

BlueAdvantage PFFSSM Evidence of Coverage

EVIDENCE OF COVERAGE:

Your Medicare Health Benefits and Services as a Member of BlueCross BlueShield of Tennessee/BlueAdvantage PFFS

January 1 – December 31, 2008

This is an Evidence of Coverage (EOC). It gives the details about Your Medicare health coverage and explains how to get the health care You need. This EOC is an important legal document. Please keep it in a safe place.

This EOC is part of the Group Agreement between BlueCross BlueShield of Tennessee, Inc. (BCBST, or We, Us or Our) and Your Group. This EOC describes the terms and conditions of Your Coverage from Us through the Group, and includes all riders and attachments, which are incorporated herein by reference. It replaces and supersedes any EOC that You have previously received from Us.

PLEASE READ THIS EOC CAREFULLY. IT DESCRIBES YOUR RIGHTS AND DUTIES AS A MEMBER. IT IS IMPORTANT TO READ THE ENTIRE EOC. CERTAIN SERVICES ARE NOT COVERED BY US. OTHER COVERED SERVICES ARE LIMITED. WE WILL NOT PAY FOR ANY SERVICE NOT SPECIFICALLY LISTED AS A COVERED SERVICE, EVEN IF A HEALTH CARE PROVIDER RECOMMENDS OR ORDERS THAT NON-COVERED SERVICE.

In order to make it easier to read and understand this EOC, defined words are capitalized. Those words are defined in the “DEFINITION OF SOME WORDS USED IN THIS EOC” section of this EOC.

Please contact one of Our customer service representatives, at the number listed on Your membership ID card, if You have any questions when reading this EOC. Our customer service representatives are also available to discuss any other matters related to Your Coverage.

BlueCross BlueShield of Tennessee Member Services:

For help or information, please call Member Services.

1-800-841-7434 (Calls to these numbers are free)

TTY users call: 1-888-423-9490

Hours of Operation: 7 days a week, from 8 a.m. until 9 p.m. ET

Note: From March to September 30, You may be required to leave a voice mail on weekends and holidays. Return calls will be made within one business day.

TABLE OF CONTENTS

1 Introduction..... 4

2 How You Get Care 11

3 Covered Benefits 18

4 Your Costs for This Plan 33

5 Your Rights and Responsibilities as a Member of our Plan 36

6 General Exclusions 41

7 How to File a Grievance 44

8 What to Do if You have Complaints about Your Part C Medical Services and Benefits..... 46

9 Ending Your Membership 60

10 Legal Notices 62

11 Definition of Some Words Used in This EOC 63

1 Introduction

Contact Information

Telephone numbers and other information for reference

How to contact our Plan Member Services

If You have any questions or concerns, please call or write to our Plan Member Services. We will be happy to help You.

During the annual enrollment period (between November 15th and December 31st) through 60 days past the beginning of the following contract year, the plan will operate a toll-free call center for both current and prospective members that is staffed seven days a week from 8:00 a.m. to 9:00 p.m. ET. During this time period, current and prospective members can speak with a Member Services representative. Note: From March to September 30, You may be required to leave a voice mail on weekends and holidays. When leaving a message, please include Your name, number and the time You called, and a representative will return Your call no later than one business day after You leave a message.

CALL	1-800-841-7434. This number is also on the cover of this EOC for easy reference. Calls to this number are free.
TTY	1-888-423-9490. This number requires special telephone equipment. It is on the cover of this EOC for easy reference. Calls to this number are free.
FAX	1-423-296-5498
WRITE	BlueCross BlueShield of Tennessee, Attention: BlueAdvantage, P.O. Box 180205, Chattanooga, TN 37402-7205
VISIT	5600 Brainerd Road, Suite E1, Chattanooga, TN 37411

Contact Information for Grievances, Organizations Determinations, Coverage Determinations and Appeals

Part C Organization Determinations

- CALL** 1-800-841-7434. Calls to this number are free.
- TTY** 1-888-423-9490. This number requires special telephone equipment. Calls to this number are free.
- FAX** 1-423-296-5498
- WRITE** BlueCross BlueShield of Tennessee, Attention: BlueAdvantage, P.O. Box 18025, Chattanooga, TN 37402-7205.

For information about Part C organization determinations, see section 9.

Part C Grievances

- CALL** 1-800-841-7434 Calls to this number are free.
- TTY** 1-888-423-9490. This number requires special telephone equipment. Calls to this number are free.
- FAX** 1-423-296-5498
- WRITE** BlueCross BlueShield of Tennessee, Attention: BlueAdvantage, P.O. Box 180205, Chattanooga, TN 37402-7205

For information about Part C grievances, see section 8.

Part C Appeals

- CALL** 1-800-841-7434. Calls to this number are free.
- TTY** 1-888-423-9490. This number requires special telephone equipment. Calls to this number are free.
- FAX** 1-423-296-5498
- WRITE** BlueCross BlueShield of Tennessee, Attention: BlueAdvantage, P.O. Box 180205, Chattanooga, TN 37402-7205

For information about Part C Appeals, see section 9.

Tennessee State Health Insurance Assistance Program (SHIP) – a state program that gives free local health insurance counseling to people with Medicare

Tennessee State Health Insurance Assistance Program is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare. Tennessee State Health Insurance Assistance Program can explain Your Medicare rights and protections, help You make complaints about care or treatment, and help straighten out problems with Medicare bills. Tennessee State Health Insurance Assistance Program has information about Medicare Advantage Plans, Medicare Prescription Drug Plans, Medicare Cost Plans, and about Medigap (Medicare supplement insurance) policies. This includes information about whether to drop Your Medigap policy while enrolled in a Medicare Advantage Plan. This also includes special Medigap rights for people who have tried a Medicare Advantage Plan for the first time. Section 2 has more information about Your Medigap guaranteed issue rights.

You may contact Tennessee State Health Insurance Assistance Program at First TN Dev. District, 207 North Boone Street, Suite 800, Johnson City, TN 37604-5699, Tel: 423-928-0224, or at East TN Human Resource Agency, 9111 Cross Park Drive, Suite D100, Knoxville, TN 37923-4517, Tel: 865-691-2551 ext. 216, or at Southeast TN Dev. District, 535 Chestnut Street, 3rd Floor, Chattanooga, TN 37402, Tel: 423-266-5781, or at Upper Cumberland Dev. District, 1225 South Willow Avenue, Cookeville, TN 38506-4194, Tel: 931-432-4111. You may also find the Web site for Tennessee State Health Insurance Assistance Program at www.medicare.gov on the Web. Under “Search Tools,” select “Helpful Phone Numbers and Websites.”

