeal of an adverse benefit determination; and, further, represents that the Plan's governing documents convey such review authority to the Sponsor. Plan Administrator shall: (i) be responsible for notifying Highmark of any decision it may make to overturn or modify Highmark's determination of a valid appeal; and (ii) instruct Highmark in writing to process the Claim in accordance with the Plan Administrator's determination. Any such notice and instruction shall be made in a form acceptable to Highmark. See Appendix 5, Appeals Process.

4.3 **Blues on Call.** Highmark shall administer its "Blues on Call" program (health education and support program) as specified in the Benefits Booklet.

4.4 **Case Management/Utilization Management.** Highmark shall administer case and utilization management services as specified in the Benefits Booklet.

4.5 **Coordination of Benefits.**

(a) Unless otherwise specified by Sponsor and set forth in the Summary Plan Description, Highmark will follow the coordination provisions of the Benefits Booklet, as may be amended from time to time. Sponsor acknowledges and agrees that Highmark does not undertake coordination of pharmacy benefits.

(b) Highmark will coordinate benefits with state Medicaid agencies and with the Centers for Medicare and Medicaid to the extent required by law by responding to data matching requests and making appropriate reimbursements based upon available Paid Claims information within its possession.

(c) Highmark conducts inquiries as to the existence of other group medical or Medicare coverage and coordinates payment of claims with other payers. In addition, Highmark sends an inquiry file to Medicare with qualifying members who are age 45 and over to identify Medicare eligible individuals and obtain Medicare data, such as Medicare coverage effective dates, HIC Number and entitlement reason. When the file is returned, it is systematically loaded to Highmark's Other Party Liability Information System, OPIS. Notification is received from the Section 111 file from Medicare regarding members who turned age 65 and who are approaching age 65. Any discrepancies between the member information and Medicare are reported to the Sponsor via the Medicare Eligibility Weekly Feedback Report.

(d) Upon notice of their diagnoses from Medicare, Highmark sends a written notice to ESRD qualifying members who are enrolled in Medicare Part A but are not enrolled in Medicare Part B informing them of the need to enroll in Part B.

(e) Highmark and its recovery vendor may share in a percentage of any recovery made pursuant to the coordination provisions of the Plan in compensation for rendering this service to Plan and Sponsor.

(f) Highmark and its recovery vendor will undertake reasonable efforts on behalf of the Plan to recover amounts from other accident and injury carriers (e.g., workers' compensation,

automobile accident and other accident or injury insurers) to the extent insurance issued by such insurers may be primarily liable for Paid Claims arising from an illness or injury suffered by a Member. Highmark and its recovery vendor may share in a percentage of any recovery from such carriers in compensation for rendering this service to Plan and Sponsor.

4.6 **Provider Network**. Highmark shall provide a network of Providers in sufficient numbers and in appropriate locations to meet the health care needs of Members (Provider Network). Highmark shall have the sole authority to select and credential Providers for its network. Sponsor may recommend Providers for the network and should refer any complaints regarding a Network Provider to Highmark for appropriate action. The final decision to add, sanction or remove a Provider from the network shall be made by Highmark.

4.7 **Credentialing**. Highmark shall ensure that physician Network Providers who render health care services to Members within its Service Area are credentialed by Highmark or its designated agent. Network Providers outside of the Highmark Service Area are credentialed by other BCBSA Licensees.

4.8 **Network Provider Listings**. Highmark shall provide Sponsor and Members with access to a list of Network Providers, which is subject to change from time to time and will be updated from time to time. Sponsor will receive a 90-day notice, when possible, of any event or negotiation that may cause a disruption to the provider network access.

4.9 **Services of Non-Participating Providers**. Subject to the Reimbursement for Benefits and Cost Savings Program provisions of this SOW, if Benefits are rendered by a Provider who is not a Participating Provider (non-participating provider), Highmark will make payment to the Member based on the calculated allowed amounts and subject to other applicable limitations in the Benefits Booklet. Highmark may calculate the allowed amount for services from nonparticipating providers in several ways, including, but not limited to any of the following: (a) pricing based upon a non-participating provider fee Appendix posted on Highmark's website; (b) pricing determined by the Host Blue; (c) pricing based upon a percentage of billed charges; (d) pricing based upon a nationwide provider reimbursement data base; or (e) pricing based upon a percentage not less than one hundred percent (100%) of the Medicare allowed charge for the same or similar service. The allowed amount calculations for these services are not intended to represent a usual, customary and reasonable charge, and the process used to determine the allowed amount for services rendered by nonparticipating providers may change from time to time without notice. Any difference between the non-participating provider's charge and Highmark's payment shall be the personal responsibility of the Member except as otherwise provided by applicable law. Highmark shall not accept an assignment of benefits to any non-participating provider unless otherwise specifically permitted under the Benefits Booklet.

4.10 **Services of Participating Providers.** If a Participating Provider performs covered services, Highmark will make payment directly to the Provider. Participating Providers have agreed to accept Highmark's payment as payment in full for covered services performed for Members, except where certain maximums, copayments, co-insurance or deductibles are specified in the Benefits Booklet.

4.11 **Reimbursement for Benefits.** Highmark will arrange to reimburse Network Providers, Participating Providers, non-Participating Providers and Members in accordance with Highmark's payment methodologies (including, but not limited to, Payment Innovation Program methodologies). Highmark will be responsible for the preparation and filing of all statements to Network Providers as required by the Internal Revenue Service

4.12 **Subrogation.** Unless otherwise directed by Sponsor, Highmark is hereby delegated full authority to pursue Subrogation, as agent for Sponsor for this purpose only. To that end, Highmark may engage the services of a subrogation management firm to assist with the identification and management of Subrogation cases.

Notwithstanding any prior SOW between the parties to the contrary, fees based on a percentage of recovery by a recovery vendor shall be charged in connection with the Subrogation. Such fees shall be negotiated by Highmark. In those cases where the Subrogation recovery efforts of the

Member's attorney should be compensated, Sponsor delegates or assigns to Highmark full authority to act on behalf of Sponsor or Plan to negotiate reasonable attorneys' fees. Highmark (directly or through its subrogation management firm) shall have the authority and discretion to settle any Paid Claim.

Monies recovered must be fully disclosed in a detailed quarterly report, accounted for, and credited to the State's claims account.

Highmark and its recovery vendor will undertake reasonable efforts on behalf of the Plan to recover amounts from other accident and injury carriers (e.g., workers' compensation, automobile accident and other accident or injury insurers) to the extent insurance issued by such insurers may be primarily liable for Paid Claims arising from an illness or injury suffered by a Member. Highmark and its recovery vendor may share in a percentage of any recovery from such carriers in compensation for rendering this service to Plan and Sponsor.

4.13 **Identification Cards.** Based on the information provided by Sponsor and subject to standard Highmark and BCBSA identification card guidelines, Highmark shall arrange for the issuance of identification cards to each newly enrolled Member within fourteen (14) calendar days upon receipt of the enrollment file. Cards issued to Members are for identification only. Possession of an identification card confers no right to services or other Benefits under the Plan. To be entitled to such services or Benefits, the holder of the card must, in fact, be a Member.

4.14 **Account Management**.

(a) Highmark will provide primary contacts who will respond promptly (within the same business day) to all of Sponsor's requests and questions within normal business hours and who will have broad and extensive expertise in at least the following areas: plan design set-up/management, claims processing, enrollment, billing, and member service. Highmark will attempt to honor the Sponsor's request for specific individuals to be assigned to managerial roles of account management.

(b) Highmark's client service team will meet with the Sponsor on a quarterly basis to review company and health plan performance.

(c) Highmark will continue to provide regular information concerning industry developments or new services and provide articles and other communications at a frequency determined by the Sponsor for inclusion in newsletters and websites.

(d) Highmark will provide on-site representation throughout Delaware for two (2) days of benefit representatives' meetings in April of each year, as well as, approximately five (5) days' representation at Health Fairs and educational sessions in May at various locations in all three (3) counties.

(e) Highmark shall provide to Plan participants and Sponsor account management personnel and HR benefit representatives a dedicated customer service unit with a toll-free telephone line that shall operate Monday through Friday during normal business hours. Highmark shall: 1) staff such customer service center with member service representatives familiar with the terms and provisions of the Plan, 2) train customer service representatives on plan design changes by May 1 for Open Enrollment and October 1 for Medicare Supplement OE, 3) provide support services for selecting and/or locating network providers, and 4) maintain procedures for monitoring and ensuring the quality of services provided by its member services representatives, including but not limited to investigating and remedying instances of possible provision of incorrect information.

(f) At no cost to the Sponsor, Highmark will provide standard communications, including the production and distribution of promotional materials, to approximately 125 human resource offices with the State of Delaware concerning the open enrollment period. The Sponsor must review and approve all communication materials. Additional fees may apply for customization and postage costs, if applicable.

4.15 **Standard Reports**.

(a) Highmark will furnish agreed-upon standard reports to Plan Representatives designated by Plan Administrator in accordance with this Agreement or in a mutually acceptable medium and format. Upon request, Highmark may deliver the same to the Sponsor if such reports do not contain PHI.

(b) Highmark will furnish Sponsor the reports as set forth in the Master Report List, an attachment to Appendix 3, Performance Measures. The Master Report List may be changed upon mutual agreement and in writing without an amendment to the Agreement. The following requirements may or may not be listed on the Master Report List:

i. The administration of the State's program into an organization of the data as three (3) separate groups – department or agencies, retirees/pensioners, and non-payroll – and include the corresponding State's accounting code and a designation of OPEB or non-OPEB status.

ii. Provide customized tracking and bi-monthly reporting to the TPAs of IVF expenses for a small number of grandfathered members for services under a plan design that was modified in 2010.

iii. Report on an annual basis Service Organization Control ("SOC") Reports 1 and 2 that address the internal control over financial reporting of vendor's services and other criteria that are applicable to non-financial reporting subject matter for vendor's services.

iv. Maintain member records that categorize members in the following employer types: Merit Agency, Public Education, Higher Education, State of Delaware Retirees, Non State Participating Groups as well as by Plan type and actives, non-Medicare retirees and Medicare retirees.

v. Provide the Sponsor with an estimate of incurred unpaid claims, administrative fees not later than 45 days following the close of each fiscal quarter

vi. Provide an initial annual report not later than June 20th and which provides the status of S-COB compliance based on forms completed during annual Open Enrollment. Thereafter, weekly reporting will be required by the State which will list all employees who are not compliant with the S-COB policy.

4.16 **Form 5500**. Highmark shall provide information requested by Sponsor as may be required for the Plan's annual Form 5500 filing with the U.S. Department of Labor.

4.17 **Plan Documents.** Upon request Highmark shall produce a Summary of Benefits and Coverage (SBC) document for each of Sponsor's plan designs and, if required, update same with material modifications of benefits for Sponsor to distribute in accordance with PPACA. Highmark will provide Benefit Booklets 60 days prior to each plan year effective date, provided however, Sponsor has provided Highmark with final plan designs 30 days prior to the booklet due date.

4.18 **Data Mining and Analysis**

Data Mining Vendor. Sponsor contracts with a vendor for Data Mining and Analysis (the "Data Mining Vendor") of covered person data. Highmark shall continue to provide data as provided under the preceding contract and on a consistent and timely basis to the Data Mining Vendor at the Plan Sponsor's request at no additional cost to Plan Sponsor. Highmark shall cooperate in honoring the requests of Plan Sponsor or the Data Mining Vendor on behalf of Plan Sponsor. Such requests may include, but are not limited to, customized programming of data, enhancement of fields in a standard data file layout as described in the RFP, and technological enhancements to ensure data can be captured, transmitted and received in an efficient manner under the terms of the current financial agreement. Additionally, the Sponsor may require that disease management data be sent to the Data Mining Vendor. Highmark shall take all commercially reasonable actions

necessary to capture information requested by Plan Sponsor for data mining purposes. Highmark shall maintain the technological resources available to it as of the effective date of the Contract as necessary to receive and distribute manual and electronic file information to the Data Mining Vendor.

Plan Sponsor shall provide Highmark reasonable advance notice of any change in Data Mining Vendor or current vendor data requirements in order to assess the need for customized programming of data, enhancements of fields in a standard data file layout, and technological enhancements required to accommodate the change.

Upon termination of this Agreement, Highmark will be responsible for submitting accurate and timely "run on" data to the Data Mining Vendor for a period of 6-12 months post termination. This "run on" data should be submitted according to standards that were established by the Data Mining Vendor and that had been in effect at the time of termination.

At no cost to the Sponsor, and in a format equivalent to that provided under the preceding contract, Highmark may, at the direction of the Sponsor, be required to provide Sponsor's claims data to other parties and/or business partners of the Sponsor, including, but not necessarily limited to, the Sponsor's healthcare consultant as determined necessary for the administration of the Sponsor's Group Health Insurance Program, and subject to Highmark's limitations with respect to Confidential and Proprietary Information.

Highmark Special Projects. Highmark may request special projects or data extractions for services that may include case management, discharge planning, etc. Highmark agrees that such extraction will require initial approval from the Plan Sponsor and should be submitted with written justification of necessity for the information. Highmark agrees that it will not utilize such data to gain unfair advantages over competitors, nor to avoid claim payments or actions that will have negative effects on behalf of the members of the plan Highmark provides. Highmark agrees that special projects or data extractions may require additional fees for extraction and such fees as are agreed upon in advance would be solely the responsibility of Highmark.

4.19 **GeoAccess.** Highmark will provide analysis and provider disruption to compare the prior year's information with the current year's census.

4.20 **Other Data/Information.** Highmark may provide such other data and information as the parties may agree. However, Highmark reserves the right to charge additional fees for such data and information. [redacted]

4.21 **Provider Agreements**. Any discounted or negotiated payment arrangements Highmark has with Network Providers shall be fully credited to the Plan unless otherwise disclosed to Sponsor.

4.22 **Claim Processing and Member Liability.** Sponsor acknowledges and agrees that Highmark will calculate Member liability on Paid Claims processed on the lower of the Participating Provider's billed covered charges or the negotiated price. Furthermore, such liability may be calculated on a per line item charge basis. Sometimes, this negotiated price may be greater than billed charges if Highmark has negotiated with its Participating Provider(s) an inclusive allowance (e.g., per case or per day amount) for specific healthcare services. In cases where the negotiated price exceeds the Provider's billed charge, Sponsor may be liable for the excess amount even when the Member's deductible has not been satisfied. This excess amount reflects an amount that may be necessary to secure (a) the provider's participation in the network and/or (b) the overall discount negotiated by Highmark or a Host Blue. In such a case, the entire contracted price is paid to the Provider, even when the contracted price is greater than the billed charge.

4.23 **Claim Reprocessing.** Sponsor may request that Highmark undertake reasonable and good faith efforts to reprocess certain Claims as result of (i) a pay-by-exception request; (ii) Claim denial due to the failure of a Member to obtain required authorization for a medical service, treatment or device; or (iii) retroactive benefit or eligibility changes that Sponsor made or in connection with other action by Sponsor, its employees or agents. Sponsor agrees and acknowledges that such requests are subject to Highmark's operational capabilities and the requirements of applicable law.

In the event the request is implemented, a reprocessing fee will be charged to Sponsor as stated in Appendix 2 to this SOW. Sponsor acknowledges and agrees that Highmark cannot guarantee the reprocessing of any or all requested Claims due to, among other things, BCBSA policies, Provider contract limitations and applicable state and federal laws or regulations. Furthermore, Sponsor agrees to indemnify and hold Highmark harmless from any losses, penalties, reasonable costs and expenses (including reasonable attorneys' fees) from Member or other third party claims arising from or out of the foregoing requests.

4.24 **Recoveries for Fraudulent or Inappropriate Paid Claims.**

Providers. Highmark reviews and investigates potentially fraudulent or inappropriate billings submitted by Providers. Highmark will not pursue legal remedies such as placing liens for overpayment without first advising the Sponsor. Whenever amounts recovered from these investigations can be associated with a Paid Claim under the Plan and result in a Paid Claim adjustment, Sponsor will receive a credit against future Paid Claims costs in the amount of the recovery, less a percentage fee that may be retained by Highmark. Highmark warrants that it will exercise reasonable efforts to determine whether a recovery is associated with a Paid Claim under the Plan and adjust applicable Paid Claims. Nevertheless, Sponsor understands and agrees that not all recoveries can be reasonably tied to a particular Paid Claim resulting in its adjustment; for example, when a recovery arises from a general settlement that takes into account Highmark's entire book of business with insufficient information for individual Paid Claim adjustments. In such circumstances, Highmark may retain the recoveries and will make available details of the same on an annual basis upon written request.

Members. Highmark reviews and investigates potentially fraudulent or inappropriate billings submitted by Members. Highmark will not pursue legal remedies such as placing liens for overpayment without first advising the Sponsor. Whenever amounts recovered from these investigations can be associated with a Paid Claim under the Plan and result in a Paid Claim adjustment, Sponsor will receive a credit against future Paid Claims costs in the amount of the recovery, less a percentage fee that may be retained by Highmark. Highmark warrants that it will exercise reasonable efforts to determine whether a recovery is associated with a Paid Claim under the Plan and adjust applicable Paid Claims. Nevertheless, Sponsor understands and agrees that not all recoveries can be reasonably tied to a particular Paid Claim resulting in its adjustment; for example, when a recovery arises from a general settlement that takes into account Highmark's entire book of business with insufficient information for individual Paid Claim adjustments. In such circumstances, Highmark may retain the recoveries and will make available details of the same on an annual basis upon written request.

Highmark will exercise reasonable efforts to recover Paid Claims and its recovery vendor may share in a percentage of any recovery pursuant to the coordination provisions in compensation for rendering this service to Plan and Sponsor.

Except as otherwise provided in this SOW, Highmark has no obligation to pursue a recovery from Providers or manufacturers of health care products or services on behalf of the Plan for causes of action arising out of a product/service defect (including, but not limited to, fitness for use or product recalls), violations of antitrust law, fraud, and claims relating to fraud (including claims under the Racketeering Influenced and Corrupt Organizations Act).

4.25 **Inaccurate Payments.** Whenever Highmark becomes aware that the payment of a claim under the Plan was, or may have been, made that was not in accordance with the terms of the Plan, whether or not such payment was Highmark's fault, and whether or not such payment was more than or less than was appropriate under the terms of the Plan, Highmark shall investigate such payment in accordance with its standard commercial insurance business practices and either 1) for a payment of $50.00 or more, make a diligent effort to recover any payment which was more than was appropriate under the Plan or 2) as the case may be, adjust any claim the payment of which was less than appropriate under the Plan. Sponsor delegates to Highmark the discretion and the authority to determine under what circumstances to compromise a claim or to settle for less than the full amount of the claim. In the event any part of an inaccurate payment is recovered, Sponsor will receive a refund from Highmark. Nothing herein shall require Highmark to institute a legal action or suit to recover payments made by Highmark.

4.26 **Cost Savings Program.** [redacted]

4.27 **Solicitation.** Without express written consent of the State, Highmark will not use the names, home addresses or any other information obtained about the Members from Sponsor to solicit or offer for sale any products or services that are not directly related to the services contracted herein.

4.28 **Communication Allowance.** Highmark agrees to rollover the June 30, 2017, communication allowance balance from the preceding contract.

4.29 **Monthly Value/Usage Reports.** Highmark is required to accurately report the administrative fees paid monthly by the Sponsor. The Statewide Benefits Office (SBO) will file the reports on the Highmark's behalf.

4.30 **2nd Tier Spending Report.** In accordance with Executive Order 44, the State of Delaware is committed to supporting its diverse business industry and population. All contractors are required to accurately report on the participation by Diversity Suppliers. Highmark will provide this information on a quarterly basis and the SBO will submit this report on Highmark's behalf.

4.31 **Discrimination**. Highmark acknowledges that the Sponsor has an obligation to ensure that public funds are not used to subsidize private discrimination. Highmark shall comply with all federal and State of Delaware laws, regulations and policies pertaining to the prevention of discriminatory employment practice. This includes the applicable portion of the Federal Civil Rights act of 1964, the Equal Employment Opportunity Act, and the Americans with Disabilities Act of 1990. The Plan Sponsor reserves the right to terminate the Agreement or consider Highmark in default for failure to comply.

4.32 **Gratuities.**

(a) The Sponsor may, by written notice to Highmark, terminate this Agreement for cause if gratuities (in the form of entertainment, gifts, or otherwise) were offered or given by Highmark or any agent or representative of Highmark to any officer or employee of the Sponsor with a view toward securing a contract or securing favorable treatment with respect to the awarding or amending or making of any determinations with respect to the performance of this Agreement.

(b) In the event this Agreement is terminated as provided in Section 4.32 (a) hereof, the Sponsor shall be entitled to pursue the same remedies against Highmark it could pursue in the event of a breach of this Agreement by Contractor.

(c) The rights and remedies of the Sponsor provided in Section 4.32 (a) shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Agreement.

Section 5 – BlueCard Program

5.1 **BlueCard Out-of-Area Services.** Highmark has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association (Association). Whenever Members access healthcare services outside the geographic area Highmark serves, the Claim for those services may be processed through one of these Inter-Plan Programs and presented to Highmark for payment in accordance with the rules of the Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

Typically, Members, when accessing care outside the geographic area Highmark serves, obtain care from healthcare providers that have a contract (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (Host Blue). In some instances, Members may obtain care from healthcare providers that do not have a contractual agreement (non-participating providers) with the Host Blue. Highmark will remain responsible for fulfilling its contractual obligations to the Sponsor. Highmark payment practices are described below.

This disclosure describes how Claims are administered for Inter-Plan Arrangements and the fees that are charged in connection with Inter-Plan Arrangements. Note that dental care benefits when not paid as medical Claims, and prescription drug benefits or vision care benefits that may be administered by us are not processed through Inter-Plan Arrangements.

5.2 **BlueCard Program**

The BlueCard Program is an Inter-Plan Arrangement. Under this arrangement, when Members access covered healthcare services within a geographic area served by a Host Blue, the Host Blue will remain responsible for contracting and handling all interactions with participating providers. The financial terms of the BlueCard Program are described generally below.

5.3 **BlueCard Liability Calculation Method per Claim – In General**

Unredacted material.

a. Member Liability Calculation

Unless subject to a fixed dollar copayment, the calculation of the Member liability on Claims for covered healthcare services will be based on the lower of the participating provider's billed covered charges or the negotiated price made available to us by the Host Blue.

b. Sponsor's Liability Calculation

[redacted]

5.4 **BlueCard Claims Pricing**

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

5.5 **BlueCard Program Fees and Compensation**

Sponsor understands and agrees to reimburse Highmark for certain fees and compensation which we are obligated under the BlueCard Program to pay to the Host Blues, to the Association and/or to vendors of BlueCard Program-related services. The specific BlueCard Program fees and compensation that are charged to Sponsor are set forth in Appendix 2. BlueCard Program Fees and compensation may be revised from time to time as described in Section 5.13 below.

5.6 **BlueCard Value-Based Programs – Definitions**

[redacted]

[redacted]

5.7 BlueCard Special Cases: Value-Based Programs

[redacted]

[redacted]

5.8 **BlueCard Return of Overpayments**

[redacted]

5.9 **BlueCard Inter-Plan Arrangements: Federal/State Taxes/Surcharges/Fees**

In some instances federal or state laws or regulations may impose a surcharge, tax or other fee that applies to self-funded accounts. If applicable, Highmark will disclose any such surcharge, tax or other fee to Sponsor, which will be Sponsor liability if the provisions of Section 3.2 apply.

5.10 **BlueCard Nonparticipating Providers Outside of Our Service Area**

Unredacted material.

a. Member Liability Calculation

i. In General

When covered healthcare services are provided outside of the Highmark service area by nonparticipating providers, the amount(s) a Member pays for such services will be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, the Member may be responsible for the difference between the amount that the nonparticipating provider bills and the payment Highmark will make for the covered services as set forth in this paragraph. Payments for out-of-network emergency services will be governed by applicable federal and state law.

ii. Exceptions

In some exception cases, Highmark may pay Claims from nonparticipating healthcare providers outside of our service area based on the provider's billed charge. This may occur in situations where a Member did not have reasonable access to a participating provider, as determined by Highmark in our sole and absolute discretion or by applicable state law. In other exception cases, Sponsor's direction Highmark may pay such Claims based on the payment Highmark would make if Highmark were paying a nonparticipating provider inside of our service area, as described elsewhere in this SOW. This may occur where the Host Blue's corresponding payment would be more than our in-service area nonparticipating provider payment. We may choose to negotiate a payment with such a provider on an exception basis.

Unless otherwise stated, in any of these exception situations, the Member may be responsible for the difference between the amount that the nonparticipating healthcare provider bills and the payment Highmark will make for the covered services as set forth in this paragraph.

b. Fees and Compensation

Sponsor understands and agrees to reimburse Highmark for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to the Association and/or to vendors of Inter-Plan Arrangement-related services. The specific fees and compensation that are charged to Sponsor are set forth in Appendix 2. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided for in Section 5.13 below.

Unredacted material.

5.11 **BlueCard Global Core Program**

a. General Information

If Members are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands (hereinafter: "BlueCard service area"), they may be able to take advantage of the BlueCard Global Core Program when accessing covered healthcare services. The BlueCard Global Core Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the BlueCard Global Core Program assists Members with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when Members receive care from providers outside the BlueCard service area, the Members will typically have to pay the providers and submit the Claims themselves to obtain reimbursement for these services.

b. Inpatient Services

In most cases, if Members contact the BlueCard Global Core Service Center for assistance, hospitals will not require Members to pay for covered inpatient services, except for their cost-share amounts/deductibles, coinsurance, etc. In such cases, the hospital will submit Member Claims to the BlueCard Global Core Service Center to initiate Claims processing. However, if the Member paid in full at the time of service, the Member must submit a Claim to obtain reimbursement for covered healthcare services. Members must contact Highmark to obtain precertification for non-emergency inpatient services.

c. Outpatient Services

Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require Members to pay in full at the time of service. Members must submit a Claim to obtain reimbursement for covered healthcare services.

d. Submitting a BlueCard Global Core Claim

When Members pay for covered healthcare services outside the BlueCard service area, they must submit a Claim to obtain reimbursement. For institutional and professional Claims, Members should complete a BlueCard Global Core International Claim form and send the Claim form with the provider's itemized bill(s) to the BlueCard Global Core Service Center address on the form to initiate Claims processing. The Claim form is available from Highmark, the BlueCard Global Core Service Center, or online at www.bcbsglobalcore.com. If Members need assistance with their Claim submissions, they should call the BlueCard Global Core Service Center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177 … 24 hours a day … seven (7) days a week.

5.12 **BlueCard Global Core Program-Related Fees**

Sponsor understands and agrees to reimburse Highmark for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to the Association and/or to vendors of Inter-Plan Arrangement-related services. The specific fees and compensation that are charged to Sponsor under the BlueCard Global Core Program are set forth in Appendix 2. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided for in Section 5.13 below.

5.13 **BlueCard Modifications or Changes to Inter-Plan Arrangement Fees or Compensation**

Modifications or changes to Inter-Plan Arrangement fees are generally made effective Jan. 1 of the calendar year, but they may occur at any time during the year. In the case of any such modifications or changes, Highmark shall provide Sponsor with at least thirty (30) days' advance written notice of any modification or change to such Inter-Plan Arrangement fees or compensation describing the change and the effective date thereof and Sponsor right to terminate this Agreement without penalty by giving written notice of termination before the effective date of the change. If Sponsor fails to respond to the notice and does not terminate this SOW during the notice period, Sponsor will be deemed to have approved the proposed changes, and Highmark will then allow such modifications to become part of this Agreement.

Section 6 – Consortium Health Plans

APPENDIX 1 TO SOW FOR HEALTH PLAN ADMINISTRATIVE SERVICES

GROUP NUMBERS

Classification of Contractholders or Description of Program	Group Number(s)
First State Basic PPO	Refer to Group Number List
Comp PPO	
Port of Wilmington POS	
Special Medicfill	

APPENDIX 2 TO SOW FOR HEALTH PLAN ADMINISTRATIVE SERVICES

PAYMENT FOR PLAN BENEFITS AND ADMINISTRATIVE FEES

A. Payment Procedure:

1. Paid Claims Payment

a. During the second week of this SOW and each week thereafter, the weekly Paid Claims payment will be the cost of all Paid Claims as determined by Highmark.

b. Highmark Delaware will send the weekly Claims Costs Invoice by electronic mail (e-mail) to the Plan Sponsor before 10:00 AM each Wednesday, with payment due by ACH transfer to Highmark Delaware on Friday (that is, within two (2) days). Weekly Claims Costs Invoices sent after the 10:00 AM cutoff will be due for payment by ACH transfer to Highmark Delaware within two (2) days from the next business day. Adjustments to the due dates for payment of the Claims Costs Invoice will be made to accommodate (i) State of Delaware holidays, (ii) instances of material inconvenience to Plan Sponsor as may be agreed upon in advance (for example, fiscal year close-outs), or (iii) such emergencies as may be mutually agreed upon by the Parties, and with written notice dependent upon the situation (potentially including, but not limited to, material technical difficulties).

c. Highmark Delaware will invoice the Plan Sponsor weekly for the Claims Costs for claims processed in the preceding week. In addition, Highmark Delaware will provide a separate Invoice of all Claims Costs by month, based on the date of the claims payment. To comply with this requirement, Highmark Delaware will make available via eBill historical data that spans two (2) calendar months.

d. The payment of an invoice by the Sponsor shall not prejudice the Sponsor's right to object or question any invoice or matter in relation thereto. Such payment by the Sponsor shall neither be construed as acceptance of any part of the work or service provided nor as an approval of any costs invoiced therein. Excepting the terms of SOW, Paragraph 4.25, Inaccurate Payments, Highmark's invoice or payment shall be subject to reduction for amounts included in any invoice or payment theretofore made which are determined by the Sponsor, based on audits, to not constitute allowable costs. Any payment shall be reduced for overpayment, or increased for underpayment, on subsequent invoices.

2. Provider Discount

100% of the Provider Discount amounts generated on the Plan Sponsor's claims will be credited to the Plan Sponsor.

3. Monthly Administrative Fees (per Contractholder per month)

a) Medical Program – per Contractholder per month – effective July 1, 2017 through June 30, 2020

Except for Special Medicfill, the Monthly Retention Charges displayed below include charges for NIA Advanced Radiology Review and Facility Site of Selection (FSS).

		2017	2018	2019
First State Basic, Comprehensive PPO and Blue Select POS Plans	[redacted]	$ 44.90	$ 45.94	$ 47.01
	[redacted]	$ 43.65	$ 44.69	$ 45.76
	[redacted]	$ 42.40	$ 43.44	$ 44.51
	[redacted]	$ 41.15	$ 42.19	$ 43.26

	[redacted]	$ 39.90	$ 40.94	$ 42.01
	[redacted]	$ 34.90	$ 35.94	$ 37.01
Special Medicfill Plan	[redacted]	$22.03	$22.48	$22.95
	[redacted]	$20.78	$21.23	$21.70
	[redacted]	$19.53	$19.98	$20.45
	[redacted]	$18.28	$18.73	$19.20
	[redacted]	$17.03	$17.48	$17.95
	[redacted]	$15.28	$15.73	$16.20

b) Delaware Health Information Network (DHIN)

Sponsor shall participate in the Delaware Health Information Network (DHIN). Effective May 23, 2013, and due to the terms of a separate agreement signed by State of Delaware's Group Health Insurance Program and DHIN, a fee of $0.75 Per Covered Member Per Month (PCMPM) shall be billed to Plan Sponsor as a DHIN Administrative Fee as a separate item on the monthly invoice identified in this Exhibit. The PCMPM charge is subject to change as determined by the DHIN.

c) Miscellaneous Administrative Charges:

i. External Review Fee (IRO) - $1,000 per Claim

ii. Claims Reprocessing Fee – $25.00 per Paid Claim

iii. Coordination of Benefits/Subrogation/Cost Savings and Recovery Fees – 30% of Recovery/Savings. Highmark will provide a detailed report of claim recoveries and related fees to Sponsor on a quarterly basis.

iv. Programming

Highmark Delaware will provide [redacted] programmer time during the Contract Term as needed to support the report requirements described in Master Report List, an attachment to Appendix 3, Performance Measures, or such other requests as needed and mutually agreed upon by the parties. Programming required by the Plan Sponsor in excess of this limit will be charge to the Plan Sponsor, subject to the Plan Sponsor's approval of the scope of work, at a rate of $250 per hour.

d) Medical Rebates

[redacted]

e) Highmark Committments

[redacted] 2017 to cover a pre[redacted]

[redacted]

f) Invoices and Other Information

i. Invoices will be considered received on the day Highmark Delaware transmits, via electronic mail, a copy of the invoice to the Plan Sponsor.

ii. Interest Charge is Prime Rate not to exceed amount specified in 29 Del Code, Sec 6516 (d) 4, currently 12% per annum.

iii. Highmark will notify Sponsor of the amount due for Administrative Fees. Sponsor shall wire transfer the payment of immediately available funds by close of business on the first business day following receipt by Sponsor of Highmark's invoice for such fees. This SOW will terminate if Sponsor fails to make timely payments.

iv. Amounts which are or shall become due and payable to the Sponsor by Highmark may be deducted by the Sponsor from administrative fees, but not from claims or premiums.

v. Monthly Administrative Fees and Administrative Fees for the post-termination services described below may change upon written notice at least ninety (90) days prior to renewal of this SOW. If a new "Appendix 2 – Payment for Plan Benefits and Administrative Fees" is not issued, such changes, if any, will be set forth in the annual renewal letter sent to Sponsor by Highmark and will supersede any previous conflicting provision. All other provisions of "Appendix 2 – Payment for Plan Benefits and Administrative Fees" will continue to apply unless otherwise amended.

vi. Additional information regarding specific fees and recovery percentages described in this SOW will be made available upon request. At the close of each Contract Year, Sponsor may request in writing a report of all amounts retained by Highmark in compensation for services rendered hereunder.

vii. Administrative fees do not include any commission percentages, brokerage or contingent fees.

g) Renewal Delivery Date..... December 31st

h) Settlement

i. Annual

Annually, and on or before a date mutally agreeable to the Parties, Highmark Delaware will deliver to the Plan Sponsor a Settlement of the Claims Costs, Retention Charges, Interest Charges and any other financial information or charges due to/from the Plan Sponsor for the Contract Term. Any amount due to Highmark Delaware or to the Plan Sponsor will be invoiced or remitted at the time of the next monthly invoice, and is payable on the invoice due date. Highmark Delaware reserves the right to impose and Plan Sponsor agrees to pay, an interest charge for late payment of the settlement balance due, at the rate specified above.

ii. Post Agreement Termination

After termination of this Agreement, the Preliminary Settlement is due within 180 days of the Contract termination date and the Final Settlement is due within 30 months of the Contract termination date.

B. Upon Termination of SOW – Administrative Fees and Paid Claims Costs:

Upon termination of this SOW, at Sponsor's request and with Highmark's consent, Highmark will continue to process and pay Claims incurred prior to termination but received after termination for a period of twelve (12) months. Sponsor shall be responsible for the Paid Claims costs paid during the twelve (12) month period in the same manner as required during the term of this SOW.

The parties agree that such Paid Claims shall not be payable nor shall such services be provided by Highmark unless Sponsor provides weekly wire funding for the Claims.

C. Upon Termination of SOW - Settlement:

After termination of this Agreement, a preliminary settlement is due within 180 days of the the termination date, and the final settlement is due within 30 months of the termination date.

If post-termination services are provided by Highmark, and unless otherwise provided in this Appendix, final settlement will occur following the completion of such services. After final settlement, Sponsor shall have no further obligation to pay Claims or Administrative Fees and Highmark shall have no further obligation to forward any Claim-related amount it may receive to the Sponsor.

D. BlueCard® Fees

The BlueCard Program Access Fee and the BlueCard Program Administrative Expense Allowance (AEA) fee may be charged separately each time a claim is processed through the BlueCard Program. All other BlueCard Program-related fees are included in the Administrative Charges.

The Access Fee is charged by the Host Blue to Highmark for making the applicable Host Blue's provider network available to Sponsor's Member's. The Access Fee will not apply if the provider does not participate in the applicable Host Blue's network. The Access Fee is charged on a per-claim basis and is charged as a percentage of the discount/differential Highmark receives from the applicable Host Blue subject to a maximum of $2,000 per claim. When charged, Highmark passes the Access Fee directly on to Sponsor.

Instances may occur in which the claim payment is zero or Highmark pays only a small amount because the amounts eligible for payment were applied to patient cost sharing (such as a deductible or coinsurance). In these instances, Highmark will pay the Host Blue's Access Fee and pass it along directly to Sponsor as stated above even though Highmark paid little or had no claim liability.

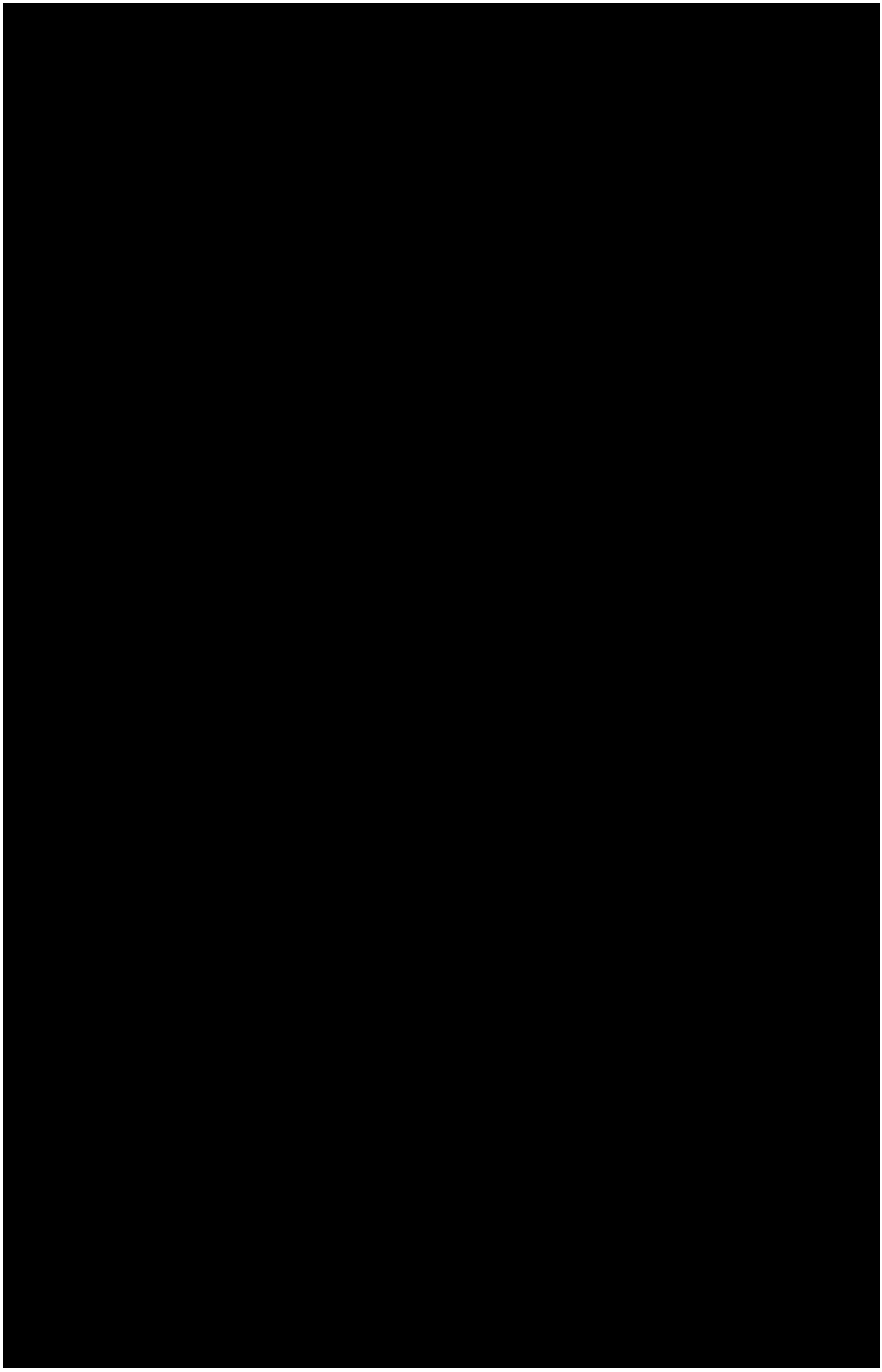
The AEA Fee is a fixed per-claim dollar amount charged by the Host Blue to Highmark for administrative services that the Host Blue provides in processing claims for Sponsor's Members. The dollar amount is normally based on the type of claim (e.g. institutional, professional, international, etc.) and can also be based on the size of your group enrollment. When charged, Highmark passes the AEA Fee directly on to Sponsor.

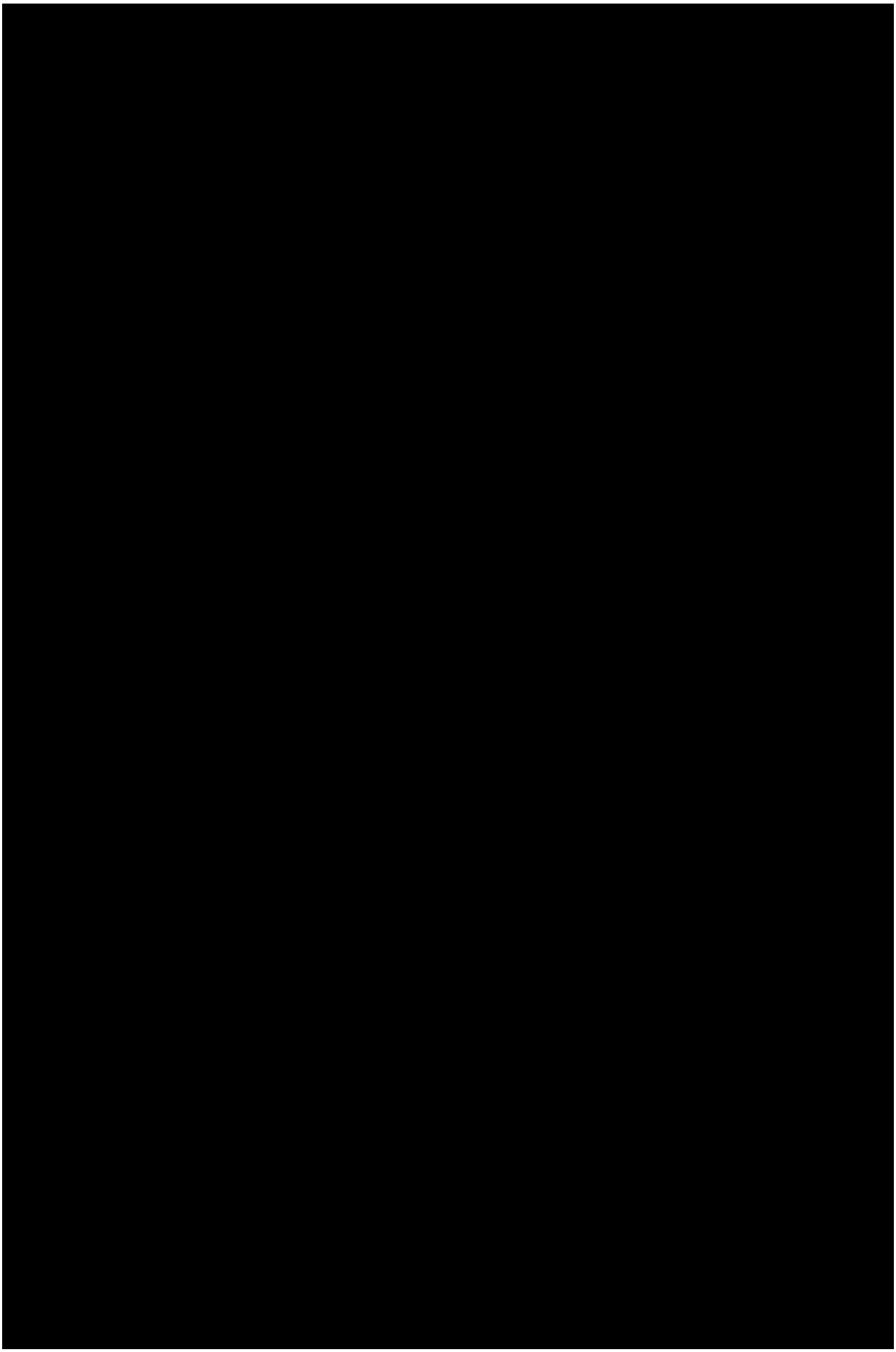
See the Fee Listing section of this Exhibit for the BlueCard Program Access Fee and AEA Fee and for Highmark Administrative Fees. The Administrative Fees includes all other fees relative to the BlueCard Program. These fees include the Central Financial Agency Fee, ITS Transaction Fee, Toll-Free Number Fee, PPO Provider Directory Fee and BlueCard Global Core Program Fees, if applicable.

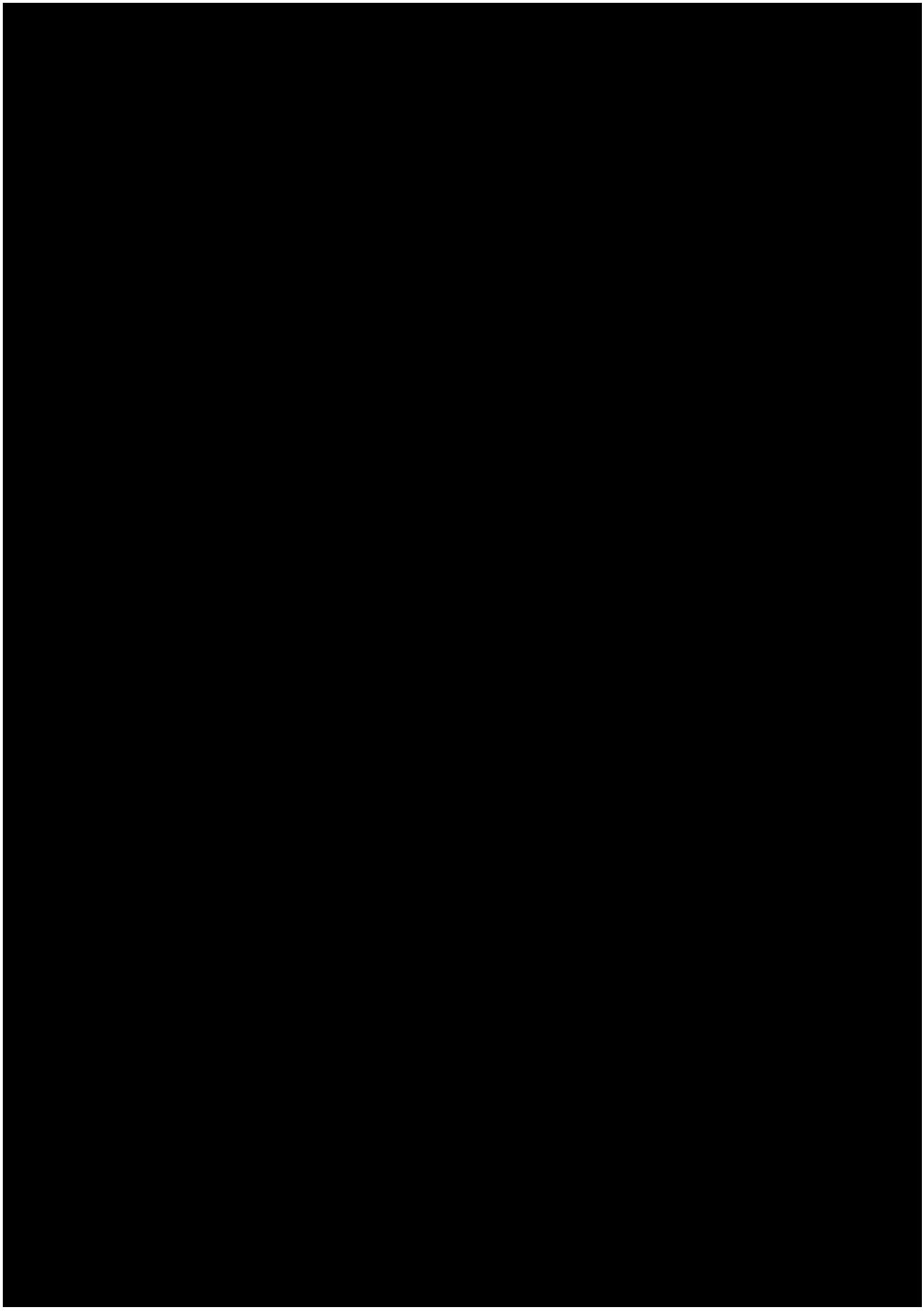
Administrative Fees encompass fees Highmark charge to Sponsor for administering Sponsor's benefit plan. They may include both local within our service area and Inter-Plan fees. For purposes of this Agreement, they include the following BlueCard Program-related fees other than the BlueCard Program Access Fee and AEA Fee: namely, Central Financial Agency Fee, ITS Transaction Fee, Toll-Free Number Fee, PPO Provider Directory Fee and BlueCard Global Core Program Fees, if applicable.

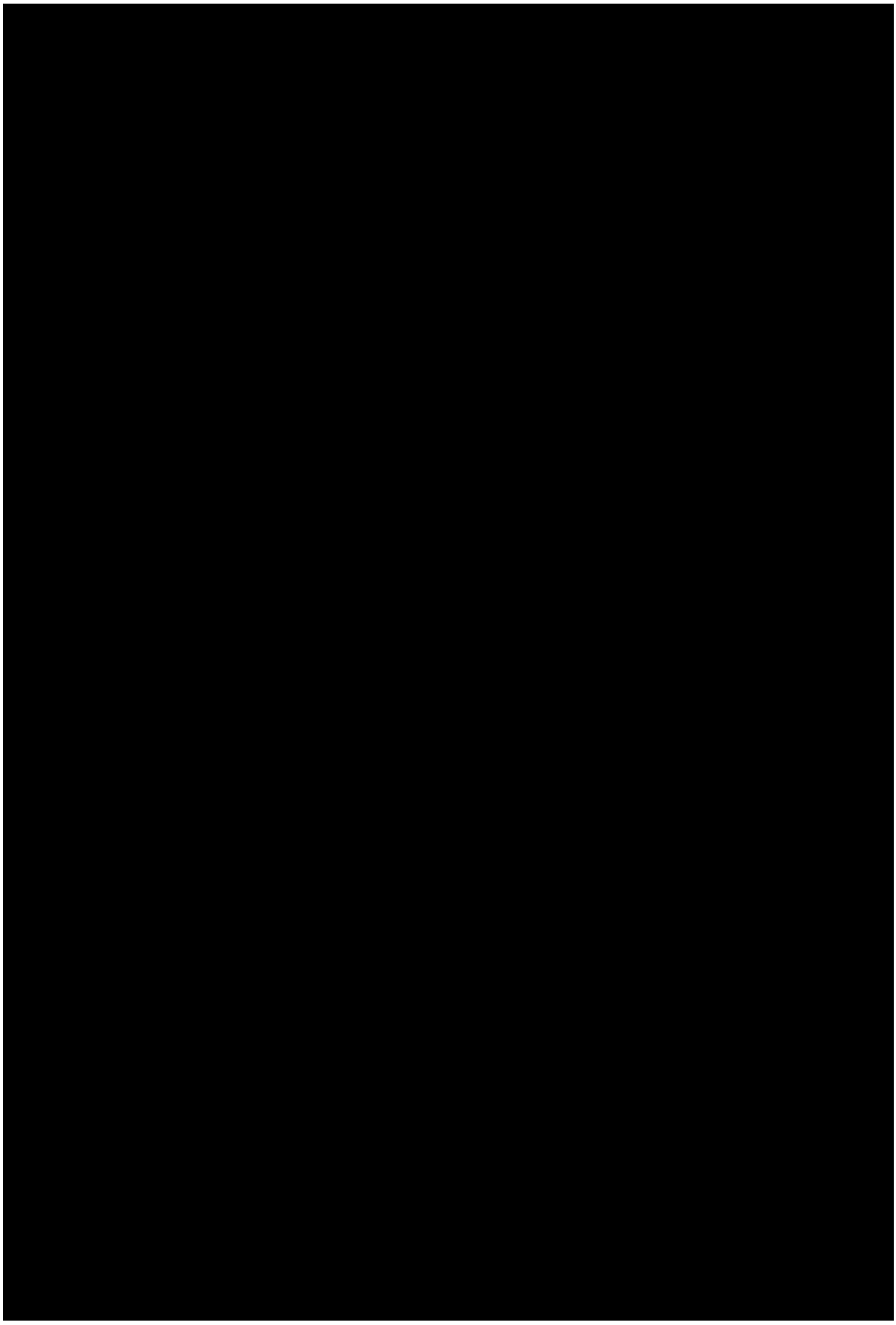
Inter-Plan Arrangements Fees:	
BlueCard Program Fees	
Access Fees:	2.33% in 2017 for 10,000–49,999 Blue PPO enrolled contracts of network savings, capped at $2,000.00 per claim.
Administrative Expense Allowances (AEAs):	$4.00 per claim professional and $9.75 per institutional claim (for 1,000 to 49,999)

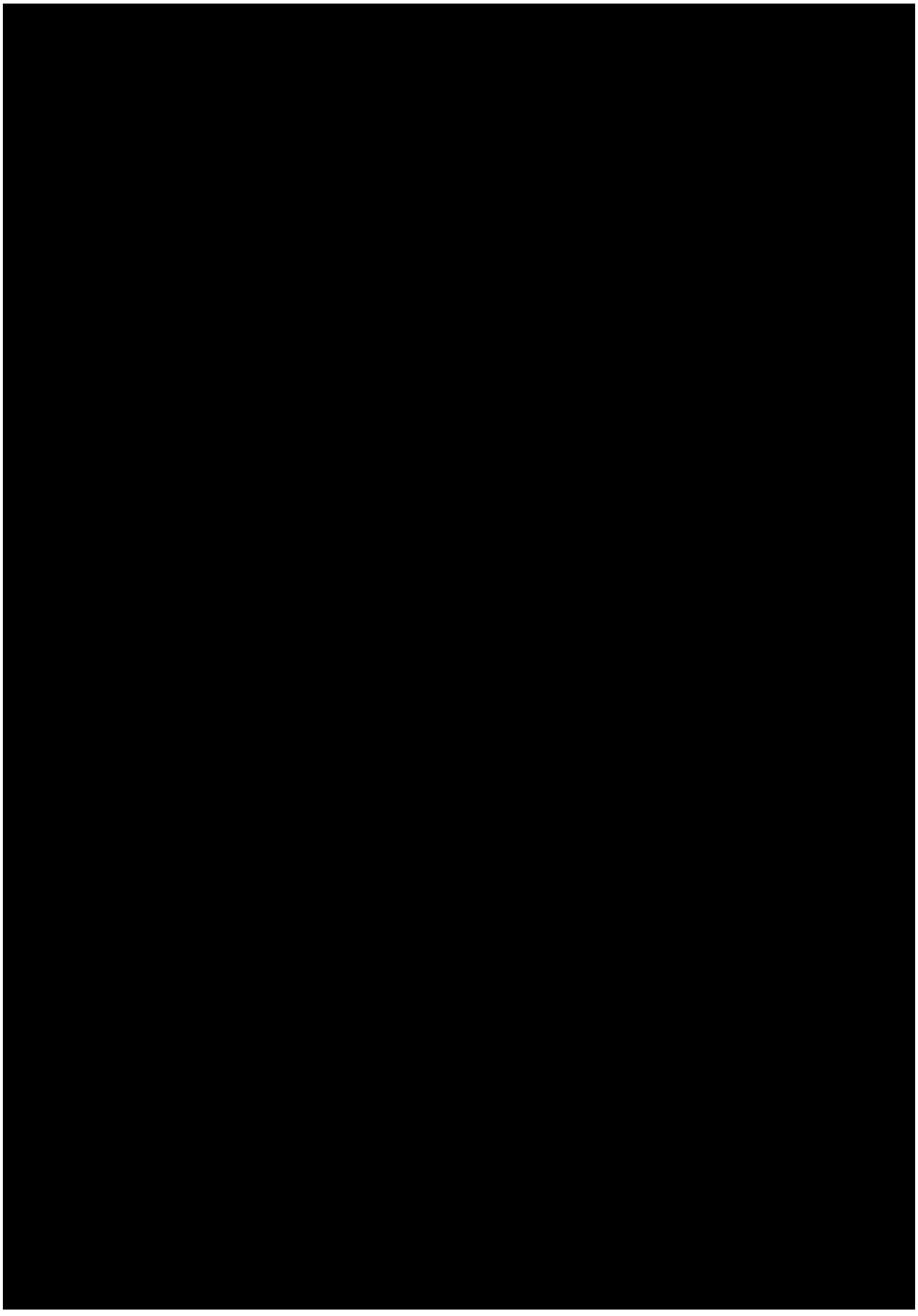
[redacted]

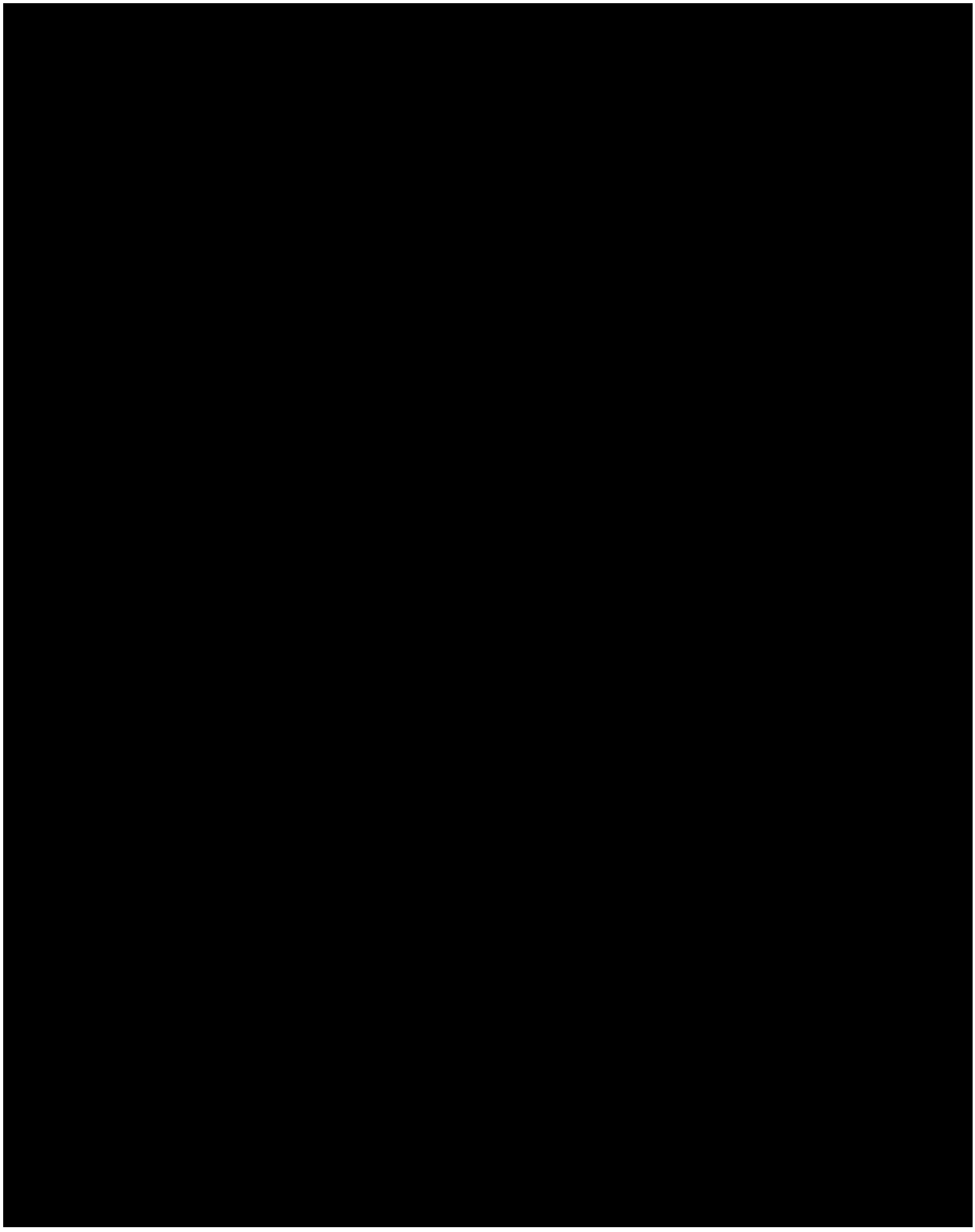












APPENDIX 4 TO SOW FOR HEALTH PLAN ADMINISTRATION

TECHNOLOGY AND SECURITY REQUIREMENTS

1. Sponsor File Layouts and Exchanges: Highmark will accept and load enrollment data in HIPAA 834 file layouts and send and receive enrollment and claims data using layouts specified by the Sponsor, subject to mutual agreement as to content of and payment for such services, Highmark will modify any existing or proposed file layouts as requested by the Sponsor to accommodate value based payment models and various engagement and consumerism tools that may be implemented.

2. Third Party Agreements: Highmark will maintain global third party agreements in place with Express Scripts, Inc., and Truven Health Analytics.

3. Indemnification: Highmark shall indemnify and hold harmless the Sponsor, its agents and employees, from any and all liability, suits, actions or claims, including any claims or expenses with respect to the resolution of any data security breaches/ or incidents, together with all reasonable costs and expenses (including attorneys' fees) directly arising out of (a) the negligence or other wrongful conduct of Highmark, its agents or employees, or (b) Highmark's breach of any material provision of this Agreement not cured after due notice and opportunity to cure, provided as to (a) or (b) that (i) Highmark shall have been notified in writing by the Sponsor of any notice of such claim; and (ii) Highmark shall have the sole control of the defense of any action on such claim and all negotiations for its settlement or compromise and provided further that this section shall not apply to claims related to a determination made by the Sponsor or with the Sponsor's explicit consent, provided that when obtaining the Sponsor's explicit consent Highmark shall disclose in writing the negligence or other wrongful conduct or breach of any material provision of this Agreement.

   Sponsor shall not indemnify Highmark under this Agreement or any related contract. Highmark shall not request the Sponsor to indemnify or provide quasi-indemnification under any contract. An example of an unacceptable quasi-indemnification provision is:

   > The State asserting it is without legal authority to agree to such indemnification, acknowledge that Vendor, on behalf of itself and any affiliate, reserves such rights as it may have to obtain reasonable compensation from the State, against any loss, damage, costs of suit or other expenses resulting from the improper use or disclosure of data or any breach of this Agreement by State.

4. State of Delaware Enterprise Standards and Policies: Highmark has standards and policies in place that are applicable to their product and that comply with the terms and standards on the date the *Request for Proposal* was issued, August 15, 2016, as posted at on: http://dti.delaware.gov/information/standards-policies.shtml.

   a) Strong Password Standard: Highmark shall maintain a password of at least ten (10) characters. The ten (10) character password requirement is applicable only for external access to the vendor's secure website by members and the Statewide Benefits Office personnel. It is not a requirement for the vendor's internal data access systems.

   b) Secure Email and Mobile Encryption: Highmark shall use a secure encryption system for confidential data via email and accessible on mobile devices that complies with the Plan Sponsor's policies (the website is reference above).

5. Single-Sign-On (SSO) Protocol: At no cost to the Plan Sponsor, Highmark will maintain SSO capabilities with the Plan Sponsor as set forth in Web Services Single Sign On Agreement, effective March 10, 2016, and incorporated herein by reference.

6. Critical Security Controls: Highmark represents that it has in place programs designed to meet or exceed the requirements of applicable state, provincial, and federal data security laws. Highmark shall use commercially reasonable efforts to assure that their data security systems are free of the vulnerabilities listed in the SANS Institute at:

https://www.sans.org/critical-security-controls/. Highmark will provide a copy of SOC audit reports upon request.

7. Additional Data Requests: If Highmark requests additional data, whether or not on a file feed or in a report, the Plan Sponsor shall determine the cost of supplying the data and may deny the request.

8. Data Ownership: The Plan Sponsor shall own all right, title and interest in the Plan Sponsor-specific data that is related to the services provided by this contract and subject to Highmark's interests in its confidential and proprietary data. Highmark shall not access State of Delaware user accounts or State of Delaware data except (i) in the course of data center operations, (ii) in response to service or technical issues, (iii) as permitted or required by the express terms of this contract, including, but not limited to, the Business Associate Agreement or (iv) at the Plan Sponsor's written request.

9. Data Protection: Protection of personal privacy and sensitive data shall be an integral part of the business activities of Highmark to ensure that there is no inappropriate or unauthorized use of Plan Sponsor's information at any time. To this end, Highmark shall safeguard the confidentiality, integrity, and availability of the Plan Sponsor's information. At no time shall any data or processes which either belong to or are expressly intended for the sole use of State of Delaware or its officers, agents, or employees, be copied, disclosed, or retained by Highmark or any party related to Highmark for subsequent use in any transaction that does not include the State of Delaware.

10. Data Location: Highmark shall not store or transfer non-public State of Delaware data outside of the United States. This includes backup data and Disaster Recovery locations. Highmark will permit its personnel and contractors to access State of Delaware data remotely only as required to provide technical support.

11. Encryption:

    a) Data in Transit: Highmark shall encrypt all non-public data in transit regardless of the transit mechanism.

    b) Encryption at Rest: Highmark agrees to encrypt Plan Sponsor's data at rest. Highmark's encryption shall be consistent with validated cryptography standards as specified in National Institute of Standards and Technology FIPS140-2, Security Requirements. Additionally, Highmark shall maintain cyber security liability insurance coverage in the amount of $50,000,000 for any loss resulting from a data breach.

12. Breach Notification and Recovery: Delaware Code, 6 Del. C. § 12B-102, requires public breach notification when citizens' personally identifiable information is lost or stolen. Additionally, unauthorized access or disclosure of non-public data is considered to be a breach. Highmark will provide notification without unreasonable delay and all communication shall be coordinated with the Plan Sponsor. When Highmark or their sub-contractors are liable for the loss, Highmark shall bear all costs associated with the investigation, response and recovery from the breach including but not limited to credit monitoring services with a term of at least three (3) years, mailing costs, website, and toll free telephone call center services.

13. Notification of Legal Requests: Highmark shall contact the Plan Sponsor and shall not respond to subpoenas, service of process, litigation holds, requests for discovery or expert testimony, or other legal requests which are related to the Plan Sponsor without first notifying the Plan Sponsor, unless prohibited by law from providing such notice. For the purposes of this section, legal requests shall not be considered as related to the Plan Sponsor when they involve matters that are primarily personal to the individual (e.g., domestic matters or auto accidents) and do not involve Highmark or the State as a party.

14. Termination and Suspension of Service:

    a) Suspension of Services: During any period of suspension or contract negotiation or disputes, Highmark shall not take any action to intentionally erase any State of Delaware data. Highmark

shall implement an orderly return of the Plan Sponsor's data in CSV or XML or other mutually agreeable format.

b) Termination of any Services or Agreement in Entirety: In the event of termination of any services or agreement in entirety, Highmark shall not take any action to intentionally erase any State of Delaware data and will continue to secure and back up the State of Delaware's data. Highmark will retain the data for business processing reasons, such as claims run-out for twelve (12) months, or, to the extent applicable, the Delaware Insurance Code requirement of five (5) years) and until federal regulatory requirements such as the Center for Medicare Services pursuant to 42 CFR 423.505 of the current year plus ten (10) years have been satisfied. After such period, Highmark shall have no obligation to maintain or provide any State of Delaware data and shall thereafter, unless legally prohibited, dispose of all State of Delaware data in its systems or otherwise in its possession or under its control as specified in Paragraph 14(d) below.

c) Post-Termination Assistance: The Plan Sponsor shall be entitled to any post-termination assistance generally made available unless a unique data retrieval arrangement has been established as part of this contract.

d) Secure Data Disposal: After all operational and regulatory retention requirements have been satisfied, Highmark shall destroy all requested data in all of its forms, for example: disk, CD/DVD, backup tape, and paper. Data shall be permanently deleted and shall not be recoverable according to the National Institute of Standards and Technology's standards.

15. Background Checks: Highmark shall conduct criminal background checks and not utilize any staff, including sub-contractors, to fulfill the obligations of the contract who have been convicted of any crime of dishonesty, including, but not limited to criminal fraud, or otherwise convicted of any felony or any misdemeanor offense for which incarceration for a minimum of one (1) year is an authorized penalty. Highmark shall promote and maintain an awareness of the importance of securing the State of Delaware's information among Highmark's employees and agents.

16. Data Dictionary: For only Delaware data and only upon request, Highmark shall provide a data dictionary in accordance with the State of Delaware Data Modeling Standard.

17. Security Logs and Reports: Highmark shall allow the State access to system security logs that affect this engagement, its data and or processes. This includes the ability for the State to request a report of the records that a specific user accessed over a specified period of time.

18. Contract Audit: Refer to the Audit Exhibit for terms.

19. Sub-Contractor Disclosure: Highmark shall identify all of its strategic business partners related to services provided under this contract, including but not limited to, all subcontractors or other entities or individuals who may be a party to a joint venture or similar agreement with Highmark who will be involved in any operations with access to the State of Delaware data. Examples include, but are not necessarily limited to, mailing and printing services (due to access to non-public information of members' names and addresses) and independent data storage companies or facilities.

20. Operational Metrics: If requested, Highmark agrees to cooperate with the Plan Sponsor to reach an agreement on operational metrics that the Plan Sponsor requires. Examples include, but are not necessarily limited to, advance notice for major upgrades and system changes, system availability/uptime guarantee/agreed-upon maintenance downtime, recovery time objective/recovery point objective, and security vulnerability scanning. (System availability, uptime guarantee, and/or agreed-upon maintenance downtime may be included in the Performance Measures.)

APPENDIX 5 TO SOW FOR HEALTH PLAN ADMINISTRATION

APPEALS PROCESS

A. INITIAL SERVICE

Employee receives service and a claim is filed by the employee (or by provider on employee's behalf) with Highmark Delaware.

IF DENIED and employee has potential liability to provider,

LEVEL I APPEAL – ADMINISTERED BY HIGHMARK DELAWARE

1. Employee may file an appeal with Highmark Delaware within 180 days from receipt of the notice of denial to request a review of the initial claim decision,

2. Highmark Delaware will review the appeal and provide a written decision to the employee

   a) Within 15 days for Pre-Service requests

   b) Within 30 days for Post-Service requests

3. Expedited appeals may be requested for a denial relating to urgent care; Highmark Delaware will notify the employee and provider within 72 hours. In the event that the denial of an expedited appeal is upheld, or if the care requested is now considered urgent, the employee would skip the Level II Appeal and move directly to a Level III Appeal.

B. IF DENIAL IS UPHELD,

LEVEL II APPEAL – ADMINISTERED BY HIGHMARK DELAWARE

1. Employee must file a Level II appeal within 60 days from receipt of the Level I appeal decision. Note: If denial is related to urgent care, employee would skip the Level II appeal and move directly to a Level III Appeal.

2. Highmark Delaware will review the appeal and provide a written decision to the employee

   a) Within 15 days for Pre-Service requests

   b) Within 30 days for Post-Service requests

C. IF DENIAL IS UPHELD,

LEVEL III APPEAL – ADMINISTERED BY THE STATE OF DELAWARE STATEWIDE BENEFITS OFFICE (SBO) AND/OR HIGHMARK DELAWARE

For medical judgment or necessity, including care that is cosmetic or experimental, the employee may choose to file a Level III voluntary appeal to the SBO and/or an appeal administered by Highmark.