Q-Source or Quality Improvement Organization – a group of doctors and health professionals in Your state that reviews medical care and handles certain types of complaints from patients with Medicare

“QIO” stands for **Q**uality **I**mprovement **O**rganization. Q-Source is paid by the Federal Government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIOs have different names, depending on which state they are in. The doctors and other health experts in Q-Source review certain types of complaints made by Medicare patients. These include complaints about quality of care and Appeals filed by Medicare patients who think the coverage for their hospital, skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation stay is ending too soon. See Section 8 for more information about complaints, Appeals and grievances.

You may contact Q-Source at 3175 Lenox Park Blvd, Suite 309, Memphis, TN 38115 or call Q-Source at 1-800-528-2655.

How to contact the Medicare program

Medicare is health insurance for people age 65 or older, under age 65 with certain disabilities, and any age with permanent kidney failure (called End-Stage Renal Disease or ESRD). The

Centers for Medicare & Medicaid Services (CMS) is the Federal agency in charge of the Medicare Program. CMS contracts with and regulates Medicare Plans (including our Plan). Here are ways to get help and information about Medicare from CMS:

- Call 1-800-MEDICARE (1-800-633-4227) to ask questions or get free information booklet's from Medicare. TTY users should call 1-877-486-2048. Customer service representatives are available 24 hours a day, including weekends.
- Visit www.medicare.gov. This is the official government Web site for Medicare information. This Web site gives You up-to-date information about Medicare and nursing homes and other current Medicare issues. It includes booklets You can print directly from Your computer. It has tools to help You compare Medicare Advantage Plans and Medicare Prescription Drug Plans in Your area. You can also search under "Search Tools" for Medicare contacts in Your state. Select "Helpful Phone Numbers and Web sites." If You do not have a computer, Your local library or senior center may be able to help You visit this Web site using its computer.

Other organizations (including Social Security and Medicaid, a state government agency that handles health care programs for people with limited resources)

Medicaid helps with medical costs for some people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid has programs that can help pay for Your Medicare premiums and other costs, if You qualify. To find out more about Medicaid and its programs, contact The Bureau of TennCare, by calling 1-866-311-4287 or writing to 310 Great Circle Road, Nashville, TN 37243. Or You may contact the Tennessee Department of Health at 1-615-741-3111 or write to 425 5th Avenue N, Nashville, TN 37247.

Social Security

Social Security programs include retirement benefits, disability benefits, family benefits, survivors' benefits, and benefits for the aged and blind. You may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You may also visit www.ssa.gov on the Web.

Railroad Retirement Board

If You get benefits from the Railroad Retirement Board, You may call Your local Railroad Retirement Board office or 1-800-808-0772. TTY users should call 312-751-4701. You may also visit www.rrb.gov on the Web.

Employer (or "Group") Coverage

If You or Your spouse get Your benefits from Your current or former employer or union, or from Your spouse's current or former employer or union, call Your employer's or union's benefits administrator or Member Services if You have any questions about Your employer/union benefits, plan premiums, or the open enrollment season. Important Note: You (or Your

spouse's) employer/union benefits may change, or You or Your spouse may lose the benefits, if You or Your spouse enrolls in Medicare Part D. Call Your employer's or union's benefits administrator or Member Services to find out whether the benefits will change or be terminated if You or Your spouse enrolls in Part D.

Welcome to *BlueAdvantage PFFS!*

We are pleased that You have chosen our Plan.

BlueAdvantage PFFS is a Private-Fee-For-Service Plan.

Thank You for Your membership in BlueAdvantage PFFS; You are getting Your health care through our Plan. BlueAdvantage PFFS is not a "Medigap" Medicare Supplement Insurance policy.

Throughout the remainder of this EOC, we refer to BlueAdvantage PFFS as "Plan" or "our Plan."

This EOC explains how to get Your health care through our Plan.

This EOC, together with Your enrollment form, riders (including optional supplemental benefit brochures), Annual Notice of Change (ANOC), formulary, and amendments that we may send to You, is part of our contract with You and Your group. It explains Your rights, benefits, and responsibilities as a Member of our Plan. The information in this EOC is in effect for the time period from January 1, 2008, - December 31, 2008.

You are still covered by Medicare, but You are getting Your Medicare services as a member of our Plan.

This EOC will explain to You:

- What is covered by our Plan and what is not covered.
- How to get the care You need including some rules You must follow.
- What to do if You are unhappy about something related to getting Your Covered Services.
- How to leave our Plan, and other Medicare options that are available.

If You need this EOC in a different format (such as audio tapes), please call us so we can send You a copy.

Eligibility Requirements

To be a Member of our Plan, You must live in our service area, be entitled to Medicare Part A, and enrolled in Medicare Part B. If You currently pay a premium for Medicare Part A and

Medicare Part B, You must continue paying Your premium in order to keep Your Medicare Part A and/or Medicare Part B and remain a Member of this Plan.

Use Your plan membership ID card, not Your red, white, and blue Medicare card

Now that You are a Member of our Plan, You must use our membership ID card for services covered by this plan. While You are a Member of our Plan and using our Plan services, You *must* use Your plan membership ID card instead of Your red, white, and blue Medicare card to get covered services. (See Section 3 for information on covered services.) Keep Your red, white, and blue Medicare card in a safe place in case You need it later. If You get Covered Services using Your red, white, and blue Medicare card instead of using our membership ID card while You are a plan member, the Medicare Program will not pay for these services and You may have to pay the full cost Yourself.

Please carry Your membership ID card that we gave You at all times and remember to show Your card when You get covered services. If Your membership ID card is damaged, lost, or stolen, call Member Services right away and we will send You a new card.

Here is a sample card to show You what it looks like:



How do I keep my membership record up to date?

We have a membership record about You as a plan Member. Doctors, hospitals, and other plan providers use Your membership record to know what services are covered for You. Your membership record has information from Your enrollment form, including Your address and telephone number. It shows Your specific Plan coverage and other information. Section 5 tells how we protect the privacy of Your personal health information.

Please help us keep Your membership record up to date by letting Member Services and Your employer group administrator know right away if there are any changes to Your name, address, or phone number, or if You go into a nursing home. Also, tell Member Services and Your Group

administrator about any changes in health insurance coverage You have from other sources, such as from Your employer, Your spouse's employer, workers' compensation, Medicaid, or liability claims such as claims from an automobile accident. Call Member Services at the phone number listed in Section 1.

The geographic service area for our Plan.

BlueAdvantage's service area includes all states in the U.S. You are free to seek care from any health care provider that accepts Medicare payments and the terms, conditions and payment rates of our plan. There is no limited provider network.

2 How You Get Care

Providers You can use to get services covered by our Plan.

While You are a Member of our Plan, You may use any provider in the United States eligible to participate in Medicare, who accepts our Plan's terms and conditions, and who agrees to provide You with services. "See Section 2, under the subheading 'Rules about using non-plan providers to get Your covered services', for a complete description of using non-plan providers in a PFFS plan."

What are "plan providers"? "Providers" is the term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by that state to provide health care services. We call them "**plan providers**" when they accept our payment as payment in full, and in some cases to coordinate as well as provide Covered Services to Members of our Plan. .

What are covered services?

Covered Services is the general term we use in this EOC to mean all the medical care, health care services, supplies, and equipment that are covered by our Plan. Covered Services are listed in the Benefits Chart in Section 3.

Rules about using non-plan providers to get Your covered services.

You may get services from any provider in the United States eligible to participate in the Medicare program and accepts our Plan. As soon as You have told Your provider that You are a Member of our Plan, for example, by showing them Your plan ID card, and they agree to treat You, Your provider is bound by the terms and conditions of payment of the Plan even if they do not explicitly accept them. We call these providers "deemed providers". Therefore, You should not pay more than the Plan cost-sharing. We will pay the provider the remainder of his/her bill. The provider cannot change his/her mind about accepting the Plan's terms and conditions of payment after furnishing services.

How do You get care from doctors, specialists and hospitals?

You may go to any doctor or hospital in the United States that is eligible to participate in Medicare as long as they are willing to provide care and accepts our Plan's terms and conditions of payment. If a particular provider does not accept Your plan's terms and conditions of payment You must get care from another provider who will. When You go to a doctor or hospital be sure to show them Your Plan membership ID card. The card ensures that the provider has a reasonable opportunity to get the terms and conditions of payment under the Plan. If the doctor or hospital decides to treat You, You are only required to pay the cost-sharing amount allowed by our Plan. The doctor or hospital will bill us for the rest of its fee. You may call us in advance of getting health care services and we will provide a written advance coverage

determination for the care You need. You may also ask us for a coverage decision in writing confirming if the service will be paid for by our Plan.

You may always ask us if You have questions about whether a certain service is covered by Your plan or if a doctor or hospital may treat You. When You go to a doctor or hospital, for non-emergent care, You must inform the provider, by showing them Your Member ID card that You are enrolled in our Plan - a Medicare Private Fee-for-Service Plan. If the doctor or hospital decides to treat You, You are only required to pay the cost-sharing amount allowed by our Plan. The doctor or hospital will bill us for the rest of the fee. When getting inpatient hospital services if Your cost-sharing will exceed \$500 hospitals must notify You with a notice of anticipated cost-sharing.

If You have any question whether we will pay for a service, including inpatient hospital services, You have the right under law to have a written / binding advance coverage determination made for the service. Call us and tell us You would like a decision if the service or item will be covered.

Note: Emergency services are covered by all Medicare plans, including PFFS plans, regardless of whether the provider is a plan or non-plan provider.

What if the doctor will not treat You as a Member of our Plan?

The rules for using providers in a PFFS plan were discussed above in Section 2 in the section "Rules about using non-plan providers to get Your covered services." Please read this section carefully. As indicated there sometimes a doctor, specialist, hospital, clinic, or other provider You are using might decide to not participate in our Plan. If this happens, You will have to choose another provider who is willing to treat You as a Member of our Plan. If You need help finding a provider who will accept our Plan's terms and conditions of payment, please contact Member Services and we will provide assistance.

Getting care if You have a medical emergency or an urgent need for care

What is a "medical emergency"?

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

What should You do if You have a medical emergency?

If You have a medical emergency:

- Get medical help as quickly as possible. Call 911 for help or go to the nearest emergency room, hospital, or urgent care center. You do not need to get approval first from Your plan.

Make sure that we know about Your emergency, because we need to be involved in following up on Your emergency care. Please call the number on the back of Your membership ID card. We will help manage and follow up on Your emergency care.

We will talk with the doctors who are giving You emergency care to help manage and follow up on Your care. When the doctors who are giving You emergency care say that Your condition is stable and the medical emergency is over, what happens next is called “post-stabilization care.” Your follow-up care (post-stabilization care) will be covered according to Medicare guidelines. In general, we will try to arrange for plan providers to take over Your care as soon as Your medical condition and the circumstances allow.

What is covered if You have a medical emergency?

- You may get covered emergency medical care whenever You need it, anywhere in the United States.
- You can receive coverage for health care services received while traveling outside of the country. Your coverage is subject to an annual deductible of \$250. Once Your deductible has been met You are responsible for 20 percent of the cost of any services that would have been covered by Medicare. There is an annual payment limit of \$25,000. Coverage is good for 60 consecutive days of foreign travel. Contact Member Services if You have any questions.

Ambulance services are covered in situations where other means of transportation in the United States would endanger Your health.

What if it was not 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 was not a medical emergency after all. If You decide to get follow-up care from the provider treating You, then You should advise them of Your plan enrollment as soon as possible. The plan will pay for all Medically Necessary plan Covered Services furnished by the provider and covers non-emergency care that You get from any provider in the United States to whom You have informed, by showing Your Member ID card, that You are a plan Member.

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

Urgently needed care refers to a non-emergency situation where You are inside the United States, and You need medical attention right away for an unforeseen illness, injury, or condition.

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

The main difference between urgently needed care and a medical emergency is in the danger to Your health. A “medical emergency” occurs when You reasonably believe that Your health is in

serious danger, regardless of where You are located. “Urgently needed care” is when You need medical help for an unforeseen illness, injury, or condition, but Your health is not in serious danger.

How to get urgently needed care?

As discussed in detail in Section 2 in the section entitled "Rules about using non-plan providers to get Your covered services", a PFFS plan allows enrollees to access care from any provider eligible for Medicare anywhere in the United States (Reread that section for important details on obtaining care.). Consequently, the concept of urgent care does not apply in a PFFS setting since the enrollee may always obtain services independent of their location. Note: Non-emergency care obtained at an urgent-care center, may have different cost-sharing than for other providers.

Hospital care, skilled nursing facility care, and other services

How do You get hospital care?

If You need hospital care, we will cover these services for You. Covered Services are listed in the Benefits Chart in [Section 3](#) under the heading “Inpatient Hospital Care”.

What happens if You join or leave our Plan during a hospital stay?

If You either join or leave our Plan during an inpatient hospital stay, special rules may apply to Your coverage for the stay and to what You owe for this stay. If this situation applies to You, please call Member Services. Member Services can explain how Your services are covered for this stay, and what You owe to providers, if anything, for the periods of Your stay when You were and were not a plan Member.

What is skilled nursing facility care?

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

How do You get skilled nursing facility care (SNF care)?

If You need skilled nursing facility care, we will cover these services for You. Covered services are listed in the Benefits Chart in [Section 3](#) under the heading “Skilled nursing facility care.” The purpose of this subsection is to tell You more about some rules that apply to Your Covered Services.