VOLUNTARY APPEAL TO THE STATEWIDE BENEFITS OFFICE

1. Employee may file an appeal of the denial in writing to SBO within 20 days of the postmark date of the notice of denial of the Level II appeal (or within 20 days of the postmark date of the notice of denial of an expedited Level I appeal). The appeal must contain employee contact information (mailing address, telephone number, etc.), a written summary of events, applicable Explanations of Benefits (EOBs), a copy of the employee's Identification Card or the plan name and employee's identification number (as on Identification Card), any additional documentation employee desires to provide to support his/her position. Additionally, employee must sign and submit with the appeal, the State of Delaware's Authorization for Release of Protected Health Information Form to provide authorization to the Statewide Benefits Office to obtain applicable information from Highmark Delaware and the SBO's Health Plan Appeal Form and Checklist, both of which are available at:
   www.ben.omb.delaware.gov/medical/bcbs.

2. Employees submitting an appeal without a signed Authorization Form and/or completed Health Plan Appeal Form and Checklist will be requested, in writing, to submit the forms. Statewide Benefits Office will not begin to review the appeal until the Authorization Form and the Appeal Form and Checklist are received. The Appeals Administrator from the Statewide Benefits Office (or his/her designee) will conduct an internal review of the appeal and provide a written notice of the decision to the employee and Highmark Delaware with 30 days of receiving the appeal. The request for appeal should be sent to:

   Appeals Administrator
   RE: APPEAL
   Statewide Benefits Office
   97 Commerce Way, Suite 201
   Dover, DE 19904

INDEPENDENT EXTERNAL REVIEW FACILITATED BY HIGHMARK DELAWARE

1. Employee may file a Level III appeal for an external review for decisions involving medical judgment or necessity, including care considered to be cosmetic or experimental care, to Highmark DE in writing within 4 months from the receipt of Highmark Delaware appeal notice. Please include the Highmark DE appeal decision letter and all relevant information. Highmark DE will initiate an independent review through an Independent Review Organization (IRO). The IRO will provide a written decision within 45 days of assignment to the IRO. If the treating physician certifies that a delay in receiving the services would jeopardize the health of the employee, the IRO will provide the employee with a written decision within 72 hours.

2. For a non-medical denial, which is defined as an administrative decision regarding fee schedules, contractual exclusions and benefit determination that do not require a medical staff review the employee may file an appeal, to:

   Appeals Administrator
   RE: APPEAL
   Statewide Benefits Office
   97 Commerce Way, Suite 201
   Dover, DE 19904

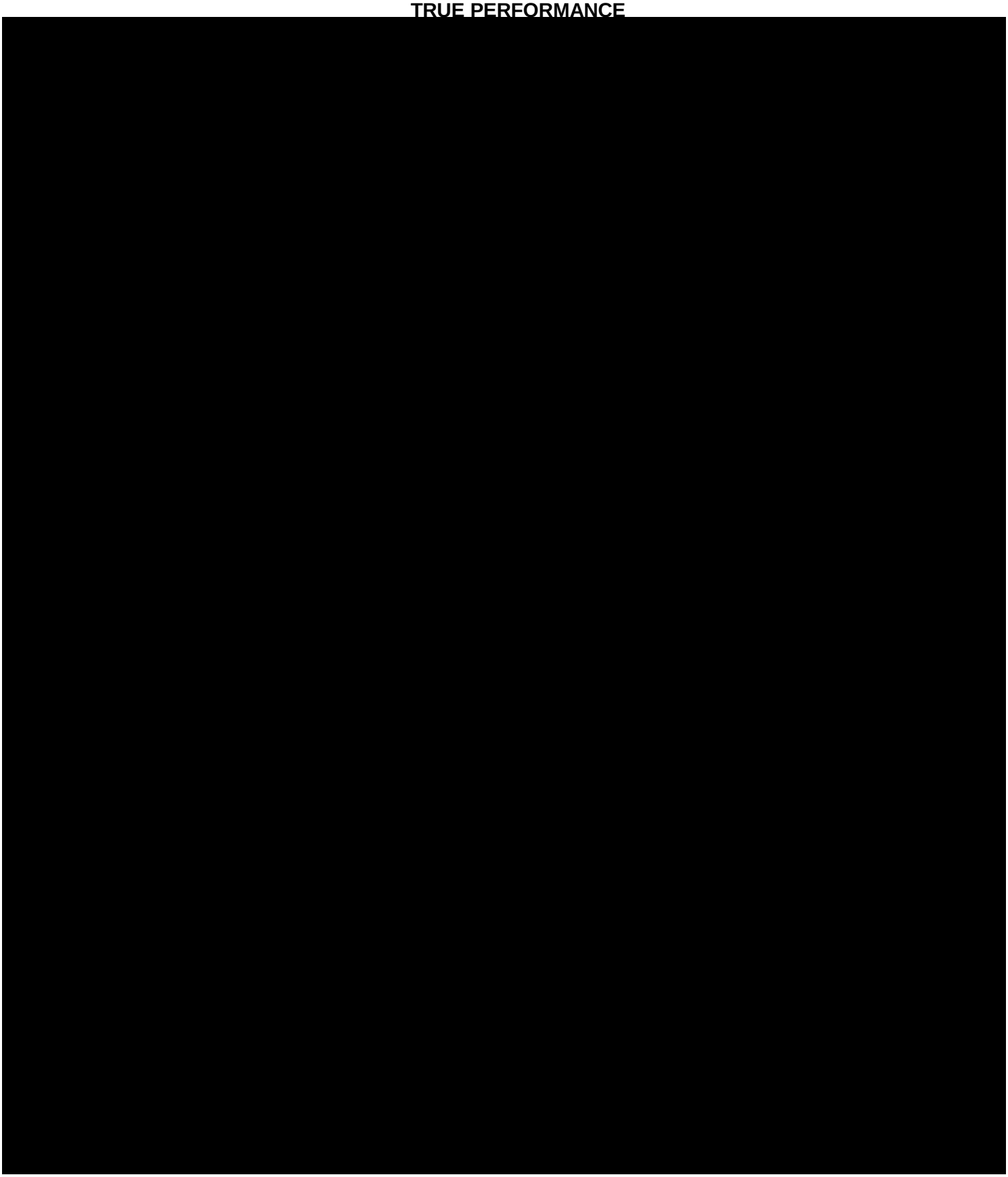
   a. Appeal must contain how the employee may be contacted (mailing address, telephone number, etc.) a written summary of events, applicable Explanation of Benefits (EOBs), a copy of the employee's Identification Card or the plan name and employee's identification number (as on Identification Card) and any additional documentation employee desires to provide to support his/her position. Additionally, employee must sign and submit with appeal the State of Delaware's Authorization for Release of Protected Health Information to provide authorization to the Statewide Benefits Office to obtain applicable information from Highmark Delaware. This form is available at
      www.ben.omb.delaware.gov/medical/bcbs. Employees submitting an appeal without signed form will be requested, in writing, to submit form. Statewide Benefits Office will not begin to

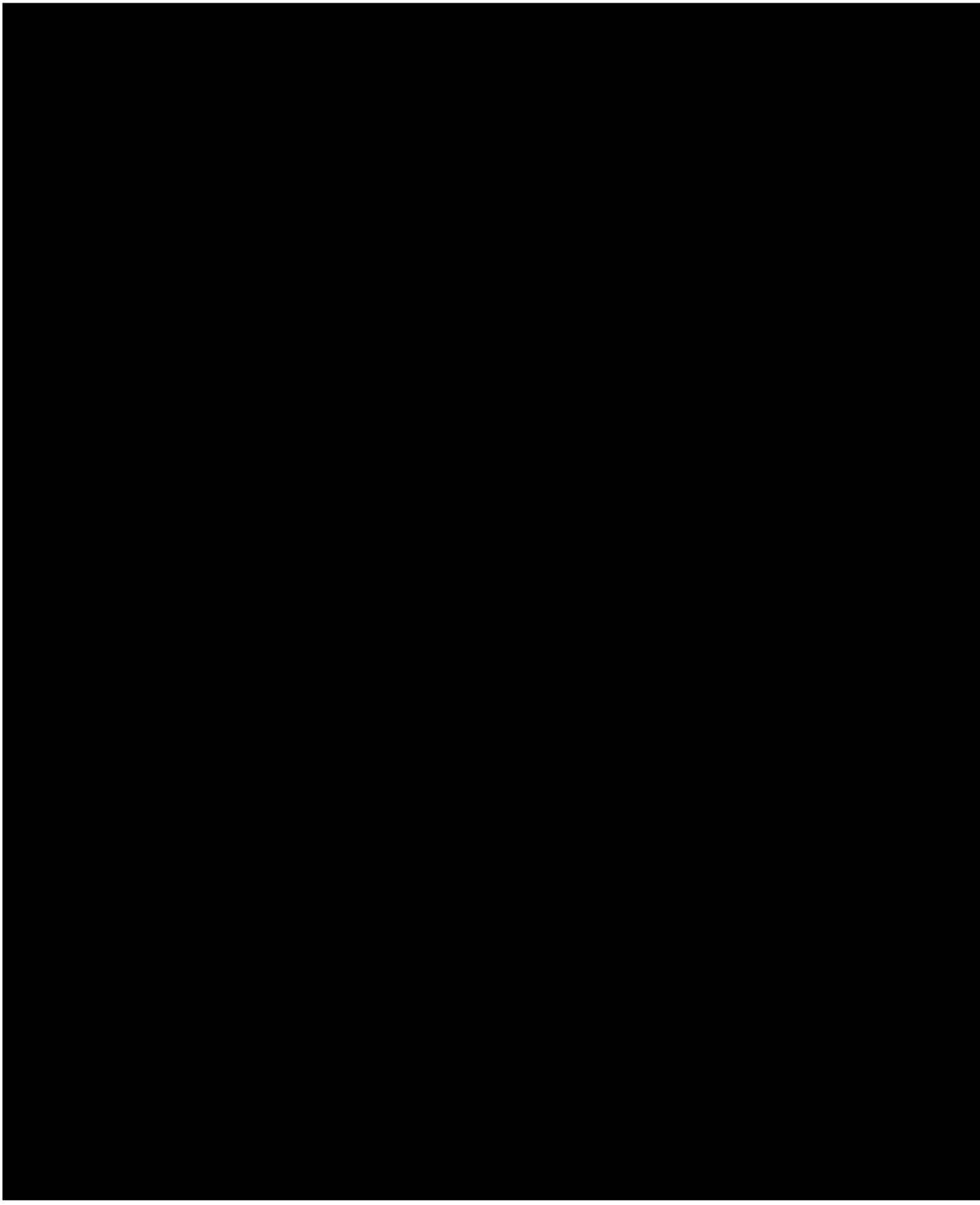
review the appeal until State of Delaware's Authorization for Release of Protected Health Information form is received.

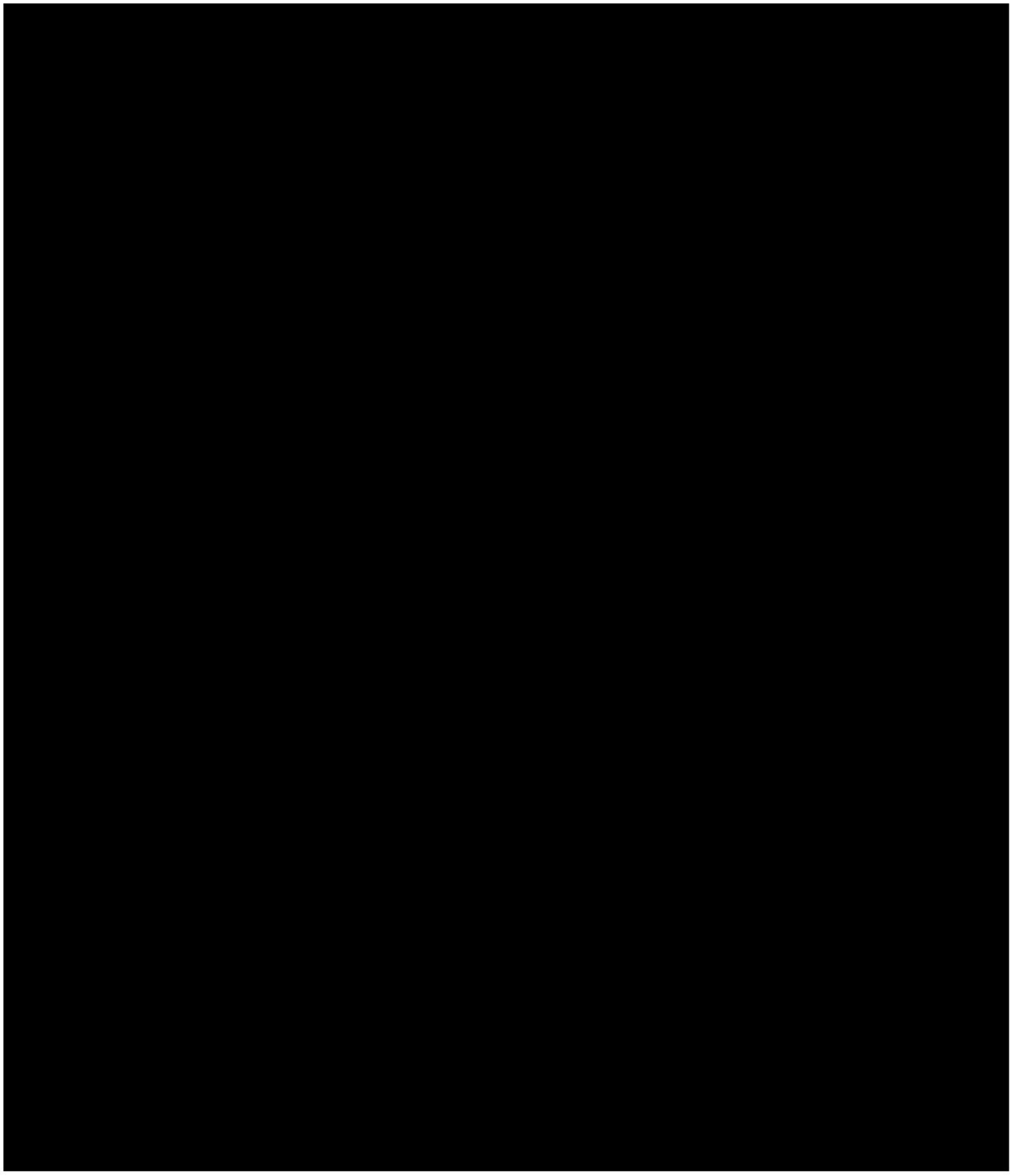
b. The Appeals Administrator from the Statewide Benefits Office (or his/her designee) will conduct an internal review of the appeal and provide a written notice of the decision to the employee and Highmark Delaware within 30 days of receiving the appeal.

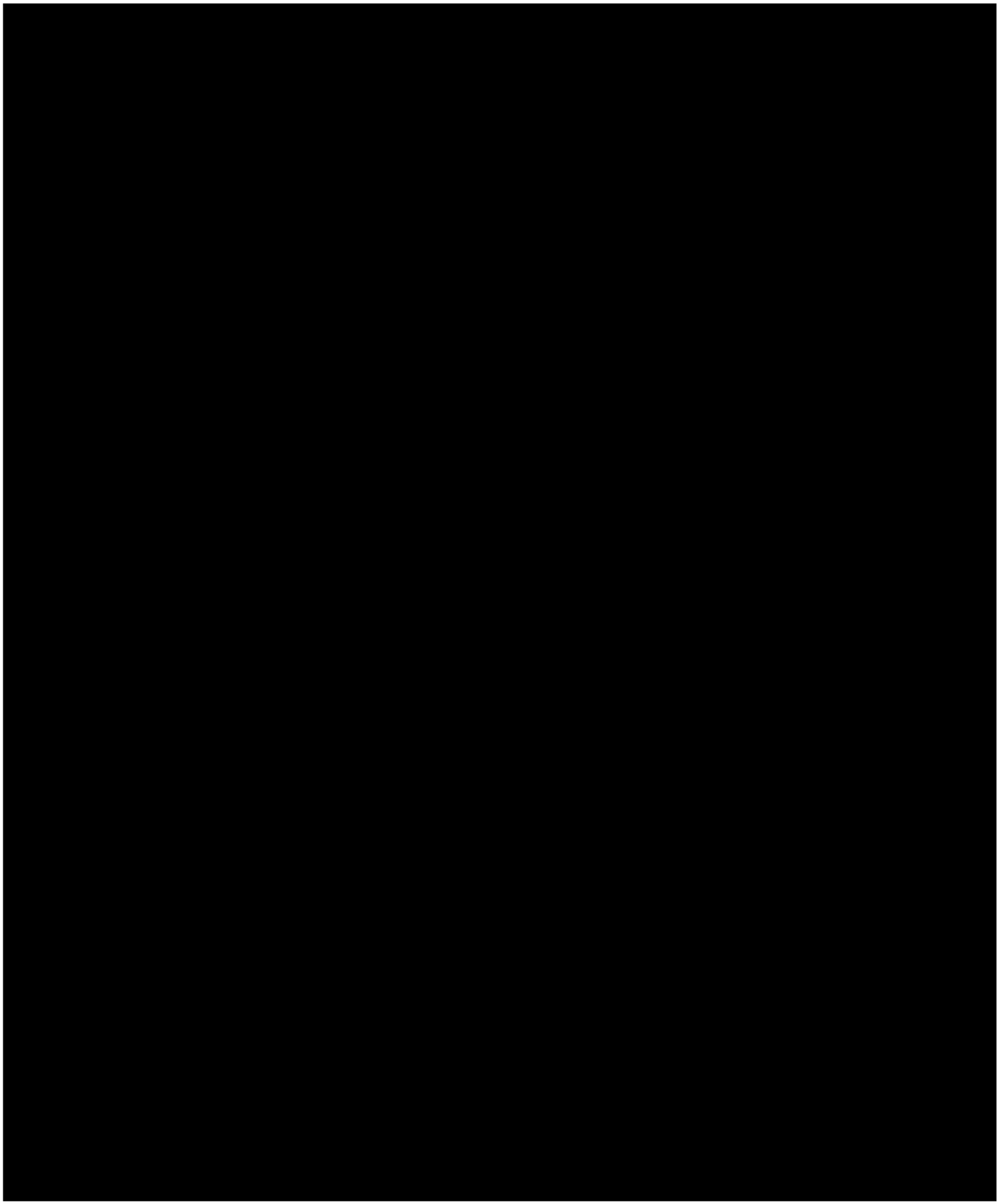
APPENDIX 6 TO SOW FOR HEALTH PLAN ADMINISTRATIVE SERVICES

TRUE PERFORMANCE









Unredacted material.

STATEMENT OF WORK

CUSTOM CARE MANAGEMENT UNITS (CCMU SOW)

Sponsor desires to retain Highmark for the "Custom Care Management Unit" (CCMU) services described in this SOW for the Administrative Fees set forth herein, subject to the performance measures and trend guarantees set forth in Appendices 1 and 2, respectively.

Section 1 - Term

The initial term of this SOW shall be the period commencing on July 1, 2017 and ending on June 30, 2020. Thereafter, this SOW shall renew for successive twelve (12) month periods upon the mutual written consent of the parties.

Section 2 – Fees

- **$7.50** PCPM for Actives and non-Medicare eligible Retirees (excludes Medicfill and COBRA)
- **$1.67** PCPM for Willis Towers Watson oversight

Services 3 - Services

Highmark, through its relationship with Willis Towers Watson (WTW), shall provide the following services:

a. Dedicated Nurse Advocates. Provide Members with access to dedicated nurses to:

- Coordinate care;
- Assist in ensuring that gaps in care are closed in accordance with evidence-based guidelines are considered in care planning;
- Actively share referrals and data with other vendors and health plans to the extent permitted by HIPAA and subject to applicable non-disclosure agreements; and
- Establish a point of accountability for on-going performance management and improvement.

b. Targeted Risk Identification and Stratification. Identify high-risk individuals for the purpose of:

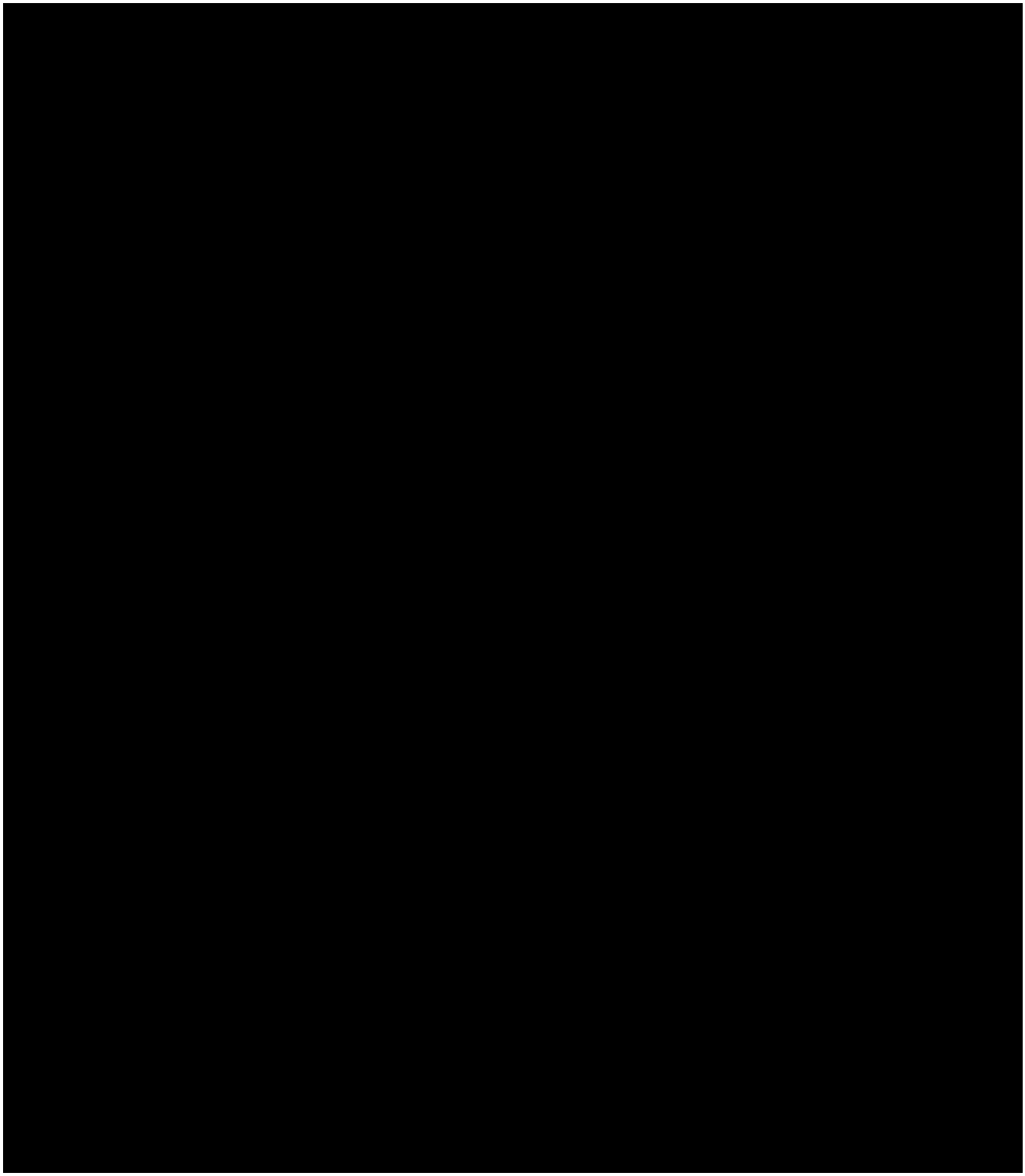
- Refining predictive modeling (e.g., lower high-risk claimant cost thresholds, adjusted risk scores);
- Making pre-admission calls on all elective admissions (except maternity and behavioral health); and
- Calling Members on a post-discharge basis.

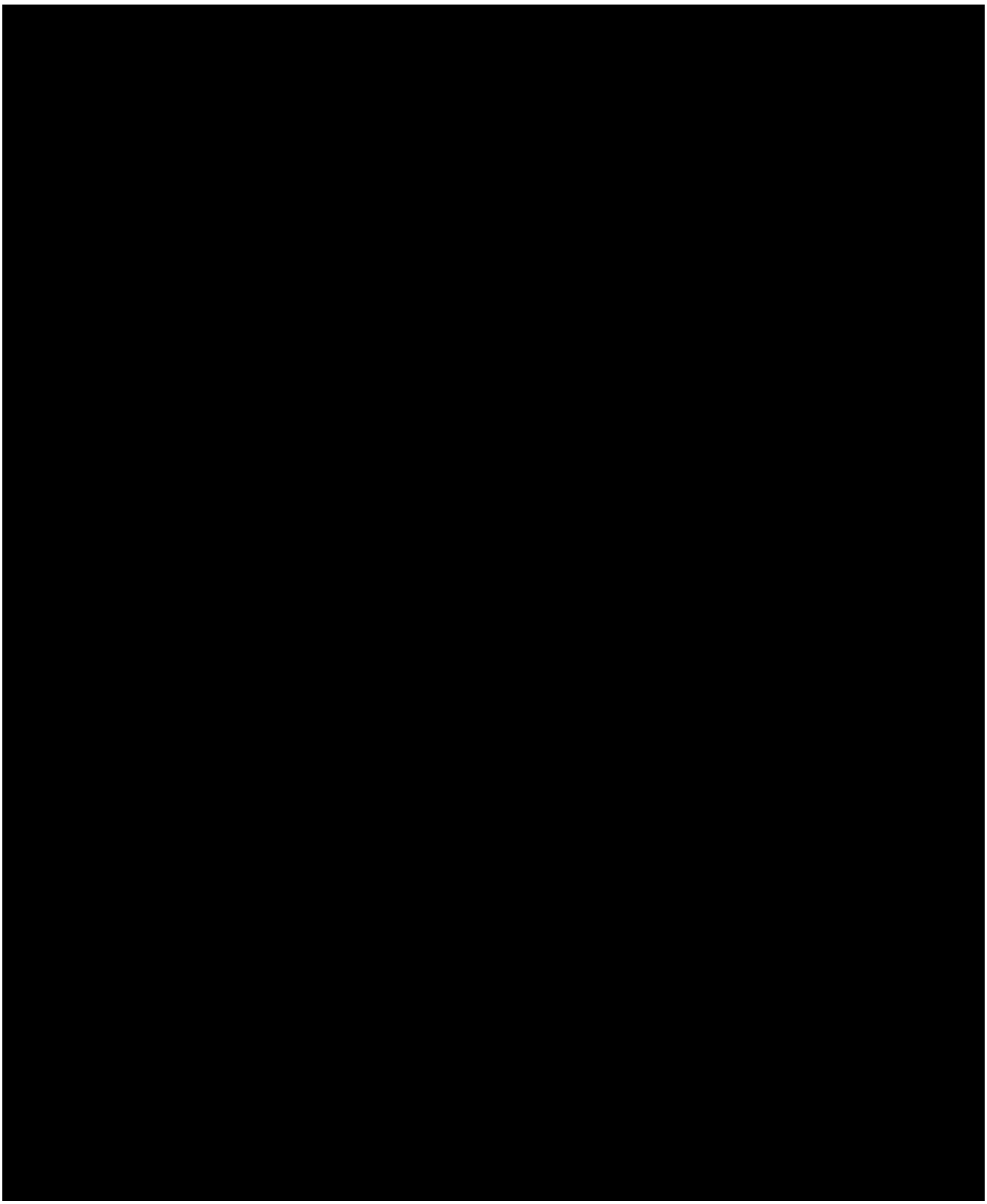
Unredacted Material. c. Specialty Resources. Provide, in addition to dedicated nurses:

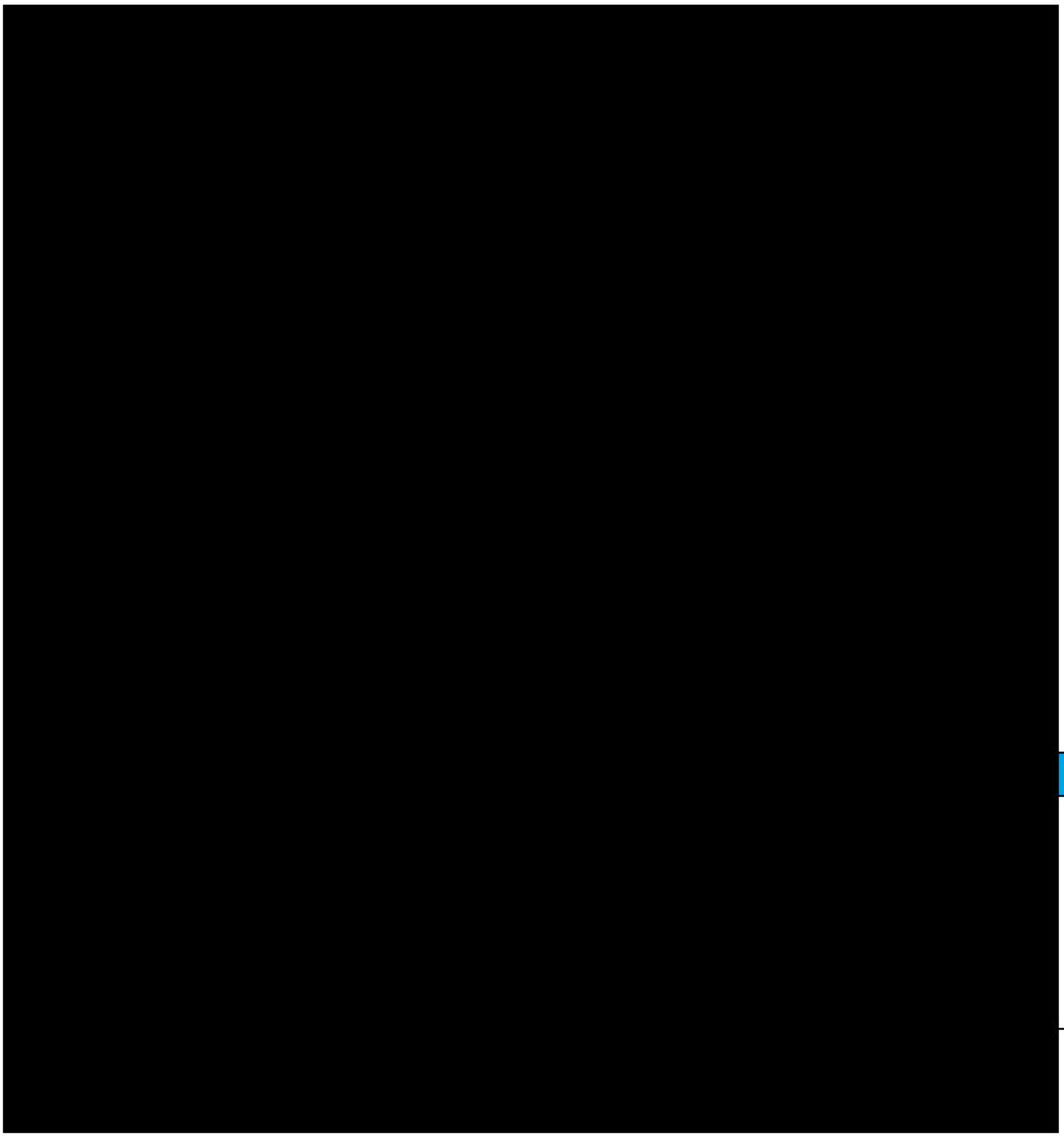
- A designated medical director and pharmacist to provide additional guidance for treatment and coordination of appropriate medication regimens with the Member's physician;
- Provide nurses with access to resources for Member referral; including:
  - Behaviorists
  - Social Workers
  - Nutritionists
  - Health Educators

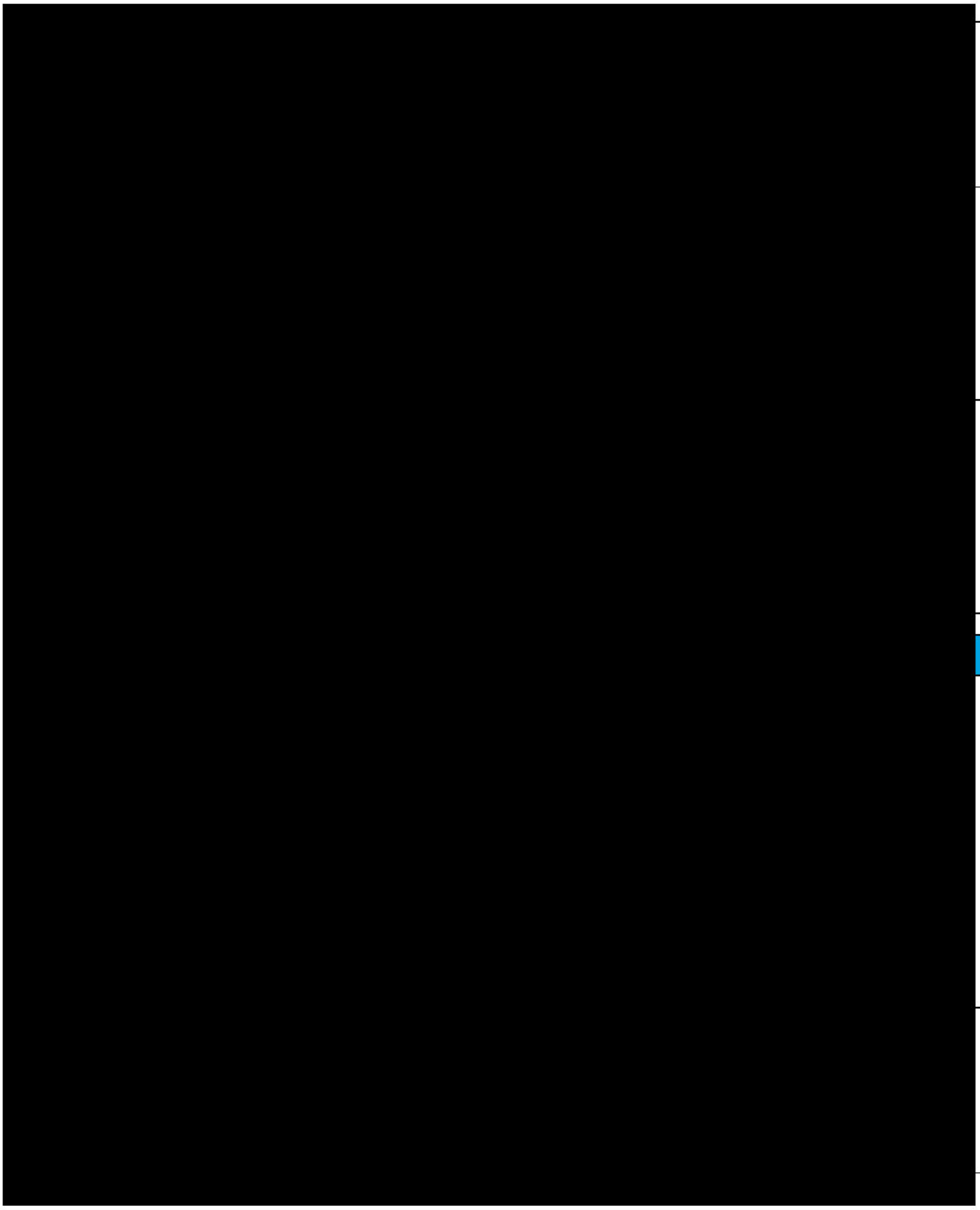
d. Measurement and Performance Management. Provide the following performance and management services:

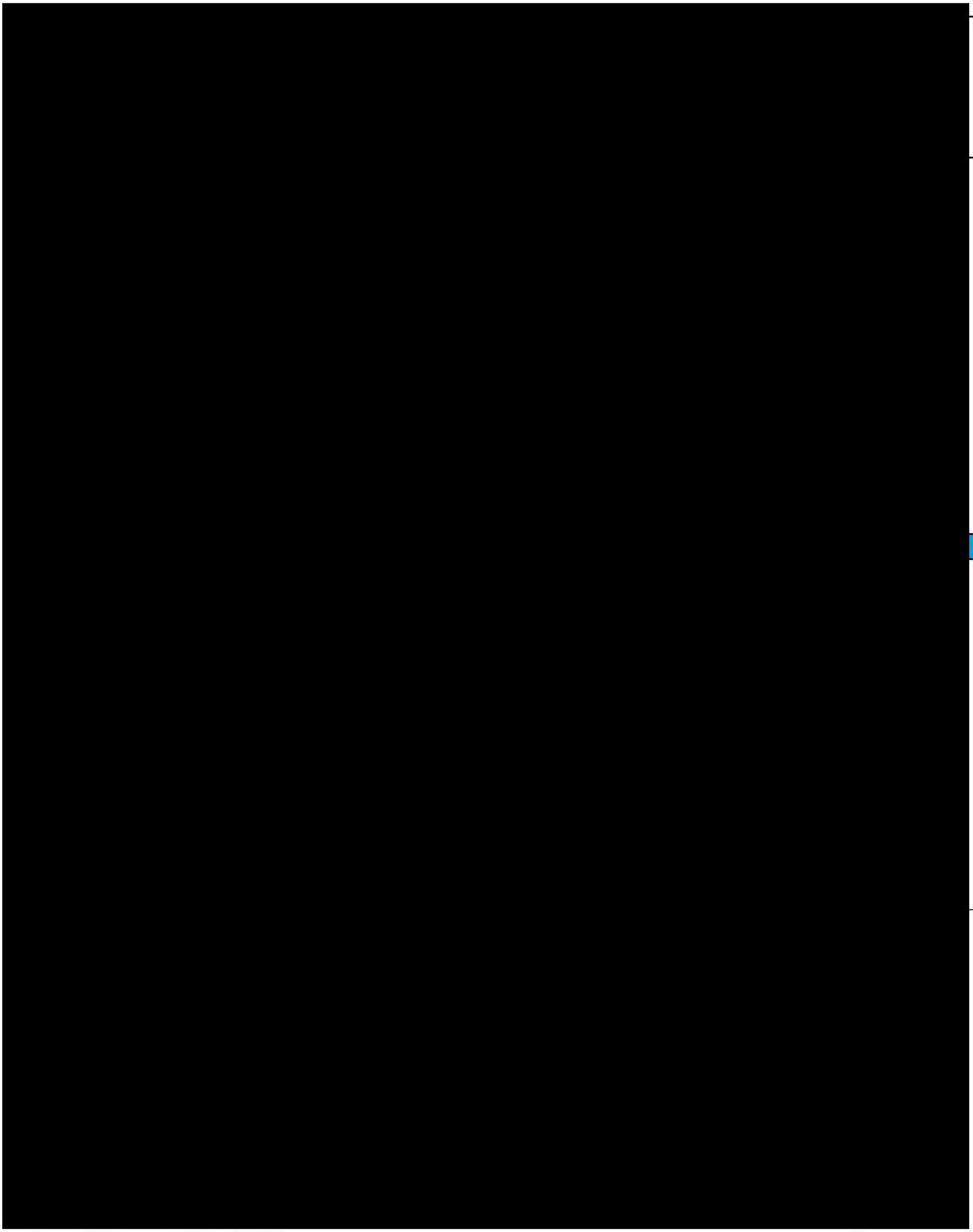
- Assist in Plan benefit strategy;
- Promote Accountability for Plan vendors, health plans and Members; and
- Measure and monitor Plan performance based on specific clinical, financial and utilization metrics.

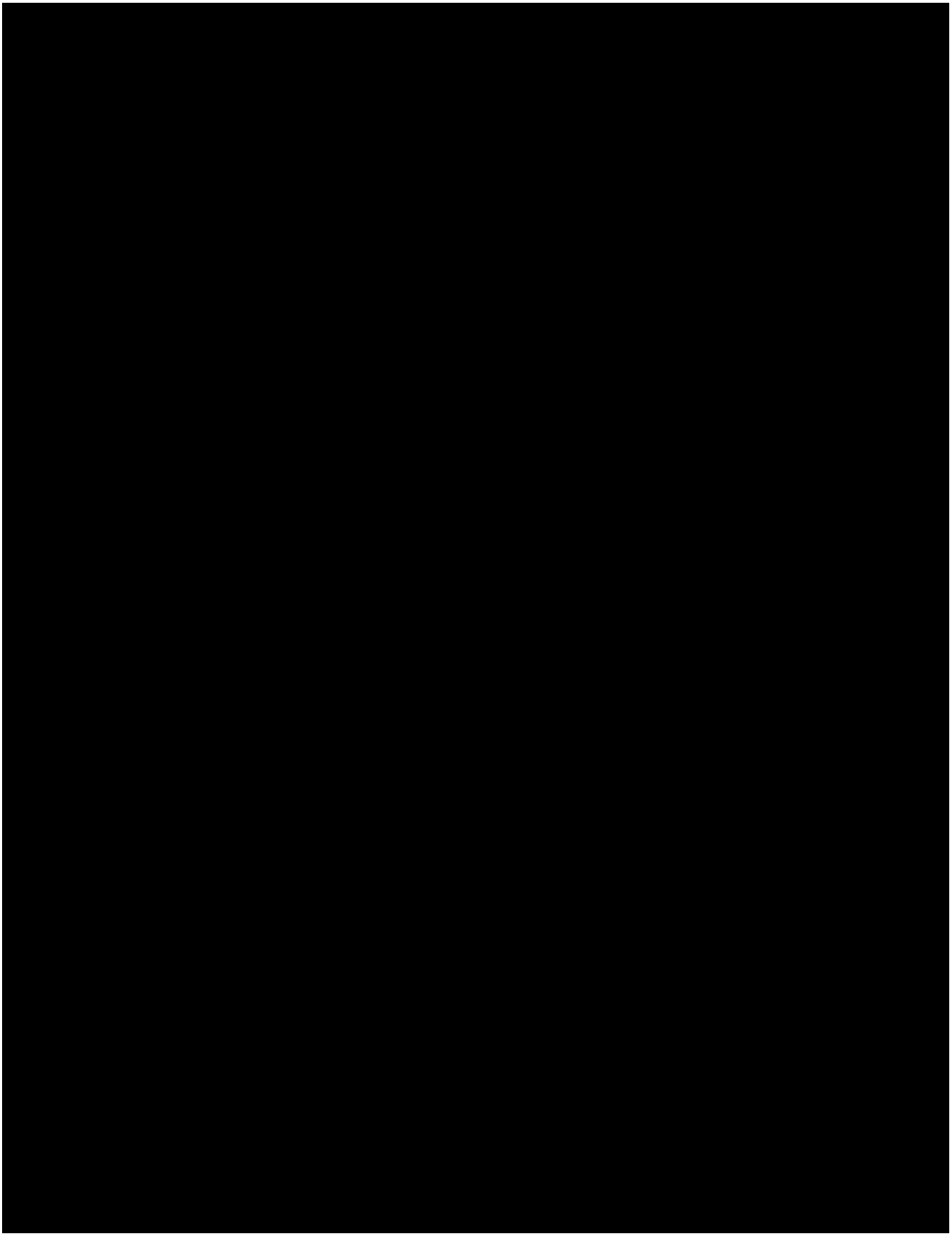


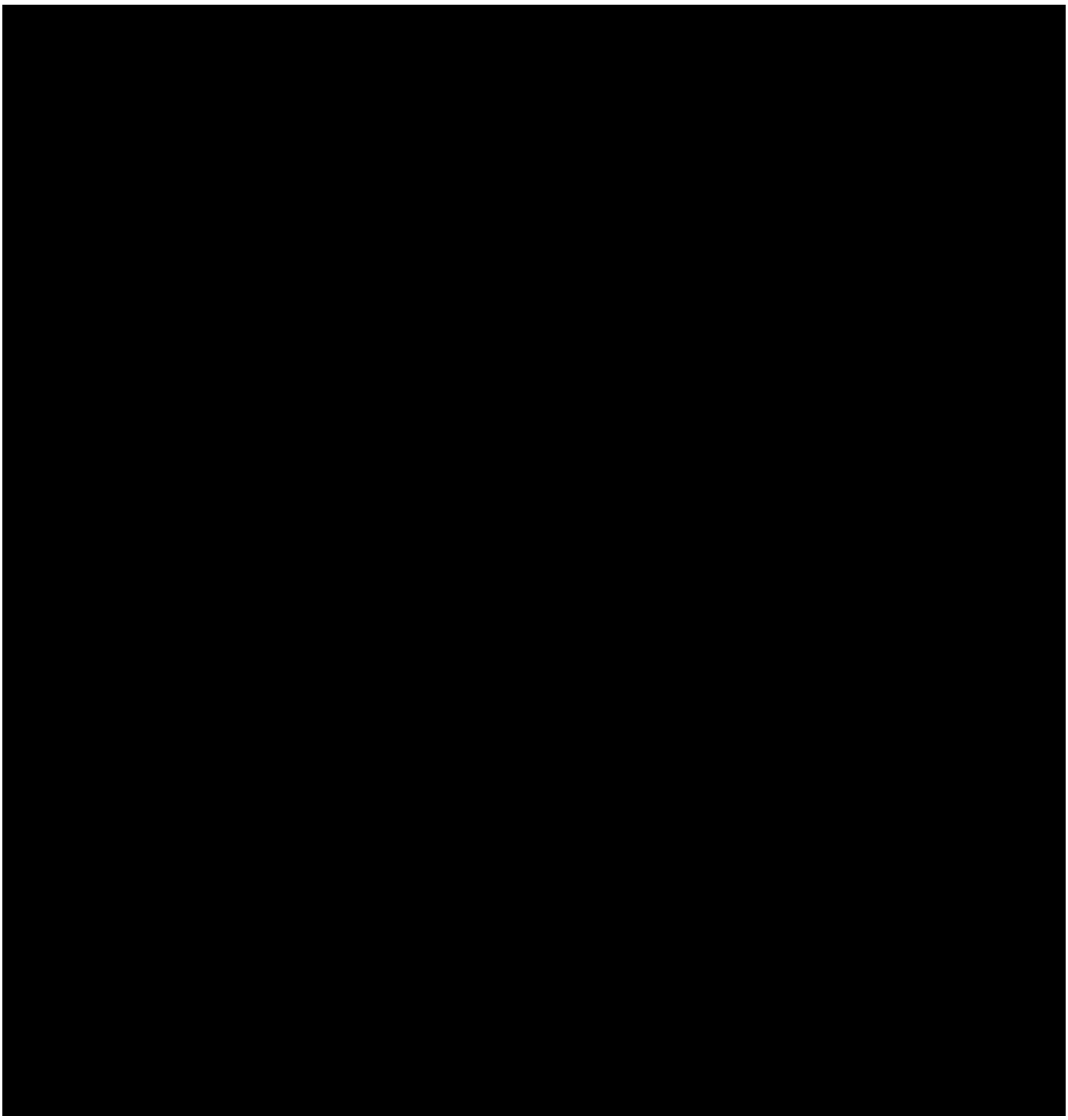












STATEMENT OF WORK

HEALTH SAVINGS ACCOUNT (HSA) SERVICES

It is understood by the Parties that on the effective date of this Agreement, Highmark does not provide services to Sponsor related to the administration of Health Savings Accounts for its Members. In the event Sponsor desires to retain Highmark to provide services described in this SOW and Appendix 1, HSA Services and Stored Value Card Administration, administrative fees for such services are set forth in Appendix 2, HSA Services – Fee Schedule.

Should Sponsor contract with Highmark for these services, Sponsor and Highmark will enter into good faith negotiations for all terms and components required to administer the program, such as, but not necessarily limited to, a implementation, account management, customer service to Members, (all of which shall be in accordance with industry standards).

A. Payment of Invoices

In accordance with the terms of Appendix 2, HSA Services – Fee Schedule, Highmark will send invoices for Service fees to one or more e-mail accounts designated by Sponsor. Sponsor shall pay the foregoing within thirty (30) days of the invoice date via: (i) Sponsor-initiated electronic funds transfer (EFT) or wire to an account designated by Highmark; (ii) Sponsor authorization of Highmark to use ACH debit for invoices via a Highmark-approved form; or (iii) other agreed-upon means.

B. Claim Payment

Highmark shall not be responsible for determining whether an expense paid by a Member via the Member's HSA is eligible for reimbursement under the Internal Revenue Code. Members retain the right to choose how they pay for their portion of the health care expenses incurred under the Plan; Member expenses may be paid for via amounts available in a Member's HSA (until HSA funds are exhausted) or by the Member on a post-tax basis. Under no circumstances will the Sponsor be required to pay for any expenses that are the Member's responsibility.

APPENDIX 1 TO SOW FOR HEALTH SAVINGS ACCOUNT (HSA) SERVICES

HSA SERVICES AND STORED VALUE CARD ADMINISTRATION

Highmark and Sponsor agree as follows with respect to the transfer of payroll deducted amounts from the Sponsor to the applicable Health Savings Account (HSA) for each affected Member:

A. HSA Services

- Provide an interactive Web site for use by the Sponsor.
- Debit the designated account of Sponsor for the amount necessary to transfer employee contributions that have been deducted by Sponsor from the pay of each respective Member for transfer to and deposit into the applicable HSA of the Member.
- Upon verification of the successful completion of the debit transaction, transfer the applicable contribution amounts to the financial institution holding the HSA of each Member provided that Highmark has been provided the necessary information for the purpose of completing the said transfer.
- Sponsor shall provide all information that is required by Highmark regarding the identification of employees enrolled in the HSA program, in the manner requested by Highmark.

Sponsor shall use a Highmark Web site or other method approved in advance by Highmark and Sponsor to report all changes that affect the administration of the program on behalf of its employees, including but not limited to, new Members, Member terminations, status changes, contribution amount changes, and applicable demographic data changes.

B. Stored Value Card Administration

Through a business relationship with a qualified and approved third party provider of stored value card reimbursement processing technology, Highmark will provide Sponsor and its employees the option to use a stored value card for access to the funds available in the employee's HSA. These services include the following:

- Integration of Claims transaction data provided by the applicable third party provider with the Highmark Claims database.
- Synchronization of all eligibility data between the Highmark database and the database of the applicable third party provider.
- Facilitate post payment adjudication of Claims where necessary; which may occur through auto-substantiation.
- Use of the audit system of the applicable third party provider to generate Member correspondence regarding necessary audits.
- Facilitation and documentation of Member Claims audits.

APPENDIX 2 TO SOW FOR HEALTH SAVINGS ACCOUNT (HSA) SERVICES

FEE SCHEDULE

Health Savings Account Fees

- Monthly Fee of $3.50 per Open Account per Month

- Sponsor and Highmark will enter into good faith negotiations for all fees and additional costs, such as, but not necessarily limited to extraordinary postage, outside special printing expenses for employee communications, special delivery charges, *ad hoc* reporting and other direct costs incurred at the request of and approval by Sponsor.

A GUIDE TO YOUR BENEFITS

HIGHMARK. Delaware

STATE OF DELAWARE
SPECIAL MEDICFILL®

HIGHMARK. Delaware

An Independent Licensee of the Blue Cross and Blue Shield Association

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文， 可向您提供免费语言协助服务。 请拨打您的身份证背面的号码（TTY：711）。

Kominike : Si se Kreyòl Ayisyen ou pale, gen sèvis entèprèt, gratis-ticheri, ki la pou ede w. Rele nan nimewo ki nan do kat idantite w la (TTY: 711).

ધ્યાન આપશો: જો તમે ગુજરાતી ભાષા બોલતા હો, તો ભાષા સહાયતા સેવાઓ, મફતમાં તમને ઉપલબ્ધ છે. તમારા ઓળખપત્રના પાછળના ભાગે આવેલા નંબર પર ફોન કરો (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ध्यान दें: यदि आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवा उपलब्ध है। आपके सदस्य पहचान (ID) कार्ड के पीछे दिए गए नंबर पर फोन करें। (TTY: 711).

توجہ فرمائیں: اگر آپ اردو بولتے ہیں، زبان معاونت سروس، مفت میں آپ کے لیے دستیاب ہے۔ اپنے شناختی کارڈ کی پشت پر درج شدہ نمبر پر کال کریں (TTY: 711)۔

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

గమనిక: మీరు తెలుగు మాట్లాడితే, లాంగ్వేజ్ అసిస్టెన్స్ సర్వీసెస్, ఛార్జీ లేకుండా, మీకు అందుబాటులో ఉన్నాయి. మీ మెంబర్ ఐడెంటిఫికేషన్ కార్డు (ఐడి) వెనుక ఉన్న నంబరుకు కాల్ చేయండి (TTY: 711).

Aandacht: Indien u Nederlands spreekt, is de taaladviesdienst gratis beschikbaar voor u. Bel het nummer op de achterkant van uw identificatie (ID) kaart (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

注： 日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください（TTY: 711）。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

BAA ÁKONÍNÍZIN: Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. ID bee nééhózingo nanitinígíí bine'dęę' (TTY: 711) jį' hodíilnih.

WELCOME

This health care plan has been selected by the State Employee Benefits Committee of the State of Delaware. The plan benefits are funded by the State of Delaware and are administered by Highmark Blue Cross Blue Shield Delaware (Highmark Delaware).

This booklet summarizes benefits of the Special Medicfill Health Care Plan that helps fill many of the gaps in Medicare coverage. For your convenience, technical terms have been defined in the *Definitions* section at the back of the booklet.

This booklet is not a contract. It is designed to provide a summary of benefits for easy reference. The benefits and the terms and conditions of your Medicfill Health Care Plan are in an Account Contract on file with the Statewide Benefits Office, DHR. The Account Contract is the final determination of the benefits and rules of your plan.

This booklet describes the Medicfill Health Care Plan in effect as of January 1, 2023 and replaces all previous booklets.

KEEP THIS BOOKLET HANDY FOR REFERENCE WHEN YOU NEED IT.

WHEN YOU HAVE QUESTIONS OR COMMENTS

Highmark Delaware welcomes questions, comments or suggestions. We study your comments to see how we can improve our service. Call or write Customer Service anytime you have a concern about Highmark Delaware's services, procedures or policies. We'll make every attempt to answer your questions and resolve any problems within 30 working days.

Here are reasons you may need to call us:

- asking about your plan;
- reporting a lost or stolen ID card;
- ordering a new ID card;
- letting us know when you have a new address; and
- asking about a claim
- getting language assistance.

You may call, write, email or visit with your questions.

To Reach Us By Phone:

All Calls: 844-459-6452

Fax: 877.544.8726

To talk to a Customer Service Representative, call 8:00 AM to 8:00 PM Eastern Standard Time (EST), Monday through Friday.

You can also get the following information when you call outside the Customer Service Representative hours. Our automated system (VRU) is available Monday through Friday, 24 hours a day, and Saturday until midnight EST for:

- enrollment information;
- claims status; and
- ID card requests.

To Reach Us By Letter:

Write to:

Customer Service
Highmark Blue Cross Blue Shield Delaware
P. O. Box 1991
Wilmington, DE 19899-1991

To Reach Us In Person:

You may also visit us at several places in New Castle, Kent and Sussex Counties. To find out the days, times and locations, call Highmark Delaware's Customer Service Department at 844-459-6452.

To Reach Us On The Internet:

Internet Address: www.highmarkbcbsde.com

TABLE OF CONTENTS

SPECIAL MEDICFILL HEALTH CARE PLAN BENEFIT HIGHLIGHTS

The following highlights your Special Medicfill benefits and how these benefits supplement your Medicare Coverage.

THESE BENEFIT HIGHLIGHTS ONLY BRIEFLY DESCRIBE THE BENEFITS AVAILABLE TO YOU FROM MEDICARE. FOR A COMPLETE DESCRIPTION OF YOUR MEDICAL BENEFITS UNDER MEDICARE, AND ANY LIMITATIONS ON THOSE BENEFITS, CONSULT MEDICARE PUBLICATIONS OR THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) AT WWW.CMS.HHS.GOV

This booklet describes the benefits, terms and conditions of your Special Medicfill Health Care Plan. This Health Care Plan is designed to supplement Medicare. Unless otherwise indicated, we will pay the benefits described in this booklet only after Medicare pays its full amount.

PREVENTIVE BENEFITS

Benefit:	Medicare Covers:	Special Medicfill Covers:	You Pay:

Note: Services identified with this symbol  **in the Medicare and You handbook are preventive services, and are listed together, below.**

See the *Medicare and You* handbook for more information about these services. The chart below assumes you receive services from providers that accept assignment.

Abdominal aortic aneurysm screening (One-time, as part of the "Welcome to Medicare" preventive visit.)	100% of allowed charges, no deductible.	Nothing.	Nothing.
Advance Care Planning (can also be covered as part of your medical treatment)	100% of allowed charges, no deductible—when this service isn't part of your "Wellness" visit, the Part B deductible and coinsurance apply.	Nothing.	Nothing.
Alcohol Misuse Counseling (One screening, and up to 4 brief counseling sessions per year.)	100% of allowed charges, no deductible.	Nothing.	Nothing.
Bone Mass Measurement (Bone Density) - every 24 months)	100% of allowed charges, no deductible.	Nothing.	Nothing.
Breast Cancer Screening (Mammograms - women age 40 & older; one baseline b/w ages 35-39 years.)	100% of allowed charges, with no deductible for annual mammograms for women age 40 and over.	Nothing.	Nothing.
Cardiovascular Disease (behavioral therapy) – one visit per year with primary doctor	100% of allowed charges, no deductible.	Nothing.	Nothing.

Benefit:	Medicare Covers:	Special Medicfill Covers:	You Pay:
Cardiovascular disease screenings (once every 5 years)	100% of allowed charges, with no Part B deductible requirement for the test. 80% of allowed after the Part B deductible for the associated doctor's visit.	When Medicare pays, this plan covers the Medicare Part B deductible and 20% coinsurance for the associated doctor's visit.	Nothing.
Cervical and Vaginal Cancer Screening –Pap Smear Only (every 24 mos. except for high risk - annually)	100% of allowed charges, with no deductible requirement for Pap smears once every 24 months for women at average risk, and once every twelve months for women at high risk. 80% of allowed after the Part B deductible for the associated doctor's visit.	When Pap smears for cancer screening are covered by Medicare, this plan pays nothing. When not covered by Medicare, this plan will pay 100% of our allowable charge for a Pap Smear every 12 months.	Nothing.
Cervical and Vaginal Cancer Screening - Pap Collection, Pelvic Exams and Breast Exams	100% of allowed charges, with no Part B deductible requirement, for Pap smears once every 24 months for women at average risk, and once every twelve months for women at high risk.	Nothing.	Nothing.
Colorectal Cancer Screening	100% of Medicare eligible expenses with no Part B deductible requirement for: Colonscopies covered once every 120 months, or every 24 months if high risk ■ (If your doctor finds and removes a polyp or other tissues during your colonoscopy, you may pay 20% of the Medicare approved amount for your. doctor's services and a copay for in a hospital outpatient setting. The Part B deductible does not apply).	Nothing.	Nothing.

Benefit:	Medicare Covers:	Special Medicfill Covers:	You Pay:
	Fecal occult blood test is covered once every 12 months if age 50 or older.	Nothing.	Nothing.
	Flex Sigmoidoscopies covered once every 12 months if age 50 or older, or 120 months after a previous screening colonoscopy if not high risk.	Nothing.	Nothing.
	Multi target stool DNA test covered once every three years if: ■ Ages 50-85 ■ No symptoms of colorectal disease ■ At an average risk for colorectal cancer ■ No family history of colorectal cancer or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer.	Nothing.	Nothing.
	Blood-based biomarker test covered if age 50-85, no symptoms of colorectal disease, and average risk of developing colorectal cancer. When barium enema tests are covered by Medicare, this plan covers the Medicare Part B deductible and 20% coins, and you pay nothing. If Medicare does not cover, this plan pays nothing.	Nothing.	Nothing.

Benefit:	Medicare Covers:	Special Medicfill Covers:	You Pay:
Depression screening (annual in a primary care setting)	100% of allowed charges, no deductible	Nothing.	Nothing.
Diabetes screenings	100% of allowed charges, no deductible for up to two diabetes screenings per year.	Nothing.	Nothing.
Diabetes self-management training.	80% of allowed charges after the Part B deductible persuant to doctor's written order.	When Medicare pays, this plan covers the Medicare Part B deductible and 20% coinsurance.	Nothing for covered services.
Flu Shots	100% of allowed charges, no deductible for one flu shot per flu season.	Nothing.	Nothing.
Glaucoma Tests	80% of allowed charges after the Part B deductible once every 12-months for glaucoma tests for persons who are at high risk for glaucoma, including diabetics and those with a family history of glaucoma.	When Medicare pays, this plan covers the Medicare Part B deductible and 20% coinsurance.	Nothing.
Hepatitis B vaccine/HBV screening	100% of allowed charges, no deductible for persons at risk.	Nothing.	Nothing.
Hepatitis C screening test	100% allowed charges for persons at risk.	Nothing.	Nothing.
HIV Screening (annually)	100% of allowed charges, no deductible	Nothing.	Nothing.
Lung Cancer screening	100% allowed charges once per year for a Low Dose Computed Tomography (LDCT) once per year if meet all of these conditions: ■ You're 55-77. ■ You're asymptomatic (don't have signs of symptoms of lung cancer).		
Lung Cancer screening	■ You're either a current smoker or have quit		

Benefit:	Medicare Covers:	Special Medicfill Covers:	You Pay:
(continued)	smoking within the last 15 years. ■ You have a tobacco smoking history of at least 30 “pack years” (an average of one pack a day for 30 years.) ■ You get a written order from a doctor or other qualified health care provider. ■ You generally pay nothing for this service of the health care provider.		
Medical Nutrition Therapy Services	100% of allowed charges, no deductible provided you meet the diagnostic criteria.	Nothing.	Nothing.
Obesity Screening and Counseling	100% of allowed charges no deductible for persons with a body mass index (BMI) of 30 or more.	Nothing.	Nothing.
Pneumococcal Shot	100% of allowed charges no deductible for one shot per lifetime.	Nothing.	Nothing.
Prostate Cancer Screening (PSA and digital rectal exam – annually for men age 50)	PSA - 100% of allowed charges, no deductible. Digital exam – 80% of allowed benefit afer the Part B deductible	Nothing.	Nothing.
Sexually Transmitted Infection (STI) screening and Counseling	Covered once per 12-months for persons who are pregnant or at an increased risk for a STI. Medicare also covers up to two individual, 20-30 minutes counseling sessions for sexually active adults at increased risk for STI’s.	Nothing.	Nothing.
Tobacco-use Cessation Counseling – up to 8 visits in a 12-month period.	100% of allowed benefit after the Part B deductible.	Nothing.	Nothing.

Benefit:	Medicare Covers:	Special Medicfill Covers:	You Pay:
Welcome to Medicare Preventive Visit (within 12 mos. of enrollment)	100% of allowed charges with no deductible.	Nothing.	Nothing.
Yearly Wellness Visits	100% of allowed charges, no deductible	Nothing.	Nothing.

PART A - INPATIENT HOSPITAL & OTHER FACILITY BENEFITS

Benefit:		Medicare Covers:	Special Medicfill Covers:	You Pay:
Inpatient Days in Acute Hospitals; Semi-Private Room and Ancillary Services (for covered expenses each benefit period)	Days 1-60	Medicare pays all but the Medicare Part A deductible.	This plan covers the Medicare Part A deductible.	Nothing.
	Days 61-90	Medicare pays all but a specified dollar amount of coinsurance per day.	This plan covers a specified dollar amount of coinsurance.	Nothing.
	Days 91-150	Medicare pays nothing. (There are 60 Lifetime Reserve Days* with all but the daily coinsurance amount covered. These days may be used at the patient's discretion.)	This plan covers inpatient care for days 91 through 150 in a general hospital except for mental and nervous treatment. These days may be used before Medicare's 60 lifetime reserve days. If the lifetime reserve days are used, the plan covers the coinsurance amount.	Nothing.
	Days 151-365	Medicare pays nothing.	This plan covers inpatient care for days 151 through 365, except for mental and nervous treatment. These days may be used before Medicare's 60 lifetime reserve days. If the lifetime reserve days are used, the plan covers the coinsurance amount.	Nothing.
Hospice		Medicare pays 100% of eligible expenses, subject to Medicare criteria.	Nothing.	Nothing.
		Medicare also covers 95% of the cost of up to 5 days of inpatient respite care.	5% of the Medicare approved amount.	

*Medicare's 60 Lifetime Reserve Days may be used only once; they are not renewable.

PART A - INPATIENT HOSPITAL & OTHER FACILITY BENEFITS (CON'T)

Benefit:		Medicare Covers:	Special Medicfill Covers:	You Pay:
Treatment for Mental or Nervous Disorders (in a Psychiatric Hospital)		Benefits are limited to 190 days for your lifetime. Medicare covers all but the Medicare Part A deductible and the specified coinsurance for days 61-150	This plan covers the Medicare Part A deductible and the specified dollar amount of coinsurance for up to the 190 lifetime days approved by Medicare.	Nothing while Medicare is paying. You pay all charges thereafter.
Inpatient Dental Surgery		Medicare covers hospital services for surgery related to the jaw or reduction of any fracture of the jaw or facial bone.	This plan covers the Medicare Part A deductible and specified dollar amount of coinsurance when Medicare standards are met.	Nothing.
Services in a Medicare Approved Skilled Nursing Facility	Days 1-20	Medicare pays 100% of eligible expenses.	This plan pays nothing.	Nothing.
	Days 21-100	Medicare pays all but a specified dollar amount of coinsurance per day.	This plan pays a specified dollar amount of coinsurance per day.	Nothing
Coverage Outside of the United States		Generally, Medicare does not pay for services provided outside the U.S.	When Medicare standards are met, and Medicare pays, this plan covers the Part A deductible and coinsurance for the first 90 days and then 100% of the allowable charge for days 91-150.	Nothing.
			If the admission does not qualify for payment under Medicare, but if it meets Medicare criteria for an inpatient admission within the United States, we will pay for services as defined by Medicare Law for 150 days of inpatient care.	Nothing for the first 150 days if the hospital confinement is approved for payment by Highmark Delaware. You pay all charges thereafter.

PART B - OUTPATIENT HOSPITAL AND OTHER COVERED BENEFITS

Benefit:	Medicare Covers:	Special Medicfill Covers:	You Pay:
■ Anesthesia ■ Clinical Services ■ Emergency Accident ■ Dialysis ■ Injections (except most routine immunizations) ■ Machine Testing ■ Medical Emergency ■ Minor Surgery ■ Physical Therapy ■ Radiation Therapy ■ Imaging Services	Medicare covers 80% of the Reasonable Charges** after the Medicare Part B deductible.	This plan covers the Medicare Part B deductible and 20% of the Reasonable Charges**.	Nothing.
Blood	Covered 100% of allowed charges after first 3 pints in any benefit year.	Nothing.	First 3 pints of blood in any benefit year.
Chemotherapy	Covered 80% of allowed charges, no deductible.	20%	Nothing.
Clinical Laboratory Services	Covered at 100% of the Reasonable Charge**	There is no coverage under this plan Clinical Laboratory Services.	Charges, if any, for services not covered by Medicare.
Diabetes Equipment & Supplies & Therapeutic	Covered 80% of allowed charges after the deductible for covered services.	Part B deductible, then 20%	Nothing for covered services.
Doctor and Other Health Care Provider Services	Covered 80% of allowed charges after the deductible for covered services.	Part B deductible, then 20%	Nothing for covered services.
Eyeglasses (limited to one pair glasses or contacts after cataract surgery with implanted lens)	Covered 80% of allowed charges after the deductible	Part B deductible, then 20%	Nothing.
Federally-Qualified Health Center Services	Covered 80% of allowed charges 100% of allowed charges, no deductible for most preventive services	20% or nothing for preventive services.	Nothing.
Home Health Services (doctor ordered care with a Medicare-certified provider)	Covered 100% of allowed charges, no deductible	Nothing.	Nothing.
Home Health Visits	Covered at 100% of the Reasonable Charge**, subject to Medicare criteria.	There is no coverage under this plan for Home Health Visits.	Charges, if any, for services not covered by Medicare.

Benefit:	Medicare Covers:	Special Medicfill Covers:	You Pay:
Laboratory Services	100% of allowed charges, no deductible	Nothing.	Nothing.
Rural Health Clinic Services	Covered 80% of allowed charges after the deductible; Preventive Care: 100% of allowed charges , no deductible	Part B deductible, then 20% Preventive Care: Nothing	Nothing.
Surgical Dressing Services	80% of allowed charges after the deductible in a doctor's office. A copayment applies in a hospital setting.	Part B deductible, then 20%	Nothing.
Tests (other than lab tests)	80% of allowed charges after the deductible for x-rays, MRIs, CT scans, EKGs and some other diagnostic tests. A copayment may apply in hospital setting.		
Transplants and Immunosuppressive Drugs	80% of allowed charges after the deductible for eligible transplants in a Medicare-certified facility	Part B deductible, then 20%	Nothing.
Travel (health care needed when traveling outside the United States)	Medicare generally doesn't cover medical care while you're traveling outside the U.S. or its territories and possessions. If emergency care is needed and covered, payment is 80% of allowed charges after the deductible.	Out of country Surgical medical benefits: For services outside the U.S. which are covered by Medicare BCBSD will pay the Medicare Part B deductible and 20% coinsurance. Benefits for services outside the U.S. not paid by Medicare are covered at 20% of the BCBSDE traditional RBRVS allowable, if these services are defined as coverable under Medicare policy guidelines.	Nothing for services covered by Medicare. 80% for services not covered by Medicare but defined as coverable under Medicare policy guidelines.
Urgently-Needed Care	80% of allowed charges after the deductible. A copayment applies in a hospital setting.	Part B deductible, then 20%	Nothing.

Benefit:	Medicare Covers:	Special Medicfill Covers:	You Pay:
Coverage Outside of the United States	Generally, Medicare does not pay for services provided outside the U.S.	When Medicare pays, this plan covers hospital benefits equivalent to Medicare hospital benefits in the U.S., including the payment of the deductible and coinsurance amounts.	Nothing.
		When Medicare does not pay, payment will be made for those covered services as defined by Medicare. Payment must be approved by Highmark Delaware	Nothing if the care is approved for payment by Highmark Delaware.

**Reasonable Charge means the amount approved by the Medicare carrier as the allowable charge for reimbursement under the Medicare program. If the medical care provider does not accept Medicare assignment, you may be responsible for the amount the charges exceed Medicare's reasonable charge.

PART B - SURGICAL-MEDICAL BENEFITS

Benefit:	Medicare Covers:	Special Medicfill Covers:	You Pay:
■ Acupuncture for back pain ■ Ambulance ■ Ambulatory Surgical Centers ■ Anesthesia ■ Appliances ■ Behavioral Health Integration Services ■ Cardiac Rehabilitation ■ Chiropractic Services (limited to correction of subluxation of the spine) ■ Chronic Care Management Services ■ Clinical Research Studies ■ Cognitive assessment and care plan services ■ Clinic Visits ■ Continuous Positive Airway Pressure (CPAP therapy) ■ Defibrillator (Implantable Automatic) ■ Durable Medical Equipment ■ EKG (once for screening; otherwise diagnostic) ■ Emergency Department Services ■ Foot Exams and Treatment ■ Hearing and Balance Exams ■ Home & Office Visits ■ Imaging Services ■ Inpatient Consultants	Medicare covers 80% of the Reasonable Charges** after the Medicare Part B deductible.	This plan covers the Medicare Part B deductible and 20% of the Reasonable Charges.**	Nothing.

Benefit:	Medicare Covers:	Special Medicfill Covers:	You Pay:
■ Inpatient Medical Visits ■ Inpatient Professional Services ■ Inpatient Skilled Nursing Facility Visits ■ Kidney Dialysis Services and Supplies ■ Kidney Disease Education Services ■ Machine Testing ■ Medical Emergency Care ■ Mental Health Care (Outpatient) ■ Occupational Therapy ■ Opioid use Disorder Treatment Services ■ Outpatient Medical and Surgical Services and Supplies ■ Physical Therapy ■ Prescription Drugs (limited) ■ Prosthetic/Orthotic Items ■ Pulmonary Rehabilitation ■ Radiation Therapy ■ Screening, Brief Intervention & Referral to Treatment ■ Second Surgical Opinions ■ Speech-Language Pathology Services ■ Surgery ■ Telehealth (limited) & other virtual visits—E-Visits and Virtual Check-ins	Medicare covers 80% of the Reasonable Charges** after the Medicare Part B deductible.	This plan covers the Medicare Part B deductible and 20% of the Reasonable Charges.**	Nothing.