Are Nursing Home stays that provide custodial care covered?

“Custodial care” is care for personal needs rather than Medically Necessary needs. Custodial care is care that can be provided by people who do not have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. We do not cover custodial care unless it is provided as other care You are getting in addition to daily skilled nursing care and/or skilled rehabilitation services.

What are the benefit period limitations on coverage of skilled nursing facility care?

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

What are the situations when You may be able to get care in a skilled nursing facility (SNF) that is not a plan provider?

You may obtain SNF services from any Medicare qualified SNF in the United States willing to accept our terms and conditions of payment.

What happens if You join or leave our Plan during a skilled nursing facility (SNF) stay?

If You either join or leave our Plan during a SNF stay, please call Member Services. Member Services can explain how Your services are covered for this stay, and what You owe, if anything, for the periods of Your stay when You were and were not a plan Member.

How do You get home health care?

Home health care is skilled nursing care and certain other health care services that You get in Your home for the treatment of an illness or injury. Covered Services are listed in the Benefits Chart in [Section 3](#) under the heading “Home health care.” If You need home health care services, we will cover these services for You provided the Medicare coverage requirements are met.

When can home health care include services from a home health aide?

As long as some qualifying skilled-nursing services are *also* included, the home health care You get can include services from a home health aide. A home health aide does not have a nursing license or provide therapy. The home health aide 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). The services from a home health aide must be part of the home care of plan for Your illness or injury, and they are not covered unless You are also getting a covered skilled nursing service. “Home health services” do not include the services of housekeepers, food service arrangements, or full-time nursing care at home.

What are “part-time” and “intermittent” home health care services?

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

- **“Part-time” or “intermittent”** means Your skilled nursing and home health aide services combined total less than eight hours per day and 35 or fewer hours each week.

What is hospice care?

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

How do You get hospice care if You are terminally ill?

As a Member of our Plan, You may receive care from any Medicare-certified hospice program. Your doctor can help You arrange hospice care. If You are interested in using hospice services, You may call Member Services to get a list of the Medicare-certified hospice providers in Your area or You may call the Regional Home Health Intermediary at 1-877-272-5786.

How is Your hospice care paid for?

If You enroll in a Medicare-certified hospice program, the Original Medicare Plan (rather than our Plan) will pay the hospice provider for the services You receive. Your hospice doctor can be a plan provider or a non-plan provider. Even if You choose to enroll in a Medicare-certified hospice, You will still be a plan Member and will continue to get the rest of Your care that is unrelated to Your terminal condition through our Plan.

How to get more information on hospice care

Visit www.medicare.gov on the Web. Under “Search Tools,” “Find a Medicare Publication” to view or download the publication “Medicare Hospice Benefits.” Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048)

How to get an organ transplant if You need it

If You need an organ transplant, we will arrange to have Your case reviewed by one of the transplant centers that is approved by Medicare (some hospitals that perform transplants are approved by Medicare, and others are not). The Medicare-approved transplant center will decide whether You are a candidate for a transplant. When all requirements are met, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, liver, heart, lung, heart-lung, bone marrow, intestinal/multivisceral, and stem cell. The following transplants are covered only if they are performed in a Medicare-approved transplant center: heart, liver, lung, heart-

lung, and intestinal/multivisceral transplants. Member participation in transplant case management is mandatory.

How can You participate in a clinical trial?

A “clinical trial” is a way of testing new types of medical care, like how well a new cancer drug works. A clinical trial is one of the final stages of a research process that helps doctors and researchers see if a new approach works and if it is safe.

Medicare pays for routine costs if You take part in a clinical trial that meets Medicare requirements. Routine costs include costs like room and board for a hospital stay that Medicare would pay for even if You were not in a trial, an operation to implant an item that is being tested, and items and services to treat side effects and complications arising from the new care. Generally, Medicare will not cover the costs of experimental care, such as the drugs or devices being tested in a clinical trial.

There are certain requirements for Medicare coverage of clinical trials. If You participate as a patient in a clinical trial that meets Medicare requirements, the Original Medicare Plan (and not our Plan) pays the clinical trial doctors and other providers for the Covered Services You get that are related to the clinical trial. When You are in a clinical trial, You may stay enrolled in our Plan and continue to get the rest of Your care that is unrelated to the clinical trial through our Plan.

You do not need to get a referral (approval in advance) from a plan provider to join a clinical trial, and the clinical trial providers do not need to be plan providers. However, please be sure to **tell us before You start participation in a clinical trial** so that we can keep track of Your health care services. When You tell us about starting participation in a clinical trial, we can let You know what services You will get from clinical trial providers and the cost for those services. You may view or download the publication “Medicare and Clinical Trials” At www.medicare.gov on the Web. Under “Search Tools,” select “Find a Medicare Publication.” Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

How to access care in Religious Non-medical Health Care Institutions

Care in a Medicare-certified **R**eligious **N**on-medical **H**ealth **C**are **I**nstitution (RNHCI) is covered by our Plan under certain conditions. Covered Services in an RNHCI are limited to non-religious aspects of care. To be eligible for Covered Services in a RNHCI, You must have a medical condition that would allow You to receive inpatient hospital care or extended care services, or care in a home health agency. You may get services when furnished in the home, but only items and services ordinarily furnished by home health agencies that are not RNHCI. In addition, You must sign a legal document that says You are conscientiously opposed to the acceptance of “non-expected” medical treatment. (“Expected” medical treatment is medical care or treatment that You receive involuntarily or that is required under federal, state or local law. “Non-expected” medical treatment is any other medical care or treatment.) You must also get an advanced determination from BlueAdvantage PFFS, or Your stay in the RNHCI may not be covered.

3 Covered Benefits

Covered Services

What are “covered services”?

This section describes the medical benefits and coverage You get as a Member of our Plan.

“Covered services” means the medical care, services, supplies, and equipment that are covered by our Plan. This section has a Benefits Chart that gives a list of Your covered services and tells what You must pay for each covered service. Section 7 tells about **services that are not covered** (these are called “exclusions”).

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

Some general requirements apply to all covered services.

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

- Services must be provided according to the Medicare coverage guidelines established by the Medicare Program.
- The medical care, services, supplies, and equipment that are listed as Covered Services must be Medically Necessary. Certain preventive care and screening tests are also covered. (See Section 13 for a definition of “Medically Necessary”.)

Inpatient Services

Inpatient hospital care

For more information about inpatient hospital care, see [Section 2](#).

Authorization rules may apply except in an emergency. Covered Services include, but are not limited to, the following:

- Semiprivate room (or a private room if Medically Necessary).
- Meals including special diets.
- Regular nursing services.
- Costs of special care units (such as intensive or coronary care units).
- Drugs and medications.
- Lab tests.
- X-rays and other radiology services.
- Necessary surgical and medical supplies.
- Use of appliances, such as wheelchairs.
- Operating and recovery room costs.
- Physical therapy, occupational therapy, and speech therapy.
- Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. See [Section 2](#) for more information about transplants.
- Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that You need - You pay for the first 3 pints of unreplaced blood. All other components of blood are covered beginning with the first pint used.
- Physician Services.

Please refer to Your Summary of Benefits for the specific benefit information.

<p>Inpatient mental health care Covered Services include mental health care services that require a hospital stay. Auth rules may apply except in an emergency. You may only receive 190 days in Psychiatric hospital in a lifetime. The 190-day limit does not apply to mental health services provided in a psychiatric unit of a general hospital..</p>	<p>Please refer to Your Summary of Benefits for the specific benefit information.</p>
<p>Skilled nursing facility care For more information about skilled nursing facility care, see Section 2. 100 days per benefit period are covered. Authorization rules may apply. No prior hospital stay is required. Covered Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Semiprivate room (or a private room if Medically Necessary). • Meals, including special diets. • Regular nursing services. • Physical therapy, occupational therapy, and speech therapy. • Drugs (This includes substances that are naturally present in the body, such as blood clotting factors). • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that You need - You pay for the first 3 pints of unreplaced blood. All other components of blood are covered beginning with the first pint used. • Medical and surgical supplies. • Laboratory tests. • X-rays and other radiology services. • Use of appliances such as wheelchairs. • Physician services. 	<p>Please refer to Your Summary of Benefits for the specific benefit information.</p>

Inpatient services (when the hospital or SNF days are not or are no longer covered)

For more information about inpatient services, see [Section 2](#). Covered Services include, but are not limited to, the following:

- Physician services.
- Tests (like X-ray or lab tests).
- X-ray, radium, and isotope therapy including technician materials and services.
- Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations.
- Prosthetics and Orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices.
- Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.
- Physical therapy, speech therapy, and occupational therapy.

Please refer to Your Summary of Benefits for the specific benefit information.

Home health agency care

For more information about home health agency care, see [Section 2](#). Covered Services include, but are not limited to, the following:

- Part-time or intermittent skilled nursing and home health aide services.
- Physical therapy, occupational therapy, and speech therapy.
- Medical social services.
- Medical equipment and supplies.

Please refer to Your Summary of Benefits for the specific benefit information.

<p>Hospice care For more information about hospice services, see Section 2. Covered Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by Medicare. • Home care. <p>Our Plan covers hospice consultation services (one time only) for a terminally ill person who has not elected the hospice benefit.</p>	<p>Please refer to Your Summary of Benefits for the specific benefit information.</p>
<p>Outpatient Services</p>	
<p>Physician services, including doctor office visits Covered Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Office visits, including medical and surgical care in a physician’s office or certified ambulatory surgical center. • Consultation, diagnosis, and treatment by a specialist. • Second opinion prior to surgery • Outpatient hospital services. • Non-routine dental care (Covered Services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a doctor). 	<p>Please refer to Your Summary of Benefits for the specific benefit information.</p>
<p>Chiropractic services Covered Services, include, but are not limited, to the following:</p> <ul style="list-style-type: none"> • Manual manipulation of the spine to correct subluxation. 	<p>Please refer to Your Summary of Benefits for the specific benefit information.</p>

<p>Podiatry services Covered Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs. 	<p>Please refer to Your Summary of Benefits for the specific benefit information.</p>
<p>Outpatient mental health care (including Partial Hospitalization Services) Covered Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. • “Partial hospitalization” is a structured program of active treatment that is more intense than the care received in Your doctor’s or therapist’s office and is an alternative to inpatient hospitalization. 	<p>Please refer to Your Summary of Benefits for the specific benefit information.</p>
<p>Outpatient substance abuse services</p>	<p>Please refer to Your Summary of Benefits for the specific benefit information.</p>
<p>Outpatient surgery</p>	<p>Please refer to Your Summary of Benefits for the specific benefit information.</p>
<p>Ambulance services Covered Services include ambulance services to an institution (like a hospital or SNF), from an institution to another institution, from an institution to Your home, and services dispatched through 911, where other means of transportation could endanger Your health.</p>	<p>Please refer to Your Summary of Benefits for the specific benefit information.</p>

<p>Emergency care For more information, see Section 2.</p> <p>Unlike the Original Medicare plan, You can receive coverage for health care services received while traveling outside of the country. Your coverage is subject to an annual deductible of \$250. Once Your deductible has been met You are responsible for 20 percent of the cost of any services that would have been covered by Medicare. There is an annual payment limit of \$25,000. Coverage is good for 60 consecutive days of foreign travel. Co-payment not waived if admitted to the hospital.</p>	<p>Please refer to Your Summary of Benefits for the specific benefit information.</p>
<p>Urgently needed care For more information, see Section 2.</p> <p>Unlike the Original Medicare plan, You can receive coverage for health care services received while traveling outside of the country. Your coverage is subject to an annual deductible of \$250. Once Your deductible has been met You are responsible for 20 percent of the cost of any services that would have been covered by Medicare. There is an annual payment limit of \$25,000. Coverage is good for 60 consecutive days of foreign travel. Co-payment not waived if admitted to the hospital</p>	<p>Please refer to Your Summary of Benefits for the specific benefit information.</p>
<p>Outpatient rehabilitation services Covered Services include, but are not limited to, the following: physical therapy, occupational therapy, and speech and language therapy</p>	<p>Please refer to Your Summary of Benefits for the specific benefit information.</p>
<p>Durable medical equipment and related supplies – such as wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker. (See definition of “durable medical equipment” in Section 12)</p>	<p>Please refer to Your Summary of Benefits for the specific benefit information.</p>

<p>Prosthetic devices and related supplies – (other than dental) that replaces a body part or function. These include colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” on page 37 for more detail.</p>	<p>Please refer to Your Summary of Benefits for the specific benefit information.</p>
<p>Diabetes self-monitoring, training and supplies – for all people who have diabetes (insulin and non-insulin users). Covered Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • One pair per calendar year of therapeutic shoes for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts. <p>Self-management training is covered under certain conditions. <i>For persons at risk of diabetes:</i> Fasting plasma glucose tests.</p>	<p>Please refer to Your Summary of Benefits for the specific benefit information.</p>
<p>Medical nutrition therapy – for people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by Your doctor.</p>	<p>Please refer to Your Summary of Benefits for the specific benefit information.</p>