Benefit:	Medicare Covers:	Special Medicfill Covers:	You Pay:
■ Tobacco Use Cessation Counseling (with diagnosis of tobacco-related illness)			
■ Transitional Care Management Services			

SURGICAL-MEDICAL BENEFITS (CON'T)

Benefit:	Medicare Covers:	Special Medicfill Covers:	You Pay:
Outpatient Treatment for Mental and Nervous Disorders	Medicare covers 80% of the Reasonable Charges** after the Medicare Part B deductible.	This plan covers the Medicare Part B deductible and 20% of the Reasonable Charges.**	Nothing.
Coverage Outside of the United States	Generally, Medicare does not pay for services provided outside the U.S.	When Medicare pays, this plan covers the Medicare Part B deductible and 20% coinsurance.	Nothing.
		When Medicare does not pay, benefits are covered as are covered under this contract at 20% of the Highmark Delaware traditional Resource Based Relative Value Scale (RBRVS) allowable.	All charges over 20% of the Highmark Delaware traditional Resource Based Relative Value Scale (RBRVS) allowable.

**Reasonable Charge means the amount approved by the Medicare carrier as the allowable charge for reimbursement under the Medicare program. If the medical care provider does not accept Medicare assignment, you may be responsible for the amount the charges exceed Medicare's reasonable charge.

OTHER COVERED BENEFITS

Benefit:	Medicare Covers:	Special Medicfill Covers:	You Pay:
Outpatient Prescription Drugs	Medicare Part B covers 80% of the reasonable charges for a **very limited number of drugs** (for example, cancer and immunosuppressive drugs) after the Medicare Part B deductible. See **medicare.gov** for more information.	This program pays the 20% coinsurance for these drugs.	Nothing.
Private Duty Nursing	No coverage under Medicare.	This plan covers the services of a Registered Professional Nurse (RN) for care provided in an acute care facility at 80% of Highmark Delaware's allowable charge, up to a maximum of 240 hours during any 12-month period. If an RN is not available, at our discretion, benefits may be provided for the services of a Licensed Practice Nurse (LPN).	Twenty percent (20%) of the allowable charges. You also pay any charges incurred after the 240-hour maximum has been met.

HUMAN ORGAN TRANSPLANT BENEFIT

Benefit:	Medicare Covers:	Special Medicfill Covers:	You Pay:
Human organ transplants	Benefits are provided on the same basis and at the same level as Inpatient Hospital Benefits, Outpatient Hospital Benefits, and Physician Services, subject to the Medicare Part A and Part B deductibles and coinsurance.	When Medicare pays for an organ transplant, this plan provides benefits on the same basis and at the same level as other Special Medicfill benefits. See the benefit description on page 15 for more information about organ transplants, including benefit limits.	Any charges not covered by Medicare or Special Medicfill, and any charges over the maximum limits of this plan.

PREVENTIVE CARE

Benefits for the following preventive care and wellness programs are paid at 100% of Highmark Delaware's allowable charge. If Medicare pays any portion, Highmark Delaware will pay the balance up to 100% of the allowable charge.

PREVENTIVE CARE

Highmark Delaware promotes preventive care to help you stay well. We administer these benefits according to the Highmark Delaware Preventive Health Guidelines materials. These materials contain details of when we pay for Preventive Care. They are available from Highmark Delaware, or online at www.highmarkbcbsde.com. All the terms and conditions of your benefit plan apply to the Preventive Health Guidelines materials.

Please note: Highmark Delaware has the right to change these benefits at any time. This plan does not cover the women's preventive services required by the Patient Protection and Affordable Care Act (PPACA).

EXAMINATIONS

Benefits are provided for:

- routine physical exam
- routine GYN exam and Pap smear

TESTS AND SCREENINGS

Some examples of covered routine tests and screenings are:

- hemoglobin test
- cholesterol test
- blood sugar test
- blood antigen test for prostate cancer
- blood occult
- lead screening test
- mammogram
- flexible sigmoidoscopy

ROUTINE IMMUNIZATIONS

Some examples of covered routine immunizations are:

- Hepatitis A
- Hepatitis B
- Varicella (chickenpox) vaccine
- DTaP (diphtheria, pertussis, tetanus)
- Td (Tetanus)
- MMR (measles, mumps, rubella)
- IPV (polio)
- Hib (haemophilus influenza)
- Influenza
- Pneumococcal

Immunizations considered by Highmark Delaware to be experimental in nature are not covered.

HOSPITAL AND OTHER FACILITY BENEFITS

INPATIENT HOSPITAL SERVICES

Benefits are provided for covered expenses for inpatient hospital care for each benefit period as follows:

- For days 1 through 60, we will pay the Medicare Part A deductible.
- For days 61 through 90, we will pay the specified daily coinsurance.
- For days 91 through 150, we will pay for hospital services for all admissions except for treatment of mental and nervous disorders. You may use these days before you use your 60 Medicare lifetime reserve days. If you use your Medicare lifetime reserve days, we will pay the coinsurance amount.
- For days 151 through 365, we will pay for hospital services except for treatment of mental and nervous disorders.

Covered services include:

- Semi-private room and board and ancillary services. If a private room is medically necessary, benefits are provided at the private room rate.
- Medicare limits coverage to 190 days for admissions for treatment of mental and nervous disorders. We will pay the Part A deductible and specified daily coinsurance for days approved by Medicare.
- When you are admitted to the hospital for dental surgical services approved by Medicare, we will pay the Medicare Part A deductible and the daily coinsurance amount. Dental services are limited to surgery related to the jaw or reduction of any fracture of the jaw or facial bone.

SKILLED NURSING FACILITY

When you are admitted to a Skilled Nursing Facility for a stay approved by Medicare, we will pay the applicable daily coinsurance for days 21 through 100.

HOSPICE

To qualify for hospice care, your doctor must certify that you're terminally ill and have 6 months or less to live. Coverage includes drugs for pain relief and symptom management, nursing, some durable medical equipment and spiritual and grief counseling.

A Medicare-approved hospice usually gives hospice care in your home or other facility where you live such as a nursing home. Hospice care doesn't pay for your stay in a facility (room and board) unless the hospice medical team determines that you need short-term inpatient stays for pain and symptom management that can't be addressed at home.

Medicare also covers inpatient respite care which is care you get in a Medicare-approved facility so that your usual caregiver can rest. You can stay up to 5 days each time you get respite care.

You can continue to get hospice care as long as the hospice medical director or hospice doctor recertifies that you're terminally ill.

This plan will pay 5% of the Medicare-approved amount for inpatient respite care.

SERVICES IN HOSPITALS OUTSIDE THE UNITED STATES

The Medicare program places certain restrictions on payments for admissions outside the United States. If Medicare approves payment for the admission, we will pay the Part A deductible and the daily coinsurance for the first 90 days. We will then pay 100% of the allowable charges for days 91-150.

If the admission does not qualify for payment under Medicare, but if it meets Medicare criteria for an inpatient admission within the United States and we approve the admission, we will pay for covered services as defined by Medicare law at 100% of the allowable charge for 150 days of inpatient care.

OUTPATIENT HOSPITAL SERVICES

We pay the Medicare Part B deductible and then we pay 20% of the reasonable charge for covered services for care in the outpatient department of the hospital. If care is rendered in a free-standing facility and Medicare pays, then we will pay the deductible, if any, and the coinsurance amount.

Covered services include:

- Emergency Treatment that is treatment for accidental injury or for sudden and serious medical conditions. These services must be rendered within 72 hours after the accident or onset of the emergency condition.
- Minor Surgery.
- Radiation Therapy and Chemotherapy for proven malignancies and neoplastic diseases.
- Diagnostic imaging services, laboratory and machine testing.
- Physical Therapy (subject to Medicare criteria).
- Anesthesia.
- Hemodialysis.
- Clinical Services.
- Injections (not including routine immunizations except for influenza, pneumococcal and hepatitis B vaccines which are fully covered by Medicare).
- Coverage Outside the United States - In those cases where Medicare will pay, we will pay the deductible and coinsurance amounts. In those cases where Medicare does not pay, we will pay for those covered services as defined by Medicare at 100% of the allowable charge.

SURGICAL-MEDICAL BENEFITS

We pay the Medicare Part B deductible, and then we pay 20% of the Medicare reasonable charge for covered professional services provided or ordered by a physician.

COVERED SERVICES

Covered services are as defined by Medicare and include:

- Acupuncture for back pain
- Ambulance Services.
- Ambulatory Surgical Centers
- Anesthesia.
- Appliances and Durable Medical Equipment.
- Behavioral Health Integration Services
- Cardiac Rehabilitation
- Chiropractic Services (limited to correction of subluxation of the spine)
- Chiropractic Services limited to manual manipulation of the spine to correct a subluxation that can be demonstrated by X-ray.
- Chronic Care Management Services
- Clinic Visits.
- Clinical Research Studies
- Continuous Positive Airway Pressure (CPAP therapy)
- Defibrillator (Implantable Automatic)
- EKG (once for screening; otherwise diagnostic)
- Emergency Department Services
- Foot Exams and Treatment
- Hearing and Balance Exams
- Home and Office Visits.
- Imaging Services.
- Injections (not including routine immunizations – See *Preventive Benefits*).
- Inpatient Consultations.
- Inpatient Hospital Medical Visits.
- Inpatient Skilled Nursing Facility medical visits.
- Kidney Dialysis Services and Supplies

- Kidney Disease Education Services
- Laboratory and machine testing.
- Medical Emergency Care in the outpatient department of a hospital or other facility approved by us.
- Mental Health Care (Outpatient)
- Occupational Therapy
- Opioid use Disorder Treatment Services
- Outpatient Medical and Surgical Services and Supplies
- Physical Therapy (subject to Medicare criteria).
- Prescription Drugs (limited)
- Prosthetic/Orthotic Items
- Pulmonary Rehabilitation
- Radiation Therapy and Chemotherapy for proven malignancies and neoplastic diseases.
- Screening, Brief Intervention & Referral to Treatment
- Second Surgical Opinions
- Speech-Language Pathology Services
- Surgery.
- Telehealth (limited) & other virtual visits—E-Visits and Virtual Check-ins
- Tobacco Use Cessation Counseling (with diagnosis of tobacco-related illness)
- Transitional Care Management Services

OUTPATIENT TREATMENT FOR MENTAL AND NERVOUS DISORDERS

We will pay the Medicare Part B deductible and then 20% of the reasonable charge for outpatient treatment of mental and nervous disorders. If you receive outpatient care in a partial hospitalization program or in the outpatient department of a hospital, we will pay 20% of the reasonable charge.

SERVICES OUTSIDE THE UNITED STATES

- For services outside of the United States, in those cases where Medicare will pay, we will pay the Part B deductible and coinsurance amounts.
- In those cases where Medicare will not pay, benefits for services outside the United States are provided at 20% of Medicare's Resource-Based Relative Value Scale (RBRVS).

OTHER COVERED BENEFITS

The following benefits are provided in addition to those in the Hospital and Surgical-Medical Benefits section of this booklet. Covered services include:

OUTPATIENT PRESCRIPTION DRUGS

Medicare Part B covers 80% of the reasonable charges for a **very limited number of drugs** (for example, cancer and immunosuppressive drugs) after the Medicare Part B deductible. See www.medicare.gov for more information.

PRIVATE DUTY NURSING - INPATIENT

When you are an inpatient in an acute hospital ('hospital' is defined in the Definitions section of this booklet), benefits are provided for the medically necessary services of a Registered Professional Nurse (R.N.) at 80% of Highmark Delaware's allowable charge, up to a maximum of 240 hours during a 12-month period.

This benefit is provided only when all of the following conditions are met:

- The nursing service is available;
- The service is prescribed by the attending doctor;
- The service is connected with the condition for which hospital care and treatment are being rendered;
- The service is medically necessary; and
- The service is approved by the hospital.

Private duty nursing is not covered when it is provided as a convenience for you, whether or not prescribed by your doctor, or when it is provided at your request or your family's request.

If an R.N. is not available, then at our discretion, benefits may be provided for a Licensed Practical Nurse (L.P.N.) at 80% of Highmark Delaware's allowable charge.

HUMAN ORGAN TRANSPLANT BENEFIT

The benefits listed in this section are only available for services related to medically necessary human organ transplants. If Medicare covers these services, services related to kidney, cornea and bone marrow transplants are covered on the same basis and at the same level as other surgical benefits under this benefit plan and are not subject to the benefits and limitations of this section.

Benefits for human organ transplants are available only when Medicare pays for an organ transplant.

Benefits Available

Subject to all the terms and conditions of this benefit plan, when a human organ transplant is medically necessary, the following benefits are available for that transplant:

- If Medicare covers these services, covered Hospital and Surgical-Medical services as specified under this benefit plan. Benefits are payable on the same basis and at the same level as other similar benefits under this benefit plan.
- If Medicare covers these services, surgical, storage and transportation costs incurred and directly related to the donation of a human organ used in a covered transplant procedure. The maximum amount payable for this benefit is $10,000 for each cadaveric organ and up to $45,000 for each organ procured from a living donor (including harvesting)..
- If Medicare covers these services, transportation to and from the site of the covered transplant procedure is covered for the transplant recipient and one other person. If the recipient is a minor, transportation costs for two other persons accompanying the recipient are covered.
- If Medicare covers these services, reasonable and necessary lodging and meal expenses incurred, up to a daily maximum of $150, by those individuals accompanying the recipient.

Benefit Limitations

- The benefits for transportation, lodging and meal expenses are subject to an aggregate maximum of $10,000 per covered transplant procedure. All covered transportation costs, lodging and meal expenses incurred are paid at the same level as outpatient doctor's visits.
- The organ transplant benefits specified in this section are available only during the applicable benefit period. For purposes of this Human Organ Transplant Benefit, the Benefit Period shall mean 5 days immediately prior to and one year immediately following a covered Organ Transplant Procedure.
- Benefits under this section are payable only for those services that Medicare will pay, with the exception of those non-Medicare covered services specified in the *Other Covered Benefits* section of this booklet.

EXCLUSIONS

The following services and other items are excluded from your coverage under this Medicfill plan:

- Services and supplies covered by Medicare Part A and Part B benefits, except those items and services expressly provided in this plan.
- Unless otherwise specified in this health care plan, charges for covered services that are over the Medicare reasonable charge for that service.
- Any service or benefit provided or available, to any extent, to you under federal, state or local Workers' Compensation laws, occupational disease laws or other laws concerning job related injuries or conditions.
- Unless federal law requires otherwise, any services or supplies furnished by the Veterans' Administration or by any institution owned or operated by the United States, any corporation, agency or bureau thereof, or any state, county or municipal government; services or supplies available, in whole or in part under the laws of the United States (including Medicare) or under the laws of any state or political subdivision thereof or furnished or available pursuant to any law hereinafter enacted.
- Any service necessitated by an act of war declared or undeclared which occurs after the effective date of this plan, or by service in the armed forces of any country, or by any criminal act in which you conspired or took part.
- Services rendered by any member of your immediate family or any person living with you. For purpose of this paragraph only, family includes parents, spouses, siblings, and natural or adopted children of whatever age.
- Services for which no charge would normally be made in the absence of insurance.
- Rest cures, custodial care or homelike care, whether or not recommended by your doctor.
- Dental X-rays and appliances and the services of a dentist, except Medicare covered surgery involving the bone of the jaw or facial bone.
- Eyeglasses, contact lenses, the examination, prescription or fitting of same, and all procedures for refractive correction.
- Hearing aids and the examination, prescription or fitting of same,
- All procedures for refractive correction.
- Orthotics, including all equipment, devices, foot inserts, arch supports, lifts and corrective shoes.
- Routine foot care.
- Blood or blood donor services, including blood components.
- Supplies or services for cosmetic purposes, including routine treatment of acne and treatment for hair loss restoration.

- Unless specified otherwise, services for routine physical examinations or other examinations or treatments including, but not limited to, those procured by you to satisfy requirements of any third party including those required or ordered by a potential employer, licensing authority, insurer, educational institution, court, or legal representative, unless specified otherwise. School, camp, and pre-marital physicals are also excluded.

- Services not directly related to or medically necessary for the diagnosis or treatment of an illness or injury. Medical necessity is defined by us as: medically necessary services or supplies provided by a hospital, doctor or other provider to identify or treat an illness or injury and which, as determined by us are:

  - Consistent with the symptom or diagnosis and treatment of a condition, disease or injury;
  - Appropriate with regard to standards of accepted professional practice;
  - Not solely for your convenience, your doctor's convenience or any other provider's convenience; and,
  - The most appropriate supply or level of service which can safely be provided to you. When applied to an inpatient it further means that your medical symptoms or condition require that the service or supplies cannot be safely provided to you as an outpatient.

  We may base payment upon Medicare's determination of medical necessity.

- Computerized gait analysis or electrodynographic testing.

- Services and supplies for or related to visual therapy or orthoptics.

- Services by a medical department maintained by your employer.

- Services and supplies which are experimental or investigational in nature meaning any treatment, procedure, facility, equipment, drugs, drug usage, devices or supplies not recognized as accepted medical practice and any of such items requiring federal or other government agency approval not granted at the time services were rendered.

- Any service or supply specified as an exclusion under the Medicare program or denied by Medicare except any service or supply expressly covered as a benefit by this plan.

- Services, supplies, or drugs obtained in violation of applicable law.

- Prescription drugs (except for the limited number of drugs covered by Medicare Part B) for use outside the hospital, even if your doctor writes you a prescription. Prescriptions are provided through the State of Delaware’s CVS Caremark/Silver Scripts Medicare Retiree Prescription Plan. Contact the State of Delaware Office of Pensions for additional information

VALUE ADDED FEATURES

Highmark Delaware offers Value Added Features. They are described below.

Value Added Features are administered only as specified in the Highmark Delaware Value Added Features materials.

Please note: Highmark Delaware has the right to change or discontinue these programs at any time.

EYEWEAR DISCOUNTS

On behalf of Highmark Delaware, your eyewear discount program is administered by Davis Vision, an independent managed vision care company.

You can save money on eyewear by going to one of the program's participating providers. To get a list of participating providers and the products subject to discount, call 888.235.3119 (TTY: 800.523.2847) or visit **www.davisvision.com**. The client code is 2722.

DISCOUNT PROGRAMS

Savings on a variety of product and services are available to Highmark Delaware members, including:

- Fitness clubs
- Alternative health services (i.e., acupuncture, chiropractic care)
- Laser vision corrective surgery
- Fitness gear
- Weight loss programs and healthy eating options
- Hearing aids

For a full listing of our discounts go to www.highmarkbcbsde.com or call us at 844-459-6452.

HOW TO CLAIM BENEFITS

Claims must be filed within 2 years from the time you receive care. Claims filed beyond 2 years will not be paid.

HOW TO CLAIM HOSPITAL AND SURGICAL-MEDICAL BENEFITS

Since this program supplements Medicare benefits, claims for benefits must first be submitted for coverage through Medicare.

A *Request for Medicare Payment Form*, must be filled out and submitted in order for Medicare to pay for services of doctors and suppliers which are covered by your medical insurance. All Social Security offices, and most doctors' offices, have copies of this form. Instructions on how to fill it out are on the back of the form.

When Medicare has paid for the services of doctors and suppliers that are covered by your medical insurance, you will receive an *Explanation of Benefits* notice explaining what coverage has been provided.

INSIDE DELAWARE

When you receive care inside Delaware, put your Highmark Delaware Identification Number on your *Request for Medicare Payment Form.* Payment will be made to the provider of services.

OUTSIDE DELAWARE

Medicare Part A Hospital Services

If you are hospitalized outside of Delaware, supply the hospital with your Highmark Delaware Identification Number. The hospital or Skilled Nursing Facility that provides you service will submit a Medicare Claim Form to the Medicare Part A Intermediary in the area where you receive care. Payment will be made to the provider of services.

Medicare Part B Doctor's Services

If you receive surgical-medical care outside of Delaware, supply the doctor or provider with your Highmark Delaware Identification Number. The doctor or provider will submit the claim to Medicare in the area where you receive care. Payment will be made to the provider of services.

OUTSIDE THE UNITED STATES

For claims incurred while on a cruise ship:

Send a copy of the *Explanation of Benefits* form you received from Medicare to:

Highmark Blue Cross Blue Shield Delaware
P.O. Box 8831
Wilmington, DE 19899-8831

Highmark Delaware will pay you directly for benefits in accordance with this health care plan.

For all other international claims:

Use the BlueCard Worldwide® International Claim Form available at www.highmarkbcbsde.com, and send the form to:

BlueCard Worldwide Service Center
P.O. Box 72017
Richmond, VA 23255-2017 USA

HOW TO CLAIM OTHER COVERED BENEFITS

PRIVATE DUTY NURSING

For private duty nursing inpatient benefits, please submit the following information to us:

- Name of the hospital.
- Date of admission to the hospital.
- Date of discharge from the hospital.
- Diagnosis.
- Attending physician's signature.
- Either a completed Claim Form CL-65, which may be obtained in any Delaware hospital, or the nurse's receipt showing the nurse's registration number. If the nurse's receipt is submitted without Form CL-65, you must also include the signed authorization of the attending physician.
- Your name, address, and Highmark Delaware Identification Number (referred to in some cases as 'contract' or 'certificate' Identification Number).

HOW TO APPEAL A CLAIM DECISION

You have the right to a full and fair review of all claim decisions. Here's how the appeal process works:

HIGHMARK DELAWARE'S APPEAL PROCESS

- To appeal a Highmark Delaware decision, you or your representative must contact Customer Service ***within 180 days*** from the date you received the decision. You may call us or you may use the Highmark Delaware *Appeal Form*, available at https://www.highmarkbcbsde.com/downloads/forms/AppealForm.pdf. There is no cost to appeal, and Highmark Delaware will provide copies of records relevant to your claim upon written request. Members should use the *Designation of Personal Representative for Appeal Purposes* form to designate a personal representative for purposes of an appeal, available at https://www.highmarkbcbsde.com/downloads/forms/Designation_of_Personal_Representative_for_Appeal_Purposes.pdf

- Please explain why you believe the decision was wrong and provide any additional relevant information. If you fail to submit your appeal within the 180-day timeframe, your appeal will be rejected and the initial decision will be upheld.

- **Y**ou will be notified of the decision within 30 to 60 days of your request for an appeal.

AFTER THE HIGHMARK DELAWARE APPEAL

- If you have appealed a decision and are not satisfied with the outcome, you may be eligible for an external review coordinated by the Delaware Department of Insurance (DOI). As

required by law, you must request an external review within four months of the date you received Highmark Delaware's appeal decision.

- For decisions involving medical judgment or necessity, you must contact Highmark Delaware Customer Service to initiate the review.
- For reviews of all other decisions, you must contact the DOI directly at 800.282.8611.

- The DOI provides free, informal mediation services which are in addition to, but do not replace, your right to an independent review. For information about mediation, you can call the DOI Consumer Services Division at **800.282.8611**, or visit the DOI office at: The Rodney Building, 841 Silver Lake Boulevard, Dover, Delaware. Office hours are 8:30 AM – 4:00 PM Monday – Friday. **Please note that the four month external review deadline will still apply if you choose mediation services.**

ADDITIONAL LEVELS OF APPEALS

For information on additional levels of appeal availability, please see https://de.gov/statewidebenefits or telephone the State of Delaware's Benefits Office at 800.489.8933; www.highmarkbcbsde.com; www.cms.gov

If you would like more information, please contact Highmark Delaware's Customer Service Appeals Team by one of the methods below.

www.s-https:

Internet:

Visit our internet Customer Service Center at www.highmarkbcbsde.com.

Telephone:

844-459-6452
800.232.5460 for the hearing impaired

Mail:

Highmark Blue Cross Blue Shield Delaware
PO Box 8832
Wilmington, DE 19899-8832

IMPORTANT NOTE

PLEASE READ *A GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE*, PROVIDED BY THE FEDERAL GOVERNMENT'S CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) TO FIND OUT WHAT BENEFITS YOU CAN RECEIVE FROM THE MEDICARE PROGRAM AT **www.cms.gov**.

COORDINATION OF BENEFITS

We reserve the right to coordinate available benefits for you so that duplication of payment of the same benefits will not occur and so that all parties having responsibility for payment for covered services perform in accordance with their benefit plan obligations. If you are entitled to benefits under any other plan as defined herein, to which you are a party or beneficiary, the amount of benefits payable under this plan and any other plan will be coordinated so that the aggregate amount paid will not exceed one hundred percent of the Allowable Expenses.

DEFINITIONS

For the purpose of interpretation of this provision, the following definitions will apply:

Allowable Expenses means a necessary, reasonable and customary health care expense when the expense is covered at least in part by one or more health benefit plans covering the individual for whom the claim is made.

Coordination of Benefits Provision means any provision of any plan that establishes the order in which plans pay benefits when an individual is insured under two or more plans.

Other Plan means any arrangement providing health care benefits or services, including but not limited to benefits or services through:

- Any form of health or other insurance, including nonprofit health service, or any other form of prepayment of insurance coverage including individual, group, blanket, franchise, fraternal, no-fault insurance or personal injury protection coverage;
- Any health maintenance organization or similar coverage;
- Coverage under any labor management trusteed plan, union welfare plan, or employee benefit organization plan;
- Coverage under any governmental or tax supported program; or
- Coverage required by statute to be offered to or procured potentially by you whether or not you have the option of declining such coverage or of purchasing such coverage subject to mandatory or optional deductibles, including but not limited to personal injury protection coverage, no-fault coverage or similar provisions of state or other statutes.

Primary Plan means the plan under which benefits are determined before those of the other plan and without considering the other plan's benefits.

Secondary Plan means the plan under which benefits are determined after those of the other plan. Benefits under a secondary plan may be reduced because of the other plan's benefits.

ORDER OF BENEFITS DETERMINATION

The primary and secondary plan responsibility is determined according to the following rules as they apply to your Medicfill health care plan:

- A plan with no provision for coordination of benefits is primary over a plan that contains such provision.
- A plan that covers you as an employee is primary over a plan that covers you as a dependent.

- A plan that covers you as an active employee (or as that employee's dependent) is primary over a plan that covers you as a laid off or retired employee (or that employee's dependent).
- If two or more plans cover a dependent child of parents not divorced or separated, the plan of the parent whose birthday occurs earlier in the calendar year is primary. If both parents have the same birthday, the plan that covered one parent longer is primary.
- If the other plan's Coordination of Benefits provision determines primary or secondary plan responsibility based upon the parent's gender rather than upon the parent's birthday, the gender rule will control. As a result, the plan covering the dependent child of the male parent will be primary.
- If two or more plans cover a dependent child of divorced or separated parents, benefits for the child are determined in the following order:
  - First, the plan of the parent with custody of the child;
  - Then, the plan of the spouse of the parent with the custody of the child; and
  - Finally, the plan of the parent not having custody of the child.

  However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the organization providing benefits has actual knowledge of the decree, the plan of that parent is primary.
- If the above rules do not establish which plan is primary, the plan that has covered the individual for the longer time period is primary.
- When there are two or more secondary plans, this order of benefit determination will be repeated until this plan's responsibility for benefits has been determined.

EFFECT ON BENEFITS

- When this plan is primary, the benefits of the secondary plan will be ignored for the purpose of determining the benefits under this plan.
- When this plan is secondary, we will coordinate payments with those of the other plan(s) so that payments made by both (or all) plans will not exceed Allowable Expenses for covered services. In no event will we pay more than would have been paid had there been no other plan.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

To determine the applicability of and to implement the terms of this provision, we may release to or obtain from any organization or individual any information deemed necessary.

You, personally, are obligated to provide information necessary to implement this provision. If you refuse to cooperate with us in providing necessary information or in securing payment, then coverage under this plan for that incident is null and void and we may, at our discretion, terminate the plan and take any other action necessary to protect our rights hereunder.

FACILITY OF PAYMENT

When this plan is determined to be primary but payment was made under another plan, we have the right to reimburse the organization making such payments the amount that we determine is our liability in accordance with this provision. By making such payment, we will have satisfied the obligation under this plan.

RIGHT OF RECOVERY

When we make payments that exceed the maximum amount of covered benefits that we must pay under the coordination of benefits rules, we have the right to recover the excess from any one of the following:

- Any person to or for whom such payments were made;
- Any insurance companies;
- Other organizations; or
- You.

ELIGIBILITY INFORMATION

WHO IS ELIGIBLE

This Health Care Plan is made available through the State of Delaware who elected to provide Medicare supplementary coverage for:

- Retired employees and their spouses
- Disabled employees, spouses and dependent children
- Employees, spouses and dependent children who have permanent kidney failure.

You must be enrolled in Part A and Part B of the Medicare program. You must also continue to be covered under both Part A and Part B to keep coverage in this plan.

WHEN YOUR COVERAGE ENDS

DEATH

Coverage for your surviving spouse and any eligible dependents ends as of the last day of the month of your death.

LOSS OF BENEFITS

You can lose coverage under this plan if you do not retain coverage under both Part A and Part B of Medicare.

Also, persons under 65 can lose their Medicare eligibility by losing their Social Security disability classification. This occurs when the disabled or blind person becomes gainfully employed or, in the case of the dialysis patient, three years after a successful kidney transplant or one year after termination of dialysis.

Contact your Pension Office for information regarding other coverage that may be available.

STATE DROPS COVERAGE

Your coverage (and your dependents coverage) ends on the date on which the State's contract with us for the provision of benefits ends.

BENEFITS AFTER YOUR COVERAGE ENDS

If you are an inpatient in a hospital, skilled nursing facility or specialized care facility on the date your coverage terminates because your employer dropped coverage with us, we will continue to provide the benefits described in this booklet for the facility and professional charges related to that admission for up to 10 days after the coverage termination date or until the day you are discharged from the hospital, skilled nursing facility or specialized care facility, whichever occurs first.

If you lose coverage for any reason other than because your employer dropped coverage, all health care benefits under this health care plan terminate on the date your group coverage terminates.

IF GROUP COVERAGE ENDS

If your group coverage ends, you may apply directly to us for conversion to a contract under which you are billed personally (a 'direct-billed' contract) at the then current premium rate. You must apply within 31 days after your coverage under the group contract ends. You have this conversion right if:

- You have left your employer; or
- You are the ex-spouse of an employee; or
- You are the surviving spouse of a deceased employee; or
- You no longer meet the dependent child requirements on age, marital status, or financial support.

The direct-billed contract offered may provide fewer benefits and/or a lower benefit payment level than what you were eligible to receive under group coverage.

If another health insurance program is available where you are employed or in an organization with which you are affiliated, you and/or your dependents are not entitled to a group conversion direct-billed contract under this provision, regardless of whether the other health insurance program contains a preexisting condition limitation or the application is denied.

GENERAL CONDITIONS

MEDICARE AMENDMENTS

If there are changes to the Medicare Law or any other applicable law that either increase or decrease the amount of benefits or provide services not previously covered, benefits under this plan will be adjusted accordingly.

RELEASING NECESSARY INFORMATION

Hospitals, doctors, pharmacies and other providers have information we need to determine your eligibility for both enrollment and benefits under this plan. By applying for coverage you agree to let any doctor, hospital, pharmacy or provider give us and our agents all the medical information we may need. This may include the diagnosis and history of any illness, disease, condition or symptom you have had, or for which coverage is sought; or other information. We will keep this information confidential to the extent permitted by law. However, by applying for coverage you authorize us to furnish any and all records including complete diagnosis and medical information to an appropriate medical review board, utilization review board, utilization review organization and/or to any other insurance carrier or administrator or health maintenance organization for purposes of administration of this health benefits plan. If such information relates to fraud or other misrepresentation, we may disclose it to legal authorities or use it in legal proceedings. We reserve the right to charge a fee for the reproduction of claims records requested from us.

TIME LIMITS

Requests for benefits must be received by us within 2 years from the date you received the service.

DENIAL OF LIABILITY

We are not responsible for the quality of care received from any institution or individual. Your coverage does not give you any claim, right or cause of action against us based on an act of omission or commission of a hospital, nursing home, doctor or other provider of care or service.

RECEIPT OF BENEFITS

In order for you to receive benefits, you must identify yourself as our customer as soon as possible. When you receive services, you must show the current membership card.

DUPLICATE COVERAGE

If you have two or more benefit plans through Blue Cross Blue Shield corporations, benefits will be coordinated.

PAYMENT OF BENEFITS

If your doctor accepts Medicare assignment, payment will be made directly to the doctor. He/she cannot bill you for any balance over the Medicare reasonable charge. However, if your doctor does not accept Medicare assignment and you have not assigned benefits under this plan to your doctor in accordance with Medicare program requirements, payment will be made directly to you and you may be responsible for any balance remaining. If you have assigned benefits under this plan to your doctor according to Medicare guidelines, we will pay benefits under this plan directly to your doctor, as required. In all other cases where benefits are payable to you, such payments shall not be assignable without our written approval.

SUBROGATION AND RIGHT OF REIMBURSEMENT:

When we pay a claim, we are subrogated to all rights you have against any third party. A third party includes, but is not limited to, another person, legal entity (such as a corporation or self-insured plan), or insurer (providing uninsured or underinsured automobile coverage, other automobile coverage, workers compensation, malpractice, or other liability coverage). We will have the sole right to interpret all rights and duties created by this section.

Some examples of Highmark Delaware's rights include:

- **Constructive trust.** Accepting benefits from Highmark Delaware makes you and your agents a constructive trustee of any funds recovered from any third party. This constructive trust will continue until Highmark Delaware receives payment. Failure to pay funds to Highmark Delaware will be considered a breach of your duty to the health care plan. No settlement can be made without Highmark Delaware's written permission.
- **Subrogation lien.** Accepting benefits from Highmark Delaware will result in an automatic lien by Highmark Delaware against any recovery from any third party. This means Highmark Delaware has the right to first dollar recovery of those funds, whether or not those funds make you whole. First dollar means that Highmark Delaware has first priority to recover from any and all payments made by the third party. Recovery means any judgment, settlement or other obligation to pay money. Highmark Delaware is entitled to recovery from any party possessing the funds.
- **Recovery from a third party.** Highmark Delaware is entitled to be paid from any recovery, no matter how the recovery is categorized. Some examples include recovery for lost wages only or pain and suffering only. You will be responsible for any attorney's fee and costs of litigation.

Some examples of your responsibilities include:

- **Notifying Highmark Delaware.** If you are involved in an accident or incident that results in both Highmark Delaware paying a claim and you having a claim against any third party, you must notify Highmark Delaware in writing within 30 days.
- **Cooperating with Highmark Delaware.** You are required to cooperate with Highmark Delaware and assist in the recovery from the third party.

LEGAL ACTION

No legal action may be brought against us for failure to provide benefits under this plan unless brought within 3 years from the date the service in question was rendered.

CANCELLATION FOR MISREPRESENTATION, FRAUD OR OTHER INTENTIONAL ACTS

We may cancel this plan at any time if we learn:

- That the statements you made at the time you applied for coverage were untrue or incomplete; or
- That you received or attempted to receive benefits under this plan under circumstances indicating fraud or other intentional misconduct; or
- You assisted another person as specified above.

HOW HIGHMARK DELAWARE PROTECTS YOUR CONFIDENTIAL INFORMATION

It is necessary for Highmark Delaware to receive information about you and your health to properly administer your plan benefits. This information is called "Personal Identifiable Health Information" and includes items such as your

- provider's name,
- tests that were done,
- diagnosis, or
- costs of treatment.

The following explains how Highmark Delaware protects the confidentiality of your Personal Identifiable Health Information.

YOUR RIGHT TO CONSENT OR DENY RELEASE OF INFORMATION

By enrolling with Highmark Delaware, you agree that we can receive information from your providers about care that you received. You also permit Highmark Delaware to release your Personal Identifiable Health Information to business associates outside Highmark Delaware, such as

- organizations that process claims,
- people who help coordinate services, or
- auditors.

We may need to release your Personal Identifiable Health Information to:

- process and pay claims,
- coordinate benefits when you're covered under another health plan,
- monitor care,
- help manage a chronic illness, such as diabetes or congestive heart failure,
- measure satisfaction through customer surveys, or
- conduct studies to measure our performance and our providers' performance.

In situations other than our routine business practice, Highmark Delaware will only release Personal Identifiable Health Information if you sign the *Notice of Specific Consent* form. The form will contain information such as what is being released, who is getting the information and why the information is needed.

WITHDRAWING CONSENT

If you signed a *Notice of Specific Consent* form, you may withdraw that consent by calling or writing Highmark Delaware's Customer Service Department. When you call, please specify which information indicated on the *Notice of Specific Consent* form you don't want released. However, if you withdraw that consent, the withdrawal will not affect any Personal Identifiable Health Information that Highmark Delaware has already released based on your signing the *Notice of Specific Consent* form.

SHARING YOUR INFORMATION WITH YOUR EMPLOYER

At times it may be necessary for Highmark Delaware to provide your employer with information such as

- medical cost experience

- claims volume
- cost savings.

This information helps your employer and Highmark Delaware to determine future premium rates. This information is also used to monitor Highmark Delaware's performance.

We do not release your Personal Identifiable Health Information to your employer without your signing a *Notice of Specific Consent* form, unless we are required to do so by law. The consent form will contain information such as what is being released, who is getting the information and why the information is needed.

YOUR RIGHT TO ACCESS MEDICAL RECORDS

You have the right to access the medical records that were originated by Highmark Delaware. Some examples of such records are the *Explanation of Benefits* and authorization of service forms. You can request your records by either writing or calling Highmark Delaware's Customer Service Department.

HOW HIGHMARK DELAWARE PROTECTS YOUR PRIVACY

All Highmark Delaware Employees are required to sign confidentiality statements when they're hired. Employees are then trained to follow certain guidelines to protect your confidential information. However, employees need to discuss your information with other employees when performing routine business practices, such as when they

- process claims,
- resolve disputes,
- answer inquiries, or
- coordinate care or benefits.

Much of your Personal Identifiable Health Information is on our computer network. Our employees are granted access to the network only on a need-to-know basis. Highmark Delaware's management determines the level of access that employees need to perform their job. Our systems are password protected. Passwords are periodically changed to prevent unauthorized access.

Highmark Delaware also requires that your providers follow confidentiality policies. We periodically audit providers to ensure that your medical records are kept private and that their staff has received confidentiality training.

USE OF MEASUREMENT DATA

We conduct surveys and health studies to measure customer satisfaction to help us improve our services. Health studies help us measure our performance and our providers' performance. Information collected during these studies is reported for the entire group rather than for one person. Your Personal Identifiable Health Information is not identified.

Highmark Delaware sometimes uses outside agencies to conduct surveys and studies. Highmark Delaware requires these agencies to sign a confidentiality agreement and to train their employees about confidentiality.

COMPLAINTS AND QUESTIONS

You have the right to file a complaint with us at anytime you feel that we have not maintained your privacy. You also have the right to ask questions about our confidential policy. To do either, please call Highmark Delaware's Customer Service Department at:

Long Distance Calls: 844-459-6452

SUGGESTIONS AND COMPLAINTS

Highmark Delaware welcomes questions, suggestions, and complaints. We study your comments to see how we can improve our service. Call or write Customer Service anytime you have a concern about Highmark Delaware's services, procedures or policies. We'll make every attempt to answer your questions and resolve any problems within 30 working days.

So that we can learn about our panel providers, you may also call or write us when you have a concern about:

- access to your PCP or other provider
- the care you received

Highmark Delaware's Address

Customer Service
Highmark Blue Cross Blue Shield Delaware
P.O. Box 8799
Wilmington, DE 19899-8799

Highmark Delaware's Customer Service Telephone Numbers

Long Distance Calls: 844-459-6452

Highmark Delaware's Internet Address:

www.highmarkbcbsde.com

To learn how to appeal benefits, see "Benefits Appeal" in the section, *A Guide to Claims.*

DEFINITIONS

Accident means accidental bodily injury that is sustained as the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while this plan is in force.

Admission means the period from the time you enter a hospital or skilled nursing facility as an inpatient until discharge.

Allowable Charge means the fee or price Blue Cross and Blue Shield of Delaware determines to be reasonable for services and supplies.

Benefit Period means the period beginning with the first day of admission to a hospital or Skilled Nursing Facility and ending when you have gone 60 consecutive days without admission to either a hospital or Skilled Nursing Facility.

Coinsurance means the portion of covered charges for services that, under Medicare, is your responsibility to pay. The coinsurance is the amount remaining after Medicare payment is made.

Deductible means a portion of covered charges for services which is payable before Medicare begins paying. The deductible amount is determined by Medicare.

Durable Medical Equipment means medically necessary equipment, prosthetic devices (artificial devices replacing body parts) and orthopedic braces used only during an illness or injury. It does not include disposable items.

Explanation of Benefits (EOB): A written statement issued to a member that provides detail concerning processing and payment of a claim for benefits, including the member's financial responsibility for services rendered.

Highmark Delaware means Highmark Blue Cross Blue Shield Delaware**.**

Hospital means any institution accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the American Osteopathic Association (AOA), and which operates pursuant to state law and which provides diagnostic and therapeutic facilities for services performed mostly on an inpatient basis. Such services must at a minimum include: surgical and medical diagnosis and treatment; and twenty-four hour a day nursing service under the direction or supervision of registered professional nurses. Hospital services must be supervised and rendered by a staff of physicians.

Inpatient means a person admitted to a hospital or skilled nursing facility for an overnight stay.

Licensed Practical Nurse means a person licensed as such by the state in which they practice nursing.

Medically Necessary means those services or supplies which are provided by a hospital, physician or other provider that are required to identify or treat an illness or injury and which, as determined by us, are:

- Consistent with the symptom or diagnosis and treatment of the condition, disease or injury;
- Appropriate with regard to standards of accepted professional practice;
- Not solely for your convenience, the doctor's convenience, or any other provider's convenience; and,
- The most appropriate supply or level of service that can safely be provided. When applied to an inpatient, it further means that the medical symptoms or condition require that the services or supplies cannot be safely provided as an outpatient.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended. Medicare includes Part A Hospital Insurance Benefits; Part B Supplementary Medical Benefits; and includes rules, regulations, directives and interpretations about these programs issued by the Secretary of Health and Human Services.

Medicare Eligible Expenses means the health care expenses of the kinds covered by Medicare and to the extent recognized as reasonable by Medicare.

Mental and Nervous Disorders means emotional and personality illnesses as classified by the International Classification of Diseases. Excluded are psychiatric services extending beyond the period necessary for evaluation and diagnosis of mental deficiency or retardation or illnesses determined by us as not amenable to favorable modification.

Outpatient means a person who is receiving services or supplies while not an inpatient in a hospital or skilled nursing facility.

Physician or Doctor means any person who is licensed to practice medicine and surgery, osteopathy, podiatry, chiropractic or dentistry and who is acting within the scope of that license.

Prescription Drugs means a substance which is used in the cure, treatment, or prevention of a disease or illness which can only be obtained upon a physician's prescription.

Reasonable Charge means the amount approved by the Medicare carrier as the allowable charge for reimbursement under the Medicare Program.

Registered Professional Nurse means a person licensed as such by the state in which he or she practices nursing.

Resource Based Relative Value Scale – a schedule established by the federal government to standardize physician payments as determined by the resource costs needed to provide them. The cost of providing each service is divided into three components: physician work, practice expense and professional liability insurance, each of which is resource-based. Payments are adjusted for geographical differences in resource costs.

Skilled Nursing Facility means extended care facilities, convalescent hospitals or rehabilitation centers providing skilled nursing care or rehabilitation services and approved by Medicare. Medicare's approval is based on the facility's guarantee of safety to the patient and effectiveness of the care rendered to the patients. These facilities provide:

- Skilled nursing and related services on an inpatient basis for patients who require continuous, 24 hour a day medical or nursing care.
- Rehabilitation for patients who require such care because of illness, disability or injury.

We, Us or Our refers to Highmark Blue Cross Blue Shield Delaware.

You and Your refers to the employee or any eligible dependents you have enrolled for coverage. You must be eligible for enrollment in the Medicare program and enter into agreement with us for supplementary coverage.

Sí necesita ayuda para traducir esta información, por favor comuníquese con el departamento de Servicios a miembros de Highmark Delaware al número al réves de su tarjeta de identificación de Highmark Delaware. Estos servicios están disponibles de lunes a viernes, de 8:00 a 19:00.

HIGHMARK BLUE CROSS BLUE SHIELD DELAWARE
NOTICE OF PRIVACY PRACTICES
PART I – NOTICE OF PRIVACY PRACTICES (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE ALSO DESCRIBES HOW WE COLLECT, USE AND DISCLOSE NON-PUBLIC PERSONAL FINANCIAL INFORMATION.

Our Legal Duties

At Highmark Blue Cross Blue Shield Delaware ("Highmark Delaware"), we are committed to protecting the privacy of your "Protected Health Information" (PHI). PHI is your individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer, or a health care clearinghouse that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you.

This Notice describes our privacy practices, which include how we may use, disclose, collect, handle, and protect our members' protected health information. We are required by applicable federal and state laws to maintain the privacy of your protected health information. We also are required by the HIPAA Privacy Rule (45 C.F.R. parts 160 and 164, as amended) to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We are also required to notify affected individuals following a breach of unsecured health information.

We will inform you of these practices the first time you become a Highmark Delaware customer. We must follow the privacy practices that are described in this Notice as long as it is in effect. This Notice becomes effective September 23, 2013, and will remain in effect unless we replace it.

On an ongoing basis, we will review and monitor our privacy practices to ensure the privacy of our members' protected health information. Due to changing circumstances, it may become necessary to revise our privacy practices and the terms of this Notice. We reserve the right to make the changes in our privacy practices and the new terms of our Notice will become effective for all protected health information that we maintain, including protected health information we created or received before we made the changes. Before we make a material change in our privacy practices, we will change this Notice and notify all affected members in writing in advance of the change. Any change to this notice will be posted on our website and we will further notify you of any changes in our annual mailing.

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

I. Uses and Disclosures of Protected Health Information

In order to administer our health benefit programs effectively, we will collect, use and disclose protected health information for certain of our activities, including payment and health care operations.

A. Uses and Disclosures of Protected Health Information for Payment and Health Care Operations

The following is a description of how we may use and/or disclose protected health information about you for payment and health care operations:

Payment

We may use and disclose your protected health information for all activities that are included within the definition of "payment" as set out in 45 C.F.R. § 164.501. We have not listed in this Notice all of the activities included within the definition of "payment," so please refer to 45 C.F.R. § 164.501 for a complete list.

►For example:

We may use and disclose your protected health information to pay claims from doctors, hospitals, pharmacies and others for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate benefits, to examine medical necessity, to obtain premiums, and/or to issue explanations of benefits/payments to the person who subscribes to the health plan in which you participate.

Health Care Operations

We may use and disclose your protected health information for all activities that are included within the definition of "health care operations" as set out in 45 C.F.R. § 164.501. We have not listed in this Notice all of the activities included within the definition of "health care operations," so please refer to 45 C.F.R. § 164.501 for a complete list.

►For example:

We may use and disclose your protected health information to rate our risk and determine the premium for your health plan, to conduct quality assessment and improvement activities, to credential health care providers, to engage in care coordination or case management, and/or to manage our business.

B. Uses and Disclosures of Protected Health Information To Other Entities

We also may use and disclose protected health information to other covered entities, business associates, or other individuals (as permitted by the HIPAA Privacy Rule) who assist us in administering our programs and delivering services to our members.

(i) Business Associates.

In connection with our payment and health care operations activities, we contract with individuals and entities (called "business associates") to perform various functions on our behalf or to provide certain types of services (such as member service support, utilization management, subrogation, or pharmacy benefit management). To perform these functions or to provide the services, business associates will receive, create, maintain, use, or disclose protected health information, but only after we require the business associates to agree in writing to contract terms designed to appropriately safeguard your information.

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

II. Other Possible Uses and Disclosures of Protected Health Information
In addition to uses and disclosures for payment and health care operations, we may use and/or disclose your protected health information for the following purposes.

A. To Plan Sponsors
We may disclose your protected health information to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan sponsor may contact us regarding a member's question, concern, issue regarding claim, benefits, service, coverage, etc. We may also disclose summary health information (this type of information is defined in the HIPAA Privacy Rule) about the enrollees in your group health plan to the plan sponsor to obtain premium bids for the health insurance coverage offered through your group health plan or to decide whether to modify, amend or terminate your group health plan.

B. Required by Law
We may use or disclose your protected health information to the extent that federal or state law requires the use or disclosure. For example, we must disclose your protected health information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws.

C. Public Health Activities
We may use or disclose your protected health information for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability.

D. Health Oversight Activities
We may disclose your protected health information to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs;
(iii) other government regulatory programs; and (iv) compliance with civil rights laws.

E. Abuse or Neglect
We may disclose your protected health information to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence.

F. Legal Proceedings
We may disclose your protected health information: (1) in the course of any judicial or administrative proceeding; (2) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (3) in response to a subpoena, a discovery request, or other lawful process, once we have met all administrative requirements of the HIPAA Privacy Rule. For example, we may disclose your protected health information in response to a subpoena for such information.

G. Law Enforcement
Under certain conditions, we also may disclose your protected health information to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (1) it is required by law or some other legal process; or (2) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person.

H. Coroners, Medical Examiners, Funeral Directors, and Organ Donation
We may disclose protected health information to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, we may disclose protected health information to organizations that handle organ, eye, or tissue donation and transplantation.

I. Research
We may disclose your protected health information to researchers when an institutional review board or privacy board has:
(1) reviewed the research proposal and established protocols to ensure the privacy of the information; and (2) approved the research.

J. To Prevent a Serious Threat to Health or Safety
Consistent with applicable federal and state laws, we may disclose your protected health information if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

K. Military Activity and National Security, Protective Services
Under certain conditions, we may disclose your protected health information if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, we may disclose, in certain circumstances, your information to the foreign military authority.
We also may disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.

L. Inmates
If you are an inmate of a correctional institution, we may disclose your protected health information to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to you; (2) your health and safety and the health and safety of others; or (3) the safety and security of the correctional institution.

M. Workers' Compensation
We may disclose your protected health information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

N. Others Involved in Your Health Care
Unless you object, we may disclose your protected health information to a friend or family member that you have identified as being involved in your health care. We also may disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you are not present or able to agree to these disclosures of your protected health information, then we may, using our professional judgment, determine whether the disclosure is in your best interest.

O. Underwriting
We may disclose your protected health information for underwriting purposes; however, we are prohibited from using or disclosing your genetic information for these purposes.

P. Health Information Exchange

We will participate in a Health Information Exchange (HIE). An HIE is primarily a secure electronic data sharing network. In accordance with federal and state privacy regulations, regional health care providers participate in the HIE to exchange patient information in order to facilitate health care, avoid duplication of services, such as tests, and to reduce the likelihood that medical errors will occur.

The HIE allows your health information to be shared among authorized participating healthcare providers, such as health systems, hospitals and physicians, for the purposes of Treatment, Payment or Healthcare Operations purposes. Examples of this health information may include:

- General laboratory, pathology, transcribed radiology reports and EKG Images.
- Results of outpatient diagnostic testing (GI testing, cardiac testing, neurological testing, etc.)
- Health Maintenance documentation/Medication
- Allergy documentation/Immunization profiles
- Progress notes/Urgent Care visit progress notes
- Consultation notes
- Inpatient operative reports
- Discharge summary/Emergency room visit discharge summary notes

All participating providers who provide services to you will have the ability to access your information. Providers that do not provide services to you will not have access to your information. Information may be provided to others as necessary for referral, consultation, treatment or the provision of other healthcare services, such as pharmacy or laboratory services. All participating providers have agreed to a set of standards relating to their use and disclosure of the information available through the HIE. Your health information shall be available to all participating providers through the HIE.

You cannot choose to have only certain providers access your information. Patients who do not want their health information to be accessible through the HIE may choose not to participate or may "opt-out."

In order to opt-out, you must call the customer service number located on the back of your membership card. You should be aware, if you choose to opt-out, your health care providers will not be able to access your health information through the HIE. Even if you chose to opt-out, your information will be sent to the HIE, but providers will not be able to access this information. Additionally, your opt-out does not affect the ability of participating providers to access health information entered into the HIE prior to your opt-out submission.

III. Required Disclosures of Your Protected Health Information
The following is a description of disclosures that we are required by law to make:

A. Disclosures to the Secretary of the U.S. Department of Health and Human Services
We are required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.

B. Disclosures to You
We are required to disclose to you most of your protected health information that is in a "designated record set" (defined below) when you request access to this information. We also are required to provide, upon your request, an accounting of many disclosures of your protected health information that are for reasons other than payment and health care operations.

IV. Other Uses and Disclosures of Your Protected Health Information

Sometimes we are required to obtain your written authorization for use or disclosure of your health information. The uses and disclosures that require an authorization under 45 C.F.R. § 164.508(a) are:

1. For marketing purposes
2. If we intend to sell your PHI
3. For use of Psychotherapy notes, which are notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. An Authorization for use of psychotherapy notes is required unless:

    a. Used by the person who created the psychotherapy note for treatment purposes, or
    b. Used or disclosed for the following purposes:
    (i) the provider's own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint family or individual counseling;
    (ii) for the provider to defend itself in a legal action or other proceeding brought by an individual that is the subject of the notes;
    (iii) if required for enforcement purposes;
    (iv) if mandated by law;
    (v) if permitted for oversight of the provider that created the note,
    (vi) to a coroner or medical examiner for investigation of the death of any individual in certain circumstances; or
    (vi) if needed to avert a serious and imminent threat to health or safety.

Other uses and disclosures of your protected health information that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of protected health information. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.

V. Your Individual Rights
The following is a description of your rights with respect to your protected health information:

A. Right to Access
You have the right to look at or get copies of your protected health information in a designated record set. Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so, if you request the information in an electronic format that is not readily producible, we will provide the information in a readable electronic format as mutually agreed upon. You must make a request in writing to obtain access to your protected health information.

To inspect and/or copy your protected health information, you may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. The first request within a 12-month period will be free. If you request access to your designated record set more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. If you request an alternative format, we will charge a cost-based fee for providing your protected health information in that format. If you prefer, we will prepare a summary or an explanation of your protected health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

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

B. Right to an Accounting
You have a right to an accounting of certain disclosures of your protected health information that are for reasons other than treatment, payment or health care operations. You should know that most disclosures of protected health information will be for purposes of payment or health care operations.

An accounting will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure.

You may request an accounting by contacting us at the Customer Service phone number on the back of your identification card, or submitting your request in writing to the Highmark Delaware Privacy Office, P. O. Box 8835, Wilmington, DE 19899-8835. Your request may be for disclosures made up to 6 years before the date of your request, but in no event, for disclosures made before April 14, 2003.

The first list you request within a 12-month period will be free. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

C. Right to Request a Restriction
You have the right to request a restriction on the protected health information we use or disclose about you for treatment, payment or health care operations. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement unless the information is needed to provide emergency treatment to you. Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing. We have a right to terminate this restriction, however if we do so, we must inform you of this restriction.

You may request a restriction by contacting us at the Customer Service phone number on the back of your identification card, or writing to the Highmark Delaware Privacy Office, P. O. Box 8835, Wilmington, DE 19899-8835. In your request tell us: (1) the information whose disclosure you want to limit; and (2) how you want to limit our use and/or disclosure of the information.

D. Right to Request Confidential Communications
If you believe that a disclosure of all or part of your protected health information may endanger you, you have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. For example, you may ask that we contact you only at your work address or via your work e-mail.

You must make your request in writing, and you must state that the information could endanger you if it is not communicated in confidence by the alternative means or to the alternative location you want. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to collect premiums and pay claims under your health plan, including issuance of explanations of benefits/ payments to the subscriber of the health plan in which you participate.

In the event that a Confidential Communication is placed against you, then you will no longer have the ability to access any of your health and/ or policy information online.

E. Right to Request Amendment
If you believe that your protected health information is incorrect or incomplete, you have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended.

We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

F. Right to a Paper Copy of this Notice
If you receive this Notice on our web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form. Please contact us using the information listed at the end of this Notice to obtain this Notice in written form.

VI. Questions and Complaints
If you want more information about our privacy policies or practices or have questions or concerns, please contact us using the information listed below.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made to amend or restrict the use or disclosure of your protected health information or to have us communicate with you in confidence by alternative means or at an alternative location, you may complain to us using the contact information listed below.

You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Office:	Highmark Delaware Privacy Office
Telephone:	1-866-568-3790 (toll free)
Fax:	1-877-750-2364
Address:	P. O. Box 1991 Wilmington, DE 19899-8835

PART II – NOTICE OF PRIVACY PRACTICES (GRAMM-LEACH-BLILEY)

Highmark Blue Cross Blue Shield Delaware (Highmark Delaware) is committed to protecting its members' privacy. This notice describes our policies and practices for collecting, handling and protecting personal information about our members. We will inform each group of these policies the first time the group becomes a Highmark Delaware member and will annually reaffirm our privacy policy for as long as the group remains a Highmark Delaware customer. We will continually review our privacy policy and monitor our business practices to help ensure the security of our members' personal information. Due to changing circumstances, it may become necessary to revise our privacy policy in the future. Should such a change be required, we will notify all affected customers in writing in advance of the change.

In order to administer our health benefit programs effectively, we must collect, use and disclose non-public personal financial information. Non-public personal financial information is information that identifies an individual member of a Highmark Delaware health plan. It may include the member's name, address, telephone number and Social Security number or it may relate to the member's participation in the plan, the provision of health care services or the payment for health care services. Non-public personal financial information does not include publicly available information or statistical information that does not identify individual persons.

Information we collect and maintain: We collect non-public personal financial information about our members from the following sources:

- We receive information from the members themselves, either directly or through their employers or group administrators.This information includes personal data provided on applications, surveys or other forms, such as name, address, Social Security number, date of birth, marital status,dependent information and employment information. It may also include information submitted to us in writing, in person, by telephone or electronically in connection with inquiries or complaints.

- We collect and create information about our members' transactions with Highmark Delaware, our affiliates, our agents and health care providers. Examples are: information provided on health care claims (including the name of the health care provider, a diagnosis code and the services provided), explanations of benefits/payments (including the reasons for claim decision, the amount charged by the provider and the amount we paid), payment history, utilization review, appeals and grievances.

Information we may disclose and the purpose: We do not sell any personal information about our members or former members for marketing purposes. We use and disclose the personal information we collect (as described above) only as necessary to deliver health care products and services to our members or to comply with legal requirements. Some examples are:

- We use personal information internally to manage enrollment, process claims, monitor the quality of the health services provided to our members, prevent fraud, audit our own performance or to respond to members' requests for information, products or services.

- We share personal information with our affiliated companies, health care providers, agents, other insurers, peer review organizations, auditors, attorneys or consultants who assist us in administering our programs and delivering health services to our members. Our contracts with all such service providers require them to protect the confidentiality of our members' personal information.

- We may share personal information with other insurers that cooperate with us to jointly market or administer health insurance products or services. All contracts with other insurers for this purpose require them to protect the confidentiality of our members' personal information.

- We may disclose information under order of a court of law in connection with a legal proceeding.

- We may disclose information to government agencies or accrediting organizations that monitor our compliance with applicable laws and standards.

- We may disclose information under a subpoena or summons to government agencies that investigate fraud or other violations of law.

How we protect information: We restrict access to our members' non-public personal information to those employees, agents, consultants and health care providers who need to know that information to provide health products or services. We maintain physical, electronic, and procedural safeguards that comply with state and federal regulations to guard non-public personal financial information from unauthorized access, use and disclosure.

For questions about this Privacy Notice, please contact:

Contact Office: Highmark Delaware Privacy Office
Telephone: 1-866-568-3790 (toll free)
Fax: 1-877-750-2364
Address: P. O. Box 1991
Wilmington, DE 19899-8835

State of DE Special Medicfill
Revised: 10/26/22

HIGHMARK Delaware | Freedom Blue PPO

FREEDOMBLUE MEDICARE ADVANTAGE
HIGHMARK BCBSD INC.
GROUP ACCOUNT AGREEMENT

This Group Account Agreement (the "Agreement") has been entered into between Highmark BCBSD Inc.("the Health Plan"), and the State of Delaware(the "Group").

The Health Plan, in consideration of the monthly payments to be paid to Health Plan by the Group or by the Member (as hereinafter defined), agrees to provide those Medicare eligible persons who enroll ("Members") under a Medicare Advantage program ("MA Plan") for the Covered Services (as defined in the Evidence of Coverage (including the Medical Benefits Chart), in accordance with the terms, conditions, limitations and exclusions of this Agreement and the Evidence of Coverage. In the event of a conflict between this Agreement and any other documents relevant to coverage for the Covered Services, the terms and conditions of the Evidence of Coverage including any addenda thereto shall apply and shall be deemed to supersede any conflicting terms and conditions.

ARTICLE I - GROUP ELIGIBILITY

On the Commencement Date (hereinafter defined) of this Agreement, the parties agree that Group is not subject to any minimum number of enrolled Members in order to be eligible for the MA Plan so long as Health Plan is the exclusive medical plan offering for all Group's Medicare-eligible participants.

ARTICLE II - TERM AND TERMINATION

This Agreement shall continue in effect from year to year, beginning on January 1, 2023 (the "Commencement Date"), for a minimum period of three years ending December 31, 2025 as set forth more fully herein. The Group has a right to terminate at the end of the three-year contract period by providing one hundred twenty (120) days' prior written notice to Health Plan. Health Plan has the right to terminate this Agreement by giving sixty (60) days prior written notice to the Group in the event the Group fails to pay any premium due. The Group and Health Plan acknowledge and agree that the coverage provided hereunder for each of the Members is in consideration of payments made by the Group on behalf of each such Member, as provided below. Health Plan has the right to disenroll any Member if the Group does not pay the premium on behalf of such Member. If the Group terminates this Agreement for any reason, Health Plan shall have no liability to any Member, except as specifically provided hereunder or under applicable laws and regulations. Any disenrollment of a Member shall be done in accordance with the Evidence of Coverage.

ARTICLE III - SERVICE AREA

The service area for this Agreement shall be the geographical areas designated by Health Plan (the "Service Area"), as approved by the Centers for Medicare and Medicaid Services ("CMS"). For purposes of this Agreement, the Service Area shall include all 50 states, the District of Columbia, and all United States territories.

ARTICLE IV - RATES

Group shall have no plan premium for the MA Plan during the first year and for the following two years (calendar years 2024 and 2025, respectively) during this Agreement. As applicable, rates per Member per month ("PMPM") under this Agreement shall be payable to Health Plan by the Group on behalf of each such Member by the 30th day of the coverage month under this Agreement as follows

January 1, 2023 through December 31, 2023	$0
January 1, 2024 through December 31, 2024	$0
January 1, 2025 through December 31, 2025	$0

If Group elects to renew this Agreement for calendar years 2026 and/or 2027, then the MA Plan will be subject to guaranteed rate caps as outlined below and as subject to Article V. Rates per Member per month under this Agreement shall be payable to Health Plan by the Group on behalf of each such Member by the 30th day of the coverage month.

YEAR	GUARANTEED RATE CAP
January 1, 2026 through December 31, 2026	$5
January 1, 2027 through December 31, 2027	$10

Group acknowledges that rates and/or rate-related terms and conditions of this Agreement are subject to the conditions set forth in Article V below. If any of the conditions set forth in Article V become applicable, Health Plan agrees to provide written notice to Group within thirty (30) days of the Group becoming aware of the Article V condition in the form of a renewal addendum detailing any such anticipated changes to rates and/or rate-related terms and conditions. Group acknowledges that the new rates and/or rate-related terms and conditions will be effective on the next January 1 following the Group (i) signing and returning such renewal addendum to Health Plan, which represents an express acceptance of the new rates and/or rate-related terms and conditions contained therein, and Group agrees to be legally bound thereunder unless Group specifically terminates this Agreement pursuant to the required procedure set forth above; or (ii) continuing to treat the Agreement as being in effect and failing to notify Health Plan in writing of its termination of the Agreement within the required notice period set forth above in Article II., Group and Health Plan acknowledge and agree that the executed renewal addendum shall be incorporated into this Agreement and made a part hereof as a rider, and the terms and conditions contained therein shall have the same force and effect of the other provisions of this Agreement.

Group agrees that if it pays or subsidizes all or any portion of the rate due for a Member, it will do so in accordance with the following:

1. If Group pays or subsidizes different amounts of rates for different classes of Members, the class differentiation must be reasonable and based on objective business criteria, such as years of service, business location, job category, and nature of compensation (hourly vs. salaried) and not on eligibility for the Low-Income Subsidy (as defined below);
2. The rate paid by a Member cannot vary within a class of Members;

ARTICLE V – GUARANTEED RATE CAP AND PREMIUM CONDITIONS

The maximum premium shown for all years is based upon Health Plan retaining at least 30,000 active contracts (includes all active employees and non-Medicare retiree contracts). If the active contract count is below 30,000 on July 1 prior to the calendar year of the MA Plan coverage, then all the premiums and guaranteed rate caps outlined in this Article IV will increase by $19 PMPM.

The guaranteed rate caps in calendar years 2026 and 2027 are subject to achievement of a minimum Medical Loss Ratio ("MLR") as outlined below:

Calendar Year 2026 (MLR measured from July 1, 2023 through June 30, 2024)

MLR <90%	$0 premium
If 90% <=MLR <=95%	$5 maximum premium (expected premium reflected in the above table)
MLR >95%	$20 maximum premium

Calendar Year 2027 (MLR measured from July 1, 2024 through June 30, 2025)

MLR <90%	$0 premium
If 90% <=MLR <=95%	$10 maximum premium (expected premium reflected in the above table)
MLR >95%	$30 maximum premium

For purposes of this Agreement, MLR is defined as (Incurred Claim Expenses + Provider Capitations + Provider/Vendor Managed Care Incentives and Payments) / (CMS Revenue + Client Premium)

In the event of a benefit change during the MLR measurement period, Highmark will make an adjustment to the MLR calculation to reflect the expected net actuarial value of the impact of the benefit change. The net adjustment will account for both the impact to incurred claims as well as any offsetting premium/revenue that may be associated with the change.

Further, the following Additional Premium Considerations conditions apply to the premium guarantees for all years:

Network contracting – There are no legislative or regulatory changes that would materially impact Health Plan's ability to contract for an efficient provider network.

CMS funding – There are no legislative or regulatory changes that reduce CMS revenue funding for Medicare Advantage, including, but not limited to, the following components: 1) benchmarks; 2) rebates; 3) coding and/or risk adjustment; and 4) Stars and/or quality bonuses.

Regulatory changes – There are no legislative, regulatory, or enforcement actions that cause a material change to any of the following: 1) benefits offered; 2) claim payment requirements or procedures; 3) taxes, fees, or assessments; 4) sequestration; 5) expected claim payment levels (for example, State or Federal Mandates that impact provider reimbursements, PCP payment levels, etc.); and 6) any other changes affecting the manner or cost of providing coverage that is required because of legislative or regulatory action.

Out-to-bid provision – Rate guarantees for calendar years 2026 and 2027 will be terminated if Group puts its Medicare Advantage coverage out to bid for the 2026 or 2027 calendar years.

Use of pharmacy data for medical management – The medical rates assume that Health Plan receives pharmacy data feeds every two weeks in a mutually agreed upon format from the Group's designated third party. The medical rates are subject to revision if either of these conditions do not occur. Health Plan agrees to work directly with the Group's prescription drug third party administrator to develop and implement appropriate pharmacy data feeds.

End stage renal disease – Group agrees not to enroll Members and their dependents who are Medicare beneficiaries diagnosed with End Stage Renal Disease ("ESRD Beneficiaries") in the MA Plan during the 30-month coordination period. Note, however, this provision does not apply to a Member who develops end stage renal disease while enrolled in the MA Plan. Further, this provision does not apply to a Member who has met the 30-month coordination period, leaves the MA Plan, and then subsequently reenrolls in the MA Plan.

Benefit Plan Changes – There are no material changes to the products, programs, current or proposed benefits under the Medicare Advantage medical plan.

Employer contribution requirements – This Agreement is based on a minimum employer contribution level of 50% of the group premium for the medical plan. If the average employer contribution falls below 50%, the medical plan rates are subject to revision.

ARTICLE VI – GAIN SHARE

This Agreement includes a Medicare Advantage Retrospective Gain Share ("Gain Share") with Group with separate settlements for each calendar year 2023 through 2025, as well as calendar years 2026 and 2027, if applicable.

Any reconciliation amount determined according to this Gain Share provision will be paid by Health Plan in a lump sum settlement. Interest will not accrue on the payments. Upon termination or non-renewal of the Agreement, Health Plan will pay Group 50% of any amount due related to the last year of coverage.

The parties understand that CMS usually performs a final payment reconciliation of CMS revenue in June of the calendar year following the year of coverage and that this is a critical part of the revenue calculation. Therefore, the reconciliation and any gain share payment will occur within 60 days after the CMS final payment is released for a given calendar year. The timing is subject to change if CMS changes the schedule of its final payment.

The Gain Share will be reconciled in aggregate across all retiree sub-groups and will be calculated as follows:

Actual Medicare Advantage Incurred Medical Loss Ratio (MLR)	**Each calendar year of coverage will be measured independently**
If the MLR is greater than or equal to 88.0%, then	There is no gain share payment
If the MLR is between 86% and 88% then:	Health Plan will pay a lump sum payment equal to 50% of the difference between the actual MLR and 86%

If the MLR is less than 86% then:	Health Plan will pay a lump sum payment equal to: • 50% of the value between 86% and 88% plus • 80% of the difference between the Actual MLR and 86%

The **Medical Loss Ratio (MLR)** will be calculated as follows:

[Incurred Claim Expenses + Provider Capitations + Provider/Vendor Managed Care Incentives and Payments]

Divided by

[CMS Revenue + Client Premium]

If CMS retroactively adjusts revenues paid to Health Plan with respect to the Group's Medicare Advantage coverage, impacting the total revenue used in the Gain Share calculation, Health Plan reserves the right to provide a revised reconciliation based on corrected CMS revenue data and the Group shall reimburse Health Plan for any overpayments. Such amounts shall be paid within one hundred twenty (120) days of receipt of the reconciliation. The maximum liability of Group is limited to the value of any gain share payments received. This provision survives the termination of this Agreement.

For purposes of this Article VI, the following definitions and assumptions shall apply:

Incurred Claim Expenses are on an incurred basis, including fee-for-service (FFS) and non-FFS claims, as well as a provision for Incurred but Not Reported (IBNR) claims.

Provider Capitations are any payments to providers paid on a capitated basis

Provider/Vendor Managed Care Incentives and Payments are any payments/incentives to providers or vendors related to value-based reimbursement arrangements, STARS, and/or Risk Adjustment

CMS Revenue includes amounts paid to Health Plan by CMS on behalf of State of DE Group Members.

Client Premium includes amounts paid to Health Plan by Group for the Medicare Advantage coverage.

ARTICLE VII – PERFORMANCE GUARANTEES

This Agreement is subject to performance guarantees by Health Plan as outlined in Exhibit 1, which is attached hereto and by reference incorporated into this Agreement.

ARTICLE VIII – REPORTING

The Health Plan agrees to provide reporting as defined and outlined by Health Plan in Exhibit 2, which is attached hereto and by reference incorporated into this Agreement.

As part of the reporting outlined by the health plan Exhibit 2, the Health Plan agrees to provide the specific reports as indicated below related to prior authorizations and appeals:

1. Total number of prior authorizations submitted, the percentage approved, the percentage of denials, in total and for defined service categories on a monthly basis.
2. Initial prior authorization decisions timing for standard and urgent/expedited requests on a monthly basis.
3. Number of prior authorization denial appeals received at 1st level – 5th level appeal on a quarterly basis.
4. Percentage of appeals that are upheld or overturned at 1st level appeal – 5th level appeal on a quarterly basis.