<p>Outpatient diagnostic tests and therapeutic services and supplies</p> <p>Covered Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • X-rays. • Radiation therapy. • Surgical supplies, such as dressings. • Supplies, such as splints and casts. • Laboratory tests. • Blood - Coverage begins with the fourth pint of blood that You need – You pay for the first 3 pints of unreplaced blood. Coverage of storage and administration begins with the first pint of blood that You need. 	<p>Please refer to Your Summary of Benefits for the specific benefit information.</p>
<p>Preventive Care and Screening Tests</p>	
<p>Bone-mass measurements</p> <p><i>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 2 years or more frequently if Medically Necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.</i></p>	<p>Please refer to Your Summary of Benefits for the specific benefit information.</p>
<p>Colorectal screening</p> <p>For people 50 and older, the following are covered:</p> <ul style="list-style-type: none"> • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months. • Fecal occult blood test, every 12 months. <p>For people at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy (or screening barium enema as an alternative) every 24 months. <p>For people not at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy. 	<p>Please refer to Your Summary of Benefits for the specific benefit information.</p>

<p>Immunizations</p> <p>Covered Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Pneumonia vaccine • Flu shots, once a year in the fall or winter. As explained in <u>Section 2</u>, You may get this service on Your own, without a referral from Your PCP (as long as You get the service from a Plan provider). • If You are at high or intermediate risk of getting Hepatitis B: Hepatitis B vaccine. • Other vaccines if You are at risk. 	<p>Please refer to Your Summary of Benefits for the specific benefit information.</p>
<p>Mammography screening</p> <p>Covered Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • One baseline exam between the ages of 35 and 39. • One screening every 12 months for women age 40 and older. 	<p>Please refer to Your Summary of Benefits for the specific benefit information.</p>
<p>Pap tests, pelvic exams, and clinical breast exam</p> <p>Covered Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • For all women, Pap tests, pelvic exams, and clinical breast exams are covered once every 24 months. • If You are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months. 	<p>Please refer to Your Summary of Benefits for the specific benefit information.</p>
<p>Prostate cancer screening exams</p> <p>For men age 50 and older, the following are covered once every 12 months:</p> <p>Covered Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Digital rectal exam. • Prostate Specific Antigen (PSA) test. 	<p>Please refer to Your Summary of Benefits for the specific benefit information.</p>

<p>Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease). Coverage of cardiovascular screening blood tests for all asymptomatic beneficiaries every 5 years (i.e. at least 5 months after the last covered screening tests).</p>	<p>Please refer to Your Summary of Benefits for the specific benefit information.</p>
<p>Physical exams</p>	<p>Please refer to Your Summary of Benefits for the specific benefit information.</p>
<p>Other Services</p>	
<p>Dialysis (Kidney) Covered Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Outpatient dialysis treatments • Inpatient dialysis treatments (if You are admitted to a hospital for special care). • Self-dialysis training (includes training for You and anyone helping You with Your home dialysis treatments). • Home dialysis equipment and supplies. • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on Your home dialysis, to help in emergencies, and check Your dialysis equipment and water supply). 	<p>Please refer to Your Summary of Benefits for the specific benefit information.</p>
<p>Prescription Drugs That are covered under the Original Medicare Plan (these drugs are covered for everyone with Medicare) “Drugs” includes substances that are naturally present in the body, such as blood-clotting factors. Covered drugs include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Drugs that usually are not self-administered by the patient and are injected while You are getting physician services. 	<p>Please refer to Your Summary of Benefits for the specific benefit information.</p>

<ul style="list-style-type: none"> • Drugs You take using durable medical equipment (such as nebulizers) that was authorized by BlueCross BlueShield of Tennessee. • Clotting factors You give Yourself by injection if You have hemophilia. • Immunosuppressive drugs, if You have had an organ transplant that was covered by Medicare. • Injectable osteoporosis drugs, if You are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug. • Antigens. • Certain oral anti-cancer drugs and anti-nausea drugs. • Certain drugs for home dialysis, including heparin, the antidote for heparin when Medically Necessary, topical anesthetics, Erythropoietin (Epogen®) or Epoetin alfa, and Darboetin Alfa (Aranesp®). • Intravenous Immune Globulin for the treatment of primary immune deficiency diseases in Your home. 	
Additional Benefits	
<p>Dental services Services by a dentist or oral surgeon are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor.</p> <p>Your plan may cover additional dental services. Please refer to Your Summary of Benefits for specific benefit information.</p>	<p>Please refer to Your Summary of Benefits for the specific benefit information.</p>

<p>Hearing services</p> <ul style="list-style-type: none"> • Diagnostic hearing exams. <p>Your plan may cover additional dental services. Please refer to Your Summary of Benefits for specific benefit information.</p>	<p>Please refer to Your Summary of Benefits for the specific benefit information.</p>
<p>Vision care</p> <p>Covered Services include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Outpatient physician services for eye care. • For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. <p>Your plan may cover additional vision services. Please refer to Your Summary of Benefits for specific benefit information.</p>	<p>Please refer to Your Summary of Benefits for the specific benefit information.</p>

Health and wellness education programs

Wellness services include preventive education and reminders for screening tests, access to a Health Information Library Audio Index, and a Personal Health Manager which is a single online source for You to receive wellness services information, health information, and interact with a nurse. You also have access to our BluePerks discount program for non-Covered Services. The Health Information Library Audio Index, Personal Health Manager and BluePerks information is located at www.bcbst-medicare.com. Lifestyle Health Management and Care Coordination programs are designed to improve Your health, lifestyle and quality of life through health educational materials, nurse consultation, community resource referrals and assistance with coordinating Your health care needs. Examples of these programs include weight management, smoking cessation, hypertension management, cholesterol management, stress management and more. Disease Management programs are available that focus on health conditions such as diabetes and congestive heart failure providing education and tools to help You manage Your condition through self-monitoring techniques, and assigning a nurse to work closely with You and Your doctor or health care provider. Complex health care needs are managed through Complex Case Management as well as Specialty Case Management which offers programs for transplant, behavioral health needs and end of life care.

Please refer to Your Summary of Benefits for the specific benefit information.

AirMedical Transportation (AirMed International Membership)

If You are traveling more than 150 miles from home and become hospitalized, You can receive the following assistance:

- Air ambulance transportation to a hospital close to Your home.
- Transportation for Your traveling companion.
- In the event of Your death, transportation of remains to funeral facility near Your home.

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

If You have any concerns or problems getting the services You believe are covered for You as a member, we want to help. Please call Member Services . You have the right to make a complaint if You have problems related to getting services or payment for services that You believe are covered as a member. See [Section 9](#) for information about making a complaint.

Can Your benefits change during the year?

Generally Your benefits will not change during the year. The Medicare Program does not allow us to decrease Your benefits during the calendar year. The only time Your benefits may decrease is at the beginning of the next calendar year. The Medicare Program must approve any decreases we make in Your benefits. We will tell You prior to Your annual election period if there are going to be any increases or decreases in Your benefits for the next calendar year that begins on January 1.

At any time during the year, the Medicare Program can change its national coverage.

Since we cover what the Original Medicare Plan covers, we would have to make any change that the Medicare Program makes. If Your benefits increase, the Original Medicare Plan will pay for the benefit for the rest of the calendar year. In those cases, You will have to pay the Original Medicare Plan out-of-pocket amounts for those services. We will let You know in advance if You will have to pay the Original Medicare Plan out-of-pocket costs for an increased benefit.

4 Your Costs for This Plan

Paying Your monthly plan premium

As a Member of our Plan, You pay:

- 1) Your monthly Medicare Part B premium
- 2) Your monthly Medicare Part A premium, if necessary (most people do not have to pay this premium).

How much is Your monthly plan premium?

If You have any questions about Your Plan premiums or the payment programs, please call Member Services and or Your Group Administrator.

As a Member of our Plan, You must pay a monthly plan premium, unless Your employer subsidizes 100% of the premium

Monthly Plan Premium: Please contact Your Group Administrator for the monthly plan premium amount You may be responsible for.

If You get Your benefits from Your current or former employer, or from Your spouse's current or former employer, call the employer's benefits administrator for information about Your Plan premium.

Paying the plan premium for Your coverage as a Member of our Plan

You will pay Your portion of Your premium directly to Your Group. Your Group will coordinate the payment with Us.

Can Your premiums change during the year?

Generally, Your Plan premium can not change during the calendar year. We will tell You in advance if there will be any changes for the next calendar year in Your Plan premiums. If there are any changes for the next calendar year, they will take effect on January 1.

What happens if You do not pay Your plan premiums, or do not pay them on time?

If Your plan premiums are late, Your Group will tell You in writing that if You do not pay Your premium by 60 days after the due date the Group will end Your membership in the Plan.

Should You decide later to re-enroll in our Plan, or to enroll in another plan offered by our Plan, You will have to pay any late plan premiums that You did not pay from Your previous enrollment in our Plan.

Paying Your share of the cost when You get Covered Services

What are “deductibles,” “co-payments,” and “coinsurance”?

- A **“co-payment”** is a payment You make for Your share of the cost of certain Covered Services You get. A co-payment is a set amount per service (such as paying \$10 for a doctor visit). You pay it when You get the service. Co-payments are listed in Your Summary of Benefits document.
- **“Coinsurance”** is a payment You make for Your share of the cost of certain Covered Services You receive. Coinsurance is a percentage of the cost of the service (such as paying 20% for Durable Medical Equipment). You pay Your coinsurance when You get the service. Co-payments are listed in Your Summary of Benefits document.
- Depending on Your Medicaid benefit, You may not have to pay out-of-pocket costs for premiums, deductibles, co-payments and coinsurances. These costs may be covered by Medicaid, as long as You qualify for Medicaid benefits and the provider accepts Medicaid. The only exception is that You are responsible Your Medicaid co-payments, if applicable.

What is the maximum amount You will pay for covered services?

There is a limit to how much You have to pay out-of-pocket for Your covered health care services each year.

What is Your cost for services that are not covered under our Plan?

You are responsible to pay the full cost of care and services that are not covered by our Plan. Other sections of this EOC describe the services that are covered under our Plan and the rules that apply to getting Your care as a plan member.

If You have any questions about whether our Plan will pay for a service or item, including inpatient hospital services, You have the right to have an organization determination or a coverage determination made for the service. You may call Member Services and tell us You would like a decision on whether the service will be covered.

For Covered Services that have a benefit limitation, You pay the full cost of any services You get after You have used up Your benefit for that type of covered service, unless Your plan offers, as a covered supplemental benefit, coverage beyond the original Medicare limits. For example, You may have to pay the full cost of any skilled nursing facility care You get after our Plan’s payments reach the benefit limit. Paying for costs once a benefit limit has been reached will not count toward an out-of-pocket maximum. You can call Members Services when You want to know how much of Your benefit limit You have already used.

Using all of Your insurance coverage

If You have additional health insurance coverage besides our Plan, it is important that You use Your other coverage in combination with Your coverage as a Member of our Plan to pay Your health care expenses. This is called “coordination of benefits” because it involves coordinating all of the health benefits that are available to You. Using all of the coverage You have helps keep the cost of health care more affordable for everyone.

You are required to tell our Plan if You have additional health insurance

You must tell us if You have any other health insurance coverage besides our Plan, and let us know whenever there are any changes in Your additional coverage. The types of additional coverage You might have include the following:

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

What should You do with Your provider bills?

You should never pay the provider more than the cost-sharing allowed by our Plan. You should ask Your provider to bill us for the rest of his or her fee and we will pay him or her according to our Plan terms and conditions of payment. If the provider asks You to pay the remainder of the bill and have You directly reimbursed from the Plan, tell him or her that You only have to pay the cost-sharing amount. Your enrollment card in our Plan will indicate how the provider can contact us for information on our terms and conditions of payment. If the provider wants further information on payment for covered services, please have him or her contact us at 1-800-841-7434 or BlueCross BlueShield of Tennessee, BlueAdvantage, P.O. Box 180205, Chattanooga, TN 37402-7205.

If You get a bill for the services, You may send the bill to us for payment. However, if You have already paid for the Covered Services we will reimburse You for our share of the cost. If You have not paid for the service we will pay Your doctor for our share of the bill and will let You know if You must pay any cost-sharing.

5 Your Rights and Responsibilities as a Member of our Plan

Introduction to Your rights and protections

Since You have Medicare, You have certain rights to help protect You. In this Section, we explain Your Medicare rights and protections as a Member of our Plan and, we explain what You can do if You think You are being treated unfairly or Your rights are not being respected. If You want to receive Medicare publications on Your rights, You may call and request them at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, or visit www.medicare.gov on the Web to view or download the publication “Your Medicare Rights & Protections.” Under “Search Tools,” select “find a Medicare Publication.” If You have any questions whether our Plan will pay for a service, including inpatient hospital services, and including services obtained from providers not affiliated with our Plan, You have the right under law to have a written/binding advance coverage determination made for the service. Call us and tell us You would like a decision if the service or item will be covered.

Your right to be treated with dignity, respect and fairness

You have the right to be treated with dignity, respect, and fairness at all times. Our Plan must obey laws that protect You from discrimination or unfair treatment. We do not discriminate based on a person’s race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. If You need help with communication, such as help from a language interpreter, please call Member Services. Member Services can also help if You need to file a complaint about access (such as wheel chair access). You may also call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or Your local Office for Civil Rights.