Attached as Exhibit 3 is a list of the current items, procedures and/or services for which prior authorization is required. The Health Plan's prior authorization list is subject to change, and the Health Plan has the authority to add or remove items, procedures and/or services from the prior authorization list at its sole discretion.

ARTICLE IX - IMPLEMENTATION

The parties agree to the following related to implementation of MA Plan:

- The Health Plan will suspend outpatient prior authorization requirements for Members for a four-month period beginning January 1, 2023 and ending May 1, 2023;
- The Health Plan shall provide $600,000 to the Group to offset the costs of the Group's communications to its participants and other costs associated with the Group's transition to the MA Plan ("Implementation Offset").
- The Implementation Offset shall be paid to the Group as an ASO administrative fee invoice credit towards the Group's administrative fees for December 2022.
- If Group cancels before the Commencement Date of this Agreement, Group shall refund the Health Plan the Implementation Offset within ten (10) business days following the cancelation.

ARTICLE X - CUSTOMER SERVICE AND CONCIERGE SUPPORT

The Health Plan agrees to provide direct concierge support to the Group and its members during the implementation period and throughout the duration of this contract. The Health Plan agrees to provide direct concierge support to members regarding provider network status in lieu of steering group members to the Health Plan self-navigate online option. The Health Plan further agrees to the following during the duration of this contract:

- Designated customer service team with a dedicated toll-free line for the Group, to be owned by the Health Plan;
- Customer service and culture trainings conducted by the Group and/or the Health plan as needed;
- The Health Plan will be responsible for the employment of an Executive Client Manager who will be dedicated to the Group account for the full duration of Agreement;
- The Group will have final approval of selected candidate for Executive Client Manager position; and
- Health Plan will hire, train, and retain a designated Medicare Advantage concierge service team for the Group for the duration of the Agreement.

ARTICLE XI - BENEFIT CHANGES

The benefit plan design of Health Plan for the Group is subject to change annually at the beginning of each calendar year in accordance with CMS guidelines and subject to CMS approval. Health Plan reserves the right to revise the benefit selection it provides to conform to changes made by CMS during the course of the calendar year. Additionally, the Group may change the benefit selection during the year by providing at least one hundred and eighty (180) days advance written notice to the Health Plan. In the event such changes affect the costs of Health Plan, Health Plan reserves the right to modify premium rates accordingly. Changes will be effective on the first day of the month immediately after the one hundred and eighty (180) day notice period has lapsed or at an agreed upon date. The Group agrees to provide all Members with at least twenty-one (21) days advance written notice of any changes.

ARTICLE XII - OPEN ENROLLMENT

The Group agrees to provide an annual coordinated election held during a designated period of time during the last four months of each calendar year (the "Open Enrollment Period"). The enrollment becomes effective the first day of the following year (January 1). The annual Open Enrollment Period shall, at minimum, consist of notification of retiree health benefit options, changes in premiums or benefits and the ability to enroll or disenroll, and other notifications required by CMS; and all such information shall be provided by Health Plan.

The Group will provide Health Plan (as directed by Health Plan) with requested information as to which employees or retirees are eligible to be Members (as set forth in the Evidence of Coverage and subject to applicable law).

Group agrees that employees or retirees can enroll using a Group enrollment process as allowed by CMS.

Health Plan will accept enrollment directly from Group without receiving an election form from each employee or retiree. Group agrees that in order to use this process:

i. Group must submit to Health Plan enrollment information that accurately reflects Group's record of the coverage election made by each individual.

ii. Group agrees that the beneficiary notice requirements prescribed by CMS are not changed by using this Group enrollment process. Group further agrees that each employee's or retiree's enrollment request must clearly denote his/her agreement to abide by Health Plan rules, certify his/her receipt of required disclosure information and include authorization by the beneficiary for the disclosure and exchange of necessary information between the U.S. Department of Health and Human Services (and its designees) and Health Plan.

iii. The enrollment request transaction must include all the data necessary for Health Plan to determine each individual's eligibility to make an enrollment request. Such data shall include at least the following: MA Plan name; MA plan/product choice; beneficiary name (first and last); beneficiary Medicare number (HICN); beneficiary date of birth; gender; permanent residence address or P.O. Box; authorized representative contact information (if applicable); and Part A and Part B effective dates.

iv. The effective date will generally be the first day of the month after the month Health Plan receives the completed enrollment request or the date specified by the Group.

v. Group and Health Plan's electronic enrollment transactions must, at a minimum, comply with CMS security policies. Examples of this method are 'FTP' file, password protected spread sheets or encrypted files.

vi. Group's record of the request to enroll must exist in a format that can be easily, accurately and quickly reproduced for later reference by each individual member, Health Plan and/or CMS, as necessary. Group shall send this record to Health Plan within three (3) business days of receipt of Health Plan's written request. The record shall be maintained by Health Plan for ten (10) years or through the date of the completion of any CMS audit, whichever is later.

ARTICLE XIII - DISENROLLMENT

In certain circumstances, a Member may be disenrolled on either a voluntary or involuntary basis. Group and Health Plan will work cooperatively to ensure that Member disenrollments are handled in accordance with the CMS Enrollment and Disenrollment Guidance. At a minimum, disenrollments will be conducted in accordance with one of the following procedures:

a. For voluntary disenrollments other than described in (c) below and for involuntary disenrollments other than those described in (b) below, Health Plan will process the disenrollment under the individual disenrollment requirements specified in the CMS Enrollment and Disenrollment Guidance.

b. For involuntary disenrollments that occur when the Group determines that a Member is no longer eligible to participate in the Group MA Plan, Group shall follow the below process, as applicable.

Group and Health Plan also agree:

i. Group will (including in cases where Health Plan or Group terminates this Agreement):

(1) Provide a prospective notice to the affected Member(s): alerting them of the termination event and describing other health plan or health insurance options that may be available through Group. This notice must be received by the member no less than twenty-one (21) days prior to the effective date of disenrollment.

(2) Provide a prospective notice of the termination event to Health Plan. This notice must be sent one hundred twenty (120) days prior to the effective date of disenrollment; and

(3) Provide Health Plan with all information necessary for Health Plan to submit a complete disenrollment request transaction to CMS.

c. Health Plan may accept a voluntary disenrollment request directly from Group without receiving an election form from each employee or retiree. Group agrees that in order to use this process:

i. Group must submit to Health Plan information that accurately reflects Group's record of the disenrollment made by each Member. Health Plan must maintain its record of information received from Group for ten (10) years or through the date of the completion of any CMS audit, whichever is later.

ii. Group and Health Plan's electronic disenrollment transactions must, at a minimum, comply with CMS electronic security policies.

iii. Health Plan's receipt date for the disenrollment request will be the date Group's record of a Member's disenrollment choice is received by Health Plan. The effective date of disenrollment cannot be prior to receipt date.

iv. Group's record of the request to disenroll must exist in a format that can be easily, accurately and quickly reproduced for later reference by each individual member, Health Plan and/or CMS, as necessary. Group shall include that record when Group sends its next weekly file to Health Plan. Health Plan shall maintain Group's record of the request to disenroll for at least ten (10) years after the effective date of the individual's disenrollment or through the date of the completion of any CMS audit, whichever is later.

d. Group agrees to retain, for a period of ten (10) years from the effective date of disenrollment, and to provide to Health Plan upon request, documents evidencing Group's adherence to the requirements set forth in this Article VII.

ARTICLE XIV - RETROACTIVITY

The Group can elect to allow for a retroactive enrollment as long as the request for enrollment of the applicant is prior to the requested effective date and the reason for the retroactive enrollment is acceptable to Health Plan. The Group will supply Health Plan with accurate and complete enrollee information, in a format mutually agreeable to the Group and Health Plan, no later than sixty (60) days after the retroactive date of coverage.

ARTICLE XV – ADDITIONS TO COVERAGE (Outside the Open Enrollment Period)

Newly eligible Members may be covered under this Agreement in accordance with the terms of this Agreement or as required by applicable law. Newly eligible Members include:

- All newly Medicare eligible retired employees and/or spouses (age 65 and over or disabled)
- Eligible plan participants of the Group with a qualifying event, who are otherwise eligible to elect coverage under this Agreement

Newly eligible members shall have coverage according to the rules for enrollment outside of the open enrollment period under the Group's retiree health benefits plan.

The Group must provide Health Plan with accurate and complete enrollee information in a format mutually agreeable to both parties. Health Plan and the Group agree to provide health care coverage effective on the first day of the month approved by CMS for each enrollment.

ARTICLE XVI – APPEALS

Group Members have the right to appeal coverage decisions made by the Health Plan. There are five (5) levels of the appeals process with specific deadlines established by CMS for a response from the party reviewing the appeal. The appeals process includes:

- Level 1 appeal made by the Member to the Health Plan, conducted by a physician employed by the Health Plan who did not make the original coverage decision and is not a subordinate of that physician.
- Level 2 appeal made by the Member to an Independent Review Organization, an independent organization hired by Medicare.
- Level 3 appeal made by the Member to an Administrative Law Judge or attorney adjudicator.
- Level 4 appeal made by either the Member or the Health Plan to the Medicare Appeals Council, part of the Federal government.
- Level 5 appeal made by either the Member or the Health Plan to a judge at the Federal District Court.

Additional details on the required timeframes associated with filing appeals and response deadlines are outlined in the Health Plan Evidence of Coverage. The parties acknowledge that CMS may change the criteria, deadlines, or the appeals process from time to time. If CMS enacts such changes that will affect this Article XVI, the parties agree to abide by the most current CMS appeals process.

ARTICLE XVII - CONFIDENTIALITY

The Group acknowledges and agrees that the Agreement contains terms and conditions that are considered trade secrets or commercial or financial information which, under Section 10002 of Title 29 of the Delaware Code would not be disclosed as a public record. Notwithstanding the foregoing, and only at the express request of the Group, Health Plan has consented to a one-time waiver of the

confidentiality of the provisions contained in this Agreement for the sole purpose that Group can publicly disclose the Agreement without redaction. The parties understand and agree that this waiver shall not constitute any course of dealing or course of performance with respect to the parties or with respect to Health Plan's trade secrets or confidential and proprietary information generally or with respect to trade secrets or confidential and proprietary information contained within any other Health Plan contracts or agreements with Group or any other governmental entity or private party. The parties agree that this one-time waiver is limited to this Agreement only and the precise terms contained within this Agreement. This provision shall survive the expiration or termination of this Agreement.

The records of Health Plan developed and maintained in conjunction with providing payments of benefits under the terms of this Agreement shall remain proprietary and confidential to Health Plan and shall not be publicly disclosed pursuant to the above paragraph of this Article. To the extent that the Group requires such information, the Group shall in every case comply with the procedures of Health Plan for obtaining such information and hold such information in the strictest confidence.

ARTICLE XVIII - RELEASE OF INFORMATION

The parties acknowledges that Members have been advised during the enrollment process that any person or entity having information relating to any illness or injury for which benefits are claimed under this Agreement may furnish to Health Plan, upon its request, any information (including copies of records) relating to the illness or injury. In addition, Health Plan may furnish similar information to other entities providing similar benefits at their request.

Health Plan may also furnish other plans or plan sponsored entities with membership and/or coverage information for the purpose of claims processing or facilitating patient care.

To the extent permitted by law, Health Plan may undertake the following actions: Health Plan may implement quality of care and medical management initiatives with CMS approval. Health Plan may review Members' medical records to evaluate care and determine if it meets professional and industry standards. Health Plan, with CMS approval, may communicate directly with Members and their providers to promote preventive care or to discuss potentially beneficial treatment options, and may solicit Member opinions through telephone and mail surveys. Health Plan, as permitted by law, may share information about Members with designated agents, including medical professionals and other health care experts.

ARTICLE XIX - PRIVACY COMPLIANCE - GROUP CUSTOMER

Member Privacy: All personally identifiable information about Members ("Protected Member Information") is subject to various statutory privacy standards, including the regulations of the Delaware Department of Insurance implementing Title V of the Gramm-Leach-Bliley Act (18 Del. Admin. C. § 904); and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and regulations adopted thereunder by the Department of Health and Human Services (45 CFR Parts 160, 162, 164). The parties will treat all such information in accordance with those standards. Health Plan may use or disclose Protected Member Information to facilitate payment, treatment and healthcare operations, or to comply with judicial process or any applicable statute or regulation.

Certification of Compliance: The Group will maintain the confidentiality of all Protected Member Information, in accordance with applicable federal, state and local laws and regulations. The Group hereby certifies its compliance with the requirements applicable to the Group, as "Plan Sponsor," to continue to receive Protected Member Information pursuant to 45 C.F.R. § 160.504(f).

Business Associate Agreements: If either party should be considered a "business associate" of either party for purposes of HIPAA, the parties will adopt an appropriate addendum to this Agreement to include the specific mandated contract clauses applicable to "business associates" under 45 C.F.R. § 164.504(e)(2).

Other Assurance: The parties further agree that they will adopt such policies and procedures, execute such written agreements, and provide such further assurances as may be required to make their activities under this Agreement compliant with any regulations of the U.S. Department of Health and Human Services adopted pursuant to HIPAA, including, without limitation, the following:

Information Safeguards	45 CFR § 164.530(c)
Standard Transactions	45 CFR Part 162
Data Security	45 CFR Part 164

ARTICLE XX - UTILIZATION MANAGEMENT

Health Plan may in certain cases allow for certain exceptions to the utilization management program provided through this Agreement, in its sole discretion, when the exceptions result in the more efficient administration of this Agreement. The exceptions may include, but are not limited to, waiver of referral requirements, waiver of authorization requirements, case management that results in the modification of benefits, and standing authorizations or referrals for certain conditions. For all other exceptions, the utilization management program (including any exceptions thereto) shall be administered as provided in the Evidence of Coverage and the internal policies and procedures of Health Plan, all in compliance with CMS regulations.

ARTICLE XXI- COMPLIANCE WITH LAW/AMENDMENT

Health Plan shall have the right for the purpose of complying with the provisions of any law or lawful order of a regulatory authority to amend this Agreement, including, without limitation, the Evidence of Coverage, any addendum and any Schedules attached hereto, or to increase, reduce or eliminate any of the benefits provided for in the Evidence of Coverage or any addendum for eligible Members enrolled under this Agreement, and each party hereby agrees to any amendment of this Agreement and/or the Evidence of Coverage which is necessary in order to accomplish such purpose.

ARTICLE XXII- NOTICES

Unless otherwise provided herein, all notices required or permitted to be sent in accordance with this Agreement may be either personally delivered or sent by regular U.S. mail or other nationally recognized overnight carrier service, to the following addresses:

To Group at:
STATE OF DELAWARE
Statewide Benefits Office
Enterprise Business Park
97 Commerce Way, Suite 201
Dover, DE 19904

To Health Plan at:
HIGHMARK BCBSD INC.
800 Delaware Avenue, Suite 900
Wilmington, DE 19801

Any party may change the address listed herein by sending notice of such change in writing to the other party in accordance with the method outlined in this Article.

ARTICLE XXIII - GOVERNING LAW/MISCELLANEOUS

The parties hereby acknowledge that this Agreement is governed by federal law. In the event that any terms or conditions contained in this Agreement are held to be invalid or unenforceable, such terms or conditions shall be severable, and the invalidity or unenforceability of those terms or conditions shall in no way affect the validity or enforceability of any other terms or conditions contained herein. The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach or violation thereof.

ARTICLE XXIV - LIMITATIONS ON LIABILITY

The Health Plan has no liability for the acts or omissions of any provider or supplier providing Covered Services. In the event that the performance of obligations or the rendering of services provided under this Agreement is delayed or rendered impractical due to circumstances not within the reasonable control of Health Plan, including, but not limited to, a major disaster, epidemic, civil insurrection or similar causes, Health Plan will make a reasonable effort to arrange for performance. Neither Health Plan nor its participating providers will incur liability or obligation for delay or failure to provide or arrange for services under such circumstance.

ARTICLE XXV - REQUIRED DISCLOSURE OF INFORMATION

The Group agrees to provide Health Plan with all information relative to eligibility waiting periods, including, but not limited to, the existence and length of any such period imposed by the Group which Health Plan deems necessary for the purposes of complying with the requirements of HIPAA and the regulations thereunder. The Group further agrees that should the Group fail to provide said information in an accurate and timely manner, it shall reimburse Health Plan for all costs (including, but not limited to, attorney fees and court costs), fines, penalties, expenses and any other monetary losses incurred by Health Plan resulting from the Group's failure to provide said information.

ARTICLE XXVI - ENTIRE AGREEMENT

This Agreement constitutes the entire agreement between the parties and supersedes all prior discussions, negotiations, agreements, and understandings, both written and oral, between Health Plan and the Group on this subject matter. No statements or representations may be used in any legal dispute regarding the terms or any exclusions or limitations hereunder unless specifically contained in this Agreement. None of the terms or provisions of the Articles of Incorporation or Bylaws of Health Plan will form a part of this Agreement or be used in any suit hereunder unless the same is set forth in full herein. No change in this Agreement shall be valid except by an amendment or addendum signed and accepted by both parties.

ARTICLE XXVII - POLICIES AND PROCEDURES

Health Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Agreement.

ARTICLE XXVIII - ASSIGNMENT

Health Plan may assign or subcontract any or all rights or obligations under this Agreement to a subsidiary or affiliate of Health Plan or any designated subcontractor.

ARTICLE XXIX - RELATIONSHIP TO BLUE CROSS AND BLUE SHIELD PLANS

This Agreement is between the Group, on behalf of itself and its Members, and Health Plan only. Health Plan is an independent corporation operating under licenses from the Blue Cross and Blue Shield Association ("the Association"), which is a national association of independent Blue Cross and Blue Shield Plans throughout the United States. Although all of these independent Blue Cross and Blue Shield Plans operate from a license with the Association, each of them is a separate and distinct corporation. The Association allows Health Plan to use the familiar Blue Cross and Blue Shield words and symbols. Health Plan, which is entering into this Agreement, is not contracting as an agent of the national Association. Only Health Plan shall be liable to the Group for any of Health Plan's obligations under this Agreement. This paragraph does not add any obligations to this Agreement.

ARTICLE XXX – OUT-OF-AREA SERVICES – BLUE CROSS AND BLUE SHIELD MEDICARE ADVANTAGE PROGRAM – FREEDOMBLUE PPO

Health Plan has relationships with other Blue Cross and/or Blue Shield Licensees ("Host Blues") to administer the Blue Cross and Blue Shield Medicare Advantage Program outside of the geographic area Health Plan serves (referred to hereinafter as the "BCBS Medicare Advantage Program."). When Members access healthcare services outside the geographic area that Health Plan has designated as the Service Area, the claim for those services will be processed through the BCBS Medicare Advantage Program and presented to Health Plan for payment in accordance with the rules of the BCBS Medicare Advantage Program policies then in effect. The BCBS Medicare Advantage Program available to Members under this Agreement is described generally below.

Member Liability Calculation

The cost of the service, on which member liability (copayment/coinsurance) is based, will be either:

- The Medicare allowable amount for covered services, or
- The amount either Health Plan negotiates with the provider, or the Host Blue negotiates with its provider on behalf of Health Plan Members, if applicable. The amount negotiated may be either higher than, lower than, or equal to the Medicare allowable amount.

IN WITNESS WHEREOF, the parties have read this Agreement and agree to be bound by it and therefore have caused it to be executed by their duly authorized representatives.

GROUP: **STATE OF DELAWARE**
Statewide Benefits Office
Enterprise Business Park
97 Commerce Way, Suite 201
Dover, DE 19904

By: Faith L. Rentz

Title: Faith Rentz, Director, Statewide Benefits Office

Date: 09/28/2022

HIGHMARK BCBSD INC.:
800 DELAWARE AVENUE, SUITE 900
WILMINGTON, DE 19801

By: _____

Title: Alexis Miller President, Highmark Federal Markets.

Date: 9/28/22

EXHIBIT 1

PERFORMANCE GUARANTEES

EXHIBIT 1

MEDICARE ADVANTAGE PERFORMANCE GUARANTEES

Plan Administration

Terms: Vendor will perform a review of its records to determine whether each standard was met for the time period of the quarter immediately preceding the 45th day of the month following the end of a quarter (for example, April 15 for the first quarter (January 1 – March 31) of the plan year (January 1 to December 31). Quarterly results will be averaged on an annual basis and penalty payments, if any, will be made annually within six (6) months of the end of the plan year. In no instance will a measurement or penalties apply to any period less than a full quarter.

Highmark reserves the right to revise or void these measures upon discussion between Highmark and the State, and with the consent of the State, such consent not to be unreasonably withheld, in the event a public health emergency is declared affecting (i) one or more Highmark service locations that support Services under this Agreement; and/or (ii) geographic area(s) of work or residence of ten (10%) or more Members. The preceding shall apply whether a public health emergency is declared by the World Health Organization or by an agency or instrumentality of government in the relevant geographic area(s) having such authority.

Performance Guarantee	Standard	Performance Measure	Frequency of Reporting	Dollars at Risk
Implementation/Open Enrollment Each Plan Year				
Future Contract Development	Highmark will incorporate all of the minimum requirements in the RFP and any variance identified in the bid response accepted by the State for performance commitments in the first draft of the contract. The vendor cannot propose changes that are not included in the terms of the RFP or their bid offering necessitating an excessive number of drafts.		n/a	$50,000
Implementation and Account Manager Performance	Implementation manager and account executive /manager will participate in every implementation call and will be		n/a	$50,000

Performance Guarantee	Standard	Performance Measure	Frequency of Reporting	Dollars at Risk
	prepared to lead the calls, based on detailed agenda sent to team in advance.			
Maintenance of Detailed Project Plan and Adherence to Key Deadlines	Project plan must delineate due dates, responsible parties and critical linkages between tasks, as appropriate. Project plan will be updated and distributed in advance of each implementation weekly call. All key dates will be met to the extent Vendor has control and/or has notified State of risks of failure in advance of due date. State and Vendor will agree at the beginning of implementation on which deadlines are critical to program success.		n/a	$50,000
Plan Design	Systems will be updated for accurate plan designs in time for State to conduct a pre-implementation audit.		n/a	$75,000
Account Structure	Vendor will be prepared to replicate existing account structure (within CMS and Medicare Advantage Standards) and conduct a meeting with the State to review current account structure to ensure it is adequate to meet current reporting needs.		n/a	$75,000
Communication Review and Distribution	Annual CMS mandated materials and educational member journey materials, including outbound call scripts, direct mail, email and SMS text messages, related to the State of Delaware should be provided for		Ongoing	$15,000 for each occurrence to annual max of $75,000

Performance Guarantee	Standard	Performance Measure	Frequency of Reporting	Dollars at Risk
	awareness no less than 10 business days prior to designated launch date. New CMS mandates, CMS required system generated member notification letters and any non-mandated ad-hoc materials (i.e., unplanned COVID communications, data breach communications, etc.) are excluded from this requirement.			
Initial ID Card Distribution	ID cards will be distributed at least 20 days in advance of plan effective date, pending timely receipt of accurate enrollment file feed and no unforeseen natural disasters or other factors outside Highmark's control. For all members confirmed by CMS by 11/28/2022.		n/a	$75,000
Customer Service	Customer Service center will be trained and available to respond to retiree inquiries prior to the open enrollment period and will remain open and available continuously from that point on and available 8:00 a.m. to 8:00 p.m. seven days/week, EST.		n/a	$100,000
Ongoing Claim Administration/Customer Service				
Turnaround Time for Claims	Percentage of Claims Processed in 10 business days 99% within 30 calendar days.	94% within 10 business days, 99% within 30 calendar days	Monthly	$10,000 for each % below target to an annual max of $100,000

Performance Guarantee	Standard	Performance Measure	Frequency of Reporting	Dollars at Risk
	Any month impacted by delays in CMS publishing the annual provider fee schedule would be excluded from performance calculation			
Financial Payment Accuracy	Percentage of claims paid accurately (Total dollars of audited claims paid minus sum of absolute dollar value of all over/under payments divided by the total dollars of audited claims paid.)	99%	Monthly	$10,000 for each % below target to an annual max of $100,000
Telephone Response Time	Maintain an average speed of answer of 30 seconds or less from the time of selection to speak to a live representative via the IVR system to the time a live	30 seconds or less	Monthly	$5,000 for each % below target to an annual max of $75,000

Performance Guarantee	Standard	Performance Measure	Frequency of Reporting	Dollars at Risk
	person is on the line.			
Call Abandonment Rate	Calculated automatically via automatic telephone call distribution system.	2%	Monthly	$5,000 for each % below target to an annual max of $50,000
First Call Resolution	90% of calls will be closed on the same day as received	The percentage of calls closed on the same day as received.	Quarterly	$10,000 for each % below target to an annual max of $100,000
Customer Service	Customer Service Center staff will be trained and available to respond to retiree inquiries and will remain open and available 8:00 a.m. to 8:00 p.m. seven days/week, EST.	Customer Service Center staff will be trained and available to respond to retiree inquiries and will remain open and available 8:00 a.m. to 8:00 p.m. 7 days/week, EST. (Excludes: Christmas Day, Thanksgiving Day, Memorial Day, July 4, Labor Day, Easter Sunday when occurs in April,	Ongoing	$50,000

Performance Guarantee	Standard	Performance Measure	Frequency of Reporting	Dollars at Risk
		Emergency or Weather-Related Office Closings)		
Eligibility Data	97% of all eligibility will be loaded within two business days of receipt of mutually agreed upon enrollment file format containing clean data	97%	Monthly	$5,000 for each day not loaded beyond 2 days max of $75,000
ID Card Distribution (routinely throughout the plan year)	100% mailed within 10 days of enrollment approval by CMS	98%	Monthly	$5,000 for each day past target of 10 days following CMS enrollment approval (annual max of $75,000)
Member Satisfaction Survey	Positive Response Rate	85% or higher	Annually	$5000 for each % below target to an annual max of $75,000
Open Issue Resolution Time	95.0 % within 7 business days	The percentage of open inquiries from members and the SBO completed within the stated number of days from initial receipt	Quarterly	$5,000 for each % below target to an annual max of $75,000

Performance Guarantee	Standard	Performance Measure	Frequency of Reporting	Dollars at Risk
		date to resolution date.		
Reporting (See Attachment, MA *Master Report List*)	Complete and Timely Submission of accurate reports, as defined in Attachments and , MA *Master Report List*.[1]	Complete, accurate and timely submission of reports, as defined in Attachments 1a and 1b, *Master Report List*, unless agreed to in writing by the State and Vendor.	Per Attachment, MA *Master Report List*	Timeliness: $1,000 for each report received more than 7 days past the due date to an annual max of $25,000
Prior Authorizations Denials - 2nd Level Appeal Overturns	For calendar year reviews, percentage of prior authorizations denials that are overturned by the Independent Review Entity (IRE) hired by CMS to review all health plan denials.	Rate of overturn not to exceed 8% following final determinations by the IRE, including the reopening process.	Quarterly	$5,000 for each % above target to an annual max of $75,000

1 Those items listed in Attachment, MA *Master Report List*, which also appear separately on this Performance Guarantee appendix, will be excluded from this specific standard.

Performance Guarantee	Standard	Performance Measure	Frequency of Reporting	Dollars at Risk
Account Management				
Account Management Satisfaction[2]	Score of 3.0 or higher on the State's Account Management Team Survey Form.	$25,000 for each 0.25% below 3.0 rating	Quarterly	$25,000 for each 0.25% below 3.0 rating (annual max of $75,000
			Total	**$1,500,000**

2 Overall Account Management performance will be measured quarterly, and the annual performance determination will be based on the arithmetic mean of the quarterly measurements. See Attachment 1 for the Account Management Survey.

Attachment 1

Account Management Team Survey

State of Delaware, Department of Human Resources, Statewide Benefits Office

Account Management Team Survey

Medical Program: (Vendor)

FY____ _____ Quarter (_____ to _____)

Account Management Team Survey – (Vendor)

For Reporting Period:

Completed by: SBO Vendor Management Team

The Vendor Management Team of the Statewide Benefits Office is using this tool to evaluate the Account Management Team of (Vendor) that serves as a provider of health insurance services to the employees and pensioners of the State of Delaware.

Knowledge: Indicate the extent to which you agree that your Account Management Team:

	Strongly Agree 5	Agree 4	Somewhat Agree 3	Disagree 2	Strongly Disagree 1	For any "1" or "2" responses, please provide specific comments in the area below
1. Understands your benefits plan.	❒	❒	❒	❒	❒	_____
2. Understands your business needs. Meets with you to establish needs and service expectations.	❒	❒	❒	❒	❒	_____
3. Understands your service expectations. Develops a business plan that incorporates the agreed upon needs and expectations.	❒	❒	❒	❒	❒	_____
4. Displays knowledge regarding health plan benefit design, programs and services.	❒	❒	❒	❒	❒	_____
5. Clearly explains your report results.	❒	❒	❒	❒	❒	_____

Average Rating _____

Professionalism: Indicate the extent to which you agree that your Account Management Team:

	Strongly Agree 5	Agree 4	Somewhat Agree 3	Disagree 2	Strongly Disagree 1	For any "1" or "2" responses, please provide specific comments in the area below
6. Actively listens to and acknowledges your issues and concerns.	❒	❒	❒	❒	❒	
7. Provides appropriate verbal communication.	❒	❒	❒	❒	❒	
8. Provides appropriate written communication.	❒	❒	❒	❒	❒	
9. Works with you to develop a positive working relationship.	❒	❒	❒	❒	❒	

Average Rating _____

Proactive Management: Indicate the extent to which you agree that your Account Management Team:

	Strongly Agree 5	Agree 4	Somewhat Agree 3	Disagree 2	Strongly Disagree 1	For any "1" or "2" responses, please provide specific comments in the area below
10. Actively monitors your account and interacts with you in a frequency that meets your needs.	❒	❒	❒	❒	❒	
11. Communicates potential problems/issues.	❒	❒	❒	❒	❒	
12. Provides viable alternative solutions that meet your business needs.	❒	❒	❒	❒	❒	
13. Manages and understands system requirements and their effect on your business.	❒	❒	❒	❒	❒	
14. Sets realistic expectations regarding turn-around time.	❒	❒	❒	❒	❒	

Average Rating _____

Accessibility: Indicate the extent to which you agree that your Account Management Team:

	Strongly Agree 5	Agree 4	Somewhat Agree 3	Disagree 2	Strongly Disagree 1	For any "1" or "2" responses, please provide specific comments in the area below
15. Available to you on a timely basis.	❒	❒	❒	❒	❒	
16. Allocates appropriate time when meeting with you.	❒	❒	❒	❒	❒	
17. Demonstrates flexibility with regard to schedule changes.	❒	❒	❒	❒	❒	
18. Provides/communicates alternate contacts in the event of their absence.	❒	❒	❒	❒	❒	
19. Advises you of schedule limitations upon contact for meetings, conference calls, projects etc.	❒	❒	❒	❒	❒	

Average Rating _____

Responsiveness: Indicate the extent to which you agree that your Account Management Team:

	Strongly Agree 5	Agree 4	Somewhat Agree 3	Disagree 2	Strongly Disagree 1	For any "1" or "2" responses, please provide specific comments in the area below
20. Responds to your inquiries in a timely manner.	❒	❒	❒	❒	❒	
21. Provides thorough responses to your inquiries.	❒	❒	❒	❒	❒	
22. Follows-through regarding outstanding problems/issues/items.	❒	❒	❒	❒	❒	
23. Solicits the assistance of product experts when needed.	❒	❒	❒	❒	❒	

Average Rating _____

Overall Average Rating _____

Please include any other comments or suggested action steps:

Kudos:

EXHIBIT 2

MASTER REPORT LIST

EXHIBIT 2

Master Report List Medicare Advantage Plan Year 2023

HD and State/SBO

Due dates can be revised only upon mutual agreement. Reports due on weekends, holidays or on dates of emergency closure become due the next business day.

Effective January 1 2022

	Report Description	Direction	Frequency	Method	Path	Sending Contact	Receiving Contact	Due Date	SBO Storage Location
Weekly 834 Enrollment Files									
Pension Office		Pension Office to HD	Weekly	SFTP	SFTP/Pensons/Highmark/	Robin Hartnett-Sterner, Kristal Diaz	DE Inbound Team	Every Friday	N/A
NEBS (Participating Groups)		State to HD	Weekly	SFTP	STFP/PHRST/HIGHMARK/NONPAYROLL	Leighann Hinkle; Nina Figueroa	DE Inbound Team	Every Friday	N/A
Summary Load of 834 data (Pre-CMS submission balancing report)									
	number of new enrollments number of new disenrollments number of address changes number of no changes (not sent to CMS)	**HD to State / Pension**	Weekly	**TBD**		HD Enrollment Team			
CMS Transaction Reply Report (TRR)									
Pension		HD to Pension Office	Weekly	TBD	N/A	HD Enrollment Team	Kristal Diaz & Meagan Iwaskiewicz	TBD	N/A
NEBS	Post CMS submission report of enrollment submissions •Accepted Enrollments •Accepted Disenrollments •Accepted Address Changes •Rejected transactions •Any CMS initiated disenrollments (i.e.: DOD, Loss of Entitlement)	HD to State	Weekly	TBD	N/A	HD Enrollment Team	Ashley Frey; Nina Figueroa	TBD	T:\GHIP COMPLIANCE\Non State Employee Groups\Discrepancy Reports\FY2023
Weekly Age-In Files									
Pension Office		Pension Office to HD	Weekly	SFTP	SFTP/Pensons/Highmark/	Robin Hartnett-Sterner, Kristal Diaz	DE Inbound Team	Every Friday	N/A
NEBS (Participating Groups)		State to HD	Weekly	SFTP	STFP/PHRST/HIGHMARK/NONPAYROLL	Leighann Hinkle; Nina Figueroa	DE Inbound Team	Every Friday	N/A
Pension Office Opt OutReporting	Highmark will create a report that includes any members who contact Highmark wishing to opt-out of coverage	HD to Pension Office	Weekly	Secure Email		HD Enrollment Team	Pension Office	Tuesday of each week	
NEBS (Participating Groups) Opt Out Reporting	Highmark will create a report that includes any members who contact Highmark wishing to opt-out of coverage	HD to State	Weekly	Secure Email		HD Enrollment Team	SBO	Tuesday of each week	
Highmark and DHIN									
Monthly Enrollment		HD to DHIN	Monthly	secure website	/Highmark/audaciousInquiry/72.237.77.55//stpput	Highmark vendor outbound team and DE Enrollment Staff	DHIN	1st Saturday of every month	N/A
Highmark and CVS Caremark									
Weekly EGWP Activity File	EGWP Activity File includes enrollment new adds, modifications, and terminations.	HD to CVS Caremark	Weekly	Secure SFTP	N/A	Highmark vendor outbound team	PBM - Eligibility Analysis	Wednesday of each week	N/A
Quarterly EGWP Full File	EGWP Full File is a 100% accounting of the records.	HD to CVS Caremark	Quarterly	Secure FTP	N/A	Highmark vendor outbound team	PBM - Eligibility Analysis	First Month of the Quarter	
PBM Claims File		CVS Caremark to HD	Biweekly	Secure Email	N/A	PBM - Eligibility Analysis	Wendy Beck; Lisa Mantegna		N/A
Highmark and Merative									
Universal File (Enrollment aka Eligibility)		HD to Merative	Monthly	Secure Transport	N/A	Highmark vendor outbound team	Vijaya Vempati	First Sunday of each month	N/A
Summary (Claims) only		HD to Merative	Monthly	Secure FTP	N/A	Highmark vendor outbound team	Vijaya Vempati	after payment of each weekly claims invoice	N/A
Highmark and CVS Caremark									

Pre-Edit Report (**State of Delaware Pensioner** Highmark Summary Load Report)	The Summary Load Report (SLR) is a 100% accounting of the records received on client file, with processing status. It is used to determine whether there are any errors that need to be corrected in the Highmark file before Vendor sends to CMS.	PBM to Highmark	Weekly	Secure Email	N/A	PBM - Eligibility Analysis	Highmark Eligibility Team / SBO Program Lead	Wednesdays	T:\Benefit Programs\Prescription\CVS Caremark\Reports\Eligibility and Enrollment\EGWP\Summary Load Report(Pre-Edit)
Pre-Edit Report (**Non-State of Delaware Pensioner** Highmark Summary Load Report)	The Summary Load Report (SLR) is a 100% accounting of the records received on client file, with processing status. It is used to determine whether there are any errors that need to be corrected in the Highmark file before Vendor sends to CMS.	PBM to Highmark	Weekly	Secure Email	N/A	PBM - Eligibility Analysis	Highmark Eligibility Team / SBO Program Lead	Wednesdays	T:\Benefit Programs\Prescription\CVS Caremark\Reports\Eligibility and Enrollment\EGWP\Summary Load Report(Pre-Edit)
Age-in Supplemental Reporting Reconciliation (2 files)	• Age In Enrollment Process • Part C vs. Part D Enrollment Rejection Sync Process	Highmark to CVS	Monthly	SFTP-being confirmed	N/A	PBM - Eligibility Analysis	Highmark Eligibility Team / SBO Program Lead	by the 25th of each month	
Highmark Reports to the State									
Highmark SOD Concierge Call Report	Call Center statistics with top call drivers	HD to State	Weekly			HM Concierge Mgr. / Lead		Wednesday of each week	
Medicare Advantage network updates (DE only)	Updates on contracting for DE Medicare Advantage network	HD to State	Monthly	Word Document		HM MA Client Team		Monthly, within 10 days of end of the prior month	
SoD Medicare Advantage Prior Authorization Reporting	1) Total number of prior authorizations submitted, the percentage approved, the percentage of denials, in total and for defined service categories 2) Initial prior authorization decisions timing for standard and urgent/expedited requests	HD to State	Monthly	TBD		HM MA Client Team		within 45 days of the end the month	
SoD Medicare Advantage Appeals Reporting	1) Number of prior authorization denial appeals received at 1st level – 5th level appeal. 2) Percentage of appeals that are upheld or overturned at 1st level appeal – 5th level appeal.	HD to State	Quarterly	TBD		HM MA Client Team		45 days after end of the period –Q4 report will be 4 months form end of the quarter	
Medical Loss Ratio (MLR) report		HD to State	Quarterly	TBD		HM MA Client Team		(90 days after end of quarter (includes 2 months of claims run out)	
Gain Share Report	Report that calculates if the gain share payment is reached	HD to State	Annually	TBD		HM MA Client Team		within 60 days after the CMS final payment is released for a given calendar year	
Highmark Group Experience Reporting Package	Comprehensive reporting package of plan performance	HD to State	Quarterly	TBD		HM MA Client Team		(90 days after end of quarter (includes 2 months of claims run out)	
DIABETES Reporting									
HB203 Report	Required details to be defined	HD - TBD	Once every other ye	TBD		TBD			

Exhibit 3
Highmark Prior Authorization List
(Effective 10-1-2022)

Exhibit 3
Highmark Prior Authorization List
Eff. 10/1/2022

Benefit Category	CODE	TERMINOLOGY
Advanced Imaging (Radiology & Cardiology)	70450	C T Head Without Contrast
Advanced Imaging (Radiology & Cardiology)	70460	C T Head With Contrast
Advanced Imaging (Radiology & Cardiology)	70470	C T Head Without & With Contrast
Advanced Imaging (Radiology & Cardiology)	70480	C T Orbit Without Contrast
Advanced Imaging (Radiology & Cardiology)	70481	C T Orbit With Contrast
Advanced Imaging (Radiology & Cardiology)	70482	C T Orbit Without & With Contrast
Advanced Imaging (Radiology & Cardiology)	70486	C T Maxillofacial Without Contrast
Advanced Imaging (Radiology & Cardiology)	70487	C T Maxillofacial With Contrast
Advanced Imaging (Radiology & Cardiology)	70488	C T Maxillofacial Without & With Contrast
Advanced Imaging (Radiology & Cardiology)	70490	C T Soft Tissue Neck Without Contrast
Advanced Imaging (Radiology & Cardiology)	70491	C T Soft Tissue Neck With Contrast
Advanced Imaging (Radiology & Cardiology)	70492	C T Soft Tissue Neck Without & With Contrast
Advanced Imaging (Radiology & Cardiology)	70496	C T Angiography Head
Advanced Imaging (Radiology & Cardiology)	70498	C T Angiography Neck
Advanced Imaging (Radiology & Cardiology)	71250	Computed tomography, thorax, diagnostic; without contrast material
Advanced Imaging (Radiology & Cardiology)	71260	Computed tomography, thorax, diagnostic; with contrast material(s)
Advanced Imaging (Radiology & Cardiology)	71270	Computed tomography, thorax, diagnostic; without contrast material, followed by contrast material(s) and further sections
Advanced Imaging (Radiology & Cardiology)	71271	Computed tomography, thorax, low dose for lung cancer screening, without contrast material(s)
Advanced Imaging (Radiology & Cardiology)	71275	C T Angiography Chest Without Contrast Material, Followed by Contrast Material and Further Sections,Including Image Postprocessing
Advanced Imaging (Radiology & Cardiology)	72125	C T Cervical Spine Without Contrast
Advanced Imaging (Radiology & Cardiology)	72126	C T Cervical Spine With Contrast
Advanced Imaging (Radiology & Cardiology)	72127	C T Cervical Spine Without & With Contrast
Advanced Imaging (Radiology & Cardiology)	72128	C T Thoracic Spine Without Contrast
Advanced Imaging (Radiology & Cardiology)	72129	C T Thoracic Spine With Contrast
Advanced Imaging (Radiology & Cardiology)	72130	C T Thoracic Spine Without & With Contrast
Advanced Imaging (Radiology & Cardiology)	72131	C T Lumbar Spine Without Contrast
Advanced Imaging (Radiology & Cardiology)	72132	C T Lumbar Spine With Contrast
Advanced Imaging (Radiology & Cardiology)	72133	C T Lumbar Spine Without & With Contrast
Advanced Imaging (Radiology & Cardiology)	72191	C T Angiography Pelvis
Advanced Imaging (Radiology & Cardiology)	72192	C T Pelvis Without Contrast
Advanced Imaging (Radiology & Cardiology)	72193	C T Pelvis With Contrast
Advanced Imaging (Radiology & Cardiology)	72194	C T Pelvis Without & With Contrast
Advanced Imaging (Radiology & Cardiology)	73200	C T Upper Extremity Without Contrast
Advanced Imaging (Radiology & Cardiology)	73201	C T Upper Extremity With Contrast
Advanced Imaging (Radiology & Cardiology)	73202	C T Upper Extremity Without & With Contrast
Advanced Imaging (Radiology & Cardiology)	73206	C T Angiography Upper Extremity
Advanced Imaging (Radiology & Cardiology)	73700	C T Lower Extremity Without Contrast
Advanced Imaging (Radiology & Cardiology)	73701	C T Lower Extremity With Contrast
Advanced Imaging (Radiology & Cardiology)	73702	C T Lower Extremity Without & With Contrast
Advanced Imaging (Radiology & Cardiology)	73706	C T Angiography Lower Extremity
Advanced Imaging (Radiology & Cardiology)	74150	C T Abdomen Without Contrast
Advanced Imaging (Radiology & Cardiology)	74160	C T Abdomen With Contrast
Advanced Imaging (Radiology & Cardiology)	74170	C T Abdomen Without & With Contrast
Advanced Imaging (Radiology & Cardiology)	74174	CT angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing
Advanced Imaging (Radiology & Cardiology)	74175	C T Angiography Abdomen
Advanced Imaging (Radiology & Cardiology)	74176	CT Abdomen And Pelvis Without Contrast
Advanced Imaging (Radiology & Cardiology)	74177	CT Abdomen And Pelvis With Contrast
Advanced Imaging (Radiology & Cardiology)	74178	Computed Tomography, Abdomen And Pelvis; Without Contrast Material In One Or Both Body Regions, Followed By Contrast Material(S) And Further Sections In One Or Both Body Regions
Advanced Imaging (Radiology & Cardiology)	74261	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material
Advanced Imaging (Radiology & Cardiology)	74262	Computed tomographic (CT) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed
Advanced Imaging (Radiology & Cardiology)	74263	Computed tomographic (CT) colonography, screening, including image postprocessing
Advanced Imaging (Radiology & Cardiology)	75635	C T Angiography Abdominal Aorta
Advanced Imaging (Radiology & Cardiology)	76380	C T Limited Or Localized Follow-Up Study
Advanced Imaging (Radiology & Cardiology)	76497	Unlisted computed tomography procedure
Advanced Imaging (Radiology & Cardiology)	70544	M R A Head Without Contrast
Advanced Imaging (Radiology & Cardiology)	70545	M R A Head With Contrast
Advanced Imaging (Radiology & Cardiology)	70546	M R A Head With & Without Contrast
Advanced Imaging (Radiology & Cardiology)	70547	M R A Neck Without Contrast
Advanced Imaging (Radiology & Cardiology)	70548	M R A Neck With Contrast
Advanced Imaging (Radiology & Cardiology)	70549	M R A Neck With & Without Contrast
Advanced Imaging (Radiology & Cardiology)	71555	M R A Chest (Excluding Myocardium) With Or Without Contrast
Advanced Imaging (Radiology & Cardiology)	72159	M R A Spinal Canal With Or Without Contrast
Advanced Imaging (Radiology & Cardiology)	72198	M R A Pelvis With Or Without Contrast
Advanced Imaging (Radiology & Cardiology)	73225	M R A Upper Extremity With Or Without Contrast
Advanced Imaging (Radiology & Cardiology)	73725	M R A Lower Extremity With Or Without Contrast
Advanced Imaging (Radiology & Cardiology)	74185	M R A Abdomen With Or Without Contrast
Advanced Imaging (Radiology & Cardiology)	70336	M R I T M J
Advanced Imaging (Radiology & Cardiology)	70540	M R I Orbit, Face, and/or Neck Without Contrast
Advanced Imaging (Radiology & Cardiology)	70542	M R I Face, Orbit, and/or Neck With Contrast
Advanced Imaging (Radiology & Cardiology)	70543	M R I Face, Orbit, and/or Neck With & Without Contrast

**Select new-to-market drugs with not otherwise classified (NOC) HCPCS codes (e.g. J3490, J3590, J9999, C9399) will require prior authorization, pending unique HCPCS assignment by CMS

Advanced Imaging (Radiology & Cardiology)	70551	M R I Head Without Contrast
Advanced Imaging (Radiology & Cardiology)	70552	M R I Head With Contrast
Advanced Imaging (Radiology & Cardiology)	70553	M R I Head With & Without Contrast
Advanced Imaging (Radiology & Cardiology)	70554	MRI Brain, functional MRI
Advanced Imaging (Radiology & Cardiology)	70555	MRI Brain, functional MRI, requiring physician
Advanced Imaging (Radiology & Cardiology)	71550	M R I Chest Without Contrast
Advanced Imaging (Radiology & Cardiology)	71551	M R I Chest With Contrast
Advanced Imaging (Radiology & Cardiology)	71552	M R I Chest With & Without Contrast
Advanced Imaging (Radiology & Cardiology)	72141	M R I Cervical Spine Without Contrast
Advanced Imaging (Radiology & Cardiology)	72142	M R I Cervical Spine With Contrast
Advanced Imaging (Radiology & Cardiology)	72146	M R I Thoracic Spine Without Contrast
Advanced Imaging (Radiology & Cardiology)	72147	M R I Thoracic Spine With Contrast
Advanced Imaging (Radiology & Cardiology)	72148	M R I Lumbar Spine Without Contrast
Advanced Imaging (Radiology & Cardiology)	72149	M R I Lumbar Spine With Contrast
Advanced Imaging (Radiology & Cardiology)	72156	M R I Cervical Spine With & Without Contrast
Advanced Imaging (Radiology & Cardiology)	72157	M R I Thoracic Spine With & Without Contrast
Advanced Imaging (Radiology & Cardiology)	72158	M R I Lumbar Spine With & Without Contrast
Advanced Imaging (Radiology & Cardiology)	72195	M R I Pelvis Without Contrast
Advanced Imaging (Radiology & Cardiology)	72196	M R I Pelvis With Contrast
Advanced Imaging (Radiology & Cardiology)	72197	M R I Pelvis With & Without Contrast
Advanced Imaging (Radiology & Cardiology)	73218	M R I Upper Extremity Without Contrast
Advanced Imaging (Radiology & Cardiology)	73219	M R I Upper Extremity With Contrast
Advanced Imaging (Radiology & Cardiology)	73220	M R I Upper Extremity With & Without Contrast
Advanced Imaging (Radiology & Cardiology)	73221	M R I Upper Extremity Joint Without Contrast
Advanced Imaging (Radiology & Cardiology)	73222	M R I Upper Extremity Joint With Contrast
Advanced Imaging (Radiology & Cardiology)	73223	M R I Upper Extremity Joint With & Without Contrast
Advanced Imaging (Radiology & Cardiology)	73718	M R I Lower Extremity Without Contrast
Advanced Imaging (Radiology & Cardiology)	73719	M R I Lower Extremity With Contrast
Advanced Imaging (Radiology & Cardiology)	73720	M R I Lower Extremity With & Without Contrast
Advanced Imaging (Radiology & Cardiology)	73721	M R I Lower Extremity Joint Without Contrast
Advanced Imaging (Radiology & Cardiology)	73722	M R I Lower Extremity Joint With Contrast
Advanced Imaging (Radiology & Cardiology)	73723	M R I Lower Extremity Joint With & Without Contrast
Advanced Imaging (Radiology & Cardiology)	74181	M R I Abdomen Without Contrast
Advanced Imaging (Radiology & Cardiology)	74182	M R I Abdomen With Contrast
Advanced Imaging (Radiology & Cardiology)	74183	M R I Abdomen With & Without Contrast
Advanced Imaging (Radiology & Cardiology)	74712	Magnetic resonance (eg, proton) imaging, fetal, including placental and maternal pelvic imaging when performed; single or first gestation
Advanced Imaging (Radiology & Cardiology)	74713	Magnetic resonance (eg, proton) imaging, fetal, including placental and maternal pelvic imaging when performed; each additional gestation (List separately in addition to code for primary procedure)
Advanced Imaging (Radiology & Cardiology)	76390	M R I Spectroscopy
Advanced Imaging (Radiology & Cardiology)	76391	Magnetic resonance (eg, vibration) elastography
Advanced Imaging (Radiology & Cardiology)	76498	Unlisted MRI Procedure
Advanced Imaging (Radiology & Cardiology)	77021	M R I Guidance For Needle Placement
Advanced Imaging (Radiology & Cardiology)	77022	Magnetic resonance guidance for, and monitoring of, parenchymal tissue ablation
Advanced Imaging (Radiology & Cardiology)	77046	Magnetic resonance imaging, breast, without contrast material; unilateral
Advanced Imaging (Radiology & Cardiology)	77047	Magnetic resonance imaging, breast, without contrast material; bilateral
Advanced Imaging (Radiology & Cardiology)	76376	3D Rendering W/O Postprocessing
Advanced Imaging (Radiology & Cardiology)	76377	3D Rendering W Postprocessing
Advanced Imaging (Radiology & Cardiology)	75571	Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium
Advanced Imaging (Radiology & Cardiology)	75572	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3d image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)
Advanced Imaging (Radiology & Cardiology)	75573	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3D image postprocessing, assessment of left ventricular [LV] cardiac function, right ventricular [RV] structure and function and evaluation of vascular structures, if performed)
Advanced Imaging (Radiology & Cardiology)	75574	Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3d image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)
Advanced Imaging (Radiology & Cardiology)	75557	Cardiac magnetic resonance imaging for morphology and function without contrast material
Advanced Imaging (Radiology & Cardiology)	75559	Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging
Advanced Imaging (Radiology & Cardiology)	75561	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences
Advanced Imaging (Radiology & Cardiology)	75563	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging
Advanced Imaging (Radiology & Cardiology)	75565	Cardiac magnetic resonance imaging for velocity flow mapping (list separately in addition to code for primary procedure)
Advanced Imaging (Radiology & Cardiology)	33274	Transcatheter insertion or replacement of permanent leadless pacemaker, right ventricular, including imaging guidance (eg, fluoroscopy, venous ultrasound, ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed
Advanced Imaging (Radiology & Cardiology)	33289	Transcatheter implantation of wireless pulmonary artery pressure sensor (CardioMEMSTM) for long-term hemodynamic monitoring, including deployment and calibration of the sensor, right heart catheterization, selective pulmonary catheterization, radiological supervision and interpretation, and pulmonary artery angiography, when performed
Advanced Imaging (Radiology & Cardiology)	0042T	CT Perfusion Brain
Advanced Imaging (Radiology & Cardiology)	0331T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment;
Advanced Imaging (Radiology & Cardiology)	0332T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment; with tomographic SPECT

Advanced Imaging (Radiology & Cardiology)	0439T	Myocardial contrast perfusion echocardiography, at rest or with stress, for assessment of myocardial ischemia or viability (List separately in addition to code for primary procedure)
Advanced Imaging (Radiology & Cardiology)	0501T	Noninvasive estimated coronary fractional flow reserve (FFR) derived from coronary computed tomography angiography data using computation fluid dynamics physiologic simulation software
Advanced Imaging (Radiology & Cardiology)	0502T	data preparation and transmission
Advanced Imaging (Radiology & Cardiology)	0503T	analysis of fluid dynamics and simulated maximal coronary hyperemia, and generation of estimated FFR model
Advanced Imaging (Radiology & Cardiology)	0504T	anatomical data review in comparison with estimated FFR model to reconcile discordant data, interpretation and report
Advanced Imaging (Radiology & Cardiology)	0515T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; complete system (includes electrode and generator [transmitter and battery])
Advanced Imaging (Radiology & Cardiology)	0516T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; electrode only
Advanced Imaging (Radiology & Cardiology)	0517T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; pulse generator component(s) (battery and/or transmitter) only
Advanced Imaging (Radiology & Cardiology)	0519T	Removal and replacement of wireless cardiac stimulator for left ventricular pacing; pulse generator component(s) (battery and/or transmitter)
Advanced Imaging (Radiology & Cardiology)	0520T	Removal and replacement of wireless cardiac stimulator for left ventricular pacing; pulse generator component(s) (battery and/or transmitter), including placement of a new electrode
Advanced Imaging (Radiology & Cardiology)	0571T	Insertion or replacement of implantable cardioverter-defibrillator system with substernal electrode(s), including all imaging guidance and electrophysiological evaluation (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters), when performed
Advanced Imaging (Radiology & Cardiology)	0572T	Insertion of substernal implantable defibrillator electrode
Advanced Imaging (Radiology & Cardiology)	0609T	Magnetic resonance spectroscopy, determination and
Advanced Imaging (Radiology & Cardiology)	0610T	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); transmission of biomarker data for software analysis
Advanced Imaging (Radiology & Cardiology)	0611T	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); postprocessing for algorithmic analysis of biomarker data for determination of relative chemical differences between discs
Advanced Imaging (Radiology & Cardiology)	0612T	Magnetic resonance spectroscopy, determination and localization of discogenic pain (cervical, thoracic, or lumbar); interpretation and report
Advanced Imaging (Radiology & Cardiology)	0614T	Removal and replacement of substernal implantable defibrillator pulse generator
Advanced Imaging (Radiology & Cardiology)	0633T	Computed tomography, breast, including 3D rendering, when performed, unilateral; without contrast material
Advanced Imaging (Radiology & Cardiology)	0634T	Computed tomography, breast, including 3D rendering, when performed, unilateral; with contrast material(s)
Advanced Imaging (Radiology & Cardiology)	0635T	Computed tomography, breast, including 3D rendering, when performed, unilateral; without contrast, followed by contrast material(s)
Advanced Imaging (Radiology & Cardiology)	0636T	Computed tomography, breast, including 3D rendering, when performed, bilateral; without contrast material(s)
Advanced Imaging (Radiology & Cardiology)	0637T	Computed tomography, breast, including 3D rendering, when performed, bilateral; with contrast material(s)
Advanced Imaging (Radiology & Cardiology)	0638T	Computed tomography, breast, including 3D rendering, when performed, bilateral; without contrast, followed by contrast material(s)
Advanced Imaging (Radiology & Cardiology)	0648T	Quantitative magnetic resonance for analysis of tissue composition (e.g., fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained without diagnostic MRI examination of the same anatomy (e.g., organ, gland, tissue, target structure) during the same session.
Advanced Imaging (Radiology & Cardiology)	0649T	Quantitative magnetic resonance for analysis of tissue composition (e.g., fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the same anatomy (e.g., organ, gland, tissue, target structure) (List separately in addition to code for primary procedure).
Advanced Imaging (Radiology & Cardiology)	0697T	Quantitative magnetic resonance for analysis of tissue composition (eg, fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained without diagnostic MRI examination of the same anatomy (eg, organ, gland, tissue, target structure) during the same session; multiple organs
Advanced Imaging (Radiology & Cardiology)	0698T	Quantitative magnetic resonance for analysis of tissue composition (eg, fat, iron, water content), including multiparametric data acquisition, data preparation and transmission, interpretation and report, obtained with diagnostic MRI examination of the same anatomy (eg, organ, gland, tissue, target structure); multiple organs (List separately in addition to code for primary procedure)
Advanced Imaging (Radiology & Cardiology)	0710T	Noninvasive arterial plaque analysis using software processing of data from non-coronary computerized tomography angiography; including data preparation and transmission, quantification of the structure and composition of the vessel wall and assessment for lipid-rich necrotic core plaque to assess atherosclerotic plaque stability, data review, interpretation and report
Advanced Imaging (Radiology & Cardiology)	0711T	Noninvasive arterial plaque analysis using software processing of data from non-coronary computerized tomography angiography; data preparation and transmission
Advanced Imaging (Radiology & Cardiology)	0712T	Noninvasive arterial plaque analysis using software processing of data from non-coronary computerized tomography angiography; quantification of the structure and composition of the vessel wall and assessment for lipid-rich necrotic core plaque to assess atherosclerotic plaque stability
Advanced Imaging (Radiology & Cardiology)	0713T	Noninvasive arterial plaque analysis using software processing of data from non-coronary computerized tomography angiography; data review, interpretation and report
Advanced Imaging (Radiology & Cardiology)	33275	Transcatheter removal of permanent leadless pacemaker, right ventricular - Effective 1/1/19
Advanced Imaging (Radiology & Cardiology)	77048	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; unilateral
Advanced Imaging (Radiology & Cardiology)	77049	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; bilateral

Advanced Imaging (Radiology & Cardiology)	77078	Computed Tomography, bone mineral density study, 1 or more sites; axial skeleton
Advanced Imaging (Radiology & Cardiology)	77084	Magnetic resonance (eg, proton) imaging, bone marrow blood supply
Advanced Imaging (Radiology & Cardiology)	78012	Thyroid uptake, single or multiple quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)
Advanced Imaging (Radiology & Cardiology)	78013	Thyroid imaging (including vascular flow, when performed)
Advanced Imaging (Radiology & Cardiology)	78014	Thyroid imaging (including vascular flow, when performed); with single or multiple uptake(s) quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)
Advanced Imaging (Radiology & Cardiology)	78015	Thyroid Met Imaging
Advanced Imaging (Radiology & Cardiology)	78016	Thyroid Met Imaging With Additional Studies
Advanced Imaging (Radiology & Cardiology)	78018	Thyroid Scan Whole Body
Advanced Imaging (Radiology & Cardiology)	78020	Thyroid Carcinoma Metastases Uptake
Advanced Imaging (Radiology & Cardiology)	78070	Parathyroid planar imaging (including subtraction, when performed)
Advanced Imaging (Radiology & Cardiology)	78071	Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT)
Advanced Imaging (Radiology & Cardiology)	78072	Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization
Advanced Imaging (Radiology & Cardiology)	78075	Adrenal Nuclear Imaging
Advanced Imaging (Radiology & Cardiology)	78102	Bone Marrow Imaging, Limited
Advanced Imaging (Radiology & Cardiology)	78103	Bone Marrow Imaging, Multiple
Advanced Imaging (Radiology & Cardiology)	78104	Bone Marrow Imaging, Whole Body
Advanced Imaging (Radiology & Cardiology)	78140	Labeled Red Cell Sequestration
Advanced Imaging (Radiology & Cardiology)	78185	Spleen Imaging With & Without Vascular Flow
Advanced Imaging (Radiology & Cardiology)	78195	Lymph System Imaging
Advanced Imaging (Radiology & Cardiology)	78201	Liver Imaging
Advanced Imaging (Radiology & Cardiology)	78202	Liver Imaging With Flow
Advanced Imaging (Radiology & Cardiology)	78215	Liver & Spleen Imaging
Advanced Imaging (Radiology & Cardiology)	78216	Liver & Spleen Imaging With Flow
Advanced Imaging (Radiology & Cardiology)	78226	Hepatobiliary system imaging, including gallbladder when present;
Advanced Imaging (Radiology & Cardiology)	78227	Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed
Advanced Imaging (Radiology & Cardiology)	78230	Salivary Gland Imaging
Advanced Imaging (Radiology & Cardiology)	78231	Serial Salivary Gland
Advanced Imaging (Radiology & Cardiology)	78232	Salivary Gland Function Exam
Advanced Imaging (Radiology & Cardiology)	78258	Esophogus Motility Study
Advanced Imaging (Radiology & Cardiology)	78261	Gastric Mucosa Imaging
Advanced Imaging (Radiology & Cardiology)	78262	Gastroesophageal Reflux Exam
Advanced Imaging (Radiology & Cardiology)	78264	Gastric Emptying Study
Advanced Imaging (Radiology & Cardiology)	78265	Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel transit
Advanced Imaging (Radiology & Cardiology)	78266	Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel and colon transit, multiple days
Advanced Imaging (Radiology & Cardiology)	78278	GI Bleeder Scan
Advanced Imaging (Radiology & Cardiology)	78290	Meckels Diverticulum Imaging
Advanced Imaging (Radiology & Cardiology)	78291	Leveen Shunt Patency Exam
Advanced Imaging (Radiology & Cardiology)	78300	Bone Or Joint Imaging Limited
Advanced Imaging (Radiology & Cardiology)	78305	Bone Or Joint Imaging Multiple
Advanced Imaging (Radiology & Cardiology)	78306	Bone Scan Whole Body
Advanced Imaging (Radiology & Cardiology)	78315	Bone Scan 3 Phase Study
Advanced Imaging (Radiology & Cardiology)	78414	Non-Imaging Heart Function
Advanced Imaging (Radiology & Cardiology)	78428	Cardiac Shunt Imaging
Advanced Imaging (Radiology & Cardiology)	78429	Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), single study; with concurrently acquired computed tomography transmission scan
Advanced Imaging (Radiology & Cardiology)	78430	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); single study, at rest or stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan
Advanced Imaging (Radiology & Cardiology)	78431	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan
Advanced Imaging (Radiology & Cardiology)	78432	Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability);
Advanced Imaging (Radiology & Cardiology)	78433	Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability); with concurrently acquired computed tomography transmission scan
Advanced Imaging (Radiology & Cardiology)	78434	Absolute quantitation of myocardial blood flow (AQMBF), positron emission tomography (PET), rest and pharmacologic stress (List separately in addition to code for primary procedure)
Advanced Imaging (Radiology & Cardiology)	78445	Radionuclide Venogram Non-Cardiac
Advanced Imaging (Radiology & Cardiology)	78451	78451 myocardial perfusion imaging, tomographic (spect) including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)
Advanced Imaging (Radiology & Cardiology)	78452	Myocardial perfusion imaging, tomographic (spect) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection
Advanced Imaging (Radiology & Cardiology)	78453	Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)
Advanced Imaging (Radiology & Cardiology)	78454	Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection
Advanced Imaging (Radiology & Cardiology)	78456	Acute Venous Thrombosis Imaging

Advanced Imaging (Radiology & Cardiology)	78457	Venous Thrombosis Imaging Unilateral
Advanced Imaging (Radiology & Cardiology)	78458	Venous Thrombosis Images, Bilateral
Advanced Imaging (Radiology & Cardiology)	78459	Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), single study
Advanced Imaging (Radiology & Cardiology)	78466	Myocardial Infarction Scan
Advanced Imaging (Radiology & Cardiology)	78468	Heart Infarct Image Ejection Fraction
Advanced Imaging (Radiology & Cardiology)	78469	Heart Infarct Image 3D SPECT
Advanced Imaging (Radiology & Cardiology)	78472	Cardiac Bloodpool Img, Single
Advanced Imaging (Radiology & Cardiology)	78473	Cardiac Bloodpool Img, Multi
Advanced Imaging (Radiology & Cardiology)	78481	Heart First Pass Single
Advanced Imaging (Radiology & Cardiology)	78483	Cardiac Blood Pool Imaging -- Multiple
Advanced Imaging (Radiology & Cardiology)	78491	Myocardial imaging, positron emission tomography (PET), perfusion study(including ventricular wall motion[s] and/or ejection fraction[s], when performed); single study, at rest or stress (exercise or pharmacologic)
Advanced Imaging (Radiology & Cardiology)	78492	Myocardial imaging, positron emission tomography (PET), perfusion study(including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and/or stress (exercise or pharmacologic)
Advanced Imaging (Radiology & Cardiology)	78494	Cardiac Blood Pool Imaging , SPECT
Advanced Imaging (Radiology & Cardiology)	78496	Cardiac blood pool imaging, gated equilibrium, single study, at rest, with right ventricular ejection fraction by first pass technique (List separately in addition to code for primary procedure)
Advanced Imaging (Radiology & Cardiology)	78499	Unlisted Cardiovascular Procedure
Advanced Imaging (Radiology & Cardiology)	78579	Pulmonary ventilation imaging (eg, aerosol or gas)
Advanced Imaging (Radiology & Cardiology)	78580	Pulmonary perfusion imaging (eg, particulate)
Advanced Imaging (Radiology & Cardiology)	78582	Pulmonary ventilation (eg, aerosol or gas) and perfusion imaging
Advanced Imaging (Radiology & Cardiology)	78597	Quantitative differential pulmonary perfusion, including imaging when performed
Advanced Imaging (Radiology & Cardiology)	78598	Quantitative differential pulmonary perfusion and ventilation (eg, aerosol or gas), including imaging when performed
Advanced Imaging (Radiology & Cardiology)	78600	Brain Imaging Limited Static
Advanced Imaging (Radiology & Cardiology)	78601	Brain Limited Imaging And Flow
Advanced Imaging (Radiology & Cardiology)	78605	Brain Imaging Complete
Advanced Imaging (Radiology & Cardiology)	78606	Brain Imaging Complete With Flow
Advanced Imaging (Radiology & Cardiology)	78608	Brain Imaging, Positron Emission Tomography (PET) Metabolic Evaluation
Advanced Imaging (Radiology & Cardiology)	78609	Brain Imaging, Positron Emission Tomography (PET) Perfusion Evaluation
Advanced Imaging (Radiology & Cardiology)	78610	Brain Flow Imaging Only
Advanced Imaging (Radiology & Cardiology)	78630	Cisternogram (Cerebrospinal Fluid Flow)
Advanced Imaging (Radiology & Cardiology)	78635	Cerebrospinal Ventriculography
Advanced Imaging (Radiology & Cardiology)	78645	CSF Shunt Evaluation
Advanced Imaging (Radiology & Cardiology)	78650	C S F Leakage Detection And Localization
Advanced Imaging (Radiology & Cardiology)	78660	Radiopharmaceutical Dacryocystography
Advanced Imaging (Radiology & Cardiology)	78699	Unlisted Nuclear Medicine Procedures on the Nervous System
Advanced Imaging (Radiology & Cardiology)	78700	Kidney Imaging Morphology
Advanced Imaging (Radiology & Cardiology)	78701	Kidney Imaging With Vascular Flow
Advanced Imaging (Radiology & Cardiology)	78707	Kidney Imaging With Vascular Flow & Function Single Study Without Pharmacological Intervention
Advanced Imaging (Radiology & Cardiology)	78708	Kidney Imaging Single Study With Pharmacological Intervention
Advanced Imaging (Radiology & Cardiology)	78709	Kidney Imaging - Multiple Studies Without & With Pharmacological Intervention
Advanced Imaging (Radiology & Cardiology)	78725	Kidney Function Study - Non-Imaging Radioisotopic
Advanced Imaging (Radiology & Cardiology)	78730	Urinary Bladder Residual Study
Advanced Imaging (Radiology & Cardiology)	78740	Ureteral Reflux Study
Advanced Imaging (Radiology & Cardiology)	78761	Testicular Imaging With Vascular Flow
Advanced Imaging (Radiology & Cardiology)	78800	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); planar, single limited area (includes vascular flow and blood pool imaging, when performed); planar, single (includes vascular flow and blood pool imaging, when performed); planar, single
Advanced Imaging (Radiology & Cardiology)	78801	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); planar, 2 or more mulitple areas (eg, abdomen and pelvis, head and chest), 1 or more days imaging or single area imaging over 2 or more days
Advanced Imaging (Radiology & Cardiology)	78802	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); planar, whole body, single day imaging
Advanced Imaging (Radiology & Cardiology)	78803	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT) , single area (eg, head, neck, chest, pelvis), single day imaging
Advanced Imaging (Radiology & Cardiology)	78804	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); planar, whole body, requiring 2 or more days imaging
Advanced Imaging (Radiology & Cardiology)	78811	PET Imaging; limited area
Advanced Imaging (Radiology & Cardiology)	78812	PET Imaging: skull base to mid-thigh
Advanced Imaging (Radiology & Cardiology)	78813	PET Imaging: whole body
Advanced Imaging (Radiology & Cardiology)	78814	PET With Concurrently Acquired Ct; Limited Area
Advanced Imaging (Radiology & Cardiology)	78815	PET With Concurrently Acquired Ct; Skull Base To Mid-Thigh
Advanced Imaging (Radiology & Cardiology)	78816	PET With Concurrently Acquired Ct; Whole Body
Advanced Imaging (Radiology & Cardiology)	78830	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, single area (eg, head, neck, chest, pelvis), single day imaging
Advanced Imaging (Radiology & Cardiology)	78831	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT), minimum 2 areas (eg, pelvis and knees, abdomen and pelvis), single day imaging, or single area imaging over 2 or more days

Advanced Imaging (Radiology & Cardiology)	78832	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, minimum 2 areas (eg, pelvis and knees, abdomen and pelvis), single day imaging, or single area imaging over 2 or more days
Advanced Imaging (Radiology & Cardiology)	78999	Unlisted procedure, diagnostic nuclear medicine-radiation therapy treatment planning
Advanced Imaging (Radiology & Cardiology)	93303	Transthoracic echocardiography for congenital cardiac anomalies; complete
Advanced Imaging (Radiology & Cardiology)	93304	Transthoracic echocardiography for congenital cardiac anomalies; follow-up or limited study
Advanced Imaging (Radiology & Cardiology)	93306	Echocardiography, transthoracic, real-time with image documentation (2d), includes m-mode recording, when performed, complete, with spectral doppler echocardiography, and with color flow doppler echocardiography
Advanced Imaging (Radiology & Cardiology)	93307	Echocardiography, transthoracic, real-time with image documentation (2d) with or without m-mode recording; complete
Advanced Imaging (Radiology & Cardiology)	93308	Echocardiography, transthoracic, real-time with image documentation (2d) with or without m-mode recording; follow-up or limited study
Advanced Imaging (Radiology & Cardiology)	93312	TEE 2D;Incl Probe Placement, Imaging/Interp/Report
Advanced Imaging (Radiology & Cardiology)	93313	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); placement of transesophageal probe only
Advanced Imaging (Radiology & Cardiology)	93314	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); image acquisition, interpretation and report only
Advanced Imaging (Radiology & Cardiology)	93315	Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report
Advanced Imaging (Radiology & Cardiology)	93316	Transesophageal echocardiography for congenital cardiac anomalies; placement of transesophageal probe only
Advanced Imaging (Radiology & Cardiology)	93317	Transesophageal echocardiography for congenital cardiac anomalies; image acquisition, interpretation and report only
Advanced Imaging (Radiology & Cardiology)	93319	3D echocardiographic imaging and postprocessing during transesophageal echocardiography, or during transthoracic echocardiography for congenital cardiac anomalies, for the assessment of cardiac structure(s) (eg, cardiac chambers and valves, left atrial appendage, interatrial septum, interventricular septum) and function, when performed (List separately in addition to code for echocardiographic imaging
Advanced Imaging (Radiology & Cardiology)	93320	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; complete
Advanced Imaging (Radiology & Cardiology)	93321	Doppler echocardiography, pulsed wave and/or continuous wave with spectral display; follow-up or limited study
Advanced Imaging (Radiology & Cardiology)	93325	Doppler echocardiography color flow velocity mapping
Advanced Imaging (Radiology & Cardiology)	93350	Echocardiography, transthoracic, real-time with image documentation (2d), with or without m-mode recording, during rest and cardiovascular stress test, with interpretation and report
Advanced Imaging (Radiology & Cardiology)	93351	Echocardiography, transthoracic, real-time with image documentation (2d), includes m-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation
Advanced Imaging (Radiology & Cardiology)	93352	Use of echocardiographic contrast agent during stress echocardiography (list separately in addition to code for primary procedure)
Advanced Imaging (Radiology & Cardiology)	93356	Myocardial strain imaging using speckle tracking-derived assessment of myocardial mechanics (List separately in addition to codes for echocardiography imaging)
Advanced Imaging (Radiology & Cardiology)	93451	Right Heart Catheterization Including Measurement(S) Of Oxygen Saturation And Cardiac Output, When Performed
Advanced Imaging (Radiology & Cardiology)	93452	Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed
Advanced Imaging (Radiology & Cardiology)	93453	Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed
Advanced Imaging (Radiology & Cardiology)	93454	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation
Advanced Imaging (Radiology & Cardiology)	93455	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial venous grafts) including intraprocedural injection(s) for bypass graft angiography
Advanced Imaging (Radiology & Cardiology)	93456	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization
Advanced Imaging (Radiology & Cardiology)	93457	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization
Advanced Imaging (Radiology & Cardiology)	93458	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed
Advanced Imaging (Radiology & Cardiology)	93459	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography
Advanced Imaging (Radiology & Cardiology)	93460	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed
Advanced Imaging (Radiology & Cardiology)	93461	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography
Advanced Imaging (Radiology & Cardiology)	93462	Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (list separately in addition to code for primary procedure)

Advanced Imaging (Radiology & Cardiology)	93593	Right heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone; normal native connections
Advanced Imaging (Radiology & Cardiology)	93594	Right heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone; abnormal native connections
Advanced Imaging (Radiology & Cardiology)	93595	Left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone, normal or abnormal native connections
Advanced Imaging (Radiology & Cardiology)	93596	Right and left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone(s); normal native connections
Advanced Imaging (Radiology & Cardiology)	93597	Right and left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone(s); abnormal native connections
Advanced Imaging (Radiology & Cardiology)	C8900	MRA Abdomen with contrast
Advanced Imaging (Radiology & Cardiology)	C8901	MRA Abdomen without contrast
Advanced Imaging (Radiology & Cardiology)	C8902	MRA Abdomen with and w/o contrast
Advanced Imaging (Radiology & Cardiology)	C8903	MRI Breast w/ contrast, unilateral
Advanced Imaging (Radiology & Cardiology)	C8905	MRI Breast w. and w/o contrast, unilateral
Advanced Imaging (Radiology & Cardiology)	C8906	MRI Breast Bilateral W/ Contrast
Advanced Imaging (Radiology & Cardiology)	C8908	MRI Breast Bilateral W/ And W/O Contrast
Advanced Imaging (Radiology & Cardiology)	C8909	MRA chest w/contrast (excluding myocardium)
Advanced Imaging (Radiology & Cardiology)	C8910	MRA chest w/o contrast (excluding myocardium)
Advanced Imaging (Radiology & Cardiology)	C8911	MRA chest w/ and w/o contrast (excluding myocardium)
Advanced Imaging (Radiology & Cardiology)	C8912	MRA lower extremity w/ contrast
Advanced Imaging (Radiology & Cardiology)	C8913	MRA lower extremity w/o contrast
Advanced Imaging (Radiology & Cardiology)	C8914	MRA lower extremity w/ and w/o contrast
Advanced Imaging (Radiology & Cardiology)	C8918	MRA pelvis w/ contrast
Advanced Imaging (Radiology & Cardiology)	C8919	MRA pelvis w/o contrast
Advanced Imaging (Radiology & Cardiology)	C8920	MRA pelvis w/ and w/o contrast
Advanced Imaging (Radiology & Cardiology)	C8921	Transthoracic echocardiography w/contrast for congenital cardiac anomalies; complete
Advanced Imaging (Radiology & Cardiology)	C8922	Transthoracic echocardiography w/contrast for congenital cardiac anomalies; f/u or limited study
Advanced Imaging (Radiology & Cardiology)	C8923	Transthoracic echocardiography w/contrast, real-time w/image documentation (2d), w/wo m-mode recording; complete
Advanced Imaging (Radiology & Cardiology)	C8924	Transthoracic echocardiography w/contrast, real-time w/image documentation (2d), w/wo m-mode recording; f/u or limited study
Advanced Imaging (Radiology & Cardiology)	C8925	Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, real time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report
Advanced Imaging (Radiology & Cardiology)	C8926	Transesophageal echocardiography (TEE) with contrast, or without contrast followed by with contrast, for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report
Advanced Imaging (Radiology & Cardiology)	C8928	Transthoracic echocardiography w/contrast, real-time w/image documentation (2d), w/wo m-mode recording, during rest and cardiovascular stress test, w/interpretation and report
Advanced Imaging (Radiology & Cardiology)	C8929	Transthoracic echocardiography with contrast, or without contrast followed by with contrast, real-time with image documentation (2d), includes m-mode recording, when performed, complete, with spectral doppler echocardiography, and with color flow doppler echocardiography
Advanced Imaging (Radiology & Cardiology)	C8930	Transthoracic echocardiography, with contrast, or without contrast followed by with contrast, real-time with image documentation (2d), includes m-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with physician supervision
Advanced Imaging (Radiology & Cardiology)	C8931	MRA, W/ Dye, Spinal Canal
Advanced Imaging (Radiology & Cardiology)	C8932	MRA, W/O Dye, Spinal Canal
Advanced Imaging (Radiology & Cardiology)	C8933	MRA, W/O & W/ Dye, Spinal Canal
Advanced Imaging (Radiology & Cardiology)	C8934	MRA, W/ Dye, Upper Extremity
Advanced Imaging (Radiology & Cardiology)	C8935	MRA, W/O Dye, Upper Extr
Advanced Imaging (Radiology & Cardiology)	C8936	MRA, W/O & W/ Dye, Upper Extr
Advanced Imaging (Radiology & Cardiology)	C9762	Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with strain imaging
Advanced Imaging (Radiology & Cardiology)	C9763	Cardiac magnetic resonance imaging for morphology and function, quantification of segmental dysfunction; with stress imaging
Advanced Imaging (Radiology & Cardiology)	G0219	PET Imaging Whole Body; Melanoma For Non-Covered Indications
Advanced Imaging (Radiology & Cardiology)	G0235	PET Imaging, Any Site, Not Otherwise Specified
Advanced Imaging (Radiology & Cardiology)	G0252	PET Imaging, Full And Partial-Ring Pet Scanners Only For Initial Diagnosis Of Breast Cancer And/Or Surgical Planning For Breast Cancer
Advanced Imaging (Radiology & Cardiology)	S8037	Magnetic resonance cholangiopancreato-graphy (MRCP)
Advanced Imaging (Radiology & Cardiology)	S8042	Magnetic Resonance Imaging (MRI), Low-Field
Advanced Imaging (Radiology & Cardiology)	S8085	Fluorine-18 Fluorodeoxyglucose (F-18 Fdg) Imaging Using Dual Head Coincidence Detection System. (Non-Dedicated Pet Scan)
Advanced Imaging (Radiology & Cardiology)	S8092	Electron Beam Computed Tomography (Also Known As Ultrafast CT, CINET)
Advanced Laboratory Testing (Laboratory Management)	81162	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis and full duplication/deletion analysis (ie, detection of large gene rearrangements
Advanced Laboratory Testing (Laboratory Management)	81163	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis
Advanced Laboratory Testing (Laboratory Management)	81164	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (ie, detection of large gene rearrangements)
Advanced Laboratory Testing (Laboratory Management)	81165	BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis
Advanced Laboratory Testing (Laboratory Management)	81166	BRCA1 (BRCA1, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full duplication/deletion anlaysis (ie, detection of large gene rearrangements)
Advanced Laboratory Testing (Laboratory Management)	81167	BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (ie, detection of large gene rearrangements)

Advanced Laboratory Testing (Laboratory Management)	81173	AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; full gene sequence
Advanced Laboratory Testing (Laboratory Management)	81174	AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; known familial variant
Advanced Laboratory Testing (Laboratory Management)	81185	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (eg, spinocerebellar ataxia) gene analysis; full gene sequence
Advanced Laboratory Testing (Laboratory Management)	81186	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (eg, spinocerebellar ataxia) gene analysis; known familial variant
Advanced Laboratory Testing (Laboratory Management)	81189	CSTB (cystatin B) (eg, Unverricht-Lundborg disease) gene analysis; full gene sequence
Advanced Laboratory Testing (Laboratory Management)	81190	CSTB (cystatin B) (eg, Unverricht-Lundborg disease) gene analysis; known familial variant (s)
Advanced Laboratory Testing (Laboratory Management)	81201	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene sequence
Advanced Laboratory Testing (Laboratory Management)	81202	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; known familial variants
Advanced Laboratory Testing (Laboratory Management)	81203	APC (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; duplication/deletion variants
Advanced Laboratory Testing (Laboratory Management)	81212	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; 185delAG, 5385insC, 6174delT variants
Advanced Laboratory Testing (Laboratory Management)	81215	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; known familial variant
Advanced Laboratory Testing (Laboratory Management)	81216	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis
Advanced Laboratory Testing (Laboratory Management)	81217	BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; known familial variant
Advanced Laboratory Testing (Laboratory Management)	81221	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; known familial variants
Advanced Laboratory Testing (Laboratory Management)	81222	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; duplication/deletion variants
Advanced Laboratory Testing (Laboratory Management)	81223	CFTR (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; full gene sequence
Advanced Laboratory Testing (Laboratory Management)	81225	CYP2C19 (cytochrome P450, family 2, subfamily C, polypeptide 19) (eg, drug metabolism), gene analysis, common variants (eg, *2,*3, *4, *8, *17)
Advanced Laboratory Testing (Laboratory Management)	81226	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3,*4, *5, *6, *9, *10, *17, *19, *29, *35, *41, *1XN, *2XN, *4XN)
Advanced Laboratory Testing (Laboratory Management)	81227	CYP2C9 (cytochrome P450, family 2, subfamily C, polypeptide 9) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *5, *6)
Advanced Laboratory Testing (Laboratory Management)	81228	Cytogenomic constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number variants (eg, bacterial artificial chromosome [BAC] or oligo-based comparative genomic hybridization [CGH] microarray analysis)
Advanced Laboratory Testing (Laboratory Management)	81229	Cytogenomic constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number and single nucleotide polymorphism (SNP) variants for chromosomal abnormalities
Advanced Laboratory Testing (Laboratory Management)	81230	CYP3A4 (cytochrome P450 family 3 subfamily A member 4) (eg, drug metabolism), gene analysis, common variant(s) (eg, *2, *22)
Advanced Laboratory Testing (Laboratory Management)	81231	CYP3A5 (cytochrome P450 family 3 subfamily A member 5) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4,*5, *6, *7)
Advanced Laboratory Testing (Laboratory Management)	81232	DPYD (dihydropyrimidine dehydrogenase) (eg, 5-fluorouracil/5-FU and capecitabine drug metabolism), gene analysis, common variant(s) (eg, *2A, *4, *5, *6)
Advanced Laboratory Testing (Laboratory Management)	81238	F9 (coagulation factor IX) (eg, hemophilia B), full gene sequence
Advanced Laboratory Testing (Laboratory Management)	81248	G6PD (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice), gene analysis; known familial variant(s)
Advanced Laboratory Testing (Laboratory Management)	81249	G6PD (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice), gene analysis; full gene sequence
Advanced Laboratory Testing (Laboratory Management)	81252	GJB2 (gap junction protein, beta 2, 26kDa, connexin 26) (eg, nonsyndromic hearing loss) gene analysis; full gene sequence
Advanced Laboratory Testing (Laboratory Management)	81253	GJB2 (gap junction protein, beta 2, 26kDa, connexin 26) (eg, nonsyndromic hearing loss) gene analysis; known familial variants
Advanced Laboratory Testing (Laboratory Management)	81257	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; common deletions or variant (eg, Southeast Asian, Thai, Filipino, Mediterranean, alpha3.7, alpha4.2, alpha20.5, Constant Spring)
Advanced Laboratory Testing (Laboratory Management)	81258	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; known familial variant
Advanced Laboratory Testing (Laboratory Management)	81259	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; full gene sequence
Advanced Laboratory Testing (Laboratory Management)	81269	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; duplication/deletion variants
Advanced Laboratory Testing (Laboratory Management)	81277	Cytogenomic neoplasia (genome-wide) microarray analysis, interrogation of genomic regions for copy number and loss-of- heterozygosity variants for chromosomal abnormalities
Advanced Laboratory Testing (Laboratory Management)	81283	IFNL3 (interferon, lambda 3) (eg, drug response), gene analysis, rs12979860 variant
Advanced Laboratory Testing (Laboratory Management)	81286	FXN (frataxin) (eg, Friedreich ataxia) gene analysis; full gene sequence
Advanced Laboratory Testing (Laboratory Management)	81289	FXN (frataxin) (eg, Friedreich ataxia) gene analysis; known familial variant (s)
Advanced Laboratory Testing (Laboratory Management)	81291	MTHFR (5,10-methylenetetrahydrofolate reductase) (eg, hereditary hypercoagulability) gene analysis, common variants (eg, 677T, 1298C)

Advanced Laboratory Testing (Laboratory Management)	81292	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis
Advanced Laboratory Testing (Laboratory Management)	81293	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants
Advanced Laboratory Testing (Laboratory Management)	81294	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants
Advanced Laboratory Testing (Laboratory Management)	81295	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis
Advanced Laboratory Testing (Laboratory Management)	81296	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants
Advanced Laboratory Testing (Laboratory Management)	81297	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants
Advanced Laboratory Testing (Laboratory Management)	81298	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis
Advanced Laboratory Testing (Laboratory Management)	81299	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants
Advanced Laboratory Testing (Laboratory Management)	81300	MSH6 (mutS homolog 6 [E. coli]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants
Advanced Laboratory Testing (Laboratory Management)	81302	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; full sequence analysis
Advanced Laboratory Testing (Laboratory Management)	81303	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; known familial variant
Advanced Laboratory Testing (Laboratory Management)	81304	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome) gene analysis; duplication/deletion variants
Advanced Laboratory Testing (Laboratory Management)	81306	NUDT15 (nudix hydrolase 15) (eg, drug metabolism) gene analysis, common variant(s) (eg, *2, *3, *4, *5, *6)
Advanced Laboratory Testing (Laboratory Management)	81307	PALB2 (partner and localizer of BRCA2) (eg, breast and pancreatic cancer) gene analysis; full gene sequence
Advanced Laboratory Testing (Laboratory Management)	81308	PALB2 (partner and localizer of BRCA2) (eg, breast and pancreatic cancer) gene analysis; known familial variant
Advanced Laboratory Testing (Laboratory Management)	81313	PCA3/KLK3 (prostate cancer antigen 3 [non-protein coding]/kallikrein-related peptidase 3 [prostate specific antigen]) ratio (eg, prostate cancer)
Advanced Laboratory Testing (Laboratory Management)	81317	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis
Advanced Laboratory Testing (Laboratory Management)	81318	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants
Advanced Laboratory Testing (Laboratory Management)	81319	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants
Advanced Laboratory Testing (Laboratory Management)	81321	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; full sequence analysis
Advanced Laboratory Testing (Laboratory Management)	81322	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; known familial variant
Advanced Laboratory Testing (Laboratory Management)	81323	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; duplication/deletion variant
Advanced Laboratory Testing (Laboratory Management)	81325	PMP22 (peripheral myelin protein 22) (eg, Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; full sequence analysis
Advanced Laboratory Testing (Laboratory Management)	81326	PMP22 (peripheral myelin protein 22) (eg, Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; known familial variant
Advanced Laboratory Testing (Laboratory Management)	81327	SEPT9 (Septin9) (eg, colorectal cancer) promoter methylation analysis
Advanced Laboratory Testing (Laboratory Management)	81335	TPMT (thiopurine S-methyltransferase) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3)
Advanced Laboratory Testing (Laboratory Management)	81336	SMN1 (survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy) gene analysis; full gene sequence
Advanced Laboratory Testing (Laboratory Management)	81337	SMN1 (survival of motor neuron 1, telomeric) (eg, spinal muscular atrophy) gene analysis; known familial sequence variant(s)
Advanced Laboratory Testing (Laboratory Management)	81346	TYMS (thymidylate synthetase) (eg, 5-fluorouracil/5-FU drug metabolism), gene analysis, common variant(s) (eg, tandem repeat variant)
Advanced Laboratory Testing (Laboratory Management)	81349	Cytogenomic (genome-wide) analysis for constitutional chromosomal abnormalities; interrogation of genomic regions for copy number and loss-of-heterozygosity variants, low-pass sequencing analysis
Advanced Laboratory Testing (Laboratory Management)	81350	UGT1A1 (UDP glucuronosyltransferase 1 family, polypeptide A1) (eg, drug metabolism, hereditary unconjugated hyperbilirubinemia [Gilbert syndrome]) gene analysis, common variants (eg, *28, *36, *37)
Advanced Laboratory Testing (Laboratory Management)	81351	TP53 (tumor protein 53) (eg, Li-Fraumeni syndrome) gene analysis; full gene sequence
Advanced Laboratory Testing (Laboratory Management)	81353	TP53 (tumor protein 53) (eg, Li-Fraumeni syndrome) gene analysis; known familial variant
Advanced Laboratory Testing (Laboratory Management)	81355	VKORC1 (vitamin K epoxide reductase complex, subunit 1) (eg, warfarin metabolism), gene analysis, common variant(s) (eg, - 1639G>A, c.173+1000C>T)
Advanced Laboratory Testing (Laboratory Management)	81361	HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); common variant(s) (eg, HbS, HbC, HbE)
Advanced Laboratory Testing (Laboratory Management)	81362	HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); known familial variant(s)
Advanced Laboratory Testing (Laboratory Management)	81363	HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); duplication/deletion variant(s)
Advanced Laboratory Testing (Laboratory Management)	81364	HBB (hemoglobin, subunit beta) (eg, sickle cell anemia, beta thalassemia, hemoglobinopathy); full gene sequence
Advanced Laboratory Testing (Laboratory Management)	81400	Molecular pathology procedure, Level 1 (eg, identification of single germline variant [eg, SNP] by techniques such as restriction enzyme digestion or melt curve analysis)

Advanced Laboratory Testing (Laboratory Management)	81401	Molecular pathology procedure, Level 2 (eg, 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat)
Advanced Laboratory Testing (Laboratory Management)	81402	Molecular pathology procedure, Level 3 (eg, >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non- sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants of 1 exon, loss of heterozygosity [LOH], uniparental disomy [UPD])
Advanced Laboratory Testing (Laboratory Management)	81403	Molecular pathology procedure, Level 4 (eg, analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)
Advanced Laboratory Testing (Laboratory Management)	81404	Molecular pathology procedure, Level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)
Advanced Laboratory Testing (Laboratory Management)	81405	Molecular pathology procedure, Level 6 (eg, analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons, regionally targeted cytogenomic array analysis)
Advanced Laboratory Testing (Laboratory Management)	81406	Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons)
Advanced Laboratory Testing (Laboratory Management)	81407	Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform)
Advanced Laboratory Testing (Laboratory Management)	81408	Molecular pathology procedure, Level 9 (eg, analysis of >50 exons in a single gene by DNA sequence analysis)
Advanced Laboratory Testing (Laboratory Management)	81410	Aortic dysfunction or dilation (eg, Marfan syndrome, Loeys Dietz syndrome, Ehler Danlos syndrome type IV, arterial tortuosity syndrome); genomic sequence analysis panel, must include sequencing of at least 9 genes, including FBN1, TGFBR1, TGFBR2, COL3A1, MYH11, ACTA2, SLC2A10, SMAD3, and MYLK
Advanced Laboratory Testing (Laboratory Management)	81411	Aortic dysfunction or dilation (eg, Marfan syndrome, Loeys Dietz syndrome, Ehler Danlos syndrome type IV, arterial tortuosity syndrome); duplication/deletion analysis panel, must include analyses for TGFBR1, TGFBR2, MYH11, and COL3A1
Advanced Laboratory Testing (Laboratory Management)	81412	Ashkenazi Jewish associated disorders (eg, Bloom syndrome, Canavan disease, cystic fibrosis, familial dysautonomia, Fanconi anemia group C, Gaucher disease, Tay-Sachs disease), genomic sequence analysis panel, must include sequencing of at least 9 genes, including ASPA, BLM, CFTR, FANCC, GBA, HEXA, IKBKAP, MCOLN1, and SMPD1
Advanced Laboratory Testing (Laboratory Management)	81413	Cardiac ion channelopathies (eg, Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia); genomic sequence analysis panel, must include sequencing of at least 10 genes, including ANK2, CASQ2, CAV3, KCNE1, KCNE2, KCNH2, KCNJ2, KCNQ1, RYR2, and SCN5A
Advanced Laboratory Testing (Laboratory Management)	81414	Cardiac ion channelopathies (eg, Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia); duplication/deletion gene analysis panel, must include analysis of at least 2 genes, including KCNH2 and KCNQ1
Advanced Laboratory Testing (Laboratory Management)	81415	Exome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis
Advanced Laboratory Testing (Laboratory Management)	81416	Exome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis, each comparator exome (eg, parents, siblings) (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	81417	Exome (eg, unexplained constitutional or heritable disorder or syndrome); re-evaluation of previously obtained exome sequence (eg, updated knowledge or unrelated condition/syndrome)
Advanced Laboratory Testing (Laboratory Management)	81419	Epilepsy genomic sequence analysis panel, must include analyses for ALDH7A1, CACNA1A, CDKL5, CHD2, GABRG2, GRIN2A, KCNQ2, MECP2, PCDH19, POLG, PRRT2, SCN1A, SCN1B, SCN2A, SCN8A, SLC2A1, SLC9A6, STXBP1, SYNGAP1, TCF4, TPP1, TSC1, TSC2, and ZEB2
Advanced Laboratory Testing (Laboratory Management)	81422	Fetal chromosomal microdeletion(s) genomic sequence analysis (eg, DiGeorge syndrome, Cri-du-chat syndrome), circulating cell- free fetal DNA in maternal blood
Advanced Laboratory Testing (Laboratory Management)	81425	Genome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis
Advanced Laboratory Testing (Laboratory Management)	81426	Genome (eg, unexplained constitutional or heritable disorder or syndrome); sequence analysis, each comparator genome (eg, parents, siblings) (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	81427	Genome (eg, unexplained constitutional or heritable disorder or syndrome); re-evaluation of previously obtained genome sequence (eg, updated knowledge or unrelated condition/syndrome)
Advanced Laboratory Testing (Laboratory Management)	81430	Hearing loss (eg, nonsyndromic hearing loss, Usher syndrome, Pendred syndrome); genomic sequence analysis panel, must include sequencing of at least 60 genes, including CDH23, CLRN1, GJB2, GPR98, MTRNR1, MYO7A, MYO15A, PCDH15, OTOF, SLC26A4, TMC1, TMPRSS3, USH1C, USH1G, USH2A, and WFS1
Advanced Laboratory Testing (Laboratory Management)	81431	Hearing loss (eg, nonsyndromic hearing loss, Usher syndrome, Pendred syndrome); duplication/deletion analysis panel, must include copy number analyses for STRC and DFNB1 deletions in GJB2 and GJB6 genes
Advanced Laboratory Testing (Laboratory Management)	81432	Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer); genomic sequence analysis panel, must include sequencing of at least 10 genes, always including BRCA1, BRCA2, CDH1, MLH1, MSH2, MSH6, PALB2, PTEN, STK11, and TP53
Advanced Laboratory Testing (Laboratory Management)	81433	Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer); duplication/deletion analysis panel, must include analyses for BRCA1, BRCA2, MLH1, MSH2, and STK11
Advanced Laboratory Testing (Laboratory Management)	81434	Hereditary retinal disorders (eg, retinitis pigmentosa, Leber congenital amaurosis, cone-rod dystrophy), genomic sequence analysis panel, must include sequencing of at least 15 genes, including ABCA4, CNGA1, CRB1, EYS, PDE6A, PDE6B, PRPF31, PRPH2, RDH12, RHO, RP1, RP2, RPE65, RPGR, and USH2A
Advanced Laboratory Testing (Laboratory Management)	81435	Hereditary colon cancer disorders (eg, Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis); genomic sequence analysis panel, must include sequencing of at least 10 genes, including APC, BMPR1A, CDH1, MLH1, MSH2, MSH6, MUTYH, PTEN, SMAD4, and STK11

Advanced Laboratory Testing (Laboratory Management)	81436	Hereditary colon cancer disorders (eg, Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis); duplication/deletion analysis panel, must include analysis of at least 5 genes, including MLH1, MSH2, EPCAM, SMAD4, and STK11
Advanced Laboratory Testing (Laboratory Management)	81437	Hereditary neuroendocrine tumor disorders (eg, medullary thyroid carcinoma, parathyroid carcinoma, malignant pheochromocytoma or paraganglioma); genomic sequence analysis panel, must include sequencing of at least 6 genes, including MAX, SDHB, SDHC, SDHD, TMEM127, and VHL
Advanced Laboratory Testing (Laboratory Management)	81438	Hereditary neuroendocrine tumor disorders (eg, medullary thyroid carcinoma, parathyroid carcinoma, malignant pheochromocytoma or paraganglioma); duplication/deletion analysis panel, must include analyses for SDHB, SDHC, SDHD, and VHL
Advanced Laboratory Testing (Laboratory Management)	81439	Hereditary cardiomyopathy (eg, hypertrophic cardiomyopathy, dilated cardiomyopathy, arrhythmogenic right ventricular cardiomyopathy), genomic sequence analysis panel, must include sequencing of at least 5 cardiomyopathy-related genes (eg, DSG2, MYBPC3, MYH7, PKP2, TTN)
Advanced Laboratory Testing (Laboratory Management)	81440	Nuclear encoded mitochondrial genes (eg, neurologic or myopathic phenotypes), genomic sequence panel, must include analysis of at least 100 genes, including BCS1L, C10orf2, COQ2, COX10, DGUOK, MPV17, OPA1, PDSS2, POLG, POLG2, RRM2B, SCO1, SCO2, SLC25A4, SUCLA2, SUCLG1, TAZ, TK2, and TYMP
Advanced Laboratory Testing (Laboratory Management)	81442	Noonan spectrum disorders (eg, Noonan syndrome, cardio-facio-cutaneous syndrome, Costello syndrome, LEOPARD syndrome, Noonan-like syndrome), genomic sequence analysis panel, must include sequencing of at least 12 genes, including BRAF, CBL, HRAS, KRAS, MAP2K1, MAP2K2, NRAS, PTPN11, RAF1, RIT1, SHOC2, and SOS1
Advanced Laboratory Testing (Laboratory Management)	81443	Genetic testing for severe inherited conditions (eg, cystic fibrosis, Ashkenazi Jewish-associated disorders [eg, Bloom syndrome, Canavan disease, Fanconi anemia type C, mucolipidosis type VI, Gaucher disease, Tay-Sachs disease], beta hemoglobinopathies, phenylketonuria, galactosemia), genomic sequence analysis panel, must include sequencing of at least 15 genes (eg, ACADM, ARSA, ASPA, ATP7B, BCKDHA, BCKDHB, BLM, CFTR, DHCR7, FANCC, G6PC, GAA, GALT, GBA, GBE1, HBB, HEXA, IKBKAP, MCOLN1, PAH)
Advanced Laboratory Testing (Laboratory Management)	81445	Targeted genomic sequence analysis panel, solid organ neoplasm, DNA analysis, and RNA analysis when performed, 5-50 genes (eg, ALK, BRAF, CDKN2A, EGFR, ERBB2, KIT, KRAS, NRAS, MET, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET), interrogation for sequence variants and copy number variants or rearrangements, if performed
Advanced Laboratory Testing (Laboratory Management)	81448	Hereditary peripheral neuropathies (eg, Charcot-Marie-Tooth, spastic paraplegia), genomic sequence analysis panel, must include sequencing of at least 5 peripheral neuropathy-related genes (eg, BSCL2, GJB1, MFN2, MPZ, REEP1, SPAST, SPG11, SPTLC1)
Advanced Laboratory Testing (Laboratory Management)	81450	Targeted genomic sequence analysis panel, hematolymphoid neoplasm or disorder, DNA analysis, and RNA analysis when performed, 5-50 genes (eg, BRAF, CEBPA, DNMT3A, EZH2, FLT3, IDH1, IDH2, JAK2, KRAS, KIT, MLL, NRAS, NPM1, NOTCH1), interrogation for sequence variants, and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed
Advanced Laboratory Testing (Laboratory Management)	81455	Targeted genomic sequence analysis panel, solid organ or hematolymphoid neoplasm, DNA analysis, and RNA analysis when performed, 51 or greater genes (eg, ALK, BRAF, CDKN2A, CEBPA, DNMT3A, EGFR, ERBB2, EZH2, FLT3, IDH1, IDH2, JAK2, KIT, KRAS, MLL, NPM1, NRAS, MET, NOTCH1, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET), interrogation for sequence variants and copy number variants or rearrangements, if performed
Advanced Laboratory Testing (Laboratory Management)	81460	Whole mitochondrial genome (eg, Leigh syndrome, mitochondrial encephalomyopathy, lactic acidosis, and stroke-like episodes [MELAS], myoclonic epilepsy with ragged-red fibers [MERFF], neuropathy, ataxia, and retinitis pigmentosa [NARP], Leber hereditary optic neuropathy [LHON]), genomic sequence, must include sequence analysis of entire mitochondrial genome with heteroplasmy detection
Advanced Laboratory Testing (Laboratory Management)	81465	Whole mitochondrial genome large deletion analysis panel (eg, Kearns-Sayre syndrome, chronic progressive external ophthalmoplegia), including heteroplasmy detection, if performed
Advanced Laboratory Testing (Laboratory Management)	81470	X-linked intellectual disability (XLID) (eg, syndromic and non-syndromic XLID); genomic sequence analysis panel, must include sequencing of at least 60 genes, including ARX, ATRX, CDKL5, FGD1, FMR1, HUWE1, IL1RAPL, KDM5C, L1CAM, MECP2, MED12, MID1, OCRL, RPS6KA3, and SLC16A2
Advanced Laboratory Testing (Laboratory Management)	81471	X-linked intellectual disability (XLID) (eg, syndromic and non-syndromic XLID); duplication/deletion gene analysis, must include analysis of at least 60 genes, including ARX, ATRX, CDKL5, FGD1, FMR1, HUWE1, IL1RAPL, KDM5C, L1CAM, MECP2, MED12, MID1, OCRL, RPS6KA3, and SLC16A2
Advanced Laboratory Testing (Laboratory Management)	81479	Unlisted molecular pathology procedure
Advanced Laboratory Testing (Laboratory Management)	81493	Coronary artery disease, mRNA, gene expression profiling by real-time RT-PCR of 23 genes, utilizing whole peripheral blood, algorithm reported as a risk score
Advanced Laboratory Testing (Laboratory Management)	81503	Oncology (ovarian), biochemical assays of five proteins (CA-125, apolipoprotein A1, beta-2 microglobulin, transferrin, and pre- albumin), utilizing serum, algorithm reported as a risk score
Advanced Laboratory Testing (Laboratory Management)	81504	Oncology (tissue of origin), microarray gene expression profiling of > 2000 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as tissue similarity scores
Advanced Laboratory Testing (Laboratory Management)	81518	Oncology (breast), mRNA, gene expression profiling by real-time RT-PCR of 11 genes (7 content and 4 housekeeping), utilizing formalin-fixed paraffin- embedded tissue, algorithms reported as percentage risk for metastatic recurrence and likelihood of benefit from extended endocrine therapy
Advanced Laboratory Testing (Laboratory Management)	81519	Oncology (breast), mRNA, gene expression profiling by real-time RT-PCR of 21 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as recurrence score
Advanced Laboratory Testing (Laboratory Management)	81520	Oncology (breast), mRNA gene expression profiling by hybrid capture of 58 genes (50 content and 8 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a recurrence risk score
Advanced Laboratory Testing (Laboratory Management)	81521	Oncology (breast), mRNA, microarray gene expression profiling of 70 content genes and 465 housekeeping genes, utilizing fresh frozen or formalin-fixed paraffin-embedded tissue, algorithm reported as index related to risk of distant metastasis
Advanced Laboratory Testing (Laboratory Management)	81522	Oncology (breast), mRNA, gene expression profiling by RT-PCR of 12 genes (8 content and 4 housekeeping), utilizing formalin- fixed paraffin-embedded tissue, algorithm reported as recurrence risk score

Advanced Laboratory Testing (Laboratory Management)	81523	Oncology (breast), mRNA, next-generation sequencing gene expression profiling of 70 content genes and 31 housekeeping genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as index related to risk to distant metastasis
Advanced Laboratory Testing (Laboratory Management)	81525	Oncology (colon), mRNA, gene expression profiling by real-time RT-PCR of 12 genes (7 content and 5 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a recurrence score
Advanced Laboratory Testing (Laboratory Management)	81529	Oncology (cutaneous melanoma), mRNA, gene expression profiling by real-time RT-PCR of 31 genes (28 content and 3 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as recurrence risk, including likelihood of sentinel lymph node metastasis
Advanced Laboratory Testing (Laboratory Management)	81535	Oncology (gynecologic), live tumor cell culture and chemotherapeutic response by DAPI stain and morphology, predictive algorithm reported as a drug response score; first single drug or drug combination
Advanced Laboratory Testing (Laboratory Management)	81536	Oncology (gynecologic), live tumor cell culture and chemotherapeutic response by DAPI stain and morphology, predictive algorithm reported as a drug response score; each additional single drug or drug combination (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	81538	Oncology (lung), mass spectrometric 8-protein signature, including amyloid A, utilizing serum, prognostic and predictive algorithm reported as good versus poor overall survival
Advanced Laboratory Testing (Laboratory Management)	81539	Oncology (high-grade prostate cancer), biochemical assay of four proteins (Total PSA, Free PSA, Intact PSA, and human kallikrein-2 [hK2]), utilizing plasma or serum, prognostic algorithm reported as a probability score
Advanced Laboratory Testing (Laboratory Management)	81541	Oncology (prostate), mRNA gene expression profiling by real-time RT-PCR of 46 genes (31 content and 15 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a disease-specific mortality risk score
Advanced Laboratory Testing (Laboratory Management)	81542	Oncology (prostate), mRNA, microarray gene expression profiling of 22 content genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as metastasis risk score
Advanced Laboratory Testing (Laboratory Management)	81546	Oncology (thyroid), mRNA, gene expression analysis of 10,196 genes, utilizing fine needle aspirate, algorithm reported as a categorical result (eg, benign or suspicious)
Advanced Laboratory Testing (Laboratory Management)	81551	Oncology (prostate), promoter methylation profiling by real-time PCR of 3 genes (GSTP1, APC, RASSF1), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a likelihood of prostate cancer detection on repeat biopsy
Advanced Laboratory Testing (Laboratory Management)	81552	Oncology (uveal melanoma), mRNA, gene expression profiling by real-time RT-PCR of 15 genes (12 content and 3 housekeeping), utilizing fine needle aspirate or formalin-fixed paraffin-embedded tissue, algorithm reported as risk of metastasis
Advanced Laboratory Testing (Laboratory Management)	81554	Pulmonary disease (idiopathic pulmonary fibrosis [IPF]), mRNA, gene expression analysis of 190 genes, utilizing transbronchial biopsies, diagnostic algorithm reported as categorical result (eg, positive or negative for high probability of usual interstitial pneumonia [UIP])
Advanced Laboratory Testing (Laboratory Management)	81595	Cardiology (heart transplant), mRNA, gene expression profiling by real-time quantitative PCR of 20 genes (11 content and 9 housekeeping), utilizing subfraction of peripheral blood, algorithm reported as a rejection risk score
Advanced Laboratory Testing (Laboratory Management)	81596	Infectious disease, chronic hepatitis C virus (HCV) infection, six biochemical assays (ALT, A2-macroglobulin, apolipoprotein A-1, total bilirubin, GGT, and haptoglobin) utilizing serum, prognostic algorithm reported as scores for fibrosis and necroinflammatory activity in liver
Advanced Laboratory Testing (Laboratory Management)	81599	Unlisted multianalyte assay with algorithmic analysis
Advanced Laboratory Testing (Laboratory Management)	84999	Unlisted chemistry procedure
Advanced Laboratory Testing (Laboratory Management)	0002M	Liver disease, ten biochemical assays (ALT, A2-macroglobulin, apolipoprotein A-1, total bilirubin, GGT, haptoglobin, AST, glucose, total cholesterol and triglycerides) utilizing serum, prognostic algorithm reported as quantitative scores for fibrosis, steatosis and alcoholic steatohepatitis (ASH)
Advanced Laboratory Testing (Laboratory Management)	0003M	Liver disease, ten biochemical assays (ALT, A2-macroglobulin, apolipoprotein A-1, total bilirubin, GGT, haptoglobin, AST, glucose, total cholesterol and triglycerides) utilizing serum, prognostic algorithm reported as quantitative scores for fibrosis, steatosis and nonalcoholic steatohepatitis (NASH)
Advanced Laboratory Testing (Laboratory Management)	0004M	Scoliosis, DNA analysis of 53 single nucleotide polymorphisms (SNPs), using saliva, prognostic algorithm reported as a risk score
Advanced Laboratory Testing (Laboratory Management)	0006M	Oncology (hepatic), mRNA expression levels of 161 genes, utilizing fresh hepatocellular carcinoma tumor tissue, with alpha- fetoprotein level, algorithm reported as a risk classifier
Advanced Laboratory Testing (Laboratory Management)	0007M	Oncology (gastrointestinal neuroendocrine tumors), real-time PCR expression analysis of 51 genes, utilizing whole peripheral blood, algorithm reported as a nomogram of tumor disease index
Advanced Laboratory Testing (Laboratory Management)	0011M	Oncology, prostate cancer, mRNA expression assay of 12 genes (10 content and 2 housekeeping), RT-PCR test utilizing blood plasma and urine, algorithms to predict high-grade prostate cancer risk
Advanced Laboratory Testing (Laboratory Management)	0012M	Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [CDK1], IGFBP5, and CXCR2), utilizing urine, algorithm reported as a risk score for having urothelial carcinoma
Advanced Laboratory Testing (Laboratory Management)	0013M	Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [CDK1], IGFBP5, and CXCR2), utilizing urine, algorithm reported as a risk score for having recurrent urothelial carcinoma
Advanced Laboratory Testing (Laboratory Management)	0016M	Oncology (bladder), mRNA, microarray gene expression profiling of 219 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as molecular subtype (luminal, luminal infiltrated, basal, basal claudin-low, neuroendocrine-like)
Advanced Laboratory Testing (Laboratory Management)	0017M	Oncology (diffuse large B-cell lymphoma [DLBCL]), mRNA, gene expression profiling by fluorescent probe hybridization of 20 genes, formalin-fixed paraffinembedded tissue, algorithm reported as cell of origin
Advanced Laboratory Testing (Laboratory Management)	0018U	Oncology (thyroid), microRNA profiling by RT-PCR of 10 microRNA sequences, utilizing fine needle aspirate, algorithm reported as a positive or negative result for moderate to high risk of malignancy
Advanced Laboratory Testing (Laboratory Management)	0019U	Oncology, RNA, gene expression by whole transcriptome sequencing, formalin-fixed paraffin embedded tissue or fresh frozen tissue, predictive algorithm reported as potential targets for therapeutic agents

Advanced Laboratory Testing (Laboratory Management)	0022U	Targeted genomic sequence analysis panel, cholangiocarcinoma and non-small cell lung neoplasia, DNA and RNA analysis, 1-23 genes, interrogation for sequence variants and rearrangements, reported as presence/absence of variants and associated therapy(ies) to consider
Advanced Laboratory Testing (Laboratory Management)	0026U	Oncology (thyroid), DNA and mRNA of 112 genes, next-generation sequencing, fine needle aspirate of thyroid nodule, algorithmic analysis reported as a categorical result ("Positive, high probability of malignancy" or "Negative, low probability of malignancy")
Advanced Laboratory Testing (Laboratory Management)	0029U	Drug metabolism (adverse drug reactions and drug response), targeted sequence analysis (ie, CYP1A2, CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, CYP4F2, SLCO1B1, VKORC1 and rs12777823)
Advanced Laboratory Testing (Laboratory Management)	0030U	Drug metabolism (warfarin drug response), targeted sequence analysis (ie, CYP2C9, CYP4F2, VKORC1, rs12777823)
Advanced Laboratory Testing (Laboratory Management)	0036U	Exome (ie, somatic mutations), paired formalin-fixed paraffin-embedded tumor tissue and normal specimen, sequence analyses
Advanced Laboratory Testing (Laboratory Management)	0037U	Targeted genomic sequence analysis, solid organ neoplasm, DNA analysis of 324 genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability and tumor mutational burden
Advanced Laboratory Testing (Laboratory Management)	0048U	Oncology (solid organ neoplasia), DNA, targeted sequencing of protein-coding exons of 468 cancer-associated genes, including interrogation for somatic mutations and microsatellite instability, matched with normal specimens, utilizing formalin-fixed paraffin- embedded tumor tissue, report of clinically significant mutation(s)
Advanced Laboratory Testing (Laboratory Management)	0050U	Targeted genomic sequence analysis panel, acute myelogenous leukemia, DNA analysis, 194 genes, interrogation for sequence variants, copy number variants or rearrangements
Advanced Laboratory Testing (Laboratory Management)	0053U	Oncology (prostate cancer), FISH analysis of 4 genes (ASAP1, HDAC9, CHD1 and PTEN), needle biopsy specimen, algorithm reported as probability of higher tumor grade
Advanced Laboratory Testing (Laboratory Management)	0055U	Cardiology (heart transplant), cell-free DNA, PCR assay of 96 DNA target sequences (94 single nucleotide polymorphism targets and two control targets), plasma
Advanced Laboratory Testing (Laboratory Management)	0067U	Oncology (breast), immunohistochemistry, protein expression profiling of 4 biomarkers (matrix metalloproteinase-1 [MMP-1], carcinoembryonic antigen-related cell adhesion molecule 6 [CEACAM6], hyaluronoglucosaminidase [HYAL1], highly expressed in cancer protein [HEC1]), formalin-fixed paraffin-embedded precancerous breast tissue, algorithm reported as carcinoma risk score
Advanced Laboratory Testing (Laboratory Management)	0069U	Oncology (colorectal), microRNA, RT-PCR expression profiling of miR-31-3p, formalin fixed paraffin-embedded tissue, algorithm reported as an expression score
Advanced Laboratory Testing (Laboratory Management)	0070U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, common and select rare variants (ie, *2, *3, *4, *4N, *5, *6, *7, *8, *9, *10, *11, *12, *13, *14A, *14B, *15, *17, *29, *35, *36, *41, *57, *61, *63, *68, *83, *xN)
Advanced Laboratory Testing (Laboratory Management)	0071U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, full gene sequence (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0072U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, targeted sequence analysis (ie, CYP2D6-2D7 hybrid gene) (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0073U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, targeted sequence analysis (ie, CYP2D7-2D6 hybrid gene) (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0074U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, targeted sequence analysis (ie, non-duplicated gene when duplication/multiplication is trans) (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0075U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, targeted sequence analysis (ie, 5' gene duplication/multiplication) (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0076U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, targeted sequence analysis (ie, 3' gene duplication/ multiplication) (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0078U	Pain management (opioid-use disorder) genotyping panel, 16 common variants (ie, ABCB1, COMT, DAT1, DBH, DOR, DRD1, DRD2, DRD4, GABA, GAL, HTR2A, HTTLPR, MTHFR, MUOR, OPRK1, OPRM1), buccal swab or other germline tissue sample, algorithm reported as positive or negative risk of opioid-use disorder
Advanced Laboratory Testing (Laboratory Management)	0084U	Red blood cell antigen typing, DNA, genotyping of 10 blood groups with phenotype prediction of 37 red blood cell antigens
Advanced Laboratory Testing (Laboratory Management)	0087U	Cardiology (heart transplant), mRNA gene expression profiling by microarray of 1283 genes, transplant biopsy tissue, allograft rejection and injury algorithm reported as a probability score
Advanced Laboratory Testing (Laboratory Management)	0088U	Transplantation medicine (kidney allograft rejection), microarray gene expression profiling of 1494 genes, utilizing transplant biopsy tissue, algorithm reported as a probability score for rejection
Advanced Laboratory Testing (Laboratory Management)	0089U	Oncology (melanoma), gene expression profiling by RTqPCR, PRAME and LINC00518, superficial collection using adhesive patch(es)
Advanced Laboratory Testing (Laboratory Management)	0094U	Genome (eg, unexplained constitutional or heritable disorder or syndrome), rapid sequence analysis
Advanced Laboratory Testing (Laboratory Management)	0101U	Hereditary colon cancer disorders (eg, Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA, and array CGH, with mRNA analytics to resolve variants of unknown significance when indicated (15 genes [sequencing and deletion/duplication], EPCAM and GREM1 [deletion/duplication only])
Advanced Laboratory Testing (Laboratory Management)	0102U	Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA, and array CGH, with mRNA analytics to resolve variants of unknown significance when indicated (17 genes [sequencing and deletion/duplication])
Advanced Laboratory Testing (Laboratory Management)	0103U	Hereditary ovarian cancer (eg, hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA, and array CGH, with mRNA analytics to resolve variants of unknown significance when indicated (24 genes [sequencing and deletion/duplication], EPCAM [deletion/duplication only])

Advanced Laboratory Testing (Laboratory Management)	0111U	Oncology (colon cancer), targeted KRAS (codons 12, 13, and 61) and NRAS (codons 12, 13, and 61) gene analysis utilizing formalin-fixed paraffin-embedded tissue
Advanced Laboratory Testing (Laboratory Management)	0113U	Oncology (prostate), measurement of PCA3 and TMPRSS2-ERG in urine and PSA in serum following prostatic massage, by RNA amplification and fluorescence-based detection, algorithm reported as risk score
Advanced Laboratory Testing (Laboratory Management)	0114U	Gastroenterology (Barrett's esophagus), VIM and CCNA1 methylation analysis, esophageal cells, algorithm reported as likelihood for Barrett's esophagus
Advanced Laboratory Testing (Laboratory Management)	0118U	Transplantation medicine, quantification of donor-derived cell-free DNA using whole genome next-generation sequencing, plasma, reported as percentage of donor-derived cell-free DNA in the total cell-free DNA
Advanced Laboratory Testing (Laboratory Management)	0120U	Oncology (B-cell lymphoma classification), mRNA, gene expression profiling by fluorescent probe hybridization of 58 genes (45 content and 13 housekeeping genes), formalin-fixed paraffin-embedded tissue, algorithm reported as likelihood for primary mediastinal B-cell lymphoma (PMBCL) and diffuse large B-cell lymphoma (DLBCL) with cell of origin subtyping in the latter
Advanced Laboratory Testing (Laboratory Management)	0129U	Hereditary breast cancer–related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis and deletion/duplication analysis panel (ATM, BRCA1, BRCA2, CDH1, CHEK2, PALB2, PTEN, and TP53)
Advanced Laboratory Testing (Laboratory Management)	0130U	Hereditary colon cancer disorders (eg, Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis), targeted mRNA sequence analysis panel (APC, CDH1, CHEK2, MLH1, MSH2, MSH6, MUTYH, PMS2, PTEN, and TP53) (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0131U	Hereditary breast cancer–related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), targeted mRNA sequence analysis panel (13 genes) (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0132U	Hereditary ovarian cancer–related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), targeted mRNA sequence analysis panel (17 genes) (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0133U	Hereditary prostate cancer–related disorders, targeted mRNA sequence analysis panel (11 genes) (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0134U	Hereditary pan cancer (eg, hereditary breast and ovarian cancer, hereditary endometrial cancer, hereditary colorectal cancer), targeted mRNA sequence analysis panel (18 genes) (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0135U	Hereditary gynecological cancer (eg, hereditary breast and ovarian cancer, hereditary endometrial cancer, hereditary colorectal cancer), targeted mRNA sequence analysis panel (12 genes) (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0136U	ATM (ataxia telangiectasia mutated) (eg, ataxia telangiectasia) mRNA sequence analysis (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0137U	PALB2 (partner and localizer of BRCA2) (eg, breast and pancreatic cancer) mRNA sequence analysis (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0138U	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) mRNA sequence analysis (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0153U	Oncology (breast), mRNA, gene expression profiling by next-generation sequencing of 101 genes, utilizing formalin-fixed paraffin- embedded tissue, algorithm reported as a triple negative breast cancer clinical subtype(s) with information on immune cell involvement
Advanced Laboratory Testing (Laboratory Management)	0156U	Copy number (eg, intellectual disability, dysmorphology), sequence analysis
Advanced Laboratory Testing (Laboratory Management)	0157U	APC (APC regulator of WNT signaling pathway) (eg, familial adenomatosis polyposis [FAP]) mRNA sequence analysis (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0158U	MLH1 (mutL homolog 1) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) mRNA sequence analysis (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0159U	MSH2 (mutS homolog 2) (eg, hereditary colon cancer, Lynch syndrome) mRNA sequence analysis (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0160U	MSH6 (mutS homolog 6) (eg, hereditary colon cancer, Lynch syndrome) mRNA sequence analysis (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0161U	PMS2 (PMS1 homolog 2, mismatch repair system component) (eg, hereditary non-polyposis colorectal cancer, Lynch syndrome) mRNA sequence analysis (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0162U	Hereditary colon cancer (Lynch syndrome), targeted mRNA sequence analysis panel (MLH1, MSH2, MSH6, PMS2) (List separately in addition to code for primary procedure)
Advanced Laboratory Testing (Laboratory Management)	0169U	NUDT15 (nudix hydrolase 15) and TPMT (thiopurine S-methyltransferase) (eg, drug metabolism) gene analysis, common variants
Advanced Laboratory Testing (Laboratory Management)	0170U	Neurology (autism spectrum disorder [ASD]), RNA, next-generation sequencing, saliva, algorithmic analysis, and results reported as predictive probability of ASD diagnosis
Advanced Laboratory Testing (Laboratory Management)	0171U	Targeted genomic sequence analysis panel, acute myeloid leukemia, myelodysplastic syndrome, and myeloproliferative neoplasms, DNA analysis, 23 genes, interrogation for sequence variants, rearrangements and minimal residual disease, reported as presence/absence
Advanced Laboratory Testing (Laboratory Management)	0172U	Oncology (solid tumor as indicated by the label), somatic mutation analysis of BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) and analysis of homologous recombination deficiency pathways, DNA, formalin-fixed paraffin- embedded tissue, algorithm quantifying tumor genomic instability score
Advanced Laboratory Testing (Laboratory Management)	0173U	Psychiatry (ie, depression, anxiety), genomic analysis panel, includes variant analysis of 14 genes
Advanced Laboratory Testing (Laboratory Management)	0175U	Psychiatry (eg, depression, anxiety), genomic analysis panel, variant analysis of 15 genes
Advanced Laboratory Testing (Laboratory Management)	0179U	Oncology (non-small cell lung cancer), cell-free DNA, targeted sequence analysis of 23 genes (single nucleotide variations, insertions and deletions, fusions without prior knowledge of partner/breakpoint, copy number variations), with report of significant mutation(s)

Advanced Laboratory Testing (Laboratory Management)	0203U	Autoimmune (inflammatory bowel disease), mRNA, gene expression profiling by quantitative RT-PCR, 17 genes (15 target and 2 reference genes), whole blood, reported as a continuous risk score and classification of inflammatory bowel disease aggressiveness
Advanced Laboratory Testing (Laboratory Management)	0204U	Oncology (thyroid), mRNA, gene expression analysis of 593 genes (including BRAF, RAS, RET, PAX8, and NTRK) for sequence variants and rearrangements, utilizing fine needle aspirate, reported as detected or not detected
Advanced Laboratory Testing (Laboratory Management)	0205U	Ophthalmology (age-related macular degeneration), analysis of 3 gene variants (2 CFH gene, 1 ARMS2 gene), using PCR and MALDI-TOF, buccal swab, reported as positive or negative for neovascular age-related macular-degeneration risk associated with zinc supplements
Advanced Laboratory Testing (Laboratory Management)	0209U	Cytogenomic constitutional (genome-wide) analysis, interrogation of genomic regions for copy number, structural changes and areas of homozygosity for chromosomal abnormalities
Advanced Laboratory Testing (Laboratory Management)	0211U	Oncology (pan-tumor), DNA and RNA by next-generation sequencing, utilizing formalin-fixed paraffin-embedded tissue, interpretative report for single nucleotide variants, copy number alterations, tumor mutational burden, and microsatellite instability, with therapy association
Advanced Laboratory Testing (Laboratory Management)	0212U	Rare diseases (constitutional/heritable disorders), whole genome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants, proband
Advanced Laboratory Testing (Laboratory Management)	0213U	Rare diseases (constitutional/heritable disorders), whole genome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants, each comparator genome (eg, parent, sibling)
Advanced Laboratory Testing (Laboratory Management)	0214U	Rare diseases (constitutional/heritable disorders), whole exome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants, proband
Advanced Laboratory Testing (Laboratory Management)	0215U	Rare diseases (constitutional/heritable disorders), whole exome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants, each comparator exome (eg, parent, sibling)
Advanced Laboratory Testing (Laboratory Management)	0216U	Neurology (inherited ataxias), genomic DNA sequence analysis of 12 common genes including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants
Advanced Laboratory Testing (Laboratory Management)	0217U	Neurology (inherited ataxias), genomic DNA sequence analysis of 51 genes including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants
Advanced Laboratory Testing (Laboratory Management)	0218U	Neurology (muscular dystrophy), DMD gene sequence analysis, including small sequence changes, deletions, duplications, and variants in non-uniquely mappable regions, blood or saliva, identification and characterization of genetic variants
Advanced Laboratory Testing (Laboratory Management)	0220U	Oncology (breast cancer), image analysis with artificial intelligence assessment of 12 histologic and immunohistochemical features, reported as a recurrence score
Advanced Laboratory Testing (Laboratory Management)	0228U	Oncology (prostate), multianalyte molecular profile by photometric detection of macromolecules adsorbed on nanosponge array slides with machine learning, utilizing first morning voided urine, algorithm reported as likelihood of prostate cancer
Advanced Laboratory Testing (Laboratory Management)	0229U	BCAT1 (Branched chain amino acid transaminase 1) and IKZF1 (IKAROS family zinc finger 1) (eg, colorectal cancer) promoter methylation analysis
Advanced Laboratory Testing (Laboratory Management)	0230U	AR (androgen receptor) (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation), full sequence analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) expansions, mobile element insertions, and variants in non-uniquely mappable regions
Advanced Laboratory Testing (Laboratory Management)	0231U	CACNA1A (calcium voltage-gated channel subunit alpha 1A) (eg, spinocerebellar ataxia), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) gene expansions, mobile element insertions, and variants in non-uniquely mappable regions
Advanced Laboratory Testing (Laboratory Management)	0232U	CSTB (cystatin B) (eg, progressive myoclonic epilepsy type 1A, Unverricht-Lundborg disease), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) expansions, mobile element insertions, and variants in non-uniquely mappable regions
Advanced Laboratory Testing (Laboratory Management)	0233U	FXN (frataxin) (eg, Friedreich ataxia), gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) expansions, mobile element insertions, and variants in non-uniquely mappable regions
Advanced Laboratory Testing (Laboratory Management)	0234U	MECP2 (methyl CpG binding protein 2) (eg, Rett syndrome), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions, and variants in non-uniquely mappable regions
Advanced Laboratory Testing (Laboratory Management)	0235U	PTEN (phosphatase and tensin homolog) (eg, Cowden syndrome, PTEN hamartoma tumor syndrome), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions, and variants in non-uniquely mappable regions
Advanced Laboratory Testing (Laboratory Management)	0236U	SMN1 (survival of motor neuron 1, telomeric) and SMN2 (survival of motor neuron 2, centromeric) (eg, spinal muscular atrophy) full gene analysis, including small sequence changes in exonic and intronic regions, duplications, deletions, and mobile element insertions
Advanced Laboratory Testing (Laboratory Management)	0237U	Cardiac ion channelopathies (eg, Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia), genomic sequence analysis panel including ANK2, CASQ2, CAV3, KCNE1, KCNE2, KCNH2, KCNJ2, KCNQ1, RYR2, and SCN5A, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions, and variants in non-uniquely mappable regions
Advanced Laboratory Testing (Laboratory Management)	0238U	Oncology (Lynch syndrome), genomic DNA sequence analysis of MLH1, MSH2, MSH6, PMS2, and EPCAM, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions, and variants in non-uniquely mappable regions

Advanced Laboratory Testing (Laboratory Management)	0239U	Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free DNA, analysis of 311 or more genes, interrogation for sequence variants, including substitutions, insertions, deletions, select rearrangements, and copy number variations
Advanced Laboratory Testing (Laboratory Management)	0242U	Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free circulating DNA analysis of 55-74 genes, interrogation for sequence variants, gene copy number amplifications, and gene rearrangements
Advanced Laboratory Testing (Laboratory Management)	0244U	Oncology (solid organ), DNA, comprehensive genomic profiling, 257 genes, interrogation for single-nucleotide variants, insertions/deletions, copy number alterations, gene rearrangements, tumor-mutational burden and microsatellite instability, utilizing formalin-fixed paraffin-embedded tumor tissue
Advanced Laboratory Testing (Laboratory Management)	0245U	Oncology (thyroid), mutation analysis of 10 genes and 37 RNA fusions and expression of 4 mRNA markers using next-generation sequencing, fine needle aspirate, report includes associated risk of malignancy expressed as a percentage
Advanced Laboratory Testing (Laboratory Management)	0246U	Red blood cell antigen typing, DNA, genotyping of at least 16 blood groups with phenotype prediction of at least 51 red blood cell antigens
Advanced Laboratory Testing (Laboratory Management)	0250U	Oncology (solid organ neoplasm), targeted genomic sequence DNA analysis of 505 genes, interrogation for somatic alterations (SNVs [single nucleotide variant], small insertions and deletions, one amplification, and four translocations), microsatellite instability and tumor-mutation burden
Advanced Laboratory Testing (Laboratory Management)	0252U	Fetal aneuploidy short tandem–repeat comparative analysis, fetal DNA from products of conception, reported as normal (euploidy), monosomy, trisomy, or partial deletion/duplication, mosaicism, and segmental aneuploidy
Advanced Laboratory Testing (Laboratory Management)	0253U	Reproductive medicine (endometrial receptivity analysis), RNA gene expression profile, 238 genes by next-generation sequencing, endometrial tissue, predictive algorithm reported as endometrial window of implantation (eg, pre-receptive, receptive, post-receptive)
Advanced Laboratory Testing (Laboratory Management)	0254U	Reproductive medicine (preimplantation genetic assessment), analysis of 24 chromosomes using embryonic DNA genomic sequence analysis for aneuploidy, and a mitochondrial DNA score in euploid embryos, results reported as normal (euploidy), monosomy, trisomy, or partial deletion/duplication, mosaicism, and segmental aneuploidy, per embryo tested
Advanced Laboratory Testing (Laboratory Management)	0258U	Autoimmune (psoriasis), mRNA, next-generation sequencing, gene expression profiling of 50-100 genes, skin-surface collection using adhesive patch, algorithm reported as likelihood of response to psoriasis biologics
Advanced Laboratory Testing (Laboratory Management)	0260U	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations, and other structural variants by optical genome mapping
Advanced Laboratory Testing (Laboratory Management)	0262U	Oncology (solid tumor), gene expression profiling by real-time RT-PCR of 7 gene pathways (ER, AR, PI3K, MAPK, HH, TGFB, Notch), formalin-fixed paraffin-embedded (FFPE), algorithm reported as gene pathway activity score
Advanced Laboratory Testing (Laboratory Management)	0264U	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations, and other structural variants by optical genome mapping
Advanced Laboratory Testing (Laboratory Management)	0265U	Rare constitutional and other heritable disorders, whole genome and mitochondrial DNA sequence analysis, blood, frozen and formalin-fixed paraffin-embedded (FFPE) tissue, saliva, buccal swabs or cell lines, identification of single nucleotide and copy number variants
Advanced Laboratory Testing (Laboratory Management)	0266U	Unexplained constitutional or other heritable disorders or syndromes, tissue-specific gene expression by whole-transcriptome and next-generation sequencing, blood, formalin-fixed paraffin-embedded (FFPE) tissue or fresh frozen tissue, reported as presence or absence of splicing or expression changes
Advanced Laboratory Testing (Laboratory Management)	0267U	Rare constitutional and other heritable disorders, identification of copy number variations, inversions, insertions, translocations, and other structural variants by optical genome mapping and whole genome sequencing
Advanced Laboratory Testing (Laboratory Management)	0268U	Hematology (atypical hemolytic uremic syndrome [aHUS]), genomic sequence analysis of 15 genes, blood, buccal swab, or amniotic fluid
Advanced Laboratory Testing (Laboratory Management)	0269U	Hematology (autosomal dominant congenital thrombocytopenia), genomic sequence analysis of 14 genes, blood, buccal swab, or amniotic fluid
Advanced Laboratory Testing (Laboratory Management)	0270U	Hematology (congenital coagulation disorders), genomic sequence analysis of 20 genes, blood, buccal swab, or amniotic fluid
Advanced Laboratory Testing (Laboratory Management)	0271U	Hematology (congenital neutropenia), genomic sequence analysis of 23 genes, blood, buccal swab, or amniotic fluid
Advanced Laboratory Testing (Laboratory Management)	0272U	Hematology (genetic bleeding disorders), genomic sequence analysis of 51 genes, blood, buccal swab, or amniotic fluid, comprehensive
Advanced Laboratory Testing (Laboratory Management)	0273U	Hematology (genetic hyperfibrinolysis, delayed bleeding), genomic sequence analysis of 8 genes (F13A1, F13B, FGA, FGB, FGG, SERPINA1, SERPINE1, SERPINF2, PLAU), blood, buccal swab, or amniotic fluid
Advanced Laboratory Testing (Laboratory Management)	0274U	Hematology (genetic platelet disorders), genomic sequence analysis of 43 genes, blood, buccal swab, or amniotic fluid
Advanced Laboratory Testing (Laboratory Management)	0276U	Hematology (inherited thrombocytopenia), genomic sequence analysis of 42 genes, blood, buccal swab, or amniotic fluid
Advanced Laboratory Testing (Laboratory Management)	0277U	Hematology (genetic platelet function disorder), genomic sequence analysis of 31 genes, blood, buccal swab, or amniotic fluid
Advanced Laboratory Testing (Laboratory Management)	0278U	Hematology (genetic thrombosis), genomic sequence analysis of 12 genes, blood, buccal swab, or amniotic fluid
Advanced Laboratory Testing (Laboratory Management)	0282U	Red blood cell antigen typing, DNA, genotyping of 12 blood group system genes to predict 44 red blood cell antigen phenotypes
Advanced Laboratory Testing (Laboratory Management)	0285U	Oncology, response to radiation, cell-free DNA, quantitative branched chain DNA amplification, plasma, reported as a radiation toxicity score
Advanced Laboratory Testing (Laboratory Management)	0286U	CEP72 (centrosomal protein, 72-KDa), NUDT15 (nudix hydrolase 15) and TPMT (thiopurine S-methyltransferase) (eg, drug metabolism) gene analysis, common variants
Advanced Laboratory Testing (Laboratory Management)	0287U	Oncology (thyroid), DNA and mRNA, next-generation sequencing analysis of 112 genes, fine needle aspirate or formalin-fixed paraffin-embedded (FFPE) tissue, algorithmic prediction of cancer recurrence, reported as a categorical risk result (low, intermediate, high)
Advanced Laboratory Testing (Laboratory Management)	0288U	Oncology (lung), mRNA, quantitative PCR analysis of 11 genes (BAG1, BRCA1, CDC6, CDK2AP1, ERBB3, FUT3, IL11, LCK, RND3, SH3BGR, WNT3A) and 3 reference genes (ESD, TBP, YAP1), formalin-fixed paraffin-embedded (FFPE) tumor tissue, algorithmic interpretation reported as a recurrence risk score

Advanced Laboratory Testing (Laboratory Management)	0289U	Neurology (Alzheimer disease), mRNA, gene expression profiling by RNA sequencing of 24 genes, whole blood, algorithm reported as predictive risk score
Advanced Laboratory Testing (Laboratory Management)	0290U	Pain management, mRNA, gene expression profiling by RNA sequencing of 36 genes, whole blood, algorithm reported as predictive risk score
Advanced Laboratory Testing (Laboratory Management)	0291U	Psychiatry (mood disorders), mRNA, gene expression profiling by RNA sequencing of 144 genes, whole blood, algorithm reported as predictive risk score
Advanced Laboratory Testing (Laboratory Management)	0292U	Psychiatry (stress disorders), mRNA, gene expression profiling by RNA sequencing of 72 genes, whole blood, algorithm reported as predictive risk score
Advanced Laboratory Testing (Laboratory Management)	0293U	Psychiatry (suicidal ideation), mRNA, gene expression profiling by RNA sequencing of 54 genes, whole blood, algorithm reported as predictive risk score
Advanced Laboratory Testing (Laboratory Management)	0294U	Longevity and mortality risk, mRNA, gene expression profiling by RNA sequencing of 18 genes, whole blood, algorithm reported as predictive risk score
Advanced Laboratory Testing (Laboratory Management)	0296U	Oncology (oral and/or oropharyngeal cancer), gene expression profiling by RNA sequencing at least 20 molecular features (eg, human and/or microbial mRNA), saliva, algorithm reported as positive or negative for signature associated with malignancy
Advanced Laboratory Testing (Laboratory Management)	0297U	Oncology (pan tumor), whole genome sequencing of paired malignant and normal DNA specimens, fresh or formalin-fixed paraffin-embedded (FFPE) tissue, blood or bone marrow, comparative sequence analyses and variant identification
Advanced Laboratory Testing (Laboratory Management)	0298U	Oncology (pan tumor), whole transcriptome sequencing of paired malignant and normal RNA specimens, fresh or formalin-fixed paraffin-embedded (FFPE) tissue, blood or bone marrow, comparative sequence analyses and expression level and chimeric transcript identification
Advanced Laboratory Testing (Laboratory Management)	0299U	Oncology (pan tumor), whole genome optical genome mapping of paired malignant and normal DNA specimens, fresh frozen tissue, blood, or bone marrow, comparative structural variant identification
Advanced Laboratory Testing (Laboratory Management)	0300U	Oncology (pan tumor), whole genome sequencing and optical genome mapping of paired malignant and normal DNA specimens, fresh tissue, blood, or bone marrow, comparative sequence analyses and variant identification
Advanced Laboratory Testing (Laboratory Management)	0306U	Oncology (minimal residual disease [MRD]), next-generation targeted sequencing analysis, cell-free DNA, initial (baseline) assessment to determine a patient-specific panel for future comparisons to evaluate for MRD
Advanced Laboratory Testing (Laboratory Management)	0307U	Oncology (minimal residual disease [MRD]), next-generation targeted sequencing analysis of a patient-specific panel, cell-free DNA, subsequent assessment with comparison to previously analyzed patient specimens to evaluate for MRD
Advanced Laboratory Testing (Laboratory Management)	0313U	Oncology (pancreas), DNA and mRNA next-generation sequencing analysis of 74 genes and analysis of CEA (CEACAM5) gene expression, pancreatic cyst fluid, algorithm reported as a categorical result (ie, negative, low probability of neoplasia or positive, high probability of neoplasia)
Advanced Laboratory Testing (Laboratory Management)	0314U	Oncology (cutaneous melanoma), mRNA gene expression profiling by RT-PCR of 35 genes (32 content and 3 housekeeping), utilizing formalin-fixed paraffin-embedded (FFPE) tissue, algorithm reported as a categorical result (ie, benign, intermediate, malignant)
Advanced Laboratory Testing (Laboratory Management)	0315U	Oncology (cutaneous squamous cell carcinoma), mRNA gene expression profiling by RT-PCR of 40 genes (34 content and 6 housekeeping), utilizing formalin-fixed paraffin-embedded (FFPE) tissue, algorithm reported as a categorical risk result (ie, Class 1, Class 2A, Class 2B)
Advanced Laboratory Testing (Laboratory Management)	0317U	Oncology (lung cancer), four-probe FISH (3q29, 3p22.1, 10q22.3, 10cen) assay, whole blood, predictive algorithm generated evaluation reported as decreased or increased risk for lung cancer
Advanced Laboratory Testing (Laboratory Management)	0318U	Pediatrics (congenital epigenetic disorders), whole genome methylation analysis by microarray for 50 or more genes, blood
Advanced Laboratory Testing (Laboratory Management)	0319U	Nephrology (renal transplant), RNA expression by select transcriptome sequencing, using pretransplant peripheral
Advanced Laboratory Testing (Laboratory Management)	0320U	Nephrology (renal transplant), RNA expression by select transcriptome sequencing, using posttransplant peripheral blood, algorithm reported as a risk score for acute cellular rejection
Advanced Laboratory Testing (Laboratory Management)	0326U	Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free circulating DNA analysis of 83 or more genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability and tumor mutational burden
Advanced Laboratory Testing (Laboratory Management)	0329U	Oncology (neoplasia), exome and transcriptome sequence analysis for sequence variants, gene copy number amplifications and deletions, gene rearrangements, microsatellite instability and tumor mutational burden utilizing DNA and RNA from tumor with DNA from normal blood or saliva for subtraction, report of clinically significant mutation(s) with therapy associations
Advanced Laboratory Testing (Laboratory Management)	0331U	Oncology (hematolymphoid neoplasia), optical genome mapping for copy number alterations and gene rearrangements utilizing DNA from blood or bone marrow, report of clinically significant alternations
Advanced Laboratory Testing (Laboratory Management)	0332U	Oncology (pan-tumor), genetic profiling of 8 DNA-regulatory (epigenetic) markers by quantitative polymerase chain reaction (qPCR), whole blood, reported as a high or low probability of responding to immune checkpoint–inhibitor therapy
Advanced Laboratory Testing (Laboratory Management)	0333U	Oncology (liver), surveillance for hepatocellular carcinoma (HCC) in high-risk patients, analysis of methylation patterns on circulating cell-free DNA (cfDNA) plus measurement of serum of AFP/AFP-L3 and oncoprotein des-gamma-carboxy prothrombin (DCP), algorithm reported as normal or abnormal result
Advanced Laboratory Testing (Laboratory Management)	0334U	Oncology (solid organ), targeted genomic sequence analysis, formalin-fixed paraffin-embedded (FFPE) tumor tissue, DNA analysis, 84 or more genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability and tumor mutational burden
Advanced Laboratory Testing (Laboratory Management)	0335U	Rare diseases (constitutional/heritable disorders), whole genome sequence analysis, including small sequence changes, copy number variants, deletions, duplications, mobile element insertions, uniparental disomy (UPD), inversions, aneuploidy, mitochondrial genome sequence analysis with heteroplasmy and large deletions, short tandem repeat (STR) gene expansions, fetal sample, identification and categorization of genetic variants
Advanced Laboratory Testing (Laboratory Management)	0336U	Rare diseases (constitutional/heritable disorders), whole genome sequence analysis, including small sequence changes, copy number variants, deletions, duplications, mobile element insertions, uniparental disomy (UPD), inversions, aneuploidy, mitochondrial genome sequence analysis with heteroplasmy and large deletions, short tandem repeat (STR) gene expansions, blood or saliva, identification and categorization of genetic variants, each comparator genome (eg, parent)

Advanced Laboratory Testing (Laboratory Management)	0339U	Oncology (prostate), mRNA expression profiling of HOXC6 and DLX1, reverse transcription polymerase chain reaction (RT-PCR), first-void urine following digital rectal examination, algorithm reported as probability of high-grade cancer
Advanced Laboratory Testing (Laboratory Management)	0340U	Oncology (pan-cancer), analysis of minimal residual disease (MRD) from plasma, with assays personalized to each patient based on prior next-generation sequencing of the patient's tumor and germline DNA, reported as absence or presence of MRD, with disease-burden correlation, if appropriate
Advanced Laboratory Testing (Laboratory Management)	0341U	Fetal aneuploidy DNA sequencing comparative analysis, fetal DNA from products of conception, reported as normal (euploidy), monosomy, trisomy, or partial deletion/duplication, mosaicism, and segmental aneuploid
Advanced Laboratory Testing (Laboratory Management)	0343U	Oncology (prostate), exosome-based analysis of 442 small noncoding RNAs (sncRNAs) by quantitative reverse transcription polymerase chain reaction (RT-qPCR), urine, reported as molecular evidence of no-, low-, intermediate- or high-risk of prostate cancer
Advanced Laboratory Testing (Laboratory Management)	0345U	Psychiatry (eg, depression, anxiety, attention deficit hyperactivity disorder [ADHD]), genomic analysis panel, variant analysis of 15 genes, including deletion/duplication analysis of CYP2D6
Advanced Laboratory Testing (Laboratory Management)	0347U	Drug metabolism or processing (multiple conditions), whole blood or buccal specimen, DNA analysis, 16 gene report, with variant analysis and reported phenotypes
Advanced Laboratory Testing (Laboratory Management)	0348U	Drug metabolism or processing (multiple conditions), whole blood or buccal specimen, DNA analysis, 25 gene report, with variant analysis and reported phenotypes
Advanced Laboratory Testing (Laboratory Management)	0349U	Drug metabolism or processing (multiple conditions), whole blood or buccal specimen, DNA analysis, 27 gene report, with variant analysis including reported phenotypes and impacted gene-drug interactions
Advanced Laboratory Testing (Laboratory Management)	0350U	Drug metabolism or processing (multiple conditions), whole blood or buccal specimen, DNA analysis, 27 gene report, with variant analysis and reported phenotypes
Advanced Laboratory Testing (Laboratory Management)	G0327	Colorectal cancer screening; blood-based biomarker
Advanced Laboratory Testing (Laboratory Management)	G9143	Warfarin responsiveness testing by genetic technique using any method, any number of specimen(s)
Advanced Laboratory Testing (Laboratory Management)	S3800	Genetic testing for amyotrophic lateral sclerosis (als)
Advanced Laboratory Testing (Laboratory Management)	S3840	Dna analysis for germline mutations of the ret proto-oncogene for susceptibility to multiple endocrine neoplasia type 2
Advanced Laboratory Testing (Laboratory Management)	S3841	Genetic testing for retinoblastoma
Advanced Laboratory Testing (Laboratory Management)	S3842	Genetic testing for von hippel-lindau disease
Advanced Laboratory Testing (Laboratory Management)	S3844	Dna analysis of the connexin 26 gene (gjb2) for susceptibility to congenital, profound deafness
Advanced Laboratory Testing (Laboratory Management)	S3845	Genetic testing for alpha-thalassemia
Advanced Laboratory Testing (Laboratory Management)	S3846	Genetic testing for hemoglobin e beta-thalassemia
Advanced Laboratory Testing (Laboratory Management)	S3850	Genetic testing for sickle cell anemia
Advanced Laboratory Testing (Laboratory Management)	S3852	Dna analysis for apoe epsilon 4 allele for susceptibility to alzheimer's disease
Advanced Laboratory Testing (Laboratory Management)	S3854	Gene expression profiling panel for use in the management of breast cancer treatment
Advanced Laboratory Testing (Laboratory Management)	S3861	Genetic testing, sodium channel, voltage-gated, type v, alpha subunit (scn5a) and variants for suspected brugada syndrome
Advanced Laboratory Testing (Laboratory Management)	S3865	Comprehensive gene sequence analysis for hypertrophic cardiomyopathy
Advanced Laboratory Testing (Laboratory Management)	S3866	Genetic analysis for a specific gene mutation for hypertrophic cardiomyopathy (hcm) in an individual with a known hcm mutation in the family
Advanced Laboratory Testing (Laboratory Management)	S3870	Comparative genomic hybridization (cgh) microarray testing for developmental delay, autism spectrum disorder and/or intellectual disability
Ambulance	A0426	AMBULANCE SERVICE, ADVANCED LIFE SUPPORT, NON-EMERGENCY TRANSPORT, LEVEL 1 (ALS1)
Ambulance	A0430	AMBULANCE SERVICE, CONVENTIONAL AIR SERVICES, TRANSPORT, ONE WAY (FIXED WING)
Ambulance	A0431	AMBULANCE SERVICE, CONVENTIONAL AIR SERVICES, TRANSPORT, ONE WAY (ROTARY WING)
Ambulance	A0432	PARAMEDIC INTERCEPT (PI), RURAL AREA, TRANSPORT FURNISHED BY A VOLUNTEER AMBULANCE COMPANY WHICH IS PROHIBITED BY STATE LAW FROM BILLING THIRD PARTY PAYERS
Ambulance	A0999	UNLISTED AMBULANCE SERVICE
Durable Medical Equipment	E0187	WATER PRESSURE MATTRESS
Durable Medical Equipment	E0193	POWERED AIR FLOTATION BED (LOW AIR LOSS THERAPY)
Durable Medical Equipment	E0197	AIR PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH
Durable Medical Equipment	E0198	WATER PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH
Durable Medical Equipment	E0295	HOSPITAL BED, SEMI-ELECTRIC (HEAD AND FOOT ADJUSTMENT), WITHOUT SIDE RAILS, WITHOUT MATTRESS
Durable Medical Equipment	E0296	HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS), WITHOUT SIDE RAILS, WITH MATTRESS
Durable Medical Equipment	E0297	HOSPITAL BED, TOTAL ELECTRIC (HEAD, FOOT AND HEIGHT ADJUSTMENTS), WITHOUT SIDE RAILS, WITHOUT MATTRESS
Durable Medical Equipment	E0302	HOSPITAL BED, EXTRA HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 600 POUNDS, WITH ANY TYPE SIDE RAILS, WITHOUT MATTRESS
Durable Medical Equipment	E0304	HOSPITAL BED, EXTRA HEAVY DUTY, EXTRA WIDE, WITH WEIGHT CAPACITY GREATER THAN 600 POUNDS, WITH ANY TYPE SIDE RAILS, WITH MATTRESS
Durable Medical Equipment	E0316	SAFETY ENCLOSURE FRAME/CANOPY FOR USE WITH HOSPITAL BED, ANY TYPE

Durable Medical Equipment	E0372	POWERED AIR OVERLAY FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH
Durable Medical Equipment	E0425	STATIONARY COMPRESSED GAS SYSTEM, PURCHASE; INCLUDES REGULATOR, FLOWMETER, HUMIDIFIER, NEBULIZER, CANNULA OR MASK, AND TUBING
Durable Medical Equipment	E0440	STATIONARY LIQUID OXYGEN SYSTEM, PURCHASE; INCLUDES USE OF RESERVOIR, CONTENTS INDICATOR, REGULATOR, FLOWMETER, HUMIDIFIER, NEBULIZER, CANNULA OR MASK, AND TUBING
Durable Medical Equipment	E0483	HIGH FREQUENCY CHEST WALL OSCILLATION AIR-PULSE GENERATOR SYSTEM, (INCLUDES HOSES AND VEST), EACH
Durable Medical Equipment	0424T	INSERTION OR REPLACEMENT OF NEUROSTIMULATOR SYSTEM FOR TREATMENT OF CENTRAL SLEEP APNEA; COMPLETE SYSTEM (TRANSVENOUS PLACEMENT OF RIGHT OR LEFT STIMULATION LEAD, SENSING LEAD, IMPLANTABLE PULSE GENERATOR)
Durable Medical Equipment	E0486	ORAL DEVICE/APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT
Durable Medical Equipment	E0635	PATIENT LIFT, ELECTRIC WITH SEAT OR SLING
Durable Medical Equipment	E0636	MULTIPOSITIONAL PATIENT SUPPORT SYSTEM, WITH INTEGRATED LIFT, PATIENT ACCESSIBLE CONTROLS
Durable Medical Equipment	E0637	COMBINATION SIT TO STAND FRAME/TABLE SYSTEM, ANY SIZE INCLUDING PEDIATRIC, WITH SEAT LIFT FEATURE, WITH OR WITHOUT WHEELS
Durable Medical Equipment	E0638	STANDING FRAME/TABLE SYSTEM, ONE POSITION (E.G., UPRIGHT, SUPINE OR PRONE STANDER), ANY SIZE INCLUDING PEDIATRIC, WITH OR WITHOUT WHEELS
Durable Medical Equipment	E0639	PATIENT LIFT, MOVEABLE FROM ROOM TO ROOM WITH DISASSEMBLY AND REASSEMBLY, INCLUDES ALL COMPONENTS/ACCESSORIES
Durable Medical Equipment	E0642	STANDING FRAME/TABLE SYSTEM, MOBILE (DYNAMIC STANDER), ANY SIZE INCLUDING PEDIATRIC
Durable Medical Equipment	E1035	MULTI-POSITIONAL PATIENT TRANSFER SYSTEM, WITH INTEGRATED SEAT, OPERATED BY CARE GIVER, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 LBS
Durable Medical Equipment	E1036	MULTI-POSITIONAL PATIENT TRANSFER SYSTEM, EXTRA-WIDE, WITH INTEGRATED SEAT, OPERATED BY CAREGIVER, PATIENT WEIGHT CAPACITY GREATER THAN 300 LBS
Durable Medical Equipment	E0691	ULTRAVIOLET LIGHT THERAPY SYSTEM, INCLUDES BULBS/LAMPS, TIMER AND EYE PROTECTION; TREATMENT AREA 2 SQUARE FEET OR LESS
Durable Medical Equipment	E0692	ULTRAVIOLET LIGHT THERAPY SYSTEM PANEL, INCLUDES BULBS/LAMPS, TIMER AND EYE PROTECTION, 4 FOOT PANEL
Durable Medical Equipment	E0693	ULTRAVIOLET LIGHT THERAPY SYSTEM PANEL, INCLUDES BULBS/LAMPS, TIMER AND EYE PROTECTION; 6 FOOT PANEL
Durable Medical Equipment	E0694	ULTRAVIOLET MULTIDIRECTIONAL LIGHT THERAPY SYSTEM IN 6 FOOT CABINET, INCLUDES BULBS/LAMPS, TIMER AND EYE PROTECTION
Durable Medical Equipment	E0747	OSTEOGENESIS STIMULATOR, ELECTRICAL, NON-INVASIVE, OTHER THAN SPINAL APPLICATIONS
Durable Medical Equipment	E0760	OSTEOGENESIS STIMULATOR, LOW INTENSITY ULTRASOUND, NON-INVASIVE
Durable Medical Equipment	E0764	FUNCTIONAL NEUROMUSCULAR STIMULATION, TRANSCUTANEOUS STIMULATION OF SEQUENTIAL MUSCLE GROUPS OF AMBULATION WITH COMPUTER CONTROL, USED FOR WALKING BY SPINAL CORD INJURED, ENTIRE SYSTEM, AFTER COMPLETION OF TRAINING PROGRAM
Durable Medical Equipment	E0766	ELECTRICAL STIMULATION DEVICE USED FOR CANCER TREATMENT, INCLUDES ALL ACCESSORIES, ANY TYPE
Durable Medical Equipment	E2510	SPEECH GENERATING DEVICE, SYNTHESIZED SPEECH, PERMITTING MULTIPLE METHODS OF MESSAGE FORMULATION AND MULTIPLE METHODS OF DEVICE ACCESS
Durable Medical Equipment	E2511	SPEECH GENERATING SOFTWARE PROGRAM, FOR PERSONAL COMPUTER OR PERSONAL DIGITAL ASSISTANT
Durable Medical Equipment	E2512	ACCESSORY FOR SPEECH GENERATING DEVICE, MOUNTING SYSTEM
Durable Medical Equipment	E2599	ACCESSORY FOR SPEECH GENERATING DEVICE, NOT OTHERWISE CLASSIFIED
Durable Medical Equipment	E1011	MODIFICATION TO PEDIATRIC SIZE WHEELCHAIR, WIDTH ADJUSTMENT PACKAGE (NOT TO BE DISPENSED WITH INITIAL CHAIR)
Durable Medical Equipment	E1017	HEAVY DUTY SHOCK ABSORBER FOR HEAVY DUTY OR EXTRA HEAVY DUTY MANUAL WHEELCHAIR, EACH
Durable Medical Equipment	E1018	HEAVY DUTY SHOCK ABSORBER FOR HEAVY DUTY OR EXTRA HEAVY DUTY POWER WHEELCHAIR, EACH
Durable Medical Equipment	E1037	TRANSPORT CHAIR, PEDIATRIC SIZE
Durable Medical Equipment	E1060	FULLY-RECLINING WHEELCHAIR, DETACHABLE ARMS (DESK OR FULL LENGTH) ELEVATING LEGREST, SWING AWAY DETACHABLE
Durable Medical Equipment	E1083	HEMI-WHEELCHAIR; FIXED FULL LENGTH ARMS, SWING AWAY, DETACHABLE ELEVATING LEG REST
Durable Medical Equipment	E1100	SEMI-RECLINING WHEELCHAIR; FIXED FULL LENGTH ARMS, SWING AWAY, DETACHABLE, ELEVATING LEGRESTS
Durable Medical Equipment	E1220	WHEELCHAIR; SPECIALLY SIZED OR CONSTRUCTED. (INDICATE BRAND NAME, MODEL NUMBER, IF ANY) AND JUSTIFICATION
Durable Medical Equipment	E1227	SPECIAL HEIGHT ARMS FOR WHEELCHAIR
Durable Medical Equipment	E1228	SPECIAL BACK HEIGHT FOR WHEELCHAIR
Durable Medical Equipment	E1231	WHEELCHAIR, PEDIATRIC SIZE, TILT-IN-SPACE, RIGID, ADJUSTABLE, WITH SEATING SYSTEM
Durable Medical Equipment	E1232	WHEELCHAIR, PEDIATRIC SIZE, TILT-IN-SPACE, FOLDING, ADJUSTABLE, WITH SEATING SYSTEM
Durable Medical Equipment	E1233	WHEELCHAIR, PEDIATRIC SIZE, TILT-IN-SPACE, RIGID, ADJUSTABLE, WITHOUT SEATING SYSTEM
Durable Medical Equipment	E1234	WHEELCHAIR, PEDIATRIC SIZE, TILT-IN-SPACE, FOLDING, ADJUSTABLE, WITHOUT SEATING SYSTEM
Durable Medical Equipment	E1235	WHEELCHAIR, PEDIATRIC SIZE, RIGID, ADJUSTABLE, WITH SEATING SYSTEM
Durable Medical Equipment	E1237	WHEELCHAIR, PEDIATRIC SIZE, RIGID, ADJUSTABLE, WITHOUT SEATING SYSTEM
Durable Medical Equipment	E1238	WHEELCHAIR, PEDIATRIC SIZE, FOLDING, ADJUSTABLE, WITHOUT SEATING SYSTEM
Durable Medical Equipment	E1239	POWER WHEELCHAIR, PEDIATRIC SIZE, NOT OTHERWISE SPECIFIED

Durable Medical Equipment	E1295	HEAVY DUTY WHEELCHAIR; FIXED FULL LENGTH ARMS, ELEVATING LEGREST
Durable Medical Equipment	E2227	MANUAL WHEELCHAIR ACCESSORY, GEAR REDUCTION DRIVE WHEEL, EACH
Durable Medical Equipment	E2230	MANUAL WHEELCHAIR ACCESSORY, MANUAL STANDING SYSTEM
Durable Medical Equipment	E2295	MANUAL WHEELCHAIR ACCESSORY, FOR PEDIATRIC SIZE WHEELCHAIR, DYNAMIC SEATING FRAME, ALLOWS COORDINATION MOVEMENT OF MULTIPLE POSITIONING FEATURES
Durable Medical Equipment	E2628	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT ATTACHED TO WHEELCHAIR, BALANCED, RECLINING
Durable Medical Equipment	E2630	WHEELCHAIR ACCESSORY, SHOULDER ELBOW, MOBILE ARM SUPPORT, MONOSUSPENSION ARM AND HAND SUPPORT, OVERHEAD ELBOW FOREARM HAND SLING SUPPORT, YOKE TYPE SUSPENSION SUPPORT
Durable Medical Equipment	E2632	WHEELCHAIR ACCESSORY, ADDITION TO MOBILE ARM SUPPORT, OFFSET OR LATERAL ROCKER ARM WITH ELASTIC BALANCE CONTROL
Durable Medical Equipment	E2633	WHEELCHAIR ACCESSORY, ADDITION TO MOBILE ARM SUPPORT, SUPINATOR
Durable Medical Equipment	K0005	ULTRALIGHTWEIGHT WHEELCHAIR
Durable Medical Equipment	K0050	RATCHET ASSEMBLY
Durable Medical Equipment	E1230	POWER OPERATED VEHICLE (THREE OR FOUR WHEEL NONHIGHWAY) SPECIFY BRAND NAME AND MODEL NUMBER
Durable Medical Equipment	E0984	MANUAL WHEELCHAIR ACCESSORY, POWER ADD-ON TO CONVERT MANUAL WHEELCHAIR TO MOTORIZED WHEELCHAIR, TILLER CONTROL
Durable Medical Equipment	E1002	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, TILT ONLY
Durable Medical Equipment	E1004	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, RECLINE ONLY, WITH MECHANICAL SHEAR REDUCTION
Durable Medical Equipment	E1005	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, RECLINE ONLY, WITH POWER SHEAR REDUCTION
Durable Medical Equipment	E1006	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, COMBINATION TILT AND RECLINE, WITHOUT SHEAR REDUCTION
Durable Medical Equipment	E1007	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, COMBINATION TILT AND RECLINE, WITH MECHANICAL SHEAR REDUCTION
Durable Medical Equipment	E1008	WHEELCHAIR ACCESSORY, POWER SEATING SYSTEM, COMBINATION TILT AND RECLINE, WITH POWER SHEAR REDUCTION
Durable Medical Equipment	E1009	WHEELCHAIR ACCESSORY, ADDITION TO POWER SEATING SYSTEM, MECHANICALLY LINKED LEG ELEVATION SYSTEM, INCLUDING PUSHROD AND LEG REST, EACH
Durable Medical Equipment	E1010	WHEELCHAIR ACCESSORY, ADDITION TO POWER SEATING SYSTEM, POWER LEG ELEVATION SYSTEM, INCLUDING LEGREST, PAIR
Durable Medical Equipment	E2300	WHEELCHAIR ACCESSORY, POWER SEAT ELEVATION SYSTEM, ANY TYPE
Durable Medical Equipment	E2301	WHEELCHAIR ACCESSORY, POWER STANDING SYSTEM, ANY TYPE
Durable Medical Equipment	E2324	POWER WHEELCHAIR ACCESSORY, CHIN CUP FOR CHIN CONTROL INTERFACE
Durable Medical Equipment	E2327	POWER WHEELCHAIR ACCESSORY, HEAD CONTROL INTERFACE, MECHANICAL, PROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS, MECHANICAL DIRECTION CHANGE SWITCH, AND FIXED MOUNTING HARDWARE
Durable Medical Equipment	E2329	POWER WHEELCHAIR ACCESSORY, HEAD CONTROL INTERFACE, CONTACT SWITCH MECHANISM, NONPROPORTIONAL, INCLUDING ALL RELATED ELECTRONICS, MECHANICAL STOP SWITCH, MECHANICAL DIRECTION CHANGE SWITCH, HEAD ARRAY, AND FIXED MOUNTING HARDWARE
Durable Medical Equipment	E2341	POWER WHEELCHAIR ACCESSORY, NONSTANDARD SEAT FRAME WIDTH, 24-27 INCHES
Durable Medical Equipment	E2343	POWER WHEELCHAIR ACCESSORY, NONSTANDARD SEAT FRAME DEPTH, 22-25 INCHES
Durable Medical Equipment	E2358	POWER WHEELCHAIR ACCESSORY, GROUP 34 NON-SEALED LEAD ACID BATTERY, EACH ,
Durable Medical Equipment	E2362	POWER WHEELCHAIR ACCESSORY, GROUP 24 NON-SEALED LEAD ACID BATTERY, EACH
Durable Medical Equipment	K0010	STANDARD - WEIGHT FRAME MOTORIZED/POWER WHEELCHAIR
Durable Medical Equipment	K0011	STANDARD - WEIGHT FRAME MOTORIZED/POWER WHEELCHAIR WITH PROGRAMMABLE CONTROL PARAMETERS FOR SPEED ADJUSTMENT, TREMOR DAMPENING, ACCELERATION CONTROL AND BRAKING
Durable Medical Equipment	K0012	LIGHTWEIGHT PORTABLE MOTORIZED/POWER WHEELCHAIR
Durable Medical Equipment	K0014	OTHER MOTORIZED/POWER WHEELCHAIR BASE
Durable Medical Equipment	K0098	DRIVE BELT FOR POWER WHEELCHAIR
Durable Medical Equipment	K0800	POWER OPERATED VEHICLE, GROUP 1 STANDARD, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0801	POWER OPERATED VEHICLE, GROUP 1 HEAVY DUTY, PATIENT WEIGHT CAPACITY, 301 TO 450 POUNDS
Durable Medical Equipment	K0802	POWER OPERATED VEHICLE, GROUP 1 VERY HEAVY DUTY, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
Durable Medical Equipment	K0806	POWER OPERATED VEHICLE, GROUP 2 STANDARD, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0807	POWER OPERATED VEHICLE, GROUP 2 HEAVY DUTY, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
Durable Medical Equipment	K0808	POWER OPERATED VEHICLE, GROUP 2 VERY HEAVY DUTY, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
Durable Medical Equipment	K0812	POWER OPERATED VEHICLE, NOT OTHERWISE CLASSIFIED
Durable Medical Equipment	K0813	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0814	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0815	POWER WHEELCHAIR, GROUP 1 STANDARD, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0816	POWER WHEELCHAIR, GROUP 1 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0820	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0821	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS

Durable Medical Equipment	K0822	POWER WHEELCHAIR, GROUP 2 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0823	POWER WHEELCHAIR, GROUP 2 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0824	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
Durable Medical Equipment	K0825	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
Durable Medical Equipment	K0826	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
Durable Medical Equipment	K0827	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
Durable Medical Equipment	K0828	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
Durable Medical Equipment	K0829	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
Durable Medical Equipment	K0830	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0831	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0835	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0836	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0837	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
Durable Medical Equipment	K0838	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
Durable Medical Equipment	K0839	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
Durable Medical Equipment	K0840	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
Durable Medical Equipment	K0841	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0842	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0843	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
Durable Medical Equipment	K0848	POWER WHEELCHAIR, GROUP 3 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0849	POWER WHEELCHAIR, GROUP 3 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0850	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
Durable Medical Equipment	K0851	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
Durable Medical Equipment	K0852	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
Durable Medical Equipment	K0853	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY, 451 TO 600 POUNDS
Durable Medical Equipment	K0854	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
Durable Medical Equipment	K0855	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
Durable Medical Equipment	K0856	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0857	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0858	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
Durable Medical Equipment	K0859	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
Durable Medical Equipment	K0860	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
Durable Medical Equipment	K0861	POWER WHEELCHAIR, GROUP 3 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0862	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
Durable Medical Equipment	K0863	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
Durable Medical Equipment	K0864	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
Durable Medical Equipment	K0868	POWER WHEELCHAIR, GROUP 4 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0869	POWER WHEELCHAIR, GROUP 4 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0870	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
Durable Medical Equipment	K0871	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS

Durable Medical Equipment	K0877	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0878	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0879	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
Durable Medical Equipment	K0880	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT 451 TO 600 POUNDS
Durable Medical Equipment	K0884	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0885	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
Durable Medical Equipment	K0886	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
Durable Medical Equipment	K0890	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS
Durable Medical Equipment	K0891	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS
Durable Medical Equipment	K0898	POWER WHEELCHAIR, NOT OTHERWISE CLASSIFIED
Durable Medical Equipment	K0899	POWER MOBILITY DEVICE, NOT CODED BY DME PDAC OR DOES NOT MEET CRITERIA
Durable Medical Equipment	E1310	WHIRLPOOL, NON-PORTABLE (BUILT-IN TYPE)
Durable Medical Equipment	K0606	AUTOMATIC EXTERNAL DEFIBRILLATOR, WITH INTEGRATED ELECTROCARDIOGRAM
Home Health	S5108	HOME CARE TRAINING TO HOME CARE CLIENT, PER 15 MINUTES
Home Health	S5109	HOME CARE TRAINING TO HOME CARE CLIENT, PER SESSION
Home Health	S5110	HOME CARE TRAINING, FAMILY; PER 15 MINUTES
Home Health	S5111	HOME CARE TRAINING, FAMILY; PER SESSION
Home Health	S5115	HOME CARE TRAINING, NON-FAMILY; PER 15 MINUTES
Home Health	S5116	HOME CARE TRAINING, NON-FAMILY; PER SESSION
Home Health	S5181	HOME HEALTH RESPIRATORY THERAPY, NOS, PER DIEM
Home Health	S9123	NURSING CARE, IN THE HOME; BY REGISTERED NURSE, PER HOUR (USE FOR GENERAL NURSING CARE ONLY, NOT TO BE USED WHEN CPT CODES 99500-99602 CAN BE USED)
Home Health	S9124	NURSING CARE, IN THE HOME; BY LICENSED PRACTICAL NURSE, PER HOUR
Hospital Outpatient	99183	PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL ATTENDANCE AND SUPERVISION OF HYPERBARIC OXYGEN THERAPY, PER SESSION
Hospital Outpatient	G0277	HYPERBARIC OXYGEN UNDER PRESSURE, FULL BODY CHAMBER, PER 30 MINUTE INTERVAL
Inpatient Detoxification/Rehabilitation	H0008	ALCOHOL AND/OR DRUG SERVICES; SUB-ACUTE DETOXIFICATION (HOSPITAL INPATIENT)
Inpatient Detoxification/Rehabilitation	H0009	ALCOHOL AND/OR DRUG SERVICES; ACUTE DETOXIFICATION (HOSPITAL INPATIENT)
Inpatient Detoxification/Rehabilitation	H0010	ALCOHOL AND/OR DRUG SERVICES; SUB-ACUTE DETOXIFICATION (RESIDENTIAL ADDICTION PROGRAM INPATIENT)
Inpatient Detoxification/Rehabilitation	H0011	ALCOHOL AND/OR DRUG SERVICES; ACUTE DETOXIFICATION (RESIDENTIAL ADDICTION PROGRAM INPATIENT)
Interventional Pain Management (Musculoskeletal)	62281	Injection/infusion of neurolytic substance (e.g., alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, cervical or thoracic
Interventional Pain Management (Musculoskeletal)	62282	Injection/infusion of neurolytic substance (e.g., alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, lumbar, sacral (caudal)
Interventional Pain Management (Musculoskeletal)	62320	Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance
Interventional Pain Management (Musculoskeletal)	62321	Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (i.e., fluoroscopy or CT)
Interventional Pain Management (Musculoskeletal)	62322	Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance
Interventional Pain Management (Musculoskeletal)	62323	Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (i.e., fluoroscopy or CT)
Interventional Pain Management (Musculoskeletal)	62324	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance
Interventional Pain Management (Musculoskeletal)	62325	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (i.e., fluoroscopy or CT)
Interventional Pain Management (Musculoskeletal)	62326	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance
Interventional Pain Management (Musculoskeletal)	62327	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (i.e., fluoroscopy or CT)
Interventional Pain Management (Musculoskeletal)	64479	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, single level
Interventional Pain Management (Musculoskeletal)	64480	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, each additional level (List separately in addition to code for primary procedure)

Interventional Pain Management (Musculoskeletal)	64483	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level
Interventional Pain Management (Musculoskeletal)	64484	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)
Interventional Pain Management (Musculoskeletal)	64490	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level
Interventional Pain Management (Musculoskeletal)	64491	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)
Interventional Pain Management (Musculoskeletal)	64492	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure)
Interventional Pain Management (Musculoskeletal)	64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level
Interventional Pain Management (Musculoskeletal)	64494	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)
Interventional Pain Management (Musculoskeletal)	64495	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure)
Interventional Pain Management (Musculoskeletal)	64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint
Interventional Pain Management (Musculoskeletal)	64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint (List separately in addition to code for primary procedure)
Interventional Pain Management (Musculoskeletal)	64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint
Interventional Pain Management (Musculoskeletal)	64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)
Interventional Pain Management (Musculoskeletal)	62350	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy
Interventional Pain Management (Musculoskeletal)	62351	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; with laminectomy
Interventional Pain Management (Musculoskeletal)	62360	Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir
Interventional Pain Management (Musculoskeletal)	62361	Implantation or replacement of device for intrathecal or epidural drug infusion; nonprogrammable pump
Interventional Pain Management (Musculoskeletal)	62362	Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming
Interventional Pain Management (Musculoskeletal)	0627T	Percutaneous injection of allogeneic cellular and/or tissue- based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; first level
Interventional Pain Management (Musculoskeletal)	0628T	Percutaneous injection of allogeneic cellular and/or tissue-based product, intervertebral disc, unilateral or bilateral injection, with fluoroscopic guidance, lumbar; each additional level (List separately in addition to code for primary procedure)
Interventional Pain Management (Musculoskeletal)	0629T	Percutaneous injection of allogeneic cellular and/or tissue- based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; first level
Interventional Pain Management (Musculoskeletal)	0630T	Percutaneous injection of allogeneic cellular and/or tissue- based product, intervertebral disc, unilateral or bilateral injection, with CT guidance, lumbar; each additional level (List separately in addition to code for primary procedure)
Interventional Pain Management (Musculoskeletal)	64510	Injection, anesthetic agent; stellate ganglion (cervical sympathetic)
Interventional Pain Management (Musculoskeletal)	64520	Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic)
Interventional Pain Management (Musculoskeletal)	22526	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level
Interventional Pain Management (Musculoskeletal)	22527	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels (List separately in addition to code for primary procedure)
Interventional Pain Management (Musculoskeletal)	62263	Percutaneous lysis of epidural adhesions using solution injection (e.g., hypertonic saline, enzyme) or mechanical means (e.g., catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days
Interventional Pain Management (Musculoskeletal)	62264	Percutaneous lysis of epidural adhesions using solution injection (e.g., hypertonic saline, enzyme) or mechanical means (e.g., catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day
Interventional Pain Management (Musculoskeletal)	62280	Injection/infusion of neurolytic substance (e.g., alcohol, phenol, iced saline solutions), with or without other therapeutic substance; subarachnoid
Interventional Pain Management (Musculoskeletal)	62292	Injection procedure for chemonucleolysis, including discography, intervertebral disc, single or multiple levels, lumbar
Interventional Pain Management (Musculoskeletal)	64451	Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)
Interventional Pain Management (Musculoskeletal)	64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)
Interventional Pain Management (Musculoskeletal)	G0260	Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography
Interventional Pain Management (Musculoskeletal)	63650	Percutaneous implantation of neurostimulator electrode array, epidural
Interventional Pain Management (Musculoskeletal)	63655	Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural

Interventional Pain Management (Musculoskeletal)	63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
Interventional Pain Management (Musculoskeletal)	27096	Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed
Joint Services (Musculoskeletal)	29916	Arthroscopy, hip, surgical; with labral repair
Joint Services (Musculoskeletal)	29915	Arthroscopy, hip, surgical; with acetabuloplasty (i.e., treatment of pincer lesion)
Joint Services (Musculoskeletal)	29914	Arthroscopy, hip, surgical; with femoroplasty (i.e., treatment of cam lesion)
Joint Services (Musculoskeletal)	29863	Arthroscopy, hip, surgical; with synovectomy
Joint Services (Musculoskeletal)	29862	Arthroscopy, hip, surgical; with debridement/shaving of articular cartilage (chondroplasty), abrasion arthroplasty, and/or resection of labrum
Joint Services (Musculoskeletal)	29861	Arthroscopy, hip, surgical; with removal of loose body or foreign body
Joint Services (Musculoskeletal)	29860	Arthroscopy, hip, diagnostic with or without synovial biopsy (separate procedure)
Joint Services (Musculoskeletal)	27138	Revision of total hip arthroplasty; femoral component only, with or without allograft
Joint Services (Musculoskeletal)	27137	Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft
Joint Services (Musculoskeletal)	27134	Revision of total hip arthroplasty; both components, with or without autograft or allograft
Joint Services (Musculoskeletal)	27132	Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft
Joint Services (Musculoskeletal)	27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft
Joint Services (Musculoskeletal)	27125	Hemiarthroplasty, hip, partial (e.g., femoral stem prosthesis, bipolar arthroplasty)
Joint Services (Musculoskeletal)	29889	Arthroscopically aided posterior cruciate ligament repair/augmentation or reconstruction
Joint Services (Musculoskeletal)	29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction
Joint Services (Musculoskeletal)	29887	Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion with internal fixation
Joint Services (Musculoskeletal)	29886	Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion
Joint Services (Musculoskeletal)	29885	Arthroscopy, knee, surgical; drilling for osteochondritis dissecans with bone grafting, with or without internal fixation (including debridement of base of lesion)
Joint Services (Musculoskeletal)	29884	Arthroscopy, knee, surgical; with lysis of adhesions, with or without manipulation (separate procedure)
Joint Services (Musculoskeletal)	29883	Arthroscopy, knee, surgical; with meniscus repair (medial AND lateral)
Joint Services (Musculoskeletal)	29882	Arthroscopy, knee, surgical; with meniscus repair (medial OR lateral)
Joint Services (Musculoskeletal)	29881	Arthroscopy, knee, surgical; with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed
Joint Services (Musculoskeletal)	29880	Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed
Joint Services (Musculoskeletal)	29879	Arthroscopy, knee, surgical; abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture
Joint Services (Musculoskeletal)	29877	Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)
Joint Services (Musculoskeletal)	29876	Arthroscopy, knee, surgical; synovectomy, major, 2 or more compartments (e.g., medial or lateral)
Joint Services (Musculoskeletal)	29875	Arthroscopy, knee, surgical; synovectomy, limited (e.g., plica or shelf resection) (separate procedure)
Joint Services (Musculoskeletal)	29874	Arthroscopy, knee, surgical; for removal of loose body or foreign body (e.g., osteochondritis dissecans fragmentation, chondral fragmentation)
Joint Services (Musculoskeletal)	29873	Arthroscopy, knee, surgical; with lateral release
Joint Services (Musculoskeletal)	29871	Arthroscopy, knee, surgical; for infection, lavage and drainage
Joint Services (Musculoskeletal)	29870	Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)
Joint Services (Musculoskeletal)	29868	Arthroscopy, knee, surgical; meniscal transplantation (includes arthrotomy for meniscal insertion), medial or lateral
Joint Services (Musculoskeletal)	29867	Arthroscopy, knee, surgical; osteochondral allograft (e.g., mosaicplasty)
Joint Services (Musculoskeletal)	29866	Arthroscopy, knee, surgical; osteochondral autograft(s) (e.g., mosaicplasty) (includes harvesting of the autograft[s])
Joint Services (Musculoskeletal)	29807	Arthroscopy, shoulder, surgical; repair of SLAP lesion
Joint Services (Musculoskeletal)	29806	Arthroscopy, shoulder, surgical; capsulorrhaphy
Joint Services (Musculoskeletal)	29805	Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)
Joint Services (Musculoskeletal)	27487	Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component
Joint Services (Musculoskeletal)	27486	Revision of total knee arthroplasty, with or without allograft; 1 component
Joint Services (Musculoskeletal)	27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)
Joint Services (Musculoskeletal)	27446	Arthroplasty, knee, condyle and plateau; medial OR lateral compartment
Joint Services (Musculoskeletal)	27443	Arthroplasty, femoral condyles or tibial plateau(s), knee; with debridement and partial synovectomy
Joint Services (Musculoskeletal)	27442	Arthroplasty, femoral condyles or tibial plateau(s), knee;
Joint Services (Musculoskeletal)	27441	Arthroplasty, knee, tibial plateau; with debridement and partial synovectomy
Joint Services (Musculoskeletal)	27440	Arthroplasty, knee, tibial plateau;
Joint Services (Musculoskeletal)	27438	Arthroplasty, patella; with prosthesis
Joint Services (Musculoskeletal)	27430	Quadricepsplasty (e.g., Bennett or Thompson type)
Joint Services (Musculoskeletal)	27429	Ligamentous reconstruction (augmentation), knee; intra-articular (open) and extra-articular
Joint Services (Musculoskeletal)	27428	Ligamentous reconstruction (augmentation), knee; intra-articular (open)
Joint Services (Musculoskeletal)	27427	Ligamentous reconstruction (augmentation), knee; extra- articular
Joint Services (Musculoskeletal)	27425	Lateral retinacular release, open
Joint Services (Musculoskeletal)	27424	Reconstruction of dislocating patella; with patellectomy
Joint Services (Musculoskeletal)	27422	Reconstruction of dislocating patella; with extensor realignment and/or muscle advancement or release (e.g., Campbell, Goldwaite type procedure)
Joint Services (Musculoskeletal)	27420	Reconstruction of dislocating patella; (e.g., Hauser type procedure)
Joint Services (Musculoskeletal)	27418	Anterior tibial tubercleplasty (e.g., Maquet type procedure)
Joint Services (Musculoskeletal)	27416	Osteochondral autograft(s), knee, open (e.g., mosaicplasty) (includes harvesting of autograft[s])
Joint Services (Musculoskeletal)	27415	Osteochondral allograft, knee, open
Joint Services (Musculoskeletal)	27412	Autologous chondrocyte implantation, knee
Joint Services (Musculoskeletal)	27403	Arthrotomy with meniscus repair, knee
Joint Services (Musculoskeletal)	27335	Arthrotomy, with synovectomy, knee; anterior AND posterior including popliteal area
Joint Services (Musculoskeletal)	27334	Arthrotomy, with synovectomy, knee; anterior OR posterior
Joint Services (Musculoskeletal)	27333	Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial AND lateral

Joint Services (Musculoskeletal)	27332	Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial OR lateral
Joint Services (Musculoskeletal)	29828	Arthroscopy, shoulder, surgical; biceps tenodesis
Joint Services (Musculoskeletal)	29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
Joint Services (Musculoskeletal)	29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (i.e., arch) release, when performed (List separately in addition to code for primary procedure)
Joint Services (Musculoskeletal)	29825	Arthroscopy, shoulder, surgical; with lysis and resection of adhesions, with or without manipulation
Joint Services (Musculoskeletal)	29824	Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure)
Joint Services (Musculoskeletal)	29823	Arthroscopy, shoulder, surgical; debridement, extensive
Joint Services (Musculoskeletal)	29822	Arthroscopy, shoulder, surgical; debridement, limited
Joint Services (Musculoskeletal)	29821	Arthroscopy, shoulder, surgical; synovectomy, complete
Joint Services (Musculoskeletal)	29820	Arthroscopy, shoulder, surgical; synovectomy, partial
Joint Services (Musculoskeletal)	29819	Arthroscopy, shoulder, surgical; with removal of loose body or foreign body
Joint Services (Musculoskeletal)	23474	Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component
Joint Services (Musculoskeletal)	23473	Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component
Joint Services (Musculoskeletal)	23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (e.g., total shoulder))
Joint Services (Musculoskeletal)	23470	Arthroplasty, glenohumeral joint; hemiarthroplasty
Joint Services (Musculoskeletal)	23466	Capsulorrhaphy, glenohumeral joint, any type multi-directional instability
Joint Services (Musculoskeletal)	23465	Capsulorrhaphy, glenohumeral joint, posterior, with or without bone block
Joint Services (Musculoskeletal)	23462	Capsulorrhaphy, anterior, any type; with coracoid process transfer
Joint Services (Musculoskeletal)	23460	Capsulorrhaphy, anterior, any type; with bone block
Joint Services (Musculoskeletal)	23455	Capsulorrhaphy, anterior; with labral repair (e.g., Bankart procedure)
Joint Services (Musculoskeletal)	23450	Capsulorrhaphy, anterior; Putti-Platt procedure or Magnuson type operation
Joint Services (Musculoskeletal)	23440	Resection or transplantation of long tendon of biceps
Joint Services (Musculoskeletal)	23430	Tenodesis of long tendon of biceps
Joint Services (Musculoskeletal)	23420	Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)
Joint Services (Musculoskeletal)	23415	Coracoacromial ligament release, with or without acromioplasty
Joint Services (Musculoskeletal)	23412	Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open; chronic
Joint Services (Musculoskeletal)	23410	Repair of ruptured musculotendinous cuff (e.g., rotator cuff) open; acute
Joint Services (Musculoskeletal)	23130	Acromioplasty or acromionectomy, partial, with or without coracoacromial ligament release
Joint Services (Musculoskeletal)	23120	Claviculectomy; partial
Joint Services (Musculoskeletal)	23020	Capsular contracture release (e.g., Sever type procedure)
Joint Services (Musculoskeletal)	23000	Removal of subdeltoid calcareous deposits, open
Medical /Surgical	21110	APPLICATION OF INTERDENTAL FIXATION DEVICE FOR CONDITIONS OTHER THAN FRACTURE OR DISLOCATION, INCLUDES REMOVAL
Medical /Surgical	21497	INTERDENTAL WIRING, FOR CONDITION OTHER THAN FRACTURE
Transplant	38242	BONE MARROW OR BLOOD-DERIVED PERIPHERAL STEM CELL TRANSPLANTATION; ALLOGENEIC DONOR LYMPHOCYTE INFUSIONS
Medical /Surgical	33999	UNLISTED PROCEDURE, CARDIAC SURGERY
Medical /Surgical	36465	INJECTION OF NON-COMPOUNDED FOAM SCLEROSANT WITH ULTRASOUND COMPRESSION MANEUVERS TO GUIDE DISPERSION OF THE INJECTATE, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING; SINGLE INCOMPETENT EXTREMITY TRUNCAL VEIN (EG, GREAT SAPHENOUS VEIN, ACCESSORY SAPHEN
Medical /Surgical	36466	INJECTION OF NON-COMPOUNDED FOAM SCLEROSANT WITH ULTRASOUND COMPRESSION MANEUVERS TO GUIDE DISPERSION OF THE INJECTATE, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING; MULTIPLE INCOMPETENT TRUNCAL VEINS (EG, GREAT SAPHENOUS VEIN, ACCESSORY SAPHENOUS VEI
Medical /Surgical	36470	INJECTION OF SCLEROSING SOLUTION; SINGLE VEIN
Medical /Surgical	36471	INJECTION OF SCLEROSING SOLUTION; MULTIPLE VEINS, SAME LEG
Medical /Surgical	36473	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS, MECHANOCHEMICAL; FIRST VEIN TREATED
Medical /Surgical	36474	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS, MECHANOCHEMICAL; SUBSEQUENT VEIN(S) TREATED IN A SINGLE EXTREMITY, EACH THROUGH SEPARATE ACCESS SITES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
Medical /Surgical	36475	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS RADIOFREQUENCY; FIRST VEIN TREATED
Medical /Surgical	36476	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS, RADIOFREQUENCY; SECOND AND SUBSEQUENT VEINS TREATED IN A SINGLE EXTREMITY, EACH THROUGH SEPARATE ACCESS SITES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
Medical /Surgical	36478	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS, LASER; FIRST VEIN TREATED
Medical /Surgical	36479	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS, LASER; SECOND AND SUBSEQUENT VEINS TREATED IN A SINGLE EXTREMITY, EACH THROUGH SEPARATE ACCESS SITES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
Medical /Surgical	36482	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, BY TRANSCATHETER DELIVERY OF A CHEMICAL ADHESIVE (EG, CYANOACRYLATE) REMOTE FROM THE ACCESS SITE, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS; FIRST VEIN TREATED

Medical /Surgical	36483	ENDOVENOUS ABLATION THERAPY OF INCOMPETENT VEIN, EXTREMITY, BY TRANSCATHETER DELIVERY OF A CHEMICAL ADHESIVE (EG, CYANOACRYLATE) REMOTE FROM THE ACCESS SITE, INCLUSIVE OF ALL IMAGING GUIDANCE AND MONITORING, PERCUTANEOUS; SUBSEQUENT VEIN(S) TREATED IN A SINGLE EXTREMITY, EACH THROUGH SEPARATE ACCESS SITES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
Medical /Surgical	37500	VASCULAR ENDOSCOPY, SURGICAL, WITH LIGATION OF PERFORATOR VEINS, SUBFASCIAL (SEPS)
Medical /Surgical	37700	LIGATION AND DIVISION OF LONG SAPHENOUS VEIN AT SAPHENOFEMORAL JUNCTION, OR DISTAL INTERRUPTIONS
Medical /Surgical	37718	LIGATION, DIVISION, AND STRIPPING, SHORT SAPHENOUS VEIN
Medical /Surgical	37722	LIGATION, DIVISION, AND STRIPPING, LONG (GREATER) SAPHENOUS VEINS FROM SAPHENOFEMORAL JUNCTION TO KNEE OR BELOW
Medical /Surgical	37735	LIGATION AND DIVISION AND COMPLETE STRIPPING OF LONG OR SHORT SAPHENOUS VEINS WITH RADICAL EXCISION OF ULCER AND SKIN GRAFT AND/OR INTERRUPTION OF COMMUNICATING VEINS OF LOWER LEG, WITH EXCISION OF DEEP FASCIA
Medical /Surgical	37760	LIGATION OF PERFORATOR VEINS, SUBFASCIAL, RADICAL (LINTON TYPE), INCLUDING SKIN GRAFT, WHEN PERFORMED, OPEN,1 LEG
Medical /Surgical	37761	LIGATION OF PERFORATOR VEIN(S), SUBFASCIAL, OPEN, INCLUDING ULTRASOUND GUIDANCE, WHEN PERFORMED, 1 LEG
Medical /Surgical	37765	STAB PHLEBECTOMY OF VARICOSE VEINS, 1 EXTREMITY; 10-20 STAB INCISIONS
Medical /Surgical	37766	STAB PHLEBECTOMY OF VARICOSE VEINS, ONE EXTREMITY; MORE THAN 20 INCISIONS
Medical /Surgical	37780	LIGATION AND DIVISION OF SHORT SAPHENOUS VEIN AT SAPHENOPOPLITEAL JUNCTION (SEPARATE PROCEDURE)
Medical /Surgical	37785	LIGATION, DIVISION, AND/OR EXCISION OF VARICOSE VEIN CLUSTER(S), 1 LEG
Medical /Surgical	S2202	ECHOSCLEROTHERAPY
Medical /Surgical	43284	LAPAROSCOPY, SURGICAL, ESOPHAGEAL SPHINCTER AUGMENTATION PROCEDURE, PLACEMENT OF SPHINCTER AUGMENTATION DEVICE (IE, MAGNETIC BAND), INCLUDING CRUROPLASTY WHEN PERFORMED
Medical /Surgical	43285	REMOVAL OF ESOPHAGEAL SPHINCTER AUGMENTATION DEVICE
Medical /Surgical	49568	IMPLANTATION OF MESH OR OTHER PROSTHESIS FOR OPEN INCISIONAL OR VENTRAL HERNIA REPAIR OR MESH FOR CLOSURE OF DEBRIDEMENT FOR NECROTIZING SOFT TISSUE INFECTION (LIST SEPARATELY IN ADDITION TO CODE FOR THE INCISIONAL OR VENTRAL HERNIA REPAIR)
Medical /Surgical	58150	TOTAL ABDOMINAL HYSTERECTOMY (CORPUS AND CERVIX), WITH OR WITHOUT REMOVAL
Medical /Surgical	58152	TOTAL ABDOMINAL HYSTERECTOMY (CORPUS AND CERVIX), WITH OR WITHOUT REMOVAL
Medical /Surgical	58180	SUPRACERVICAL ABDOMINAL HYSTERECTOMY (SUBTOTAL HYSTERECTOMY), WITH OR
Medical /Surgical	58541	LAPAROSCOPY, SURGICAL, SUPRACERVICAL HYSTERECTOMY, FOR UTERUS 250 G OR LESS;
Medical /Surgical	58542	LAPAROSCOPY, SURGICAL, SUPRACERVICAL HYSTERECTOMY, FOR UTERUS 250 G OR LESS; WITH REMOVAL OF TUBE(S) AND/OR OVARY(S)
Medical /Surgical	58543	LAPAROSCOPY, SURGICAL, SUPRACERVICAL HYSTERECTOMY, FOR UTERUS
Medical /Surgical	58544	LAPAROSCOPY, SURGICAL, SUPRACERVICAL HYSTERECTOMY, FOR UTERUS
Medical /Surgical	58550	LAPAROSCOPY SURGICAL, WITH VAGINAL HYSTERECTOMY, FOR UTERUS 250 GRAMS OR
Medical /Surgical	58552	LAPAROSCOPY SURGICAL, WITH VAGINAL HYSTERECTOMY, FOR UTERUS 250 GRAMS OR LESS; WITH REMOVAL OF TUBE(S) AND/OR OVARY(S)
Medical /Surgical	58553	LAPAROSCOPY SURGICAL, WITH VAGINAL HYSTERECTOMY, FOR UTERUS GREATER THAN
Medical /Surgical	58554	LAPAROSCOPY SURGICAL, WITH VAGINAL HYSTERECTOMY, FOR UTERUS GREATER THAN 250 GRAMS; WITH REMOVAL OF TUBE(S) AND/OR OVARY(S)
Medical /Surgical	58570	LAPAROSCOPY, SURGICAL, WITH TOTAL HYSTERECTOMY, FOR UTERUS
Medical /Surgical	58571	LAPAROSCOPY, SURGICAL, WITH TOTAL HYSTERECTOMY, FOR UTERUS 250 G OR LESS; WITH REMOVAL OF TUBE(S) AND/OR OVARY(S)
Medical /Surgical	58572	LAPAROSCOPY, SURGICAL, WITH TOTAL HYSTERECTOMY, FOR UTERUS
Medical /Surgical	58573	LAPAROSCOPY, SURGICAL, WITH TOTAL HYSTERECTOMY, FOR UTERUS GREATER THAN 250 G; WITH REMOVAL OF TUBE(S) AND/OR OVARY(S)
Medical /Surgical	21899	UNLISTED PROCEDURE, NECK OR THORAX
Medical /Surgical	27437	ARTHROPLASTY, PATELLA; WITHOUT PROSTHESIS
Medical /Surgical	22899	UNLISTED PROCEDURE, SPINE
Medical /Surgical	27599	UNLISTED PROCEDURE, FEMUR OR KNEE
Medical /Surgical	29999	UNLISTED PROCEDURE, ARTHROSCOPY
Medical /Surgical	37799	UNLISTED PROCEDURE, VASCULAR SURGERY
Medical /Surgical	49999	UNLISTED PROCEDURE, ABDOMEN, PERITONEUM AND OMENTUM
Medical /Surgical	58578	UNLISTED LAPAROSCOPY PROCEDURE, UTERUS
Medical /Surgical	58579	UNLISTED HYSTEROSCOPY PROCEDURE, UTERUS
Medical /Surgical	58679	UNLISTED LAPAROSCOPY PROCEDURE, OVIDUCT, OVARY
Medical /Surgical	67999	UNLISTED PROCEDURE, EYELIDS
Medical /Surgical	68899	UNLISTED PROCEDURE, LACRIMAL SYSTEM
Medical /Surgical	D2999	UNSPECIFIED RESTORATIVE PROCEDURE, BY REPORT
Medical /Surgical	64561	PERCUTANEOUS IMPLANTATION OF NEUROSTIMULATOR ELECTRODE ARRAY; SACRAL NERVE (TRANSFORAMINAL PLACEMENT) INCLUDING IMAGE GUIDANCE, IF PERFORMED
Medical /Surgical	64568	INCISION FOR IMPLANTATION OF CRANIAL NERVE (EG, VAGUS NERVE) NEUROSTIMULATOR ELECTRODE ARRAY AND PULSE GENERATOR
Medical /Surgical	64590	INSERTION OR REPLACEMENT OF PERIPHERAL OR GASTRIC NEUROSTIMULATOR PULSE GENERATOR OR RECEIVER, DIRECT OR INDUCTIVE COUPLING
Medical /Surgical	65760	KERATOMILEUSIS
Medical /Surgical	65765	KERATOPHAKIA
Medical /Surgical	65771	RADIAL KERATOTOMY
Medical /Surgical	S0810	PHOTOREFRACTIVE KERATECTOMY (PRK)
Medical /Surgical	21120	GENIOPLASTY; AUGMENTATION (AUTOGRAFT, ALLOGRAFT, PROSTHETIC MATERIAL)
Medical /Surgical	21122	GENIOPLASTY; SLIDING OSTEOTOMIES, TWO OR MORE OSTEOTOMIES (EG, WEDGE EXCISION OR BONE WEDGE REVERSAL FOR ASYMMETRICAL CHIN)

Medical /Surgical	21123	GENIOPLASTY; SLIDING, AUGMENTATION WITH INTERPOSITIONAL BONE GRAFTS (INCLUDES OBTAINING AUTOGRAFTS)
Medical /Surgical	21125	AUGMENTATION, MANDIBULAR BODY OR ANGLE; PROSTHETIC MATERIAL
Medical /Surgical	21127	AUGMENTATION, MANDIBULAR BODY OR ANGLE; WITH BONE GRAFT, ONLAY OR INTERPOSITIONAL (INCLUDES OBTAINING AUTOGRAFT)
Medical /Surgical	67900	REPAIR OF BROW PTOSIS (SUPRACILIARY, MID-FOREHEAD OR CORONAL APPROACH)
Medical /Surgical	67901	REPAIR OF BLEPHAROPTOSIS; FRONTALIS MUSCLE TECHNIQUE WITH SUTURE OR OTHER MATERIAL (EG, BANKED FASCIA)
Medical /Surgical	67902	REPAIR OF BLEPHAROPTOSIS; FRONTALIS MUSCLE TECHNIQUE WITH AUTOLOGOUS FASCIAL SLING (INCLUDES OBTAINING FASCIA)
Medical /Surgical	67903	REPAIR OF BLEPHAROPTOSIS; (TARSO) LEVATOR RESECTION OR ADVANCEMENT, INTERNAL APPROACH
Medical /Surgical	67904	REPAIR OF BLEPHAROPTOSIS; (TARSO) LEVATOR RESECTION OR ADVANCEMENT, EXTERNAL APPROACH
Medical /Surgical	67906	REPAIR OF BLEPHAROPTOSIS; SUPERIOR RECTUS TECHNIQUE WITH FASCIAL SLING (INCLUDES OBTAINING FASCIA)
Medical /Surgical	67908	REPAIR OF BLEPHAROPTOSIS; CONJUNCTIVO-TARSO-MULLER S MUSCLE-LEVATOR RESECTION (EG, FASANELLA-SERVAT TYPE)
Medical /Surgical	67911	CORRECTION OF LID RETRACTION
Surgery (Musculoskeletal)	62287	Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar
Medical /Surgical	20912	CARTILAGE GRAFT; NASAL SEPTUM
Medical /Surgical	30400	RHINOPLASTY, PRIMARY; LATERAL AND ALAR CARTILAGES AND/OR ELEVATION OF NASAL TIP
Medical /Surgical	30410	RHINOPLASTY, PRIMARY; COMPLETE, EXTERNAL PARTS INCLUDING BONY PYRAMID, LATERAL AND ALAR CARTILAGES, AND/OR ELEVATION OF NASAL TIP
Medical /Surgical	30420	RHINOPLASTY, PRIMARY; INCLUDING MAJOR SEPTAL REPAIR
Medical /Surgical	30430	RHINOPLASTY, SECONDARY; MINOR REVISION (SMALL AMOUNT OF NASAL TIP WORK)
Medical /Surgical	30435	RHINOPLASTY, SECONDARY; INTERMEDIATE REVISION (BONY WORK WITH OSTEOTOMIES)
Medical /Surgical	30450	RHINOPLASTY, SECONDARY; MAJOR REVISION (NASAL TIP WORK AND OSTEOTOMIES)
Medical /Surgical	30520	SEPTOPLASTY OR SUBMUCOUS RESECTION, WITH OR WITHOUT CARTILAGE SCORING CONTOURING OR REPLACEMENT WITH GRAFT
Medical /Surgical	31255	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH ETHMOIDECTOMY, TOTAL (ANTERIOR AND POSTERIOR)
Medical /Surgical	69300	OTOPLASTY PROTRUDING EAR, WITH OR WITHOUT SIZE REDUCTION
Medical /Surgical	69714	IMPLANTATION, OSSEOINTEGRATED IMPLANT, TEMPORAL BONE, WITH PERCUTANEOUS ATTACHMENT TO EXTERNAL SPEECH PROCESSOR/COCHLEAR STIMULATOR; WITHOUT MASTOIDECTOMY
Medical /Surgical	69715	IMPLANTATION, OSSEOINTEGRATED IMPLANT, TEMPORAL BONE, WITH PERCUTANEOUS ATTACHMENT TO EXTERNAL SPEECH PROCESSOR/COCHLEAR STIMULATOR; WITH MASTOIDECTOMY
Medical /Surgical	69718	REPLACEMENT (INCLUDING REMOVAL OF EXISTING DEVICE), OSSEOINTEGRATED
Medical /Surgical	69930	COCHLEAR DEVICE IMPLANTATION, WITH OR WITHOUT MASTOIDECTOMY
Medical /Surgical	L8614	COCHLEAR DEVICE, INCLUDES ALL INTERNAL AND EXTERNAL COMPONENTS
Medical /Surgical	L8619	COCHLEAR IMPLANT, EXTERNAL SPEECH PROCESSOR AND CONTROLLER, INTEGRATED SYSTEM, REPLACEMENT
Medical /Surgical	91110	GASTROINTESTINAL TRACT IMAGING, INTRALUMINAL (EG, CAPSULE ENDOSCOPY), ESOPHAGUS THROUGH ILEUM, WITH PHYSICIAN INTERPRETATION AND REPORT
Medical /Surgical	91111	GASTROINTESTINAL TRACT IMAGING, INTRALUMINAL (EG, CAPSULE ENDOSCOPY), ESOPHAGUS WITH INTERPRETATION AND REPORT
Medical /Surgical	92507	TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/OR AUDITORY PROCESSING DISORDER; INDIVIDUAL
Medical /Surgical	92508	TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/OR AUDITORY PROCESSING DISORDER; GROUP, 2 OR MORE INDIVIDUALS
Medical /Surgical	92526	TREATMENT OF SWALLOWING DYSFUNCTION AND/OR ORAL FUNCTION FOR FEEDING
Medical /Surgical	93229	EXTERNAL MOBILE CARDIOVASCULAR TELEMETRY WITH ELECTROCARDIOGRAPHIC RECORDING, CONCURRENT COMPUTERIZED REAL TIME DATA ANALYSIS AND GREATER THAN 24 HOURS OF ACCESSIBLE ECG DATA STORAGE (RETRIEVABLE WITH QUERY) WITH ECG TRIGGERED AND PATIENT SELECTED EVENTS TRANSMITTED TO A REMOTE ATTENDED SURVEILLANCE CENTER FOR UP TO 30 DAYS; TECHNICAL SUPPORT FOR CONNECTION AND PATIENT INSTRUCTIONS FOR USE, ATTENDED SURVEILLANCE, ANALYSIS AND TRANSMISSION OF DAILY AND EMERGENT DATA REPORTS AS PRESCRIBED BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL
Medical /Surgical	95807	SLEEP STUDY, SIMULTANEOUS RECORDING OF VENTILATION, RESPIRATORY EFFORT, ECG OR HEART RATE, AND OXYGEN SATURATION, ATTENDED BY A TECHNOLOGIST
Medical /Surgical	95808	POLYSOMNOGRAPHY; ANY AGE, SLEEP STAGING WITH 1-3 ADDITIONAL PARAMETERS OF SLEEP, ATTENDED BY A TECHNOLOGIST
Medical /Surgical	95810	POLYSOMNOGRAPHY; AGE 6 YEARS OR OLDER, SLEEP STAGING WITH 4 OR MORE ADDITIONAL PARAMETERS OF SLEEP, ATTENDED BY A TECHNOLOGIST
Medical /Surgical	95811	POLYSOMNOGRAPHY; AGE 6 YEARS OR OLDER, SLEEP STAGING WITH 4 OR MORE ADDITIONAL PARAMETERS OF SLEEP, WITH INITIATION OF CONTINUOUS POSITIVE AIRWAY PRESSURE THERAPY OR BILEVEL VENTILATION, ATTENDED BY A TECHNOLOGIST
Medical /Surgical	V5281	ASSISTIVE LISTENING DEVICE, PERSONAL FM/DM SYSTEM, MONAURAL, (1 RECEIVER, TRANSMITTER, MICROPHONE), ANY TYPE
Medical /Surgical	V5282	ASSISTIVE LISTENING DEVICE, PERSONAL FM/DM SYSTEM, BINAURAL, (2 RECEIVERS, TRANSMITTER, MICROPHONE), ANY TYPE
Medical /Surgical	V5286	ASSISTIVE LISTENING DEVICE, PERSONAL BLUE TOOTH FM/DM RECEIVER
Medical /Surgical	V5287	ASSISTIVE LISTENING DEVICE, PERSONAL FM/DM RECEIVER, NOT OTHERWISE SPECIFIED

Medical /Surgical	V5288	ASSISTIVE LISTENING DEVICE, PERSONAL FM/DM TRANSMITTER ASSISTIVE LISTENING DEVICE
Medical /Surgical	V5289	ASSISTIVE LISTENING DEVICE, PERSONAL FM/DM ADAPTER/BOOT COUPLING DEVICE FOR RECEIVER, ANY TYPE
Medical /Surgical	33289	TRANSCATHETER IMPLANTATION OF WIRELESS PULMONARY ARTERY PRESSURE SENSOR FOR LONG-TERM HEMODYNAMIC MONITORING, INCLUDING DEPLOYMENT AND CALIBRATION OF THE SENSOR, RIGHT HEART CATHETERIZATION, SELECTIVE PULMONARY CATHETERIZATION, RADIOLOGICAL SUPERVISION AND INTERPRETATION, AND PULMONARY ARTERY ANGIOGRAPHY, WHEN PERFORMED
Transplant	38242	ALLOGENEIC LYMPHOCYTE INFUSIONS
Specialty Surgeries	62287	DECOMPRESSION PROCEDURE, PERCUTANEOUS, OF NUCLEUS PULPOSUS OF INTERVERTEBRAL DISC, ANY METHOD UTILIZING NEEDLE BASED TECHNIQUE TO REMOVE DISC MATERIAL UNDER FLUOROSCOPIC IMAGING OR OTHER FORM OF INDIRECT VISUALIZATION, WITH DISCOGRAPHY AND/OR EPIDURAL INJ
Reconstructive /Possibly Cosmetic (Medical / Surgical)	G0429	DERMAL FILLER INJECTION(S) FOR THE TREATMENT OF FACIAL LIPODYSTROPHY SYNDROME (LDS) (E.G., AS A RESULT OF HIGHLY ACTIVE ANTIRETROVIRAL THERAPY)
Site of Care	J0256	INJECTION, ALPHA 1 PROTEINASE INHIBITOR (HUMAN) (ARALAST)
Site of Care	J0256	INJECTION, ALPHA 1 PROTEINASE INHIBITOR (HUMAN) (ZEMAIRA)
Site of Care	J0256	INJECTION, ALPHA-1 PROTEINASE INHIBITOR (HUMAN) (PROLASTIN)
Other	J0897	INJECTION, DENOSUMAB, 1 MG (PROLIA)
Other	J0897	INJECTION, DENOSUMAB, 1 MG (XGEVA)
Other	J1325	INJECTION, EPOPROSTENOL, 0.5 MG (FLOLAN)
Other	J1325	INJECTION, EPOPROSTENOL, 0.5 MG (VELETRI)
Site of Care	J1566	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, LYOPHILIZED (E.G., POWDER), 500 MG (CARIMUNE NF)
Site of Care	J1566	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, LYOPHILIZED (E.G., POWDER), 500 MG (GAMMAGARD S/D)
NOC Oncology	NOC**	BEVACIZUMAB-MALY (ALYMSYS)
NOC Oncology	NOC**	TEBENTAFUSP-TEBN (KIMMTRAK)
NOC Oncology	NOC**	NIVOLUMAB/RELATLIMAB-RMBW (OPDUALAG)
NOC Oncology	NOC**	CILTACABTAGENE AUTOLEUCEL (CARVYKTI)
NOC Other	NOC**	ALIROCUMAB (PRALUENT)
NOC Other	NOC**	EVOLOCUMAB (REPATHA)
NOC Other	NOC**	PEGFILGRASTIM-PBBK (FYLNETRA)
Oncology	C9076	LISOCABTAGENE MARALEUCEL, UP TO 110 MILLION AUTOLOGOUS ANTI-CD19 CAR-POSITIVE VIABLE T CELLS, INCLUSING LEUKAPHERESIS AND DOSE PREPARATION PROCEDURES, PER THERAPEUTIC DOSE (BREYANZI)
Oncology	C9095	INJECTION, TEBENTASFUSP-TEBN, 1 MCG (KIMMTRAK)
Oncology	C9098	AUTOLOGOUS B-CELL MATURATION ANTIGEN (BCMA) DIRECTED CAR-POSITIVE T CELLS, INCLUDING LEUKAPHERESIS AND DOSE PREPARATION PROCEDURES, PER THERAPEUTIC DOSE (CARVYKTI)
Oncology	J1448	INJECTION, TRILACICLIB, 1 MG (COSELA)
Oncology	J1930	INJECTION, LANREOTIDE, 1 MG (SOMATULINE DEPOT)
Oncology	J1932	INJECTION, LANREOTIDE, (CIPLA), 1 MG
Oncology	J1950	INJECTION, LEUPROLIDE ACETATE (FOR DEPOT SUSPENSION), PER 3.75 MG
Oncology	J1952	LEUPROLIDE INJECTABLE, CAMCEVI, 1 MG
Oncology	J2860	INJECTION, SILTUXIMAB (SYLVANT)
Oncology	J9019	INJECTION, ASPARAGINASE (ERWINAZE), 1,000 IU
Oncology	J9021	INJECTION, ASPARAGINASE, RECOMBINANT, (RYLAZE), 0.1 MG
Oncology	J9022	INJECTION, ATEZOLIZUMAB, 10 MG (TECENTRIQ)
Oncology	J9023	INJECTION, AVELUMAB, 10 MG (BAVENCIO)
Oncology	J9032	INJECTION, BELINOSTAT, 10 MG (BELEODAQ)
Oncology	J9033	INJECTION, BENDAMUSTINE HCL, 1 MG (TREANDA)
Oncology	J9034	INJECTION, BENDAMUSTINE HCL (BENDEKA), 1 MG
Oncology	J9035	INJECTION, BEVACIZUMAB 10 MG (AVASTIN)
Oncology	J9036	INJECTION, BENDAMUSTINE HYDROCHLORIDE, 1 MG (BELRAPZO)
Oncology	J9037	INJECTION, BELANTAMAB MAFODONTIN-BLMF, 0.5 MG (BLENREP)
Oncology	J9039	INJECTION, BLINATUMOMAB, 1 MICROGRAM (BLINCYTO)
Oncology	J9041	INJECTION, BORTEZOMIB, 0.1 MG (VELCADE)
Oncology	J9042	INJECTION, BRENTUXIMAB VEDOTIN, 1 MG (ADCETRIS)
Oncology	J9044	INJECTION, BORTEZOMIB, NOT OTHERWISE SPECIFIED, 0.1 MG
Oncology	J9047	INJECTION, CARFILZOMIB, 1 MG (KYPROLIS)
Oncology	J9055	INJECTION, CETUXIMAB, 10 MG (ERBITUX)
Oncology	J9061	INJECTION, AMIVANTAMAB-VMJW, 2 MG (RYBREVANT)
Oncology	J9098	INJECTION, CYTARABINE LIPOSOME, 10 MG (DEPOCYT)
Oncology	J9118	INJECTION, CALASPARGASE PEGOL-MKNL, 10 UNITS (ASPARLAS)
Oncology	J9119	INJECTION, CEMIPLIMAB-RWLC, 1 MG (LIBTAYO)
Oncology	J9144	INJECTION, DARATUMUMAB, 10MG AND HYALURONIDASE-FIHJ (DARZALEX FASPRO)
Oncology	J9145	INJECTION, DARATUMUMAB, 10 MG (DARZALEX)
Oncology	J9173	INJECTION, DURVALUMAB, 10 MG (IMFINZI)
Oncology	J9177	INJECTION, ENFORTUMAB VEDOTIN-EJFV, 0.25 MG (PADCEV)
Oncology	J9205	INJECTION, IRINOTECAN LIPOSOME, 1 MG (ONIVYDE)
Oncology	J9210	INJECTION, EMAPALUMAB-LZSG, 1MG (GAMIFANT)
Oncology	J9225	HISTRELIN IMPLANT (VANTAS), 50 MG
Oncology	J9227	INJECTION, ISATUXIMAB-IRFC, 10 MG (SARCLISA)
Oncology	J9228	INJECTION, IPILIMUMAB, 1 MG (YERVOY)
Oncology	J9229	INJECTION, INOTUZUMAB OZOGAMICIN, 0.1 MG (BESPONSA)
Oncology	J9247	INJECTION, MELPHALAN FLUFENAMIDE, 1 MG (PEPAXTO)
Oncology	J9266	INJECTION, PEGASPARGASE, PER SINGLE DOSE VIAL (ONCASPAR)
Oncology	J9269	INJECTION, TAGRAXOFUSP-ERZS, 10 MCG (ELZONRIS)
Oncology	J9271	INJECTION, PEMBROLIZUMAB, 1 MG (KEYTRUDA)

**Select new-to-market drugs with not otherwise classified (NOC) HCPCS codes (e.g. J3490, J3590, J9999, C9399) will require prior authorization, pending unique HCPCS assignment by CMS

Oncology	J9272	INJECTION, DOSTARLIMAB--GXLY, 10 MG (JEMPERLI)
Oncology	J9273	INJECTION, TISOTUMAB VEDOTIN-TFTV, 1 MG (TIVDAK)
Oncology	J9295	INJECTION, NECITUMUMAB, 1 MG (PORTRAZZA)
Oncology	J9299	INJECTION, NIVOLUMAB, 1 MG (OPDIVO)
Oncology	J9301	INJECTION, OBINUTUZUMAB, 10 MG (GAZYVA)
Oncology	J9303	INJECTION, PANITUMUMAB, 10 MG (VECTIBIX)
Oncology	J9306	INJECTION, PERTUZUMAB, 1 MG (PERJETA)
Oncology	J9308	INJECTION, RAMUCIRUMAB, 5 MG (CYRAMZA)
Oncology	J9309	INJECTION, POLATUZUMAB VEDOTIN-PIIQ, 1 MG (POLIVY)
Oncology	J9311	INJECTION, RITUXIMAB 10 MG AND HYALURONIDASE (RITUXAN HYCELA)
Oncology	J9312	INJECTION, RITUXIMAB, 10 MG (RITUXAN)
Oncology	J9316	INJECTION, PERTUZUMAB, TRASTUZUMAB, AND HYALURONIDASE-ZZXF, PER 10MG (PHESGO)
Oncology	J9317	INJECTION, SACITUZUMAB GOVITECAN-HZIY, 2.5 MG (TRODELVY)
Oncology	J9330	INJECTION, TEMSIROLIMUS, 1 MG (TORISEL)
Oncology	J9331	INJECTION SIROLIMUS PROTEIN-BOUND PARTICLES, 1 MG (FYARRO)
Oncology	J9349	INJECTION, TAFASITAMAB-CXIX, 2MG (MONJUVI)
Oncology	J9353	INJECTION, MARGETUXIMAB-CMKB, 5 MG (MARGENZA)
Oncology	J9354	INJECTION, ADO-TRASTUZUMAB EMTANSINE, 1 MG (KADCYLA)
Oncology	J9355	INJECTION, TRASTUZUMAB, 10 MG (HERCEPTIN)
Oncology	J9356	INJECTION, TRASTUZUMAB, AND HYALURONIDASE-OYSK (HERCEPTIN HYLECTRA) 10 MG
Oncology	J9358	INJECTION, FAM-TRASTUZUMAB DERUXTECAN-NXKI, 1 MG (ENHERTU)
Oncology	J9359	INJECTION, LONCASTUXIMAB TESIRINE-LPYL, 0.075 MG (ZYNLONTA)
Oncology	J9395	INJECTION, FULVESTRANT, 25 MG (FASLODEX)
Oncology	J9999	NOT OTHERWISE CLASSIFIED, ANTINEOPLASTIC DRUGS
Oncology	Q2041	AXICABTAGENE CILOLEUCEL, UP TO 200 MILLION AUTOLOGOUS ANTI-CD19 CAR T CELLS, INCLUDING LEUKAPHERESIS AND DOSE PREPARATION PROCEDURES, PER INFUSION (YESCARTA)
Oncology	Q2042	TISAGENLECLEUCEL, UP TO 600 MILLION CAR-POSITIVE VIABLE T CELLS, INCLUDING LEUKAPHERESIS AND DOSE PREPARATION PROCEDURES, PER THERAPEUTIC DOSE (KYMRIAH)
Oncology	Q2043	SIPULEUCEL-T, MINIMUM OF 50 MILLION AUTOLOGOUS CD54+ CELLS ACTIVATED WITH PAP-GM-CSF, INCLUDING LEUKAPHERESIS AND ALL OTHER PREPARATORY PROCEDURES, PER INFUSION (PROVENGE)
Oncology	Q2053	BREXUCABTAGENE AUTOLEUCEL, UP TO 200 MILLION AUTOLOGOUS ANIT-CD 19 CAR POSITIVE VIABLE T-CELLS, INCLUDING LEUKAPHERESIS AND DOSE PREPARATION PROCEDURES, PER THERAPEUTIC DOSE (TECARUS)
Oncology	Q2054	LISOCABTAGENE MARALEUCEL, UP TO 110 MILLION AUTOLOGOUS ANTI-CD19 CAR-POSITIVE VIABLE T CELLS, INCLUSING LEUKAPHERESIS AND DOSE PREPARATION PROCEDURES, PER THERAPEUTIC DOSE (BREYANZI)
Oncology	Q2055	IDECABTAGENE VICLEUCEL, UP TO 460 MILLION AUTOLOGOUS B-CELL MATURATION ANTIGEN (BCMA) DIRECTED CAR-POSITIVE T CELLS, INCLUDING LEUKAPHERESIS AND DOSE PREPARATION PROCEDURES, PER THERAPEUTIC DOSE (ABCEMA)
Oncology	Q5107	INJECTION, BEVACIZUMAB-AWWB, BIOSIMILAR, (MVASI), 10 MG
Oncology	Q5112	INJECTION, TRASTUZUMAB-DTTB, BIOSIMILAR, (ONTRUZANT), 10 MG
Oncology	Q5113	INJECTION, TRASTUZUMAB-PKRB, BIOSIMILAR, (HERZUMA), 10 MG
Oncology	Q5114	INJECTION, TRASTUZUMAB-DKST, BIOSIMILAR, (OGIVRI), 10 MG
Oncology	Q5115	INJECTION, RITUXIMAB-ABBS, BIOSIMILAR, (TRUXIMA), 10 MG
Oncology	Q5116	INJECTION, TRASTUZUMAB-QYYP, BIOSIMILAR, (TRAZIMERA), 10 MG
Oncology	Q5117	INJECTION, TRASTUZUMAB-ANNS, BIOSIMILAR, (KANJINTI), 10 MG
Oncology	Q5118	INJECTION, BEVACIZUMAB-BVZR, BIOSIMILIAR, (ZIRABEV), 10 MG
Oncology	Q5119	INJECTION, RITUXIMAB-PVVR, BIOSIMILAR, (RUXIENCE), 10 MG
Oncology	Q5123	INJECTION, RETUXIMAB-ARRX, BIOSIMILAR, (RIABNI), 10 MG
Other	90378	RESPIRATORY SYNCYTIAL VIRUS, MONOCLONAL ANTIBODY, RECOMBINANT, FOR INTRAMUSCULAR USE, 50 MG, EACH (SYNAGIS)
Other	C9075	INJECTION, CASIMERSEN, 10 MG (AMONDYS 45)
Other	C9090	INJECTION, PLASMINOGEN, HUMAN-TVMH, 1 MG (RYPLAZIM)
Other	C9094	INJECTION, SUTIMLIMAB-JOME, 10 MG (ENJAYMO)
Other	C9097	INJECTION, FARICIMAB-SVOA, 0.1 MG (VABYSMO)
Other	C9399	UNCLASSIFIED DRUGS OR BIOLOGICALS
Other	J0172	INJECTION, ADUCANUMAB-AVWA, 2 MG (ADUHELM)
Other	J0178	INJECTION, AFLIBERCEPT, 1 MG (EYLEA)
Other	J0179	INJECTION, BROLUCIZUMAB-DBLL, 1 MG (BEOVU)
Other	J0202	INJECTION, ALEMTUZUMAB, 1 MG (LEMTRADA)
Other	J0223	INJECTION, GIVOSIRAN, 0.5 MG (GIVLAARI)
Other	J0224	INJECTION, LUMASIRAN, 0.5 MG (OXLUMO)
Other	J0480	INJECTION, BASILIXIMAB, 20 MG (SIMULECT)
Other	J0517	INJECTION, BENRALIZUMAB, 1 MG (FASENRA)
Other	J0565	INJECTION, BEZLOTOXUMAB, 10 MG (ZINPLAVA)
Other	J0567	INJECTION, CERLIPONASE ALFA, 1 MG (BRINEURA)
Other	J0585	INJECTION, ONABOTULINUMTOXINA, 1 UNIT BOTULINUM TOXIN TYPE A, PER UNIT) (BOTOX)
Other	J0586	INJECTION, ABOBOTULINUMTOXINA, 5 UNITS (DYSPORT)
Other	J0587	INJECTION, RIMABOTULINUMTOXINB, 100 UNITS BOTULINUM TOXIN TYPE B, PER 100 UNITS (MYOBLOC)
Other	J0588	INJECTION, INCOBOTULINUMTOXIN A, 1 UNIT (XEOMIN)
Other	J0593	INJECTION, LANADELUMAB-FLYO, 1 MG (TAKHZYRO)
Other	J0599	INJECTION, C-1 ESTERASE INHIBITOR (HUMAN), HAEGARDA, 10 UNITS
Other	J0630	INJECTION, CALCITONIN SALMON, UP TO 400 UNITS (MIACALCIN)
Other	J0638	INJECTION, CANAKINUMAB, 1 MG (ILARIS)

Other	J0717	INJECTION, CERTOLIZUMAB PEGOL, 1 MG (CODE MAY BE USED FOR MEDICARE WHEN DRUG ADMINISTERED UNDER THE DIRECT SUPERVISION OF A PHYSICIAN, NOT FOR USE WHEN DRUG IS SELF ADMINISTERED) (CIMZIA)
Other	J0800	INJECTION, CORTICOTROPIN, UP TO 40 UNITS (H.P. ACTHAR GEL, REPOSITORY CORTICOTROPIN INJECTION
Other	J0896	INJECTION, LUSPATERCEPT-AAMT, 0.25 MG (REBLOZYL)
NOC Other	NOC**	LEUPROLIDE ACETATE FOR DEPOT SUSPENSION (LUPANETA PACK)
NOC Other	NOC**	FARICIMAB-SVOA (VABYSMO)
Other	J1290	INJECTION, ECALLANTIDE, 1 MG (KALBITOR)
Other	J1306	INJECTION, INCLISIRAN, 1 MG (LEQVIO)
NOC Other	NOC**	RISANKIZUMAB-RZAA (SKYRIZI)
NOC Other	NOC**	RANIBIZUMAB-EQURN (CIMERLI)
Other	J1426	INJECTION, CASIMERSEN, 10 MG (AMONDYS 45)
Other	J1427	INJECTION, VILTOLARSEN, 10 MG (VILTEPSO)
Other	J1428	INJECTION, ETEPLIRSEN, 10 MG (EXONDYS 51)
Other	J1429	INJECTION, GOLODIRSEN, 10 MG (VYONDYS 53)
Other	J1555	INJECTION, IMMUNE GLOBULIN (CUVITRU), 100 MG
Other	J1558	INJECTION, IMMUNE GLOBULIN (XEMBIFY), 100 MG
Other	J1559	INJECTION, IMMUNE GLOBULIN 100 MG (HIZENTRA)
Other	J1575	INJECTION, IMMUNE GLOBULIN/HYALURONIDASE, (HYQVIA), 100 MG IMMUNOGLOBULIN
Other	J1632	INJECTION, BREXANOLONE, 1 MG (ZULRESSO)
Other	J1726	INJECTION, HYDROXYPROGESTERONE CAPROATE, 10 MG (MAKENA)
Other	J1729	INJECTION, HYDROXYPROGESTERONE CAPROATE, NOT OTHERWISE SPECIFIED, 10 MG
Other	J1744	INJECTION, ICATIBANT, 1 MG (FIRAZYR)
Other	J1746	INJECTION, IBALIZUMAB-UIYK, 1- MG (TROGARZO)
Other	J2182	INJECTION, MEPOLIZUMAB, 1 MG (NUCALA)
Other	J2323	INJECTION, NATALIZUMAB, 1 MG (TYSABRI)
Other	J2326	INJECTION, NUSINERSEN, 0.1 MG (SPINRAZA)
Other	J2353	INJECTION, OCTREOTIDE, DEPOT FORM FOR INTRAMUSCULAR INJECTION, 1 MG (SANDOSTATIN LAR)
Other	J2356	INJECTION, TEZEPELUMAB-EKKO, 1 MG (TEZSPIRE)
Other	J2357	INJECTION, OMALIZUMAB, 5 MG (XOLAIR)
Other	J2469	INJECTION, PALONOSETRON HCL, 25 MCG (ALOXI)
Other	J2503	INJECTION, PEGAPTANIB SODIUM, 0.3 MG (MACUGEN)
Other	J2506	INJECTION, PEGFILGRASTIM, 6 MG (NEULASTA)
Other	J2507	INJECTION, PEGLOTICASE, 1 MG (KRYSTEXXA)
Other	J2778	INJECTION, RANIBIZUMAB, 0.1 MG (LUCENTIS)
Other	J2779	INJECTION, RANIBIZUMAB, VIA INTRVITREAL IMPLANT (SUSVIMO), 0.1 MG
Other	J2786	INJECTION, RESLIZUMAB, 1 MG (CINQAIR)
Other	J2820	INJECTION, SARGRAMOSTIM (GM-CSF), 50 MCG (LEUKINE)
Other	J2941	INJECTION, SOMATROPIN, 1MG
Other	J2998	INJECTION, PLASMINOGEN, HUMAN-TVMH, 1 MG (RYPLAZIM)
Other	J3111	INJECTION, ROMOSOZUMAB-AQG, 1 MG (EVENITY)
Other	J3285	INJECTION, TREPROSTINIL, 1 MG (REMODULIN)
Other	J3316	INJECTION, TRIPTORELIN, EXTENDED-RELEASE, 3.75 MG (TRIPTODUR)
Other	J3357	USTEKINUMAB, FOR SUBCUTANEOUS INJECTION, 1 MG (STELARA)
Other	J3358	USTEKINUMAB, FOR INTRAVENOUS INJECTION, 1 MG (STELARA)
Other	J3398	INJECTION, VORETIGENE NEPARVOVEC-RZYL, 1 BILLION VECTOR GENOME (LUXTURNA)
Other	J3399	INJECTION, ONASEMNOGENE ABEPARVOVEC-XIOI, PER TREATMENT, UP TO 5X1015 VECTOR GENOMES (ZOLGENSMA)
Other	J3590	UNCLASSIFIED BIOLOGICS
Other	J7313	INJECTION, FLUOCINOLONE ACETONIDE, INTRAVITREAL IMPLANT, 0.01 MG
Other	J7316	INJECTION, OCRIPLASMIN, 0.125 MG (JETREA)
Other	J7320	HYALURONAN OR DERIVITIVE, GENVISC 850, FOR INTRA-ARTICULAR INJECTION, 1 MG
Other	J7322	HYALURONAN OR DERIVATIVE, HYMOVIS, FOR INTRA-ARTICULAR INJECTION, 1 MG
Other	J7324	HYALURONAN OR DERIVATIVE, ORTHOVISC, FOR INTRA-ARTICULAR INJECTION, PER DOSE
Other	J7325	HYALURONAN OR DERIVATIVE, SYNVISC OR SYNVISC-ONE, FOR INTRA-ARTICULAR INJECTION, 1 MG
Other	J7326	HYALURONAN OR DERIVATIVE, GEL-ONE, FOR INTRA-ARTICULAR INJECTION, PER DOSE
Other	J7327	HYALURONAN OR DERIVATIVE, MONOVISC, FOR INTRA-ARTICULAR INJECTION, PER DOSE
Other	J7329	HYALURONAN OR DERIVATIVE, TRIVISC, FOR INTRA-ARTICULAR INJECTION, 1 MG
Other	J7639	DORNASE ALFA, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, PER MILLIGRAM
Other	J7682	TOBRAMYCIN, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED UNIT DOSE FORM, ADMINISTERED THROUGH DME, PER 300 MILLIGRAMS (KITABIS, TOBI, BETHKIS)
Other	J7686	TREPROSTINIL, INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, UNIT DOSE FORM, 1.74 MG (TYVASO)
Other	Q5108	INJECTION, PEGFILGRASTIME-JMDB, BIOSIMILAR, (FULPHILA), 0.5 MG
Other	Q5111	INJECTION PEGFILGRASTIME-CBQV, BIOSIMILAR (UDENYCA), 0.5 MG
Other	Q5120	INJECTION, PEGFILGRASTIM-BMEZ, BIOSIMILAR, (ZIEXTENZO), 0.5 MG
Other	Q5122	INJECTION, PEGFILGRASTIM-APGF, BIOSIMILAR, (NYVEPRIA), 0.5 MG
Other	Q5124	INJECTION, RANIBIZUMAB-NUNA, BIOSILIMAR, (BYOOVIZ), 0.1 MG
Outpatient	H0012	ALCOHOL AND/OR DRUG SERVICES; SUB-ACUTE DETOXIFICATION (RESIDENTIAL ADDICTION PROGRAM OUTPATIENT)
Outpatient	H0013	ALCOHOL AND/OR DRUG SERVICES; ACUTE DETOXIFICATION (RESIDENTIAL ADDICTION PROGRAM OUTPATIENT)
Outpatient	H0017	BEHAVIORAL HEALTH; RESIDENTIAL (HOSPITAL RESIDENTIAL TREATMENT PROGRAM), WITHOUT ROOM AND BOARD, PER DIEM
Outpatient	H0018	BEHAVIORAL HEALTH; SHORT-TERM RESIDENTIAL (NONHOSPITAL RESIDENTIAL TREATMENT PROGRAM), WITHOUT ROOM AND BOARD, PER DIEM

Outpatient	H0019	BEHAVIORAL HEALTH; LONG-TERM RESIDENTIAL (NONMEDICAL, NONACUTE CARE IN A RESIDENTIAL TREATMENT PROGRAM WHERE STAY IS TYPICALLY LONGER THAN 30 DAYS), WITHOUT ROOM AND BOARD, PER DIEM
Outpatient	H0022	ALCOHOL AND/OR DRUG INTERVENTION SERVICE (PLANNED FACILITATION)
Outpatient	H0043	SUPPORTED HOUSING, PER DIEM
Outpatient	H0047	ALCOHOL AND/OR OTHER DRUG ABUSE SERVICES, NOT OTHERWISE SPECIFIED
Outpatient	H2001	REHABILITATION PROGRAM, PER 1/2 DAY
Outpatient	H2012	BEHAVIORAL HEALTH DAY TREATMENT, PER HOUR
Outpatient	H2013	PSYCHIATRIC HEALTH FACILITY SERVICE, PER DIEM
Outpatient	H2022	COMMUNITY-BASED WRAP-AROUND SERVICES, PER DIEM
Outpatient	H2036	ALCOHOL AND/OR OTHER DRUG TREATMENT PROGRAM, PER DIEM
Outpatient	T2048	BEHAVIORAL HEALTH; LONG-TERM CARE RESIDENTIAL (NON-ACUTE CARE IN A RESIDENTIAL TREATEMENT PROGRAM WHERE STAY IS TYPICALLY LONGER THAN 30 DAYS), WITH ROOM AND BOARD, PER DIEM
Prosthetics & Orthotics	21089	UNLISTED MAXILLOFACIAL PROSTHETIC PROCEDURE
Prosthetics & Orthotics	L1840	KNEE ORTHOSIS (KO), DEROTATION, MEDIAL-LATERAL, ANTERIOR CRUCIATE LIGAMENT, CUSTOM FABRICATED
Prosthetics & Orthotics	L1844	KNEE ORTHOSIS (KO), SINGLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, CUSTOM FABRICATED
Prosthetics & Orthotics	L1846	KNEE ORTHOSIS (KO), DOUBLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLY CENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, CUSTOMER FABRICATED
Prosthetics & Orthotics	L2005	KNEE-ANKLE-FOOT ORTHOSIS (KAFO) ANY MATERIAL, SINGLE OR DOUBLE UPRIGHT, STANCE CONTROL, AUTOMATIC LOCK AND SWING PHASE RELEASE, ANY TYPE ACTIVATION, INCLUDES ANKLE JOINT, ANY TYPE, CUSTOM FABRICATED
Prosthetics & Orthotics	L3570	ORTHOPEDIC SHOE ADDITION, SPECIAL EXTENSION TO INSTEP (LEATHER WITH EYELETS)
Prosthetics & Orthotics	L3971	SHOULDER ELBOW WRIST HAND ORTHOSIS, SHOULDER CAP DESIGN, INCLUDES ONE OR MORE NONTORSION JOINTS, ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT
Prosthetics & Orthotics	L3975	SHOULDER ELBOW WRIST HAND FINGER ORTHOSIS, SHOULDER CAP DESIGN, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT
Prosthetics & Orthotics	L3976	SHOULDER ELBOW WRIST HAND FINGER ORTHOSIS, ABDUCTION POSITIONING (AIRPLANE DESIGN), THORACIC COMPONENT AND SUPPORT BAR, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT
Prosthetics & Orthotics	L3977	SHOULDER ELBOW WRIST HAND FINGER ORTHOSIS, SHOULDER CAP DESIGN, INCLUDES ON OR MORE NONTORSION JOINTS, ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT
Prosthetics & Orthotics	L5610	ADDITION TO LOWER EXTREMITY, ENDOSKELETAL SYSTEM, ABOVE KNEE, HYDRACADENCE SYSTEM
Prosthetics & Orthotics	L5616	ADDITION TO LOWER EXTREMITY, ENDOSKELETAL SYSTEM, ABOVE KNEE (AK) UNIVERSAL MULTIPLEX SYSTEM, FRICTION SWING PHASE CONTROL
Prosthetics & Orthotics	L5638	ADDITION TO LOWER EXTREMITY, BELOW KNEE, LEATHER SOCKET
Prosthetics & Orthotics	L5639	ADDITION TO LOWER EXTREMITY, BELOW KNEE, WOOD SOCKET
Prosthetics & Orthotics	L5642	ADDITION TO LOWER EXTREMITY, ABOVE KNEE, LEATHER SOCKET
Prosthetics & Orthotics	L5644	ADDITION TO LOWER EXTREMITY, ABOVE KNEE, WOOD SOCKET
Prosthetics & Orthotics	L5651	ADDITION TO LOWER EXTREMITY, ABOVE KNEE (AK), FLEXIBLE INNER SOCKET, EXTERNAL FRAME
Prosthetics & Orthotics	L5683	ADDITION TO LOWER EXTREMITY, BELOW KNEE (BK)/ABOVE KNEE (AK), CUSTOM FABRICATED SOCKET INSERT FOR OTHER THAN CONGENITAL OR ATYPICAL TRAUMATIC AMPUTEE, SILICONE GEL, ELASTOMERIC OR EQUAL, FOR USE WITH OR WITHOUT LOCKING MECHANISM, INITIAL ONLY
Prosthetics & Orthotics	L5714	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, VARIABLE FRICTION SWING PHASE CONTROL (SAFETY KNEE)
Prosthetics & Orthotics	L5722	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, PNEUMATIC SWING, FRICTION STANCE PHASE CONTROL
Prosthetics & Orthotics	L5724	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, FLUID SWING PHASE CONTROL
Prosthetics & Orthotics	L5780	ADDITION, EXOSKELETAL KNEE-SHIN SYSTEM, SINGLE AXIS, PNEUMATIC/HYDRA PNEUMATIC SWING PHASE CONTROL
Prosthetics & Orthotics	L5795	ADDITION, EXOSKELETAL SYSTEM, HIP DISARTICULATION, ULTRA-LIGHT MATERIAL (TITANIUM, CARBON FIBER OR EQUAL)
Prosthetics & Orthotics	L5857	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE-SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, SWING PHASE ONLY, INCLUDES ELECTRONIC SENSOR(S) ANY TYPE
Prosthetics & Orthotics	L5858	ADDITION TO LOWER EXTREMITY PROSTHESIS, ENDOSKELETAL KNEE SHIN SYSTEM, MICROPROCESSOR CONTROL FEATURE, STANCE PHASE ONLY, INCLUDES ELECTRONIC SENSOR(S), ANY TYPE
Prosthetics & Orthotics	L6020	PARTIAL HAND, NO FINGER REMAINING
Prosthetics & Orthotics	L6120	BELOW ELBOW, MOLDED DOUBLE WALL SPLIT SOCKET, STEP-UP HINGES, HALF CUFF
Prosthetics & Orthotics	L6130	BELOW ELBOW, MOLDED DOUBLE WALL SPLIT SOCKET, STUMP ACTIVATED LOCKING HINGE, HALF CUFF
Prosthetics & Orthotics	L6310	SHOULDER DISARTICULATION, PASSIVE RESTORATION (COMPLETE PROSTHESIS)
Prosthetics & Orthotics	L6320	SHOULDER DISARTICULATION, PASSIVE RESTORATION (SHOULDER CAP ONLY)
Prosthetics & Orthotics	L6350	INTERSCAPULAR THORACIC, MOLDED SOCKET, SHOULDER BULKHEAD, HUMERAL SECTION INTERNAL LOCKING ELBOW, FOREARM
Prosthetics & Orthotics	L6360	INTERSCAPULAR THORACIC, PASSIVE RESTORATION (COMPLETE PROSTHESIS)

Prosthetics & Orthotics	L6582	PREPARATORY, WRIST DISARTICULATION OR BELOW ELBOW, SINGLE WALL SOCKET FRICTION WRIST, FLEXIBLE ELBOW HINGES, FIGURE OF EIGHT HARNESS, HUMERAL CUFF, BOWDEN CABLE CONTROL, USMC OR EQUAL PYLON, NO COVER, DIRECT FORMED
Prosthetics & Orthotics	L6586	PREPARATORY, ELBOW DISARTICULATION OR ABOVE ELBOW, SINGLE WALL SOCKET, FRICTION WRIST, LOCKING ELBOW, FIGURE OF EIGHT HARNESS, FAIR LEAD CABLE CONTROL USMC OR EQUAL PYLON, NO COVER, DIRECT FORMED
Prosthetics & Orthotics	L6588	PREPARATORY, SHOULDER DISARTICULATION OR INTERSCAPULAR THORACIC, SINGLE WALL PLASTIC SOCKET, SHOULDER JOINT, LOCKING ELBOW, FRICTION WRIST, CHEST STRAP, FAIR LEAD CABLE CONTROL, USMC OR EQUAL PYLON, NO COVER, MOLDED TO PATIENT MODEL
Prosthetics & Orthotics	L6590	PREPARATORY, SHOULDER DISARTICULATION OR INTERSCAPULAR THORACIC, SINGLE WALL SOCKET, SHOULDER JOINT, LOCKING ELBOW, FRICTION WRIST, CHEST STRAP, FAIR LEAD CABLE CONTROL, USMC OR EQUAL PYLON, NO COVER, DIRECT FORMED
Prosthetics & Orthotics	L6625	UPPER EXTREMITY ADDITION, ROTATION WRIST UNIT WITH CABLE LOCK
Prosthetics & Orthotics	L6642	UPPER EXTREMITY ADDITION, EXCURSION AMPLIFIER, LEVER TYPE
Prosthetics & Orthotics	L6647	UPPER EXTREMITY ADDITION, SHOULDER LOCK MECHANISM, BODY POWERED ACTUATOR
Prosthetics & Orthotics	L6648	UPPER EXTREMITY ADDITION, SHOULDER LOCK MECHANISM, EXTERNAL POWERED ACTUATOR
Prosthetics & Orthotics	L6677	UPPER EXTREMITY ADDITION, HARNESS, TRIPLE CONTROL, SIMULTANEOUS OPERATION OF TERMINAL DEVICE AND ELBOW
Prosthetics & Orthotics	L6885	REPLACEMENT SOCKET, SHOULDER DISARTICULATION/INTERSCAPULAR THORACIC, MOLDED TO PATIENT MODEL, FOR USE WITH OR WITHOUT EXTERNAL POWER
Prosthetics & Orthotics	L6920	WRIST DISARTICULATION, EXTERNAL POWER, SELF-SUSPENDED INNER SOCKET, REMOVABLE FOREARM SHELL, OTTO BOCK OR EQUAL SWITCH, CABLES, TWO BATTERIES AND ONE CHARGER, SWITCH CONTROL OF TERMINAL DEVICE
Prosthetics & Orthotics	L6925	WRIST DISARTICULATION, EXTERNAL POWER, SELF-SUSPENDED INNER SOCKET, REMOVABLE FOREARM SHELL, OTTO BOCK OR EQUAL ELECTRODES, CABLES, TWO BATTERIES AND ONE CHARGER, MYOELECTRONIC CONTROL OF TERMINAL DEVICE
Prosthetics & Orthotics	L6930	BELOW ELBOW, EXTERNAL POWER, SELF-SUSPENDED INNER SOCKET, REMOVABLE FOREARM SHELL, OTTO BOCK OR EQUAL SWITCH, CABLES, TWO BATTERIES AND ONE CHARGER, SWITCH CONTROL OF TERMINAL DEVICE
Prosthetics & Orthotics	L6940	ELBOW DISARTICULATION, EXTERNAL POWER, MOLDED INNER SOCKET, REMOVABLE HUMERAL SHELL, OUTSIDE LOCKING HINGES, FOREARM, OTTO BOCK OR EQUAL SWITCH, CABLES, TWO BATTERIES AND ONE CHARGER, SWITCH CONTROL OF TERMINAL DEVICE
Prosthetics & Orthotics	L6945	ELBOW DISARTICULATION, EXTERNAL POWER, MOLDED INNER SOCKET, REMOVABLE HUMERAL SHELL, OUTSIDE LOCKING HINGES, FOREARM, OTTO BOCK OR EQUAL ELECTRODES, CABLES, 2 BATTERIES AND ONE CHARGER, MYOELECTRONIC CONTROL OF TERMINAL DEVICE
Prosthetics & Orthotics	L6950	ABOVE ELBOW, EXTERNAL POWER, MOLDED INNER SOCKET, REMOVABLE HUMERAL SHELL, INTERNAL LOCKING ELBOW, FOREARM, OTTO BOCK OR EQUAL SWITCH, CABLES, TWO BATTERIES AND ONE CHARGER, SWITCH CONTROL OF TERMINAL DEVICE
Prosthetics & Orthotics	L6960	SHOULDER DISARTICULATION, EXTERNAL POWER, MOLDED INNER SOCKET, REMOVABLE SHOULDER SHELL, SHOULDER BULKHEAD, HUMERAL SECTION, MECHANICAL ELBOW, FOREARM, OTTO BOCK OR EQUAL SWITCH, CABLES, TWO BATTERIES AND ONE CHARGER, SWITCH CONTROL OF TERMINAL
Prosthetics & Orthotics	L6965	SHOULDER DISARTICULATION, EXTERNAL POWER, MOLDED INNER SOCKET, REMOVABLE SHOULDER SHELL, SHOULDER BULKHEAD, HUMERAL SECTION, MECHANICAL ELBOW, FOREARM, OTTO BOCK OR EQUAL ELECTRODES, CABLES, TWO BATTERIES AND ONE CHARGER, MYOELECTRONIC CONT
Prosthetics & Orthotics	L6970	INTERSCAPULAR-THORACIC, EXTERNAL POWER, MOLDED INNER SOCKET, REMOVABLE SHOULDER SHELL, SHOULDER BULKHEAD, HUMERAL SECTION, MECHANICAL ELBOW, FOREARM, OTTO BOCK OR EQUAL SWITCH, CABLES, TWO BATTERIES AND ONE CHARGER, SWITCH CONTROL OF TERMINAL
Prosthetics & Orthotics	L6975	INTERSCAPULAR-THORACIC, EXTERNAL POWER, MOLDED INNER SOCKET, REMOVABLE SHOULDER SHELL, SHOULDER BULKHEAD, HUMERAL SECTION, MECHANICAL ELBOW, FOREARM, OTTO BOCK OR EQUAL ELECTRODES, CABLES, TWO BATTERIES AND ONE CHARGER, MYOELECTRONIC CONT
Prosthetics & Orthotics	L7040	PREHENSILE ACTUATOR, SWITCH CONTROLLED
Prosthetics & Orthotics	L7045	ELECTRIC HOOK, SWITCH OR MYOELECTRIC CONTROLLED, PEDIATRIC
Prosthetics & Orthotics	L7170	ELECTRONIC ELBOW, HOSMER OR EQUAL, SWITCH CONTROLLED
Prosthetics & Orthotics	L7180	ELECTRONIC ELBOW, MICROPROCESSOR SEQUENTIAL CONTROL OF ELBOW AND TERMINAL DEVICE
Prosthetics & Orthotics	L7181	ELECTRONIC ELBOW, MICROPROCESSOR SIMULTANEOUS CONTROL OR ELBOW AND TERMINAL DEVICE
Prosthetics & Orthotics	L7185	ELECTRONIC ELBOW, ADOLESCENT, VARIETY VILLAGE OR-EQUAL, SWITCH CONTROLLED
Prosthetics & Orthotics	L7186	ELECTRONIC ELBOW, CHILD, VARIETY VILLAGE OR EQUAL, SWITCH CONTROLLED
Prosthetics & Orthotics	L7190	ELECTRONIC ELBOW, VARIETY VILLAGE OR EQUAL, MYOELECTRONICALLY CONTROLLED
Prosthetics & Orthotics	L7191	ELECTRONIC ELBOW CHILD, VARIETY VILLAGE OR EQUAL, MYOELECTRONICALLY CONTROLLED
Prosthetics & Orthotics	L8699	PROSTHETIC IMPLANT, NOT OTHERWISE SPECIFIED
PT/OT/ Chiropractic (Physical Medicine)	G0283	Electrical stimulation (unattended), to one or more areas for indication (s) other than wound care, as part of a therapy plan of care (prior authorization required effective 2/1/2020)
PT/OT/ Chiropractic (Physical Medicine)	G0515	Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes (effective 1/1/2018)
PT/OT/ Chiropractic (Physical Medicine)	97010	Application of a modality to one (1) or more areas; hot or cold packs
PT/OT/ Chiropractic (Physical Medicine)	97012	Application of a modality to one (1) or more areas; traction, mechanical
PT/OT/ Chiropractic (Physical Medicine)	97014	Application of a modality to one (1) or more areas; electrical stimulation (unattended)
PT/OT/ Chiropractic (Physical Medicine)	97016	Application of a modality to one (1) or more areas; vasopneumatic devices
PT/OT/ Chiropractic (Physical Medicine)	97018	Application of a modality to one (1) or more areas; paraffin bath
PT/OT/ Chiropractic (Physical Medicine)	97022	Application of a modality to one (1) or more areas; whirlpool
PT/OT/ Chiropractic (Physical Medicine)	97024	Application of a modality to one (1) or more areas; diathermy (e.g., microwave)

PT/OT/ Chiropractic (Physical Medicine)	97026	Application of a modality to one (1) or more areas; infrared
PT/OT/ Chiropractic (Physical Medicine)	97028	Application of a modality to one (1) or more areas; ultraviolet
PT/OT/ Chiropractic (Physical Medicine)	97032	Application of a modality to one (1) or more areas; electrical stimulation (manual), each 15 minutes
PT/OT/ Chiropractic (Physical Medicine)	97033	Application of a modality to one (1) or more areas; iontophoresis, each 15 minutes
PT/OT/ Chiropractic (Physical Medicine)	97034	Application of a modality to one (1) or more areas; contrast baths, each 15 minutes
PT/OT/ Chiropractic (Physical Medicine)	97035	Application of a modality to one (1) or more areas; ultrasound, each 15 minutes
PT/OT/ Chiropractic (Physical Medicine)	97036	Application of a modality to one (1) or more areas; hubbard tank, each 15 minutes
PT/OT/ Chiropractic (Physical Medicine)	97039	Unlisted modality (specify type and time if constant attendance (prior authorization required effective 2/1/2020)
PT/OT/ Chiropractic (Physical Medicine)	97110	Therapeutic procedure, one (1) or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility
PT/OT/ Chiropractic (Physical Medicine)	97112	Therapeutic procedure, one (1) or more areas, each fifteen minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
PT/OT/ Chiropractic (Physical Medicine)	97113	Therapeutic procedure, one (1) or more areas, each 15 minutes; aquatic therapy with therapeutic exercises
PT/OT/ Chiropractic (Physical Medicine)	97116	Therapeutic procedure, one (1) or more areas, each 15 minutes; gait training (includes stair climbing)
PT/OT/ Chiropractic (Physical Medicine)	97124	Therapeutic procedure, one (1) or more areas, each 15 minutes; massage including effleurage, petrissage, and/or tapotement (stroking, compression, percussion)
PT/OT/ Chiropractic (Physical Medicine)	97129	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes (replaces 97127; prior authorization required effective 2/1/2020)
PT/OT/ Chiropractic (Physical Medicine)	97130	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (list separately in addition to code for primary procedure) (replaces 97127; prior authorization required effective 2/1/2020)
PT/OT/ Chiropractic (Physical Medicine)	97139	Unlisted therapeutic procedure (specify) (prior authorization required effective 2/1/2020)
PT/OT/ Chiropractic (Physical Medicine)	97140	Manual therapy techniques, (e.g., mobilization/manipulation, manual lymphatic drainage, traction), one (1) or more regions, each 15 minutes
PT/OT/ Chiropractic (Physical Medicine)	97150	Therapeutic procedure(s), group (two [2] or more individuals)
PT/OT/ Chiropractic (Physical Medicine)	97164	Re-evaluation of physical therapy (prior authorization required effective 2/1/2020)
PT/OT/ Chiropractic (Physical Medicine)	97168	Re-evaluation of occupational therapy (prior authorization required effective 2/1/2020)
PT/OT/ Chiropractic (Physical Medicine)	97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
PT/OT/ Chiropractic (Physical Medicine)	97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by provider, each 15 minutes
PT/OT/ Chiropractic (Physical Medicine)	97535	Self-care/home management training (e.g., activities of daily living [ADL] and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology device/adaptive equipment), direct one-on-one contact by provider, each 15 minutes
PT/OT/ Chiropractic (Physical Medicine)	97537	Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact by provider, each 15 minutes
PT/OT/ Chiropractic (Physical Medicine)	97542	Wheelchair management (e.g., assessment, fitting, training), each 15 minutes
PT/OT/ Chiropractic (Physical Medicine)	97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes
PT/OT/ Chiropractic (Physical Medicine)	97755	Assistive technology assessment (e.g., to restore, augment, or compensate for existing function, optimize functional tasks, and/or maximize environmental accessibility), direct one-on-one contact by provider, with written report, each 15 minutes
PT/OT/ Chiropractic (Physical Medicine)	97799	Unlisted physical medicine/rehabilitation service or procedure (prior authorization required effective 2/1/2020)
PT/OT/ Chiropractic (Physical Medicine)	98925	Osteopathic manipulative treatment (OMT); one (1) to two (2) body regions involved
PT/OT/ Chiropractic (Physical Medicine)	98926	Osteopathic manipulative treatment (OMT); three (3) to four (4) body regions involved
PT/OT/ Chiropractic (Physical Medicine)	98927	Osteopathic manipulative treatment (OMT); five (5) to six (6) body regions involved
PT/OT/ Chiropractic (Physical Medicine)	98928	Osteopathic manipulative treatment (OMT); seven (7) to eight (8) body regions involved
PT/OT/ Chiropractic (Physical Medicine)	98929	Osteopathic manipulative treatment (OMT); nine (9) to ten (10) body regions involved
PT/OT/ Chiropractic (Physical Medicine)	98940	Chiropractic manipulative treatment (CMT); spinal, one (1) to two (2) regions
PT/OT/ Chiropractic (Physical Medicine)	98941	Chiropractic manipulative treatment (CMT); spinal, three (3) to four (4) regions
PT/OT/ Chiropractic (Physical Medicine)	98942	Chiropractic manipulative treatment (CMT); spinal, five (5) regions
PT/OT/ Chiropractic (Physical Medicine)	98943	Chiropractic manipulative treatment (CMT); extraspinal, one (1) or more regions
Radiation Therapy (Radiation Oncology)	0394T	HDR electronic brachytherapy, skin surface application, per fraction
Radiation Therapy (Radiation Oncology)	0395T	HDR electronic brachytherapy, interstitial or intracavitary treatment, per fraction
Radiation Therapy (Radiation Oncology)	77316	Brachytherapy isodose plan; simple (calculation[s] made from 1 to 4 sources, or remote afterloading brachytherapy, 1 channel), includes basic dosimetry calculation(s)
Radiation Therapy (Radiation Oncology)	77317	Brachytherapy isodose plan; intermediate (calculation[s] made from 5 to 10 sources, or remote afterloading brachytherapy, 2-12 channels), includes basic dosimetry calculation(s)
Radiation Therapy (Radiation Oncology)	77318	Brachytherapy isodose plan; complex (calculation[s] made from over 10 sources, or remote afterloading brachytherapy, over 12 channels), includes basic dosimetry calculation(s)
Radiation Therapy (Radiation Oncology)	77750	Infusion or instillation of radioelement solution (includes 3-month follow-up care)
Radiation Therapy (Radiation Oncology)	77761	Intracavitary radiation source application; simple
Radiation Therapy (Radiation Oncology)	77762	Intracavitary radiation source application; intermediate
Radiation Therapy (Radiation Oncology)	77763	Intracavitary radiation source application; complex
Radiation Therapy (Radiation Oncology)	77767	HDR radionuclide skin surface brachytherapy; lesion diameter up to 2.0 cm or 1 channel
Radiation Therapy (Radiation Oncology)	77768	HDR radionuclide skin surface brachytherapy; lesion diameter over 2.0 cm and 2 or more channels, or multiple lesions
Radiation Therapy (Radiation Oncology)	77770	HDR radionuclide interstitial or intracavitary brachytherapy; 1 channel
Radiation Therapy (Radiation Oncology)	77771	HDR radionuclide rate interstitial or intracavitary brachytherapy; 2 to 12 channels

Radiation Therapy (Radiation Oncology)	77772	HDR radionuclide interstitial or intracavitary brachytherapy; over 12 channels
Radiation Therapy (Radiation Oncology)	77778	Interstitial radiation source application, complex, includes supervision, handling, loading of radiation source when performed
Radiation Therapy (Radiation Oncology)	77789	Surface application of low dose rate radionuclide source
Radiation Therapy (Radiation Oncology)	77790	Supervision, handling, loading of radiation source
Radiation Therapy (Radiation Oncology)	77799	Unlisted procedure, clinical brachytherapy (this code to be used in place of 77776 and 77777)
Radiation Therapy (Radiation Oncology)	C2616	Brachytherapy source, nonstranded, yttrium-90, per source
Radiation Therapy (Radiation Oncology)	C9726	Placement and removal (if performed) of applicator into breast for radiation therapy
Radiation Therapy (Radiation Oncology)	G0458	Low dose rate (LDR) prostate brachytherapy services, composite rate
Radiation Therapy (Radiation Oncology)	S2095	Transcatheter occlusion or embolization for tumor destruction, percutaneous, any method, using yttrium-90 microspheres
Radiation Therapy (Radiation Oncology)	77371	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based
Radiation Therapy (Radiation Oncology)	77372	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based
Radiation Therapy (Radiation Oncology)	77373	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions
Radiation Therapy (Radiation Oncology)	77432	Stereotactic radiation treatment management of cranial lesion(s) (complete course of treatment consisting of 1 session)
Radiation Therapy (Radiation Oncology)	77435	Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions
Radiation Therapy (Radiation Oncology)	G0339	Image guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session or first session of fractionated treatment
Radiation Therapy (Radiation Oncology)	G0340	Image guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum 5 sessions per course of treatment
Radiation Therapy (Radiation Oncology)	77301	Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications
Radiation Therapy (Radiation Oncology)	77338	Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan
Radiation Therapy (Radiation Oncology)	77385	Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; simple
Radiation Therapy (Radiation Oncology)	77386	Intensity modulated radiation treatment delivery (IMRT), includes guidance and tracking, when performed; complex
Radiation Therapy (Radiation Oncology)	G6015	Intensity modulated treatment delivery, single or multiple fields/arcs,via narrow spatially and temporally modulated beams, binary, dynamic mlc, per treatment session
Radiation Therapy (Radiation Oncology)	G6016	Compensator-based beam modulation treatment delivery of inverse planned treatment using 3 or more high resolution (milled or cast) compensator, convergent beam modulated fields, per treatment session
Radiation Therapy (Radiation Oncology)	77423	High energy neutron radiation treatment delivery; 1 or more isocenter(s) with coplanar or non-coplanar geometry with blocking and/or wedge, and/or compensator(s)
Radiation Therapy (Radiation Oncology)	19294	Preparation of tumor cavity, with placement of radiation therapy applicator for intraoperative radiation therapy (IORT), concurrent with partial mastectomy
Radiation Therapy (Radiation Oncology)	77424	Intraoperative radiation treatment delivery, x-ray, single treatment session
Radiation Therapy (Radiation Oncology)	77425	Intraoperative radiation treatment delivery, electrons, single treatment session
Radiation Therapy (Radiation Oncology)	77469	Intraoperative radiation treatment management
Radiation Therapy (Radiation Oncology)	77520	Proton treatment delivery; simple, without compensation
Radiation Therapy (Radiation Oncology)	77522	Proton treatment delivery; simple, with compensation
Radiation Therapy (Radiation Oncology)	77523	Proton treatment delivery; intermediate
Radiation Therapy (Radiation Oncology)	77525	Proton treatment delivery; complex
Radiation Therapy (Radiation Oncology)	S8030	Scleral application of tantalum ring(s) for localization of lesions for proton beam therapy
Radiation Therapy (Radiation Oncology)	77600	Hyperthermia, externally generated; superficial (ie, heating to a depth of 4 cm or less)
Radiation Therapy (Radiation Oncology)	77605	Hyperthermia, externally generated; deep (ie, heating to depths greater than 4 cm)
Radiation Therapy (Radiation Oncology)	77610	Hyperthermia generated by interstitial probe(s); 5 or fewer interstitial applicators
Radiation Therapy (Radiation Oncology)	77615	Hyperthermia generated by interstitial probe(s); more than 5 interstitial applicators
Radiation Therapy (Radiation Oncology)	77620	Hyperthermia generated by intracavitary probe(s)
Radiation Therapy (Radiation Oncology)	77427	Radiation treatment management, 5 treatments
Radiation Therapy (Radiation Oncology)	77431	Radiation therapy management with complete course of therapy consisting of 1 or 2 fractions only
Radiation Therapy (Radiation Oncology)	77470	Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral or endocavitary irradiation)
Radiation Therapy (Radiation Oncology)	77499	Unlisted procedure, therapeutic radiology treatment management
Radiation Therapy (Radiation Oncology)	G6017	Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (eg, 3d positional tracking, gating, 3d surface tracking), each fraction of treatment
Radiation Therapy (Radiation Oncology)	77261	Therapeutic radiology treatment planning; simple
Radiation Therapy (Radiation Oncology)	77262	Therapeutic radiology treatment planning; intermediate
Radiation Therapy (Radiation Oncology)	77263	Therapeutic radiology treatment planning; complex
Radiation Therapy (Radiation Oncology)	77280	Therapeutic radiology simulation-aided field setting; simple
Radiation Therapy (Radiation Oncology)	77285	Therapeutic radiology simulation-aided field setting; intermediate
Radiation Therapy (Radiation Oncology)	77290	Therapeutic radiology simulation-aided field setting; complex
Radiation Therapy (Radiation Oncology)	77293	Respiratory motion management simulation (List separately in addition to code for primary procedure)
Radiation Therapy (Radiation Oncology)	77299	Unlisted procedure, therapeutic radiology clinical treatment planning
Radiation Therapy (Radiation Oncology)	77401	Radiation treatment delivery, superficial and/or ortho voltage, per day
Radiation Therapy (Radiation Oncology)	77402	Radiation treatment delivery, >1 MeV; simple
Radiation Therapy (Radiation Oncology)	77407	Radiation treatment delivery; two separate treatment areas; three or more ports on a single treatment area; or three or more simple blocks;>=1 MeV; intermediate
Radiation Therapy (Radiation Oncology)	77412	Radiation treatment delivery; three or more separate treatment areas; custom blocking; tangential ports; wedges; rotational beam; field-in-field or other tissue compensation that does not meet IMRT guidelines; or electron beam; >=1 MeV; complex
Radiation Therapy (Radiation Oncology)	77417	Therapeutic radiology port images(s)

Radiation Therapy (Radiation Oncology)	G6003	Radiation treatment delivery, single treatment area,single port or parallel opposed ports, simple blocks or no blocks: up to 5mev
Radiation Therapy (Radiation Oncology)	G6004	Radiation treatment delivery, single treatment area,single port or parallel opposed ports, simple blocks or no blocks: 6-10mev
Radiation Therapy (Radiation Oncology)	G6005	Radiation treatment delivery, single treatment area,single port or parallel opposed ports, simple blocks or no blocks: 11-19mev
Radiation Therapy (Radiation Oncology)	G6006	Radiation treatment delivery, single treatment area,single port or parallel opposed ports, simple blocks or no blocks: 20mev or greater
Radiation Therapy (Radiation Oncology)	G6007	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: up to 5mev
Radiation Therapy (Radiation Oncology)	G6008	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: 6-10mev
Radiation Therapy (Radiation Oncology)	G6009	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: 11-19mev
Radiation Therapy (Radiation Oncology)	G6010	Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks: 20 mev or greater
Radiation Therapy (Radiation Oncology)	G6011	Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; up to 5mev
Radiation Therapy (Radiation Oncology)	G6012	Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 6-10mev
Radiation Therapy (Radiation Oncology)	G6013	Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 11-19mev
Radiation Therapy (Radiation Oncology)	G6014	Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 20mev or greater
Radiation Therapy (Radiation Oncology)	77014	Computed tomography guidance for placement of radiation therapy fields
Radiation Therapy (Radiation Oncology)	77387	Guidance for localization of target volume for delivery of radiation treatment, includes intrafraction tracking, when performed
Radiation Therapy (Radiation Oncology)	G6001	Ultrasonic guidance for placement of radiation therapy fields
Radiation Therapy (Radiation Oncology)	G6002	Stereoscopic x-ray guidance for localization of target volume for the delivery of radiation therapy
Radiation Therapy (Radiation Oncology)	77295	3-dimensional radiotherapy plan, including dose-volume histograms
Radiation Therapy (Radiation Oncology)	77300	Basic radiation dosimetry calculation, central axis depth dose calculation, TDF, NSD, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, onl
Radiation Therapy (Radiation Oncology)	77306	Teletherapy isodose plan; simple (1 or 2 unmodified ports directed to a single area of interest), includes basic dosimetry calculation(s)
Radiation Therapy (Radiation Oncology)	77307	Teletherapy isodose plan; complex (multiple treatment areas, tangential ports, the use of wedges, blocking, rotational beam, or special beam considerations), includes basic dosimetry calculation(s)
Radiation Therapy (Radiation Oncology)	77321	Special teletherapy port plan, particles, hemibody, total body
Radiation Therapy (Radiation Oncology)	77331	Special dosimetry (eg, TLD, microdosimetry) (specify), only when prescribed by the treating physician
Radiation Therapy (Radiation Oncology)	77332	Treatment devices, design and construction; simple (simple block, simple bolus)
Radiation Therapy (Radiation Oncology)	77333	Treatment devices, design and construction; intermediate (multiple blocks, stents, bite blocks, special bolus)
Radiation Therapy (Radiation Oncology)	77334	Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)
Radiation Therapy (Radiation Oncology)	77336	Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy
Radiation Therapy (Radiation Oncology)	77370	Special medical radiation physics consultation
Radiation Therapy (Radiation Oncology)	77399	Unlisted procedure, medical radiation physics, dosimetry and treatment devices, and special services
Radiation Therapy (Radiation Oncology)	79005	Radiopharmaceutical therapy, by oral administration; used for I-131 treatment
Radiation Therapy (Radiation Oncology)	79101	Radiopharmaceutical, therapy, by intravenous administration
Radiation Therapy (Radiation Oncology)	79403	Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion
Radiation Therapy (Radiation Oncology)	A9513	Lutetium Lu 177, dotatate, therapeutic, 1 mCi
Radiation Therapy (Radiation Oncology)	A9543	Yttrium 90 Ibritumomab Tiuxetan (Zevalin)
Radiation Therapy (Radiation Oncology)	A9606	Radium RA-223 dichloride, therapeutic, per microcurie (Xofigo)
Radiation Therapy (Radiation Oncology)	A9590	Iodine i-131, iobenguane, 1 millicurie
Radiation Therapy (Radiation Oncology)	A9699	Radiopharmaceutical, therapeutic, not otherwise classified
Radiation Therapy (Radiation Oncology)	19296	Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy
Radiation Therapy (Radiation Oncology)	19297	Placement of radiotherapy afterloading expandable catheter (single or multichannel) into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; concurrent with partial mastectomy (List separately in addition to code for primary procedure)
Radiation Therapy (Radiation Oncology)	19298	Placement of radiotherapy after loading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance
Radiation Therapy (Radiation Oncology)	31643	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of catheter(s) for intracavitary radioelement application
Radiation Therapy (Radiation Oncology)	32553	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple
Radiation Therapy (Radiation Oncology)	41019	Placement of needles, catheters, or other device(s) into the head and/or neck region (percutaneous, transoral, or transnasal) for subsequent interstitial radioelement application
Radiation Therapy (Radiation Oncology)	49411	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum, single or multiple
Radiation Therapy (Radiation Oncology)	49412	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), open, intra-abdominal, intrapelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple (List separately in addition to code for primary procedure)
Radiation Therapy (Radiation Oncology)	55875	Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy

Radiation Therapy (Radiation Oncology)	55876	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple
Radiation Therapy (Radiation Oncology)	55920	Placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for subsequent interstitial radioelement application
Radiation Therapy (Radiation Oncology)	57155	Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy
Radiation Therapy (Radiation Oncology)	57156	Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy
Radiation Therapy (Radiation Oncology)	58346	Insertion of Heyman capsules for clinical brachytherapy
Radiation Therapy (Radiation Oncology)	76873	Ultrasound, transrectal; prostate volume study for brachytherapy treatment planning (separate procedure)
Radiation Therapy (Radiation Oncology)	76965	Ultrasonic guidance for interstitial radioelement application
Radiation Therapy (Radiation Oncology)	61796	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 simple cranial lesion
Radiation Therapy (Radiation Oncology)	61797	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, simple (List separately in addition to code for primary procedure)
Radiation Therapy (Radiation Oncology)	61798	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 complex cranial lesion
Radiation Therapy (Radiation Oncology)	61799	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, complex (List separately in addition to code for primary procedure)
Radiation Therapy (Radiation Oncology)	61800	Application of stereotactic headframe for stereotactic radiosurgery (List separately in addition to code for primary procedure)
Reconstructive /Possibly Cosmetic	11960	INSERTION OF TISSUE EXPANDER(S) FOR OTHER THAN BREAST, INCLUDING SUBSEQUENT EXPANSION
Reconstructive /Possibly Cosmetic	15775	PUNCH GRAFT FOR HAIR TRANSPLANT; 1 TO 15 PUNCH GRAFTS
Reconstructive /Possibly Cosmetic	15776	PUNCH GRAFT FOR HAIR TRANSPLANT; MORE THAN 15 PUNCH GRAFTS
Reconstructive /Possibly Cosmetic	15780	DERMABRASION; TOTAL FACE (EG, FOR ACNE SCARRING, FINE WRINKLING, RHYTIDS, GENERAL KERATOSIS)
Reconstructive /Possibly Cosmetic	15781	DERMABRASION; SEGMENTAL, FACE
Reconstructive /Possibly Cosmetic	15782	DERMABRASION REGIONAL, OTHER THAN FACE
Reconstructive /Possibly Cosmetic	15783	DERMABRASION; SUPERFICIAL, ANY SITE (EG, TATTOO REMOVAL)
Reconstructive /Possibly Cosmetic	15786	ABRASION; SINGLE LESION (EG, KERATOSIS, SCAR)
Reconstructive /Possibly Cosmetic	15787	ABRASION; EACH ADDITIONAL 4 LESIONS OR LESS (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
Reconstructive /Possibly Cosmetic	15788	CHEMICAL PEEL, FACIAL; EPIDERMAL
Reconstructive /Possibly Cosmetic	15789	CHEMICAL PEEL, FACIAL; DERMAL
Reconstructive /Possibly Cosmetic	15792	CHEMICAL PEEL, NONFACIAL; EPIDERMAL
Reconstructive /Possibly Cosmetic	15793	CHEMICAL PEEL, NONFACIAL; DERMAL
Reconstructive /Possibly Cosmetic	15819	CERVICOPLASTY
Reconstructive /Possibly Cosmetic	15820	BLEPHAROPLASTY, LOWER EYELID;
Reconstructive /Possibly Cosmetic	15821	BLEPHAROPLASTY, LOWER EYELID; WITH EXTENSIVE HERNIATED FAT PAD
Reconstructive /Possibly Cosmetic	15822	BLEPHAROPLASTY, UPPER EYELID;
Reconstructive /Possibly Cosmetic	15823	BLEPHAROPLASTY, UPPER EYELID; WITH EXTENSIVE SKIN WEIGHTING DOWN LID
Reconstructive /Possibly Cosmetic	15824	RHYTIDECTOMY; FOREHEAD
Reconstructive /Possibly Cosmetic	15825	RHYTIDECTOMY; NECK WITH PLATYSMAL TIGHTENING (PLATYSMAL FLAP, P-FLAP)
Reconstructive /Possibly Cosmetic	15826	RHYTIDECTOMY; GLABELLAR FROWN LINES
Reconstructive /Possibly Cosmetic	15828	RHYTIDECTOMY; CHEEK, CHIN, AND NECK
Reconstructive /Possibly Cosmetic	15829	RHYTIDECTOMY; SUPERFICIAL MUSCULOAPONEUROTIC SYSTEM (SMAS) FLAP
Reconstructive /Possibly Cosmetic	15830	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY); ABDOMEN, INFRAUMBILICAL PANNICULECTOMY
Reconstructive /Possibly Cosmetic	15832	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY; THIGH
Reconstructive /Possibly Cosmetic	15833	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY; LEG
Reconstructive /Possibly Cosmetic	15834	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY; HIPS
Reconstructive /Possibly Cosmetic	15835	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY; BUTTOCK
Reconstructive /Possibly Cosmetic	15836	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY; ARM
Reconstructive /Possibly Cosmetic	15837	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY; FOREARM OR HAND
Reconstructive /Possibly Cosmetic	15838	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); SUBMENTAL FAT PAD
Reconstructive /Possibly Cosmetic	15839	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDING LIPECTOMY); OTHER AREAS
Reconstructive /Possibly Cosmetic	15847	EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE (INCLUDES LIPECTOMY), ABDOMEN (EG, ABDOMINOPLASTY) (INCLUDES UMBILICAL TRANSPOSITION AND FASCIAL PLICATION) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
Reconstructive /Possibly Cosmetic	15876	SUCTION ASSISTED LIPECTOMY; HEAD AND NECK
Reconstructive /Possibly Cosmetic	15877	SUCTION ASSISTED LIPECTOMY; TRUNK
Reconstructive /Possibly Cosmetic	15878	SUCTION ASSISTED LIPECTOMY; UPPER EXTREMITY
Reconstructive /Possibly Cosmetic	15879	SUCTION ASSISTED LIPECTOMY; LOWER EXTREMITY
Reconstructive /Possibly Cosmetic	17106	DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS (EG, LASER TECHNIQUE); LESS THAN 10 SQ CM
Reconstructive /Possibly Cosmetic	17107	DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS (EG, LASER TECHNIQUE); 10.0 - 50 SQ CM
Reconstructive /Possibly Cosmetic	17108	DESTRUCTION OF CUTANEOUS VASCULAR PROLIFERATIVE LESIONS (EG, LASER TECHNIQUE); OVER 50 SQ CM
Reconstructive /Possibly Cosmetic	17999	UNLISTED PROCEDURE, SKIN, MUCOUS MEMBRANE AND SUBCUTANEOUS TISSUE
Reconstructive /Possibly Cosmetic	19318	REDUCTION MAMMOPLASTY
Reconstructive /Possibly Cosmetic	19324	MAMMOPLASTY, AUGMENTATION; WITHOUT PROSTHETIC IMPLANT
Reconstructive /Possibly Cosmetic	19325	MAMMOPLASTY, AUGMENTATION; WITH PROSTHETIC IMPLANT
Reconstructive /Possibly Cosmetic	19355	CORRECTION OF INVERTED NIPPLES
Reconstructive /Possibly Cosmetic	19396	PREPARATION OF MOULAGE FOR CUSTOM BREAST IMPLANT
NOC Other	NOC**	OLIPUDASE ALFA (XENPOZYME)
Site of Care	J0129	INJECTION, ABATACEPT, 10 MG (ORENCIA)
Site of Care	J0180	INJECTION, AGALSIDASE BETA, 1 MG (FABRAZYME)
Site of Care	J0219	INJECTION, AVALGLUCOSIDASE ALFA-NGPT, 4 MG (NEXVIAZYME)

**Select new-to-market drugs with not otherwise classified (NOC) HCPCS codes (e.g. J3490, J3590, J9999, C9399) will require prior authorization, pending unique HCPCS assignment by CMS

Site of Care	J0221	INJECTION ALGLUCOSIDASE ALFA, (LUMIZYME), 10 MG
Site of Care	J0222	INJECTION, PATISIRAN, 0.1 MG (ONPATTRO)
NOC Other	NOC**	PEGFILGRASTIM-FPGK (STIMUFEND)
NOC Other	NOC**	SPESOLIMAB-SBZO (SPEVIGO)
NOC Other	NOC**	VUTRISIRAN (AMVUTTRA)
Site of Care	J0257	INJECTION, ALPHA 1 PROTEINASE INHIBITOR (HUMAN) 10 MG (GLASSIA)
Site of Care	J0490	INJECTION, BELIMUMAB, 10 MG (BENLYSTA)
Site of Care	J0491	INJECTION, ANIFROLUMAB-FNIA, 1 MG (SAPHNELO)
Site of Care	J0596	INJECTION, C1 ESTERASE INHIBITOR (RECOMBINANT), RUCONEST, 10 UNITS
Site of Care	J0597	INJECTION, C1 ESTERASE INHIBITOR (HUMAN), BERINERT, 10 UNITS
Site of Care	J0598	INJECTION, C-1 ESTERASE INHIBITOR (HUMAN), CINRYZE, 10 UNITS
Site of Care	J0791	INJECTION, CRIZANLIZUMAB-TMCA, 5 MG (ADAKVEO)
Site of Care	J1300	INJECTION, ECULIZUMAB, 10 MG (SOLIRIS)
Site of Care	J1301	INJECTION, EDARAVONE, 1 MG (RADICAVA)
Site of Care	J1303	INJECTION, RAVULIZUMAB-CWVZ, 10 MG (ULTOMIRIS)
Site of Care	J1305	INJECTION, EVINACUMAB-DGNB, 5 MG (EVKEEZA)
Site of Care	J1322	INJECTION, ELOSULFASE ALFA, 1 MG (VIMIZIM)
Site of Care	J1458	INJECTION, GALSULFASE, 1 MG (NAGLAZYME)
Site of Care	J1459	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, NON-LYOPHILIZED (E.G.LIQUID), 500 MG (PRIVIGEN)
Site of Care	J1554	INJECTION, IMMUNE GLOBULIN (ASCENIV), 500 MG
Site of Care	J1556	INJECTION, IMMUNE GLOBULIN (BIVIGAM), 500 MG
Site of Care	J1557	INJECTION, IMMUNE GLOBULIN, (GAMMAPLEX), INTRAVENOUS, NON-LYOPHILIZED (E.G.LIQUID), 500 MG
Site of Care	J1561	INJECTION, IMMUNE GLOBULIN, (GAMUNEX-C/GAMMAKED), NON-LYOPHILIZED (E.G. LIQUID), 500 MG
NOC Other	NOC**	SUTIMLIMAB-JOME (ENJAYMO)
NOC Other	NOC**	BETIBEGLOGENE AUTOTEMCEL (ZYNTEGLO)
Site of Care	J1568	INJECTION, IMMUNE GLOBULIN, (OCTAGAM), INTRAVENOUS, NON-LYOPHILIZED (E.G., LIQUID), 500 MG
Site of Care	J1569	INJECTION, IMMUNE GLOBULIN, (GAMMAGARD LIQUID), NON-LYOPHILIZED, (E.G. LIQUID), 500MG
Site of Care	J1572	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, (FLEBOGAMMA/FLEBOGAMMA DIF), INTRAVENOUS, NON- LYOPHILIZED (E.G. LIQUID), 500 MG
Site of Care	J1599	INJECTION, IMMUNE GLOBULIN, INTRAVENOUS, NON-LYOPHILIZED (E.G. LIQUID), NOT OTHERWISE SPECIFIED, 500 MG
Site of Care	J1602	INJECTION, GOLIMUMAB, 1 MG, FOR INTRAVENOUS USE (SIMPONI ARIA)
Site of Care	J1743	INJECTION, IDURSULFASE, 1 MG (ELAPRASE)
Site of Care	J1745	INJECTION INFLIXIMAB, 10 MG (REMICADE)
Site of Care	J1786	INJECTION, IMIGLUCERASE, 10 UNITS (CEREZYME)
Site of Care	J1823	INJECTION, INEBILIZUMAB-CDON, 1MG (UPLIZNA)
Site of Care	J1931	INJECTION, LARONIDASE, 0.1 MG (ALDURAZYME)
Site of Care	J2350	INJECTION, OCRELIZUMAB, 1 MG (OCREVUS)
Site of Care	J2840	INJECTION, SEBELIPASE ALFA, 1 MG (KANUMA)
Site of Care	J3032	INJECTION, EPTINEZUMAB-JJMR, 1MG (VYEPTI)
Site of Care	J3060	INJECTION, TALIGLUCERACE ALFA, 10 UNITS (ELELYSO)
Site of Care	J3241	INJECTION, TEPROTUMUMAB-TRBW, 10 MG (TEPEZZA)
Site of Care	J3262	INJECTION, TOCILIZUMAB, 1 MG (ACTEMRA)
Site of Care	J3380	INJECTION, VEDOLIZUMAB, 1 MG (ENTYVIO)
Site of Care	J3385	INJECTION, VELAGLUCERASE ALFA, 100 UNITS (VPRIV)
Site of Care	J3397	INJECTION, VESTRONIDASE ALFA-VJBK, 1 MG (MEPSEVII)
Site of Care	J9332	INJECTION, EFGARTIGIMOD ALFA-FCAB, 2MG (VYVGART)
Site of Care	Q5103	INJECTION, INFLIXIMAB-DYYB, BIOSIMILAR, (INFLECTRA), 10 MG
Site of Care	Q5104	INJECTION, INFLIXIMAB-ABDA, BIOSIMILAR, (RENFLEXIS), 10 MG
Site of Care	Q5121	INJECTION, INFLIXIMAB-AXXQ, BIOSIMILAR, (AVSOLA), 10 MG
Specialty Surgeries	43644	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; WITH GASTRIC BYPASS AND ROUX-EN-Y GASTROENTEROSTOMY (ROUX LIMB 150 CM OR LESS)
Specialty Surgeries	43645	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; WITH GASTRIC BYPASS AND SMALL INTESTINE RECONSTRUCTION TO LIMIT ABSORPTION
Specialty Surgeries	43647	LAPAROSCOPY, SURGICAL; IMPLANTATION OR REPLACEMENT OF GASTRIC NEUROSTIMULATOR ELECTRODES, ANTRUM
Specialty Surgeries	43659	UNLISTED LAPAROSCOPY PROCEDURE, STOMACH
Specialty Surgeries	43770	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; PLACEMENT OF ADJUSTABLE GASTRIC RESTRICTIVE DEVICE (E.G., GASTRIC BAND AND SUBCUTANEOUS PORT COMPONENTS)
Specialty Surgeries	43771	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; REVISION OF ADJUSTABLE GASTRIC RESTRICTIVE DEVICE COMPONENT ONLY
Specialty Surgeries	43772	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; REMOVAL OF ADJUSTABLE GASTRIC RESTRICTIVE DEVICE COMPONENT ONLY
Specialty Surgeries	43773	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; REMOVAL AND REPLACEMENT OF ADJUSTABLE GASTRIC RESTRICTIVE DEVICE COMPONENT ONLY
Specialty Surgeries	43774	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; REMOVAL OF ADJUSTABLE GASTRIC RESTRICTIVE DEVICE AND SUBCUTANEOUS PORT COMPONENTS
Specialty Surgeries	43775	LAPAROSCOPY, SURGICAL, GASTRIC RESTRICTIVE PROCEDURE; LONGITUDINAL GASTRECTOMY (IE, SLEEVE GASTRECTOMY)
Specialty Surgeries	43842	GASTRIC RESTRICTIVE PROCEDURE, WITHOUT GASTRIC BYPASS, FOR MORBID OBESITY; VERTICAL-BANDED GASTROPLASTY
Specialty Surgeries	43843	GASTRIC RESTRICTIVE PROCEDURE, WITHOUT GASTRIC BYPASS, FOR MORBID OBESITY; OTHER THAN VERTICAL-BANDED GASTROPLASTY

Specialty Surgeries	43845	GASTRIC RESTRICTIVE PROCEDURE WITH PARTIAL GASTRECTOMY, PYLORUS-PRESERVING DUODENOILEOSTOMY AND ILEOILEOSTOMY (50 TO 100 CM COMMON CHANNEL) TO LIMIT ABSORPTION (BILIOPANCREATIC DIVERSION WITH DUODENAL SWITCH)
Specialty Surgeries	43846	GASTRIC RESTRICTIVE PROCEDURE, WITH GASTRIC BYPASS FOR MORBID OBESITY; WITH SHORT LIMB (150 CM OR LESS) ROUX-EN-Y GASTROENTEROSTOMY
Specialty Surgeries	43847	GASTRIC RESTRICTIVE PROCEDURE, WITH GASTRIC BYPASS FOR MORBID OBESITY; WITH SMALL INTESTINE RECONSTRUCTION TO LIMIT ABSORPTION
Specialty Surgeries	43848	REVISION, OPEN, OF GASTRIC RESTRICTIVE PROCEDURE FOR MORBID OBESITY, OTHER THAN ADJUSTABLE GASTRIC RESTRICTIVE DEVICE (SEPARATE PROCEDURE)
Specialty Surgeries	43881	IMPLANTATION OR REPLACEMENT OF GASTRIC NEUROSTIMULATOR ELECTRODES, ANTRUM, OPEN
Specialty Surgeries	43886	GASTRIC RESTRICTIVE PROCEDURE, OPEN; REVISION OF SUBCUTANEOUS PORT COMPONENT ONLY
Specialty Surgeries	43887	GASTRIC RESTRICTIVE PROCEDURE, OPEN; REMOVAL OF SUBCUTANEOUS PORT COMPONENT ONLY
Specialty Surgeries	43888	GASTRIC RESTRICTIVE PROCEDURE, OPEN; REMOVAL AND REPLACEMENT OF SUBCUTANEOUS PORT COMPONENT ONLY
Specialty Surgeries	43999	UNLISTED PROCEDURE, STOMACH
NOC Other	NOC**	PARATHYROID HORMONE (NATPARA)
Surgery (Musculoskeletal)	20930	Allograft, morselized, or placement of osteopromotive material, for spine surgery only (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	20931	Allograft, structural, for spine surgery only (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	20936	Autograft for spine surgery only (includes harvesting the graft); local (e.g., ribs, spinous process, or laminar fragments) obtained from same incision (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	20937	Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision) (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	20938	Autograft for spine surgery only (includes harvesting the graft); structural, bicortical or tricortical (through separate skin or fascial incision) (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	20974	Electrical stimulation to aid bone healing; noninvasive (nonoperative)
Surgery (Musculoskeletal)	20975	Electrical stimulation to aid bone healing; invasive (operative)
Surgery (Musculoskeletal)	22214	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar
Surgery (Musculoskeletal)	22510	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic
Surgery (Musculoskeletal)	22511	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral
Surgery (Musculoskeletal)	22512	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	22513	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic
Surgery (Musculoskeletal)	22514	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar
Surgery (Musculoskeletal)	22515	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed)
Surgery (Musculoskeletal)	22532	Lateral Extracavitary Approach Technique ArthrodesisProcedures on the Spine (Vertebral Column).
Surgery (Musculoskeletal)	22533	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar
Surgery (Musculoskeletal)	22534	Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); thoracic or lumbar, each additional vertebral segment (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2
Surgery (Musculoskeletal)	22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace (List separately in addition to code for separate procedure)
Surgery (Musculoskeletal)	22554	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2
Surgery (Musculoskeletal)	22558	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar
Surgery (Musculoskeletal)	22585	Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	22600	Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment
Surgery (Musculoskeletal)	22612	Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)
Surgery (Musculoskeletal)	22614	Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar
Surgery (Musculoskeletal)	22632	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar

Surgery (Musculoskeletal)	22634	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; each additional interspace and segment (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	22830	Exploration of spinal fusion
Surgery (Musculoskeletal)	22840	Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	22841	Internal spinal fixation by wiring of spinous processes (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	22842	Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	22843	Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	22844	Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 13 or more vertebral segments (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	22845	Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	22846	Anterior instrumentation; 4 to 7 vertebral segments (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	22847	Anterior instrumentation; 8 or more vertebral segments (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	22848	Pelvic fixation (attachment of caudal end of instrumentation to pelvic bony structures) other than sacrum (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	22852	Removal of posterior segmental instrumentation
Surgery (Musculoskeletal)	22853	Insertion of interbody biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (List separately in addition to code for primary procedure
Surgery (Musculoskeletal)	22854	Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh) with integral anterior instrumentation for device anchoring (e.g., screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	22855	Removal of anterior instrumentation
Surgery (Musculoskeletal)	22856	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical
Surgery (Musculoskeletal)	22857	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar
Surgery (Musculoskeletal)	22858	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	22859	Insertion of intervertebral biomechanical device(s) (e.g., synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	22861	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical
Surgery (Musculoskeletal)	22862	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar
Surgery (Musculoskeletal)	22867	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level
Surgery (Musculoskeletal)	22868	Insertion Of Interlaminar/Interspinous Process Stabilization/Distraction Device, Without Fusion, Including Image Guidance When Performed, With Open Decompression, Lumbar; Second Level (List Separately In Addition To Code For Primary Procedure)
Surgery (Musculoskeletal)	22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level
Surgery (Musculoskeletal)	22870	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure)
NOC Other	NOC**	PEGCETACOPLAN (EMPAVELI)
Surgery (Musculoskeletal)	62380	Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar
Surgery (Musculoskeletal)	63001	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), 1 or 2 vertebral segments; cervical
Surgery (Musculoskeletal)	63005	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy
Surgery (Musculoskeletal)	63012	Laminectomy with removal of abnormal facets and/or pars inter- articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure)
Surgery (Musculoskeletal)	63015	Laminectomy with exploration and/or decompression of spinal
Surgery (Musculoskeletal)	63017	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), more than 2 vertebral segments; lumbar
Surgery (Musculoskeletal)	63020	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical
Surgery (Musculoskeletal)	63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar

Surgery (Musculoskeletal)	63035	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	63040	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical
Surgery (Musculoskeletal)	63042	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar
Surgery (Musculoskeletal)	63043	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional cervical interspace (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	63044	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional lumbar interspace (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	63045	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; cervical
Surgery (Musculoskeletal)	63047	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; lumbar
Surgery (Musculoskeletal)	63048	Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [e.g., spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	63050	Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments;
Surgery (Musculoskeletal)	63051	Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments; with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices [e.g., wire, suture, mini- plates], when performed)
Surgery (Musculoskeletal)	63056	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (e.g., herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (e.g., far lateral herniated intervertebral disc)
Surgery (Musculoskeletal)	63057	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (e.g., herniated intervertebral disc), single segment; each additional segment, thoracic or lumbar (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	63075	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace
Surgery (Musculoskeletal)	63076	Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	63081	Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment
Surgery (Musculoskeletal)	63082	Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, each additional segment (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	0095T	Removal of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	0098T	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	0163T	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), each additional interspace, lumbar (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	0164T	Removal of total disc arthroplasty, (artificial disc), anterior approach, each additional interspace, lumbar (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	0165T	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, lumbar (List separately in addition to code for primary procedure)
Surgery (Musculoskeletal)	0274T	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (e.g., fluoroscopic, CT), single or multiple levels, unilateral or bilateral; cervical or thoracic
Surgery (Musculoskeletal)	0275T	Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (e.g., fluoroscopic, CT), single or multiple levels, unilateral or bilateral; lumbar
Surgery (Musculoskeletal)	C9757	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and excision of herniated intervertebral disc, and repair of annular defect with implantation of bone anchored annular closure device, including annular defect measurement, alignment and sizing assessment, and image guidance; 1 interspace, lumbar
Surgery (Musculoskeletal)	E0748	Osteogenesis stimulator, electrical, noninvasive, spinal applications
Surgery (Musculoskeletal)	E0749	Osteogenesis stimulator, electrical, surgically implanted
Transplant	32851	LUNG TRANSPLANT, SINGLE; WITHOUT CARDIOPULMONARY BYPASS
Transplant	32852	LUNG TRANSPLANT, SINGLE; WITH CARDIOPULMONARY BYPASS
Transplant	32853	LUNG TRANSPLANT, DOUBLE (BILATERAL DEQUENTIAL OR EN BLOC); WITHOUT CARDIOPULMONARY BYPASS
Transplant	32854	LUNG TRANSPLANT, DOUBLE (BILATERAL DEQUENTIAL OR EN BLOC); WITH CARDIOPULMONARY BYPASS
NOC Other	NOC**	CASIMERSEN (AMONDYS 45)
Transplant	38243	HEMATOPOIETIC PROGENITOR CELL (HPC); HPC BOOST
Transplant	33935	HEART-LUNG TRANSPLANT WITH RECIPIENT CARDIECTOMY-PNEUMONECTOMY
Transplant	33945	HEART TRANSPLANT, WITH OR WITHOUT RECIPIENT CARDIECTOMY
Transplant	38240	HEMATOPOIETIC PROGENITOR CELL (HPC); ALLOGENEIC TRANSPLANTATION PER DONOR
Transplant	38241	HEMATOPOIETIC PROGENITOR CELL (HPC); AUTOLOGOUS TRANSPLANTATION

NOC Other	NOC**	PEGINTERFERON BETA-1A (PLEGRIDY)
Transplant	44135	INTESTINAL ALLOTRANSPLANTATION; FROM CADAVER DONOR
Transplant	44136	INTESTINAL ALLOTRANSPLANTATION; FROM LIVING DONOR
Transplant	47135	LIVER ALLOTRANSPLANTATION; ORTHOTOPIC, PARTIAL OR WHOLE, FROM CADAVER OR LIVING DONOR, ANY AGE
Transplant	48554	TRANSPLANTATION OF PANCREATIC ALLOGRAFT
Transplant	50360	RENAL ALLOTRANSPLANTATION, IMPLANTATION OF GRAFT; WITHOUT RECIPIENT NEPHRECTOMY
Transplant	50365	RENAL ALLOTRANSPLANTATION, IMPLANTATION OF GRAFT; WITH RECIPIENT NEPHRECTOMY
Transplant	S2053	TRANSPLANTATION OF SMALL INTESTINE AND LIVER ALLOGRAFTS
Transplant	S2054	TRANSPLANTATION OF MULTIVISCERAL ORGANS
Transplant	S2060	LOBAR LUNG TRANSPLANTATION
Transplant	S2065	SIMULTANEOUS PANCREAS KIDNEY TRANSPLANTATION

Exhibit 3
Highmark Prior Authorization List
Part B Drugs at Point of Sale (Pharmacy)
(Effective 10/1/22)

Label Name	Drug Category
CYRAMZA 100 MG/10 ML VIAL	Infusion Pump
CYRAMZA 500 MG/50 ML VIAL	Infusion Pump
PORTRAZZA 800 MG/50 ML VIAL	Infusion Pump
NULOJIX 250 MG VIAL	Immunosuppressant
EMPLICITI 300 MG VIAL	Infusion Pump
EMPLICITI 400 MG VIAL	Infusion Pump
CELLCEPT 250 MG CAPSULE	Immunosuppressant
CELLCEPT 500 MG TABLET	Immunosuppressant
CELLCEPT 200 MG/ML ORAL SUSP	Immunosuppressant
CELLCEPT 500 MG VIAL	Immunosuppressant
CYTOVENE 500 MG VIAL	Infusion Pump
EMEND 80 MG CAPSULE	Antiemetic for CINV
EMEND 125 MG CAPSULE	Antiemetic for CINV
EMEND 40 MG CAPSULE	Antiemetic for CINV
EMEND 125 MG POWDER PACKET	Antiemetic for CINV
EMEND TRIPACK	Antiemetic for CINV
RECOMBIVAX HB 5 MCG/0.5 ML SYR	Hepatitis B vaccine
RECOMBIVAX HB 10 MCG/ML SYR	Hepatitis B vaccine
RECOMBIVAX HB 5 MCG/0.5 ML VL	Hepatitis B vaccine
RECOMBIVAX HB 40 MCG/ML VIAL	Hepatitis B vaccine
RECOMBIVAX HB 10 MCG/ML VIAL	Hepatitis B vaccine
RAPAMUNE 1 MG/ML ORAL SOLN	Immunosuppressant
RAPAMUNE 0.5 MG TABLET	Immunosuppressant
RAPAMUNE 1 MG TABLET	Immunosuppressant
RAPAMUNE 2 MG TABLET	Immunosuppressant
MEDROL 2 MG TABLET	Immunosuppressant
MEDROL 8 MG TABLET	Immunosuppressant
MEDROL 4 MG TABLET	Immunosuppressant
MEDROL 16 MG TABLET	Immunosuppressant
MEDROL 32 MG TABLET	Immunosuppressant
ATGAM 50 MG/ML AMPUL	Immunosuppressant
CESAMET 1 MG CAPSULE	Antiemetic for CINV
MARINOL 2.5 MG CAPSULE	Antiemetic for CINV
MARINOL 5 MG CAPSULE	Antiemetic for CINV
MARINOL 10 MG CAPSULE	Antiemetic for CINV
ONDANSETRON 4 MG/5 ML SOLUTION	Antiemetic for CINV
GRANISETRON HCL 1 MG TABLET	Antiemetic for CINV
MYCOPHENOLATE 250 MG CAPSULE	Immunosuppressant
MYCOPHENOLATE 500 MG TABLET	Immunosuppressant
CYCLOPHOSPHAMIDE 25 MG CAPSUL	Oral Chemo
CYCLOPHOSPHAMIDE 50 MG CAPSUL	Oral Chemo

EVEROLIMUS 0.25 MG TABLET	Immunosuppressant
EVEROLIMUS 0.5 MG TABLET	Immunosuppressant
EVEROLIMUS 0.75 MG TABLET	Immunosuppressant
EVEROLIMUS 1 MG TABLET	Immunosuppressant
METHOTREXATE 2.5 MG TABLET	Oral Chemo
DUOPA 4.63 MG-20 MG/ML SUSPENS	Infusion Pump
GENGRAF 25 MG CAPSULE	Immunosuppressant
GENGRAF 100 MG CAPSULE	Immunosuppressant
GENGRAF 100 MG/ML SOLUTION	Immunosuppressant
SANDIMMUNE 50 MG/ML AMPUL	Immunosuppressant
SANDIMMUNE 100 MG/ML SOLN	Immunosuppressant
SANDIMMUNE 25 MG CAPSULE	Immunosuppressant
SANDIMMUNE 100 MG CAPSULE	Immunosuppressant
NEORAL 25 MG GELATIN CAPSULE	Immunosuppressant
NEORAL 100 MG GELATIN CAPSULE	Immunosuppressant
NEORAL 100 MG/ML SOLUTION	Immunosuppressant
SIMULECT 20 MG VIAL	Immunosuppressant
MYFORTIC 180 MG TABLET	Immunosuppressant
MYFORTIC 360 MG TABLET	Immunosuppressant
SIMULECT 10 MG VIAL	Immunosuppressant
ZORTRESS 0.5 MG TABLET	Immunosuppressant
ZORTRESS 0.75 MG TABLET	Immunosuppressant
ZORTRESS 0.25 MG TABLET	Immunosuppressant
ZORTRESS 1 MG TABLET	Immunosuppressant
TOBI 300 MG/5 ML SOLUTION	Nebulizer
ARZERRA 100 MG/5 ML VIAL	Infusion Pump
ZOFRAN 4 MG TABLET	Antiemetic for CINV
ZOFRAN 8 MG TABLET	Antiemetic for CINV
ARZERRA 1,000 MG/50 ML VIAL	Infusion Pump
TOBRAMYCIN 300 MG/4 ML AMPULE	Nebulizer
FORMOTEROL 20 MCG/2 ML NEB VL	Nebulizer
TOBRAMYCIN 300 MG/5 ML AMPULE	Nebulizer
LEVALBUTEROL 0.31 MG/3 ML SOL	Nebulizer
LEVALBUTEROL 0.63 MG/3 ML SOL	Nebulizer
LEVALBUTEROL CONC 1.25 MG/0.5	Nebulizer
LEVALBUTEROL 1.25 MG/3 ML SOL	Nebulizer
CYCLOSPORINE MODIFIED 25 MG	Immunosuppressant
CYCLOSPORINE MODIFIED 50 MG	Immunosuppressant
CYCLOSPORINE MODIFIED 100 MG	Immunosuppressant
ARFORMOTEROL 15 MCG/2 ML SOLN	Nebulizer
BUDESONIDE 0.25 MG/2 ML SUSP	Nebulizer
BUDESONIDE 0.5 MG/2 ML SUSP	Nebulizer
BUDESONIDE 1 MG/2 ML INH SUSP	Nebulizer
MYCOPHENOLIC ACID DR 180 MG TB	Immunosuppressant
MYCOPHENOLIC ACID DR 360 MG TB	Immunosuppressant
BLEOMYCIN SULFATE 15 UNIT VIAL	Infusion Pump
BLEOMYCIN SULFATE 30 UNIT VIAL	Infusion Pump
DOPAMINE 200 MG/5 ML VIAL	Infusion Pump

DOPAMINE 400 MG/10 ML VIAL	Infusion Pump
FLOXURIDINE 500 MG VIAL	Infusion Pump
GANCICLOVIR 500 MG VIAL	Infusion Pump
MILRINONE LACT 20 MG/20 ML VL	Infusion Pump
MILRINONE LACT 10 MG/10 ML VL	Infusion Pump
METHOTREXATE 50 MG/2 ML VIAL	Oral Chemo
AZATHIOPRINE SOD 100 MG VIAL	Immunosuppressant
MILRINONE LACT 50 MG/50 ML VL	Infusion Pump
MILRINONE-D5W 40 MG/200 ML	Infusion Pump
MILRINONE-D5W 20 MG/100 ML	Infusion Pump
CLADRIBINE 10 MG/10 ML VIAL	Infusion Pump
AMIODARONE 150 MG/3 ML VIAL	Infusion Pump
CROMOLYN 20 MG/2 ML NEB SOLN	Nebulizer
CYCLOSPORINE MODIFIED 100MG/ML	Immunosuppressant
ZOFRAN 4 MG/5 ML ORAL SOLN	Antiemetic for CINV
FLOLAN 0.5 MG VIAL	Infusion Pump
FLOLAN 1.5 MG VIAL	Infusion Pump
PULMICORT 0.25 MG/2 ML RESPUL	Nebulizer
PULMICORT 0.5 MG/2 ML RESPULE	Nebulizer
PULMICORT 1 MG/2 ML RESPULE	Nebulizer
NITROPRESS 50 MG/2 ML VIAL	Infusion Pump
DOPAMINE 200 MG-D5W 250 ML	Infusion Pump
DOPAMINE 400 MG-D5W 500 ML	Infusion Pump
DOPAMINE 400 MG/250 ML-D5W BAG	Infusion Pump
DOPAMINE 800 MG/500 ML-D5W BAG	Infusion Pump
DOPAMINE 800 MG/250 ML-D5W BAG	Infusion Pump
NTG 25 MG/250 ML IN D5W	Infusion Pump
NTG 0.2 MG/ML IN D5W	Infusion Pump
NTG 100 MG/250 ML IN D5W	Infusion Pump
DOBUTAMINE 250 MG/250 ML-D5W	Infusion Pump
DOBUTAMINE 500 MG/250 ML D5W	Infusion Pump
DOBUTAMINE 1,000 MG/250 ML D5W	Infusion Pump
ONDANSETRON HCL 4 MG TABLET	Antiemetic for CINV
ONDANSETRON HCL 8 MG TABLET	Antiemetic for CINV
AZATHIOPRINE 50 MG TABLET	Immunosuppressant
TACROLIMUS 0.5 MG CAPSULE (IR)	Immunosuppressant
TACROLIMUS 1 MG CAPSULE (IR)	Immunosuppressant
TACROLIMUS 5 MG CAPSULE (IR)	Immunosuppressant
PREDNISOLONE ODT 10 MG TABLET	Immunosuppressant
PREDNISOLONE ODT 15 MG TABLET	Immunosuppressant
PREDNISOLONE ODT 30 MG TABLET	Immunosuppressant
ALBUTEROL SUL 0.63 MG/3 ML SOL	Nebulizer
ALBUTEROL SUL 1.25 MG/3 ML SOL	Nebulizer
ONDANSETRON ODT 4 MG TABLET	Antiemetic for CINV
ONDANSETRON ODT 8 MG TABLET	Antiemetic for CINV
IPRATROPIUM BR 0.02% SOLN	Nebulizer
ALBUTEROL SUL 2.5 MG/3 ML SOLN	Nebulizer
IPRAT-ALBUT 0.5-3(2.5) MG/3 ML	Nebulizer

NTG 50 MG/500 ML IN D5W	Infusion Pump
NTG 200 MG/500 ML IN D5W	Infusion Pump
DOBUTAMINE 250 MG/20 ML VIAL	Infusion Pump
DOBUTAMINE 12.5 MG/ML VIAL	Infusion Pump
MORPHINE SULFATE 1 MG/ML VIAL	Infusion Pump
ACETYLCYSTEINE 10% VIAL	Nebulizer
ACETYLCYSTEINE 20% VIAL	Nebulizer
DOPAMINE 80 MG/ML VIAL	Infusion Pump
MORPHINE 5 MG/ML VIAL	Infusion Pump
PROGRAF 0.5 MG CAPSULE	Immunosuppressant
PROGRAF 1 MG CAPSULE	Immunosuppressant
ASTAGRAF XL 0.5 MG CAPSULE	Immunosuppressant
PROGRAF 5 MG CAPSULE	Immunosuppressant
ASTAGRAF XL 1 MG CAPSULE	Immunosuppressant
ASTAGRAF XL 5 MG CAPSULE	Immunosuppressant
PROGRAF 0.2 MG GRANULE PACKET	Immunosuppressant
PROGRAF 1 MG GRANULE PACKET	Immunosuppressant
PROGRAF 5 MG/ML AMPULE	Immunosuppressant
AMBISOME 50 MG VIAL	Infusion Pump
ALBUTEROL 2.5 MG/0.5 ML SOL	Nebulizer
CYCLOSPORINE 250 MG/5 ML AMPUL	Immunosuppressant
DOPAMINE 160 MG/ML VIAL	Infusion Pump
NITROGLYCERIN 5 MG/ML VIAL	Infusion Pump
DRONABINOL 2.5 MG CAPSULE	Antiemetic for CINV
DRONABINOL 5 MG CAPSULE	Antiemetic for CINV
DRONABINOL 10 MG CAPSULE	Antiemetic for CINV
MYCOPHENOLATE 200 MG/ML SUSP	Immunosuppressant
METHYLPREDNISOLONE 4 MG TABLE	Immunosuppressant
INFUMORPH 200 MG/20 ML AMPUL	Infusion Pump
INFUMORPH 500 MG/20 ML AMPUL	Infusion Pump
EPOPROSTENOL SODIUM 0.5 MG VL	Infusion Pump
EPOPROSTENOL SODIUM 1.5 MG VL	Infusion Pump
ADRUCIL 500 MG/10 ML VIAL	Infusion Pump
ADRUCIL 2,500 MG/50 ML VIAL	Infusion Pump
ADRUCIL 5 GRAM/100 ML VIAL	Infusion Pump
METHOTREXATE 250 MG/10 ML VIAL	Oral Chemo
METHOTREXATE 1 GRAM/40 ML VIAL	Oral Chemo
VINCASAR PFS 1 MG/ML VIAL	Infusion Pump
VINCASAR PFS 2 MG/2 ML VIAL	Infusion Pump
APREPITANT 40 MG CAPSULE	Antiemetic for CINV
APREPITANT 80 MG CAPSULE	Antiemetic for CINV
APREPITANT 125 MG CAPSULE	Antiemetic for CINV
APREPITANT 125-80-80 MG PACK	Antiemetic for CINV
DEXCOM G4 TRANSMITTER KIT	Continuous Glucose Monitor
DEXCOM G5 TRANSMITTER KIT	Continuous Glucose Monitor
DEXCOM G6 TRANSMITTER	Continuous Glucose Monitor
DEXCOM G4 RECEIVER KIT	Continuous Glucose Monitor
DEXCOM G4 (PED) RECEIVER KIT	Continuous Glucose Monitor

DEXCOM G4 RECEIVER-SHARE KIT	Continuous Glucose Monitor
DEXCOM G5-G4 SENSOR KIT	Continuous Glucose Monitor
DEXCOM G6 SENSOR	Continuous Glucose Monitor
DEXCOM G4 RECEIVER-SHARE (PED)	Continuous Glucose Monitor
DEXCOM G5 RECEIVER KIT	Continuous Glucose Monitor
DEXCOM RECEIVER KIT	Continuous Glucose Monitor
DEXCOM G6 RECEIVER	Continuous Glucose Monitor
BETHKIS 300 MG/4 ML AMPULE	Nebulizer
PENTAMIDINE 300 MG INHAL POWDR	Nebulizer
SODIUM NITROPRUSSIDE 50 MG/2ML	Infusion Pump
FLUOROURACIL 500 MG/10 ML VIAL	Infusion Pump
FLUOROURACIL 1 GRAM/20 ML VIAL	Infusion Pump
FLUOROURACIL 2.5 GRAM/50 ML VL	Infusion Pump
FLUOROURACIL 5 GRAM/100 ML VL	Infusion Pump
XOPENEX CONC 1.25 MG/0.5 ML	Nebulizer
XOPENEX 0.31 MG/3 ML SOLUTION	Nebulizer
XOPENEX 0.63 MG/3 ML SOLUTION	Nebulizer
XOPENEX 1.25 MG/3 ML SOLUTION	Nebulizer
MYCOPHENOLATE 500 MG VIAL	Immunosuppressant
ONDANSETRON 2 MG/2.5 ML ENFIT	Antiemetic for CINV
ONDANSETRON 2 MG/2.5 ML SYRING	Antiemetic for CINV
PRIALT 100 MCG/ML VIAL	Infusion Pump
PRIALT 25 MCG/ML VIAL	Infusion Pump
SYNDROS 5 MG/ML SOLUTION	Antiemetic for CINV
MARQIBO KIT	Infusion Pump
CIDOFOVIR 375 MG/5 ML VIAL	Infusion Pump
MILLIPRED 5 MG TABLET	Immunosuppressant
GANCICLOVIR 500 MG/10 ML VIAL	Infusion Pump
FOSCARNET 6,000 MG/250 ML BAG	Infusion Pump
AMIODARONE 150 MG/3 ML SYRINGE	Infusion Pump
BACLOFEN 10 MG/20 ML VIAL	Infusion Pump
BACLOFEN 40 MG/20 ML VIAL	Infusion Pump
BACLOFEN 20,000 MCG/20 ML VIAL	Infusion Pump
BACLOFEN 0.05 MG/ML SYRINGE	Infusion Pump
AGGRASTAT 3.75 MG/15 ML VIAL	Infusion Pump
AGGRASTAT 5 MG/100 ML IV SOLN	Infusion Pump
AGGRASTAT 12.5 MG/250 ML	Infusion Pump
AGGRASTAT 5 MG/100 ML VIAL	Infusion Pump
AMPHOTERICIN B 50 MG VIAL	Infusion Pump
NEXTERONE 150 MG/100 ML BAG	Infusion Pump
NEXTERONE 360 MG/200 ML BAG	Infusion Pump
GUARDIAN SENSOR 3	Continuous Glucose Monitor
MINIMED 630G GUARDIAN START KT	Continuous Glucose Monitor
GUARDIAN LINK 3 TRANSMITTER	Continuous Glucose Monitor
CYTOGAM 2.5 GM/50 ML VIAL	Infusion Pump
MELPHALAN 2 MG TABLET	Oral Chemo
PERFOROMIST 20 MCG/2 ML SOLN	Nebulizer
YUPELRI 175 MCG/3 ML SOLUTION	Nebulizer

ALBUTEROL 5 MG/ML SOLUTION	Nebulizer
PULMOZYME 1 MG/ML AMPUL	Nebulizer
SIROLIMUS 1 MG TABLET	Immunosuppressant
TREXALL 5 MG TABLET	Oral Chemo
TREXALL 7.5 MG TABLET	Oral Chemo
TREXALL 10 MG TABLET	Oral Chemo
TREXALL 15 MG TABLET	Oral Chemo
NIPRIDE RTU 50 MG/100 ML VIAL	Infusion Pump
NIPRIDE RTU 10 MG/50 ML VIAL	Infusion Pump
NIPRIDE RTU 20 MG/100 ML VIAL	Infusion Pump
GANCICLOVIR 500 MG/250 ML BAG	Infusion Pump
ALKERAN 2 MG TABLET	Oral Chemo
XATMEP 2.5 MG/ML ORAL SOLUTION	Oral Chemo
IMURAN 50 MG TABLET	Immunosuppressant
ONDANSETRON HCL 24 MG TABLET	Antiemetic for CINV
SIROLIMUS 2 MG TABLET	Immunosuppressant
ACYCLOVIR 500 MG/10 ML VIAL	Infusion Pump
ACYCLOVIR 1,000 MG/20 ML VIAL	Infusion Pump
AMIODARONE 450 MG/9 ML VIAL	Infusion Pump
AMIODARONE 900 MG/18 ML VIAL	Infusion Pump
ACYCLOVIR SODIUM 500 MG VIAL	Infusion Pump
ACYCLOVIR SODIUM 1 GM VIAL	Infusion Pump
BLINCYTO 35MCG VL W-STABILIZER	Infusion Pump
VECTIBIX 100 MG/5 ML VIAL	Infusion Pump
VECTIBIX 400 MG/20 ML VIAL	Infusion Pump
FREESTYLE LIBRE 10 DAY SENSOR	Continuous Glucose Monitor
FREESTYLE LIBRE 10 DAY READER	Continuous Glucose Monitor
FREESTYLE LIBRE 14 DAY SENSOR	Continuous Glucose Monitor
FREESTYLE LIBRE 14 DAY READER	Continuous Glucose Monitor
FREESTYLE LIBRE 2 SENSOR	Continuous Glucose Monitor
FREESTYLE LIBRE 2 READER	Continuous Glucose Monitor
ABELCET 100 MG/20 ML VIAL	Infusion Pump
ENGERIX-B PEDI 10 MCG/0.5 SYRN	Hepatitis B vaccine
ENGERIX-B 20 MCG/ML VIAL	Hepatitis B vaccine
ENGERIX-B 20 MCG/ML SYRN	Hepatitis B vaccine
THYMOGLOBULIN 25 MG VIAL	Immunosuppressant
ORAPRED ODT 10 MG TABLET	Immunosuppressant
ORAPRED ODT 15 MG TABLET	Immunosuppressant
ORAPRED ODT 30 MG TABLET	Immunosuppressant
METHYLPREDNISOLONE 8 MG TAB	Immunosuppressant
METHYLPREDNISOLONE 16 MG TAB	Immunosuppressant
METHYLPREDNISOLONE 32 MG TAB	Immunosuppressant
SIROLIMUS 0.5 MG TABLET	Immunosuppressant
SIROLIMUS 1 MG/ML SOLUTION	Immunosuppressant
AZATHIOPRINE 75 MG TABLET	Immunosuppressant
AZATHIOPRINE 100 MG TABLET	Immunosuppressant
CYCLOSPORINE 25 MG CAPSULE	Immunosuppressant
CYCLOSPORINE 100 MG CAPSULE	Immunosuppressant

CYTARABINE 20 MG/ML VIAL	Infusion Pump
CYTARABINE 100 MG/5 ML VIAL	Infusion Pump
VINCRISTINE 1 MG/ML VIAL	Infusion Pump
VINCRISTINE 2 MG/2 ML VIAL	Infusion Pump
CYTARABINE 2 G/20 ML VIAL	Infusion Pump
AMPHOTERICIN B LIPOSOME 50 MG	Infusion Pump
METHOTREXATE 25 MG/ML VIAL	Oral Chemo
VINBLASTINE 1 MG/ML VIAL	Infusion Pump
FOSCARNET 6,000 MG/250 ML BTTL	Infusion Pump
NEBUPENT 300 MG INHAL POWDER	Nebulizer
BROVANA 15 MCG/2 ML SOLUTION	Nebulizer
AZASAN 75 MG TABLET	Immunosuppressant
AZASAN 100 MG TABLET	Immunosuppressant
VENTAVIS 10 MCG/1 ML SOLUTION	Nebulizer
VENTAVIS 20 MCG/1 ML SOLUTION	Nebulizer
VELETRI 1.5 MG VIAL	Infusion Pump
VELETRI 0.5 MG VIAL	Infusion Pump
TYVASO INHALATION STARTER KIT	Nebulizer
TYVASO INHALATION REFILL KIT	Nebulizer
TYVASO 1.74 MG/2.9 ML SOLUTION	Nebulizer
TYVASO INSTITUTIONAL START KIT	Nebulizer
GABLOFEN 50 MCG/ML SYRINGE	Infusion Pump
GABLOFEN 10,000 MCG/20 ML SYRG	Infusion Pump
GABLOFEN 10,000 MCG/20 ML VIAL	Infusion Pump
GABLOFEN 20,000 MCG/20 ML SYRG	Infusion Pump
GABLOFEN 20,000 MCG/20 ML VIAL	Infusion Pump
GABLOFEN 40,000 MCG/20 ML SYRG	Infusion Pump
GABLOFEN 40,000 MCG/20 ML VIAL	Infusion Pump
CYTARABINE 1000 MG/50 ML VIAL	Infusion Pump
VYXEOS 44 MG-100 MG VIAL	Infusion Pump
ENVARSUS XR 1 MG TABLET	Immunosuppressant
ENVARSUS XR 4 MG TABLET	Immunosuppressant
ENVARSUS XR 0.75 MG TABLET	Immunosuppressant
VARUBI 90 MG TABLET	Antiemetic for CINV
LIORESAL IT 10 MG/20 ML KIT	Infusion Pump
LIORESAL IT 10 MG/20 ML AMPULE	Infusion Pump
LIORESAL IT 10 MG/5 ML KIT	Infusion Pump
LIORESAL IT 10 MG/5 ML AMPULE	Infusion Pump
LIORESAL IT 0.05 MG/1 ML AMP	Infusion Pump
LIORESAL IT 40 MG/20 ML KIT	Infusion Pump
LIORESAL IT 40 MG/20 ML AMPULE	Infusion Pump
VARUBI 180 MG DOSE(2X 90MG TB)	Antiemetic for CINV
PRIALT 500 MCG/5 ML VIAL	Infusion Pump
PRIALT 500 MCG/20 ML VIAL	Infusion Pump
OLINVYK 30 MG/30 ML PCA VIAL	Infusion Pump
PREHEVBRIO 10 MCG/ML VIAL	Hepatitis B vaccine
PHOTOFRIN 75 MG VIAL	Infusion Pump
ENLITE GLUCOSE SENSOR	Continuous Glucose Monitor

PARADIGM REAL-TIME SYSTEM	Continuous Glucose Monitor
GUARDIAN REAL-TIME GLU MONITOR	Continuous Glucose Monitor
MINILINK REAL-TIME TRANSMITTER	Continuous Glucose Monitor
ENLITE SYSTEM KIT	Continuous Glucose Monitor
FOSCAVIR 6,000 MG/250 ML BTTL	Infusion Pump
FOSCAVIR 6,000 MG/250 ML BAG	Infusion Pump
MORPHINE 30 MG/30 ML PCA VIAL	Infusion Pump
ZUPLENZ 4 MG SOLUBLE FILM	Antiemetic for CINV
ZUPLENZ 8 MG SOLUBLE FILM	Antiemetic for CINV
FREESTYLE NAVIGATOR SENSOR KIT	Continuous Glucose Monitor
CYCLOPHOSPHAMIDE 25 MG TABLET	Oral Chemo
CYCLOPHOSPHAMIDE 50 MG TABLET	Oral Chemo
KITABIS PAK 300 MG/5 ML	Nebulizer

HIGHMARK® DELAWARE

January 1 – December 31, 2023

Evidence of Coverage:

Your Medicare Health Benefits and Services as a Member of Freedom Blue PPO

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

For questions about this document, please contact our Member Service number at 1-888-328-2960. (TTY users should call 711 National Relay Service). Hours are Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time.

This plan, Freedom Blue PPO, is offered by Highmark BCBSD, INC.. (When this *Evidence of Coverage* says "we," "us," or "our," it means Highmark BCBSD, INC.. When it says "plan" or "our plan," it means Freedom Blue PPO.)

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

Benefits required by Medicare may change on January 1, 2024.

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

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

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

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

2023 Evidence of Coverage

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CHAPTER 1:

Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in Freedom Blue PPO, which is a Medicare PPO

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

Freedom Blue PPO is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company. This plan does not include Part D prescription drug coverage.

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

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

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

The word "coverage" and "covered services" refers to the medical care and services available to you as a member of Freedom Blue PPO.

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

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

Section 1.3 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how Freedom Blue PPO covers your care. Other parts of this contract include your enrollment form and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for months in which you are enrolled in Freedom Blue PPO between January 1, 2023 and December 31, 2023.

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

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

Section 2.1 Your eligibility requirements

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

- You have both Medicare Part A and Medicare Part B
- -- *and* -- you live in our geographic service area (Section 2.2 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- -- *and* -- you are a United States citizen or are lawfully present in the United States
- you and your dependent(s) must meet the State of Delaware eligibility for Medicare retiree benefits

Section 2.2 Here is the plan service area for Freedom Blue PPO

Freedom Blue PPO is available only to individuals who live in the United States and its territories. To remain a member of our plan, you must continue to reside in the United States and its territories. The service area is described in Chapter 3, section 2.2 *Blue Cross Blue Shield Association Network Sharing* and the *Network Sharing* appendix in the back of this document.

If you plan to move out of the United States or its territories, you cannot remain a member of this plan. Please contact Member Service or your group administrator. When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

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

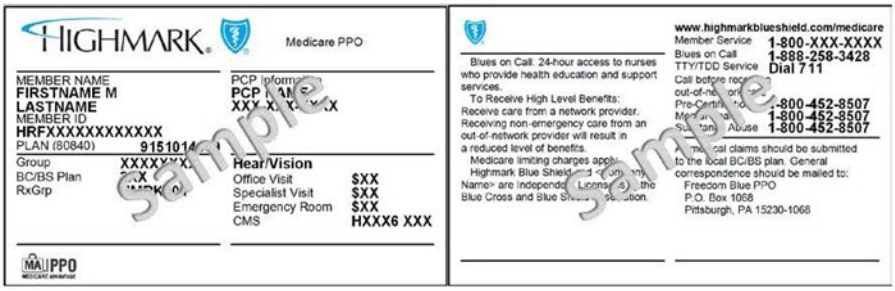
Section 2.3 U.S. Citizen or Lawful Presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify Freedom Blue PPO if you are not eligible to remain a member on this basis. Freedom Blue PPO must disenroll you if you do not meet this requirement.

SECTION 3 Important membership materials you will receive

Section 3.1 Your plan membership card

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



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

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

Section 3.2 Provider Directory

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

If you use out-of-network providers that do not submit claims to their local Blue Cross Blue Shield or to Highmark, they may ask you to pay in full. The only exceptions are emergencies, urgently needed services when the network is not available (that is, in situations when it is unreasonable or not possible to obtain services in-network), out-of-area dialysis services, and cases in which Freedom Blue PPO authorizes use of out-of-network providers. **For additional information on out-of-network providers, please see Chapter 3, Section 2.5.**

If you don't have your copy of the *Provider Directory*, you can request a copy from Member Service.

SECTION 4 Your monthly costs for Freedom Blue PPO

Your costs may include the following:

- Monthly Part B Premium (Section 4.2)

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

Section 4.1 Plan premium

Please contact the State of Delaware for more information about the premium for this plan.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

You must continue paying your Medicare premiums to remain a member of the plan. This includes your premium for Part B. It may also include a premium for Part A which affects members who aren't eligible for premium free Part A.

SECTION 5 More information about your monthly premium

Section 5.1 Can we change your monthly plan premium during the year?

No. Unless the State of Delaware makes a change, we are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year, the State of Delaware will tell you in your open enrollment communications for the State of Delaware and the change will take effect on January 1.

SECTION 6 Keeping your plan membership record up to date

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

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

Let us know about these changes:

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

- If you are participating in a clinical research study. (**Note:** You are not required to tell your plan about the clinical research studies you intend to participate in, but we encourage you to do so).

If any of this information changes, please let us know by calling Member Service.

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

SECTION 7 How other insurance works with our plan

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

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

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

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

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

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

- No-fault insurance (including automobile insurance)

- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

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

CHAPTER 2:

Important phone numbers and resources

SECTION 1 Freedom Blue PPO contacts (How to contact us, including how to reach Member Service)

How to contact our plan's Member Service

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

Method	Member Service – Contact Information
CALL	1-888-328-2960 Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time. Member Service also has free language interpreter services available for non-English speakers.
TTY	711 National Relay Service This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time.
FAX	1-717-635-4235
WRITE	P.O. Box 1068 Pittsburgh, PA 15230-1068
WEBSITE	medicare.highmark.com

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

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

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

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

Method	Appeals for Medical Care – Contact Information
CALL	1-888-328-2960 Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time. To file an expedited appeal, call NY_Table.Appeals_Med_Care_Phone_Expedited.
TTY	711 National Relay Service This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time.
FAX	1-717-635-4209 To file an expedited appeal, fax your request to 1-800-894-7947.
WRITE	Appeals and Grievance Dept. P.O. Box 535047 Pittsburgh, PA 15253-5047
WEBSITE	medicare.highmark.com

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

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

Method	Complaints About Medical Care – Contact Information
CALL	1-888-328-2960 Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time.
TTY	711 National Relay Service This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time.
FAX	1-717-635-4209
WRITE	Appeals and Grievance Dept. P.O. Box 535047 Pittsburgh, PA 15253-5047
MEDICARE WEBSITE	You can submit a complaint about directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx.

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

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

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

Method	Payment Requests – Contact Information
CALL	1-888-328-2960 Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time.

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

SECTION 2 Medicare
(how to get help and information directly from the Federal Medicare program)

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

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

Method	Medicare – Contact Information
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	www.medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home

Method	Medicare – Contact Information
	health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about Freedom Blue PPO: • **Tell Medicare about your complaint:** You can submit a complaint about Freedom Blue PPO directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

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

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. Please refer to the ***Agency Contact Information*** appendix in the back of this document for a list of SHIP contact information by state.

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

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

METHOD TO ACCESS SHIP and OTHER RESOURCES:

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

SECTION 4 Quality Improvement Organization

There is a designated Quality Improvement Organization (QIO) for serving Medicare beneficiaries in each state. Please refer to the ***Agency Contact Information*** appendix in the back of this document for a list of QIO contact information by state.

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

You should contact QIO in any of these situations:

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

SECTION 5 Social Security

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

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

Method	Social Security– Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 8:00 a.m. to 7:00 p.m., Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8:00 a.m. to 7:00 p.m., Monday through Friday.
WEBSITE	www.ssa.gov

SECTION 6 Medicaid

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

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

To find out more about Medicaid and its programs, please refer to ***Agency Contact Information*** appendix in the back of this document for a list of Medicaid contact information by state.

SECTION 7 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

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

SECTION 8 Do you have "group insurance" or other health insurance from an employer?

As a State of Delaware retiree healthcare plan participant, you may call the State of Delaware Office of Pensions or your participating group that manages your retiree benefits. Call if you have any questions on your retiree health benefits including:

- retiree health plan eligibility
- you or your spouse/dependent(s) are eligible for other health insurance benefits
- plan premiums
- information about the annual enrollment period.

Call the office that manages your retiree benefits.

Office of Pensions	1-302-739-4208 or 1-800-722-7300
City of Dover	1-302-736-7790
City of Rehoboth Beach	1-302-722-8194
Delaware Transit Corporation (DART)	1-302-576-6082
Delaware State Housing Authority	1-302-739-0260
Town of Smyrna	1-302-389-2320
University of Delaware	1-302-831-2171

You may also call 1-800-MEDICARE (1-800-633-4227; TTY:1-877-486-2048) with questions related to your Medicare coverage under this plan.

CHAPTER 3:

Using the plan's coverage for your medical services

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

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

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

Section 1.1 What are "network providers" and "covered services"?

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

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

As a Medicare health plan, Freedom Blue PPO must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

Freedom Blue PPO will generally cover your medical care as long as:

- **The care you receive is included in the plan's *Medical Benefits Chart* appendix.**
- **The care you receive is considered medically necessary**. "Medically necessary" means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You receive your care from a provider who is eligible to provide services under Original Medicare.** As a member of our plan, you can receive your care from either a network provider or an out-of-network provider (for more about this, see Section 2 in this chapter).
  - The providers in our network are listed in the *Provider Directory*.
  - If you use an out-of-network provider, your share of the costs for your covered services will be the same for Medicare benefits as a network provider.

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

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

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

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

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

How do you choose your PCP?

PCPs and their group practices, if applicable, are listed in the *Provider Directory*. You can also find PCPs on our website at medicare.highmark.com. Click on the "Find a Provider" link to access our online *Provider Directory*. Because your PCP plays a central role in your health care, please select one with careful consideration to hospital affiliation and office location.

To view board certification information and the hospital affiliation of your PCP or Network specialist, visit our website at medicare.highmark.com. Click on the "Find a Provider" link to access our online *Provider Directory*. Search for the physician, then click on the provider's name to view this information. In addition to this information, to obtain the full professional qualifications of network providers, including medical schools attended and residencies completed, call Member Service.

Simply call Member Service to add your PCP selection to your file.

Changing your PCP

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

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

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

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

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

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

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

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

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

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

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

Section 2.3 Blue Cross Blue Shield Association Network Sharing

Freedom Blue PPO members have access to the Blue Cross Blue Shield Association service area providers. Freedom Blue PPO members may visit any participating Blue Cross and/or Blue Shield Medicare Advantage PPO provider in any geographic area where the Part A, Part B and supplemental services of Blue Cross Blue Shield providers are offered, and pay network cost sharing.

The Service Area includes specific counties in the following 48 states and 2 territories: Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin, and West Virginia. For some of the states listed, Medicare Advantage PPO networks are only available in portions of the state. ***See the Network Sharing appendix in the back of this book for a list of BCBSA network sharing counties by state.***

To find Blue Cross and/or Blue Shield Medicare Advantage PPO providers in the above locations, you may:

- Call Freedom Blue PPO Member Service (numbers on the back of your ID card), Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time. Hearing-impaired TTY users call 711 National Relay Service.
- Visit medicare.highmark.com and select "Find Providers" or visit "Find a Doctor" at www.BCBS.com.

Freedom Blue PPO members may see any Blue Cross and/or Blue Shield Medicare Advantage PPO contracted doctor or hospital outside the Freedom Blue PPO service area in the above locations and receive coverage at the same level of benefits.

In locations where participating Blue Cross and/or Blue Shield Medicare Advantage PPO providers are not available, members may visit **any Medicare-eligible provider** and receive coverage at the same level of benefits.

Emergency and urgently needed care is always covered at the higher network level of benefits, regardless of where the care is received.

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

Section 2.4 What you pay for covered services

The following charts are for members **who live** within a county that includes participating Blue Cross and/or Blue Shield Medicare Advantage providers.

While at home, you can go to the following providers and receive:

Network Doctors and Hospitals	Non-Network Doctors and Hospitals
Full coverage for all Medicare benefits	Full coverage for all Medicare benefits

When traveling outside of your county or across the country, you can go to the following providers and receive:

If you seek care in a county…	Network Doctors/Hospitals	Non-Network Doctors/Hospitals
***With* a participating Medicare Advantage PPO network**	Full coverage for all Medicare benefits	Full coverage for all Medicare benefits
***Without* a participating Medicare Advantage PPO network**	Full coverage for all Medicare benefits	Full coverage for all Medicare benefits

The following charts are for members who **do not live** in a county that includes participating Blue Cross and/or Blue Shield Medicare Advantage providers.

While at home, you can go to any Medicare participating provider in your county and receive:

Network Doctors and Hospitals	Non-Network Doctors and Hospitals
Covered in full.	Full coverage for all Medicare benefits

When traveling outside of your county or across the country, you can go to the following providers and receive:

If you seek care in a county…	Network Doctors/Hospitals	Non-Network Doctors/Hospitals
***With* a participating Medicare Advantage PPO network**	Full coverage for all Medicare benefits	Full coverage for all Medicare benefits
***Without* a participating Medicare Advantage PPO network**	Full coverage for all Medicare benefits	Full coverage for all Medicare benefits

When you call a provider's office to make an appointment, be sure to tell them that you have coverage through a Blue Cross and/or Blue Shield Medicare Advantage PPO. And when you visit, show them your Freedom Blue PPO ID card. It's important that you show your Freedom Blue PPO ID card to the provider when you seek medical care. Your card has a special "suitcase" in the lower left corner of the card. This suitcase alerts your doctor, hospital or other provider that you are a member of a Blue Cross and/or Blue Shield Medicare Advantage PPO. It also directs them to file any claims for services they provide to their local Blue Cross and/or Blue Shield Plan.

The cost of the service, on which member liability (copayment/coinsurance) is based, will be either:

- The Medicare allowable amount for covered services, or
- The amount either Highmark Blue Shield negotiates with the provider or the local Blue Medicare Advantage plan negotiates with its provider on behalf of our members, if applicable. The amount negotiated may be either higher than, lower than, or equal to the Medicare allowable amount.

Section 2.5 How to get care from out-of-network providers

As a member of our plan, you can choose to receive care from out-of-network providers. However, please note providers that do not contract with us are under no obligation to treat you, except in emergency situations. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and are medically necessary. Here are other important things to know about using out-of-network providers:

- You can get your care from an out-of-network provider, however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you receive care from a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.
- You don't need to get a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers you may want to ask for a pre-visit coverage decision to confirm that the services you are getting are covered

and are medically necessary. (See Chapter 7, Section 4 for information about asking for coverage decisions.) This is important because:

- Without a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 7 *(What to do if you have a problem or complaint)* to learn how to make an appeal.

- It is best to ask an out-of-network provider to bill the plan first. But, if you have already paid for the covered services, we will reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill that you think we should pay, you can send it to us for payment. See Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services*) for information about what to do if you receive a bill or if you need to ask for reimbursement.
- If you are using an out-of-network provider for emergency care, urgently needed services, or out-of-area dialysis, you will have the same level of benefits as using a network provider. See Section 3 for more information about these situations.

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

Section 3.1 Getting care if you have a medical emergency

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

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

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP. You do not need to use a network doctor. You may get covered emergency medical care whenever you need it, anywhere in the United States, its territories or worldwide, and from any provider with an appropriate state license even if they are not part of our network.

What is covered if you have a medical emergency?

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

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

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

What if it wasn't a medical emergency?

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

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

What are "urgently needed services"?

An urgently needed service is a non-emergency situation requiring immediate medical care but given your circumstances, it is not possible or not reasonable to obtain these services from a network provider. The plan must cover urgently needed services provided out of network. Some examples of urgently needed services are i) a severe sore throat that occurs over the weekend or ii) an unforeseen flare-up of a known condition when you are temporarily outside the service area.

If you believe you have an urgent need for care, go to the nearest emergency room or urgent care facility. Urgent care centers can be located in the *Provider Directory* or at medicare.highmark.com. See the *Medical Benefits Chart* appendix for more information.

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

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

Section 3.3 Getting care during a disaster

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

Please visit the following website: medicare.highmark.com for information on how to obtain needed care during a disaster.

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

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

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

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

Freedom Blue PPO covers all medically necessary services as listed in the *Medical Benefits Chart* appendix. If you receive services not covered by our plan, you are responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you have used up your benefit for that type of covered service. These payments will not count toward your out-of-pocket maximum. You can call Member Service when you want to know how much of your benefit limit you have already used.

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

Section 5.1 What is a "clinical research study"?

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

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

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. If you tell us that you are in a qualified clinical trial, then you are only responsible for the in-network cost sharing for the services in that trial. If you paid more, for example, if you already paid the Original Medicare cost sharing amount, we will reimburse the difference between what you paid and the in-network cost sharing. However, you will need to provide documentation to show us how much you paid. When you are in a clinical

research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

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

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

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

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

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

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

After Medicare has paid its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan. However, you are required to submit documentation showing how much cost sharing you paid. Please see Chapter 7 for more information for submitting requests for payments.

Here's an example of how the cost sharing works: Let's say that you have a lab test that costs $100 as part of the research study. Let's also say that your share of the costs for this test is $20 under Original Medicare, but the test would be $0 under our plan's benefits. In this case, Original Medicare would pay $80 for the test, and you would pay the $20 copay required under Original Medicare. You would then notify your plan that you received a qualified clinical trial service and submit documentation such as a provider bill to the plan. The plan would then directly pay you $20. Therefore, your net payment is $0, which is the same amount you would pay under our plan's benefits. Please note that in order to receive payment from your plan, you must submit documentation to your plan such as a provider bill.

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

- Generally, Medicare will *not* pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.

- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.

Do you want to know more?

You can get more information about joining a clinical research study by visiting the Medicare website to read or download the publication "Medicare and Clinical Research Studies". The publication is available at: www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf.) You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

Section 6.1 What is a religious non-medical health care institution?

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

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

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

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

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

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

All Medicare Inpatient Hospital coverage limits apply. See the *Medical Benefits Chart* appendix for details.

SECTION 7 Rules for ownership of durable medical equipment

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

Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

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

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

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

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

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

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage, Freedom Blue PPO will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents

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

If you leave Freedom Blue PPO or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

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

Original Medicare requires an oxygen supplier to provide you services for five years. During the first 36 months you rent the equipment. The remaining 24 months the supplier provides the equipment and maintenance (you still have a $0 copayment for oxygen). After five years you may choose to stay with the same company or go to another company. At this point, the five-year cycle begins again, even if you remain with the same company, requiring you to pay copayments (based on your benefit coverage at the time) for the first 36 months. If you join or leave our plan, the five-year cycle starts over.

CHAPTER 4:

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

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

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

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

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

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

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

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

Under our plan, there are two different limits on what you have to pay out-of-pocket for covered medical services (please see the *Medical Benefits Chart* appendix for your group's specific maximum amount):

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

- Your **combined maximum out-of-pocket amount** can be found in the *Medical Benefits Chart* appendix. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from both in-network and out-of-network providers. The amounts you pay for deductibles (if applicable), copayments, and coinsurance for covered services count toward this combined maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your combined maximum out-of-pocket amount. These services are noted as such in the *Medical Benefits Chart* appendix.) If your combined maximum amount for covered services has been met, you will have 100% coverage and will not have any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

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

As a member of Freedom Blue PPO, an important protection for you is that you only have to pay your cost sharing amount when you get services covered by our plan. Providers may not add additional separate charges for Medicare-covered services in the United States or its territories , called "balance billing." This protection applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.

Here is how this protection works.

- If your cost sharing is a copayment (a set amount of dollars, for example, $0.00), then you will not have any cost sharing for any covered services from an in or out-of-network provider.
- If your cost sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
    - If you receive the covered services from a network provider, you pay the 0% coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
    - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the 0% coinsurance percentage multiplied by the Medicare payment rate for participating providers.
    - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the 0% coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- If you believe a provider has "balance billed" you, call Member Service.

Members that utilize the foreign travel routine care coverage benefit could be liable for a balance bill after the member pays their share of costs for services if the foreign provider charges more than Medicare-allowed amount.

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

The *Medical Benefits Chart* appendix which lists your covered services is provided separately with the open enrollment materials and in the Welcome Kit when you first joined the plan. It is then provided every year with the Annual Notice of Change (ANOC) you receive during the Annual Election Period.

SECTION 3 What services are not covered by the plan?

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

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

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

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

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Acupuncture		Available for people with chronic low back pain under certain circumstances.
Cosmetic surgery or procedures		• Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Custodial care Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.	✓	
Experimental medical and surgical procedures, equipment, and medications. Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.		May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
Fees charged for care by your immediate relatives or members of your household.	✓	
Full-time nursing care in your home.	✓	
Home-delivered meals		Some limited coverage provided upon discharge from an inpatient hospital stay. See your *Medical Benefits Chart*.
Homemaker services include basic household assistance, such as light housekeeping or light meal preparation.	✓	
Naturopath services (uses natural or alternative treatments).	✓	
Non-routine dental care		Dental care required to treat illness or injury may be covered as inpatient or outpatient care.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Orthopedic shoes or supportive devices for the feet		Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	✓	
Private room in a hospital.		Covered only when medically necessary.
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	✓	
Routine chiropractic care		Manual manipulation of the spine to correct a subluxation is covered.
Routine dental care, such as cleanings, filling or dentures.	✓	
Routine eye examinations and eyeglasses		Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery.
Routine foot care		Some limited coverage provided according to Medicare guidelines, e.g., if you have diabetes.
Routine hearing exams, hearing aids, or exams to fit hearing aids. Includes hearing aid service provider visits for the following: ear molds, hearing aid accessories, return fees, warranty claim fees, and hearing aid batteries not included with the initial purchase of the aid	✓	
Services considered not reasonable and necessary,	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
according to Original Medicare standards		
Telehealth services other than those listed in the *Medical Benefits Chart* appendix.	✓	
Vision - Radial keratotomy, LASIK surgery, vision therapy and other low vision aids.	✓	

CHAPTER 5:

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

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

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

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

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

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

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

   When you received care from a provider who is not part of our network, you are only responsible for paying your share of the cost. Ask the provider to bill the plan for our share of the cost.

   - You have no cost share for emergency or urgently needed services. Emergency providers are legally required to provide emergency care. If you accidentally pay the entire amount yourself at the time you receive the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
   - You may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
     - If the provider is owed anything, we will pay the provider directly.
     - If you have already paid more than your $0 cost share, we will pay you back for our share of the cost.
   - Please note: While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If the provider is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive.

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

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

- You only have to pay your cost sharing amount when you get covered services (which is $0 for Medicare-covered benefits). We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.
- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. If you are retroactively enrolled in our plan

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

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

4. If you've paid for a flu shot

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

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 of this document (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has information about how to make an appeal.

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

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

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

- You don't have to use the form, but it will help us process the information faster. Please include your name, member number from your identification card, address, phone number and a copy of an itemized receipt.
- Either download a copy of the form from our website (medicare.highmark.com) or call Member Service and ask for the form.

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

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

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

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

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

- If we decide that the medical care is covered and you followed all the rules, we will pay for our share of the cost. If you have already paid for the service, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service yet, we will mail the payment directly to the provider.
- If we decide that the medical care is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. We will send you a letter explaining the reasons why we are not sending the payment and your right to appeal that decision.

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

If you think we have made a mistake in turning down your request for payment or the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For details on how to make this appeal, go to Chapter 7 of this document.

CHAPTER 6:

Your rights and responsibilities

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

Section 1.1 We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, in large print or other alternate formats, etc.)

Your plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how a plan may meet these accessibility requirements include, but are not limited to provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

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

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

If providers in the plan's network for a specialty are not available, it is the plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care and you will have the same level of benefits as using a network provider. If you find yourself in a situation where there are no specialists in the plan's network that cover a service you need, call the plan for information on where to go to obtain this service at in-network cost sharing.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Member Service at 1-888-328-2960. You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

Section 1.2 We must ensure that you get timely access to your covered services

You have the right to choose a provider in the plan's network.

You have the right to get appointments and covered services from your providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care.

If you think that you are not getting your medical care within a reasonable amount of time, Chapter 7, Section 9 of this document tells what you can do.

Section 1.3 We must protect the privacy of your personal health information

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

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

How do we protect the privacy of your health information?

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

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

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

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

If you have questions or concerns about the privacy of your personal health information, please call Member Service.

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

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

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

As a member of Freedom Blue PPO, you have the right to get several kinds of information from us.

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

- **Information about our plan**. This includes, for example, information about the plan's financial condition.
- **Information about our network providers.** You have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your** coverage. Chapters 3 and 4 provide information regarding medical services.
- **Information about why something is not covered and what you can do about** it. Chapter 7 provides information on asking for a written explanation on why a medical service is not covered or if your coverage is restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 We must support your right to make decisions about your care

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

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

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

- **To know about all of your choices.** You have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no.**" You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. Of course, if you refuse treatment, you accept full responsibility for what happens to your body as a result.

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

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

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

The legal documents that you can use to give your directions in advance of these situations are called "**advance directives**." There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

If you want to use an "advance directive" to give your instructions, here is what to do:

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

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

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with your State Department of Heath.

State	Physician	Hospital
Delaware	Division of Professional Regulation	Division of Professional Regulation

	Cannon Building, Suite 203 861 Silver Lake Blvd. Dover, Delaware 19904 1-302-744-4500 dpr.delaware.gov	Cannon Building, Suite 203 861 Silver Lake Blvd. Dover, Delaware 19904 1-302-744-4500 dpr.delaware.gov
New York	Office of Professional Medical Conduct Central Intake Unit Riverview Center 150 Broadway- Suite 355 Albany, NY 12204-2719 1-800-663-6114 www.health.ny.gov/professionals/doctors/conduct/	New York State Department of Health Centralized Hospital Intake Program Mailstop: CA/DCS Empire State Plaza Albany, NY 12237 1-800-804-5447 apps.health.ny.gov/surveyd8/facility-complaint-form
Pennsylvania	Department of State Bureau of Professional and Occupational Affairs Compliance Office P.O. Box 2649 Harrisburg, PA 17105 717-787-8503 www.dos.pa.gov/Pages/File-a-Complaint.aspx	Pennsylvania Department of Health Division of Acute and Ambulatory Care H&W Building, Room 532 625 Forster Street Harrisburg, PA 17120 1-717-783-8980 apps.health.pa.gov/dohforms/FacilityComplaint.aspx
West Virginia	West Virginia Board of Medicine Attn: Complaints Coordinator 101 Dee Drive, Suite 103 Charleston, West Virginia 25311 1-304-558-2921 ext. 49867 https://wvbom.wv.gov/Instructions_and_Forms.asp	Office of Health Facility Licensure & Certification Attention: [Health Care Facility Type] Complaint Intake 408 Leon Sullivan Way Charleston, WV 25301-1713 1-304-558-005 https://ohflac.wvdhhr.org/complaint.html

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

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

Section 1.7 What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

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

Is it about something else?

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

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

Section 1.8 How to get more information about your rights

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

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

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

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

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapters 3 and 4 give the details about your medical services.
- **If you have any other health insurance coverage in addition to our plan, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - You must continue to pay your Medicare Part B to remain a member of the plan.
  - For most of your medical services covered by the plan, you must pay your share of the cost when you get the service.
- **If you move *within* our service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* of the United States or its territories, you cannot remain a member of our plan.**
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

CHAPTER 7:

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

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

SECTION 1 Introduction

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

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

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

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

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

Section 1.2 What about the legal terms?

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

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

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

SECTION 2 Where to get more information and personalized assistance

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

State Health Insurance Assistance Program (SHIP)

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

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

Medicare

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

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

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

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

Is your problem or concern about your benefits or coverage?

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

Yes.

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

No.

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

COVERAGE DECISIONS AND APPEALS

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

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

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

Asking for coverage decisions prior to receiving services

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

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

Making an appeal

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

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

If we do not dismiss your case but say no to all or part of your Level 1 appeal, you can go on to a Level 2 appeal. The Level 2 appeal is conducted by an independent review organization that is not connected to us. (Appeals for medical services and Part B drugs will be automatically sent to the independent review organization for a Level 2 appeal – you do not need to do anything. If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 8 in this chapter explains the Level 3, 4, and 5 appeals processes).

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

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

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

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

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

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

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

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

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

This section is about your benefits for medical care and services. These benefits are described in the *Medical Benefits Chart* appendix. To keep things simple, we generally refer to "medical care coverage" or "medical care" which includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

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

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

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

Section 5.2 Step-by-step: How to ask for a coverage decision

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

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

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

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

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

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

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

For standard coverage decisions we use the standard deadlines

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

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

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

For Fast Coverage decisions we use an expedited timeframe

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

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

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

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

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

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

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

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

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

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

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

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

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

Deadlines for a "fast appeal"

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

Deadlines for a "standard appeal"

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

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

- However, if you ask for more time, or if we need more information that may benefit you, we can take **up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a "fast complaint.". When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
- If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug.
- **If our plan says no to part or all of your appeal**, we will automatically send your appeal to the independent review organization for a Level 2 appeal.

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

Legal Terms

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

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

Step 1: The independent review organization reviews your appeal.

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

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

- For the "fast appeal" the review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it receives your appeal.
- However, if your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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

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

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

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

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

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

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

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

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

Asking for reimbursement is asking for a coverage decision from us

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

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

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

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

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

SECTION 6 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about our coverage for your hospital care, including any limitations on this coverage, see the *Medical Benefits Chart* appendix.

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

- The day you leave the hospital is called your "**discharge date**."
- When your discharge date has been decided, your doctor or the hospital staff will let you know.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask.

Section 6.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

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

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:
   - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay.
   - Where to report any concerns you have about the quality of your hospital care.
   - Your right to **request an immediate review** of the decision to discharge you if you think you are being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time.
2. **You will be asked to sign the written notice to show that you received it and understand your rights.**
   - You or someone who is acting on your behalf will be asked to sign the notice.
   - Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does *not* mean** you are agreeing on a discharge date.

3. **Keep your copy** of the notice handy so you will have the information about making an appeal (or reporting a concern about quality of care) if you need it.
   - If you sign the notice more than two days before your discharge date, you will get another copy before you are scheduled to be discharged.
   - To look at a copy of this notice in advance, you can call Member Service or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

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

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

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

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

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

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

How can you contact this organization?

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

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge.**
  - **If you meet this deadline,** you may stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.

- **If you do *not* meet this deadline,** and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see Section 6.4.

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

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

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

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

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

What happens if the answer is no?

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

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

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

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

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

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

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

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

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

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

If the review organization says yes:

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

If the review organization says no:

- It means they agree with the decision they made on your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process.

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.

- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 6.4 What if you miss the deadline for making your Level 1 appeal?

Legal Terms
A "fast review" (or "fast appeal") is also called an **"expedited appeal."**

You can appeal to us instead

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

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

Step-by-Step: How to make a Level 1 *Alternate* appeal

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

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

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

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

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

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

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

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

Legal Terms
The formal name for the "independent review organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

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

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

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

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

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

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

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

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

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

When you are getting **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *we will stop paying our share of the cost for your care*.

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

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

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

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

Section 7.3 Step-by-step: How to make a Level 1 appeal to have our plan cover your care for a longer time

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

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

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

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

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

How can you contact this organization?

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

Act quickly:

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

Your deadline for contacting this organization.

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

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

Legal Terms
"**Detailed Explanation of Non-Coverage."** Notice that provides details on reasons for ending coverage.

What happens during this review?

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

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

What happens if the reviewers say yes?

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

What happens if the reviewers say no?

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

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

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

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

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

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

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

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

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

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

What happens if the review organization says yes?

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

What happens if the review organization says no?

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

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

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

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

You can appeal to us instead

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

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

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

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

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

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

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

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

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

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

Legal Terms
The formal name for the "independent review organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

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

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

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

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

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

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

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

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

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

SECTION 8 Taking your appeal to Level 3 and beyond

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

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

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

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

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

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

- If we decide to appeal the decision, we will send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the service in dispute.

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

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

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

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

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

MAKING COMPLAINTS

SECTION 9 How to make a complaint about quality of care, waiting times, customer service, or other concerns

If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

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

Section 9.1 What kinds of problems are handled by the complaint process?

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

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Member Service? • Do you feel you are being encouraged to leave the plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors or other health professionals? Or by our Member Service or other staff at the plan? ◦ Examples include waiting too long on the phone, in the waiting or exam room
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)	If you already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a "fast coverage decision" or a "fast appeal," and we have said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we are not meeting deadlines for covering or reimbursing you for certain medical services that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

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

Section 9.2 How to make a complaint

Legal Terms

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

Section 9.3 Step-by-step: Making a complaint

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

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

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

  Appeals and Grievance Dept.
  P.O. Box 535047
  Pittsburgh, PA 15253-5047

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

  The Expedited or "Fast Grievance" Procedure is as follows:

  The expedited grievance procedure is used in the following instances:

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

Your initial inquiry should be directed to the Member Service department. You may call the number on your member ID card, Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time. Outside these hours, please call 1-888-328-2960 (TTY users, call 711).

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

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

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

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

Section 9.4 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you also have two extra options:

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

Or

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

Section 9.5 You can also tell Medicare about your complaint

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

CHAPTER 8:

Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in Freedom Blue PPO may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you want to leave. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

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

SECTION 2 When can you end your membership in our plan?

Section 2.1 You can end your membership during the Annual Enrollment Period

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

- **Review your State of Delaware open enrollment information.**
- **The Centers for Medicare and Medicaid (CMS) Annual Enrollment Period** is from **October 15 to December 7**.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to cancel your coverage through your former employer and change to a new plan, you can choose any of the following types of plans:
  - Another Medicare health plan, with or without prescription drug coverage.
  - Original Medicare *with* a separate Medicare prescription drug plan.

  OR

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

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

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

- **The annual Medicare Advantage Open Enrollment Period** is from January 1 to March 31.

- **During the annual Medicare Advantage Open Enrollment Period** you can:
  - Switch to another Medicare Advantage Plan with or without prescription drug coverage.
  - Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

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

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

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

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

The enrollment time periods vary depending on your situation.

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

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

OR

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

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

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

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

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

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

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

If you would like to switch from our plan to:	This is what you should do:
• Another Medicare health plan.	• Enroll in the new Medicare health plan. • You will automatically be disenrolled from Freedom Blue PPO when your new plan's coverage begins.
• Original Medicare *with* a separate Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan. • You will automatically be disenrolled from Freedom Blue PPO when your new plan's coverage begins.
• Original Medicare *without* a separate Medicare prescription drug plan.	• **Send us a written request to disenroll.** Contact Member Service if you need more information on how to do this. • You can also contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from Freedom Blue PPO when your coverage in Original Medicare begins.

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

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

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

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

SECTION 5 Freedom Blue PPO must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

Freedom Blue PPO must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If you move out of the United States.
- If you are away from the United States or its territories for more than twelve months.
- If you become incarcerated (go to prison).
- If you are no longer a United States citizen or lawfully present in the United States.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

Where can you get more information?

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

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

Freedom Blue PPO is not allowed to ask you to leave our plan for any health related reason.

What should you do if this happens?

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

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

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

CHAPTER 9:
Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about non-discrimination

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

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

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

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

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

NOTICE OF MEDICARE SECONDARY PAYER SUBROGATION RIGHTS

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

insurance, workers compensation, any other insurance or any individual or other liable party(including companies, corporations or other entities).

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

Reimbursement

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

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

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

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

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

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

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

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

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

Subrogation

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

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

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

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

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

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

Medical experts are constantly searching for and testing new equipment and methods for treating health conditions. In turn, health care plans like Highmark BCBSD, INC. must evaluate these technologies to determine if they are covered by your Freedom Blue PPO plan.

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

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

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

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

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

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

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

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

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

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

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

No Rewards For Denying Coverage

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

Who Reviews Requests?

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

Need More Information?

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

- Your physician may request this information by calling 1-800-452-8507 for medical or surgical decisions, and 1-800-258-9808 for a behavioral health decision.

You may also request information about your coverage or benefits by calling Member Service.

SECTION 7 Notice about coordination of benefits

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

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

CHAPTER 10:

Definitions of important words

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Annual Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or payment for services you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving.

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

Benefit Period – The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you have not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare.

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services.

Combined Maximum Out-of-Pocket Amount – This is the most you will pay in a year for all Part A and Part B services from both network (preferred) providers and out-of-network (non-preferred) providers. See Chapter 4, Section 1.2 for information about your combined maximum out-of-pocket amount.

Complaint – The formal name for "making a complaint" is "filing a grievance." The complaint process is used *only* for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

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

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services are received. Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services are covered; (2) any fixed "copayment" amount that a plan requires when a specific service is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is received.

Covered Services – The term we use in this EOC to mean all of the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care provided by people who do not have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Deductible – The amount you must pay for health care before our plan pays.

Disenroll or **Disenrollment** – The process of ending your membership in our plan.

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

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

Emergency Care – Covered services that are: 1) provided by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

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

Extra Help – A Medicare or a State program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

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

Home Health Aide – A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an "outpatient."

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

In-Network Maximum Out-of-Pocket Amount – The most you will pay for covered Part A and Part B services received from network (preferred) providers. After you have reached this limit, you will not have to pay anything when you get covered services from network providers for the rest of the contract year. However, until you reach your combined out-of-pocket amount, you must continue to pay your share of the costs when you seek care from an out-of-network (non-preferred) provider. In addition to the maximum out-of-pocket amount for in-network covered Part A and Part B medical services, your plan may also have a maximum out-of-pocket amount for certain types of services.

Low Income Subsidy (LIS) – See "Extra Help."

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Open Enrollment Period – The time period from January 1 until March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan, or obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription

drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after an individual is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an i) HMO, ii) PPO, a iii) Private Fee-for-Service (PFFS) plan, or a iv) Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Freedom Blue PPO does not offer Medicare prescription drug coverage.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and B. The term Medicare-Covered Services does not include the extra benefits, such as vision, dental or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

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

"Medigap" (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or "Plan Member") – A person with Medicare who is eligible to get covered services, who has enrolled in our plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Service – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Network Provider – "Provider" is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. "**Network providers**" have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called "plan providers."

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called "coverage decisions" in this document.

Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare) – Original Medicare is offered by the government, and not a private health plan such as Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors,

hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that does not have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan.

Out-of-Pocket Costs – See the definition for "cost sharing" above. A member's cost sharing requirement to pay for a portion of services received is also referred to as the member's "out-of-pocket" cost requirement.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care (LTC) services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Part C – see "Medicare Advantage (MA) Plan."

Part D – The voluntary Medicare Prescription Drug Benefit Program.

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

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

Primary Care Provider (PCP) – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization – Approval in advance to get covered services. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other network provider gets "prior authorization" from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. However, you may want to check with the plan before obtaining services from out-of-network providers to confirm that the service is covered by your plan and what your cost sharing responsibility is. Covered services that need prior authorization are marked in the *Medical Benefits Chart* appendix.

Prosthetics and Orthotics – Medical devices including, but are not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan must disenroll you if you permanently move out of the plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you move into a nursing home, or if we violate our contract with you.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

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

Urgently Needed Services – Covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。

请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

Geb Acht: Wann du Deitsch schwetzscht, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht du die Nummer an deinre ID Kard dahinner uffrufe (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

ધ્યાન આપશોઃ જો તમે ગુજરાતી ભાષા બોલતા હો, તો ભાષા સહાયતા સેવાઓ, મફતમાં તમને ઉપલબ્ધ છે. તમારા ઓળખપત્રના પાછળના ભાગે આવેલા નંબર પર ફોન કરો (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATTENTION: Si c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le numéro qui est au dos de votre carte d'identité. (TTY: 711).

ប្រការចាំបាច់ ៖ បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដែលអាចផ្តល់ជូនលោកអ្នក ដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅលេខដែលមាននៅលើខ្នងកាតសម្គាល់របស់របស់លោកអ្នក (TTY: 711)។

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

注：日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください (TTY: 711)。

توجه : اگر شما به زبان **فارسی** صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

BAA ÁKONÍNÍZIN: Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. ID bee nééhózingo nanitinígíí bine'dęę' (TTY: 711) jį' hodíilnih.

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Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield Delaware is an independent licensee of the Blue Cross Blue Shield Association. All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration.

SilverSneakers is a registered mark of Tivity Health Inc. Tivity Health Inc., is a separate company that administers the SilverSneakers program.

Freedom Blue PPO Member Service

Method	Contact Information
CALL	1-888-328-2960 Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time. Member Service also has free language interpreter services available for non-English speakers.
TTY	711 National Relay Service This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time.
FAX	1-717-635-4235
WRITE	P.O. Box 1068 Pittsburgh, PA 15230-1068
WEBSITE	medicare.highmark.com

State Health Insurance Assistance Program

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

Your state-specific SHIP can be found in the *Agency Contact Information* appendix in this document.