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

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

The laws that protect Your privacy give You rights related to getting information and controlling how Your health information is used. We are required to provide You with a notice that tells about these rights and explains how we protect the privacy of Your health information. For example, You have the right to look at medical records held at the Plan, and to get a copy of Your records (there may be a fee charged 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 review Your request and figure out whether the changes are appropriate). You have the right to know

how Your health information has been given out and used for non-routine purposes. If You have questions or concerns about privacy of Your personal information and medical records, please call Member Services. “The Plan will release Your information to Medicare, which may release it for research and other purposes that follow all applicable Federal statutes and regulations.”

Your right to see providers, get covered services within a reasonable period of time

As explained in this EOC, You will get most or all of Your care from licensed providers who have agreed to treat You under our Plan terms and conditions of payment. You have the right to seek care from any provider in the U.S. who is eligible to be paid by Medicare and accepts our Plan terms and conditions of payment? You also have the right to timely access. “Timely access” means that You can get appointments and services within a reasonable amount of time. Section 2 explains how to use providers to get the care and services You need.

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

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

You have the right to receive a detailed explanation from us if You believe that a provider has denied care that You believe You were entitled to receive or care You believe You should continue to receive. In these cases, You must request an initial decision called an organization determination or a coverage determination. Organization determinations are discussed in Section 8. Coverage determinations are discussed in Section 9.

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

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

You have the right to ask someone such as a family member or friend to help You with decisions about Your health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If You want to, You can use a special form to give someone the legal authority to make decisions for You if You ever become unable to make decisions for Yourself. You also have the right to give Your doctors written instructions about

how You want them to handle Your medical care if You become unable to make decisions for Yourself. The legal documents that You can use to give Your directions in advance in these situations are called “**advance directives.**” There are different types of advance directives and different names for them. Documents called “**living will**” and “**power of attorney for health care**” are examples of advance directives.

If You want to have an advance directive, You can get a form from Your lawyer, from a social worker, or from some office supply stores.

You can sometimes get advance directive forms from organizations that give people information about Medicare. Section 1 of this EOC tells how to contact Tennessee State Health Insurance Assistance Program/ Your SHIP, which stands for State Health Insurance Assistance Program. Regardless of where You get this form, keep in mind that it is a legal document. You should consider having a lawyer help You prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to Your doctor and to the person You name on the form as the one to make decisions for You if You can not. You may want to give copies to close friends or family members as well.

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

Remember, it is *Your choice* whether You want to fill out an advance directive (including whether You want to sign one if You are in the hospital). According to law, no one can deny You care or discriminate against You based on whether or not You have signed an advance directive. If You *have* signed an advance directive, and You believe that a doctor or hospital has not followed the instructions in it, You may file a complaint with the Tennessee Department of Health, 425 5th Avenue, North, Cordell Hull Building, 3rd Floor, Nashville, TN 37247.

Your right to make complaints

You have the right to make a complaint if You have concerns or problems related to Your coverage or care. A complaint can be called a grievance, an organization determination, or a coverage determination depending on the situation. See Section 8 for more information about complaints.

If You make a complaint, we must treat You fairly (i.e., not retaliate against You) because You made a complaint. You have the right to get a summary of information about the Appeals and grievances that members have filed against our Plan in the past. To get this information, call Member Services.

Your right to get information about our Plan, providers, health care coverage, and costs

This EOC tells You what medical services are covered for You as a plan member. The Summary of Benefits documents tell You what You have to pay.

If You need more information, please call Member Services . You have the right to an explanation from us about any bills You may get for services not covered by our Plan. *We must tell You in writing why we will not pay for or approve a service, and how You can file an Appeal to ask us to change this decision.* See [Section 8](#) and [Section 9](#) for more information about filing an Appeal.

You also have the right to get information from us about our Plan. This includes information about our financial condition, about our Plan health care providers and their qualifications, and how our Plan compares to other health plans. You have the right to find out from us how we pay doctors. To get any of this information, call Member Services. You have the right under law to have a written/binding advance coverage determination made for the service.

How to get more information about Your rights

If You have questions or concerns about Your rights and protections, please call Member Services. You can also get free help and information from Your SHIP (contact information for Your SHIP in Section 1 of this EOC). You can also visit www.medicare.gov on the Web to view or download the publication “Your Medicare Rights & Protections.” Under “Search Tools,” select “Find a Medicare Publication.” Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

What You do if You think You have been treated unfairly or Your rights are not being respected?

If You think You have been treated unfairly or Your rights have not been respected, You may call Member Services or:

- If You think You have been treated unfairly due to Your race, color, national origin, disability, age, or religion, You can call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or call Your local Office for Civil Rights.
- If You have any other kind of concern or problem related to Your Medicare rights and protections described in this section, You can also get help from Your SHIP (contact information for Your SHIP is in Section 1 of this EOC).

Your responsibilities as a Member of our Plan

Your responsibilities include the following:

- Getting familiar with Your coverage and the rules You must follow to get care as a member. You can use this EOC to learn about Your coverage and the rules You need to follow. Please call Member Services if You have any questions.

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- Letting us know if You have additional health insurance coverage.
 - Notifying providers when seeking care (unless it is an emergency) that You are enrolled in our Plan and You must present Your plan enrollment card to the provider.
 - Giving Your doctor and other providers the information they need to care for You, and following the treatment plans and instructions that You and Your doctors agree upon. Be sure to ask Your doctors and other providers if You have any questions and have them explain Your treatment in a way You can understand.
 - Acting in a way that supports the care given to other patients and helps the smooth running of Your doctor's office, hospitals, and other offices.
 - Paying Your plan premiums and Your co-payments/coinsurance for Your Covered Services. You must pay for services that are not covered.
 - Letting us know if You have any questions, concerns, problems, or suggestions. If You do, please call Member Services.

6 General Exclusions

Introduction

The purpose of this section is to tell You about medical care and services that are not covered (“excluded”) or are limited by our Plan. The list below tells about these exclusions and limitations. The list describes services and items that are not covered under any conditions, and some services that are covered only under specific conditions. (The Benefits Chart in [Section 3](#) also explains about some restrictions or limitations that apply to certain services).

If You get services and items that are not covered, You must pay for them Yourself

We will not pay for the exclusions that are listed in this section (or elsewhere in this EOC), and neither will the Original Medicare Plan, unless they are found upon Appeal to be services or items that we should have paid or covered (Appeals are discussed in [Section 8](#) and [Section 9](#)).

What services are not covered or are limited by our Plan?

If You have any questions whether our Plan will pay for a service, including inpatient hospital services, You have the right under law to have a written/binding advance coverage determination made for the service. Call our Plan and tell us You would like a decision if the service or item will be covered.

In addition to any exclusions or limitations described in the Benefits Chart in [Section 3](#), or anywhere else in this EOC, **the following items and services are not covered except as indicated by our Plan. Please refer to Your Summary of Benefits document for additional information:**

1. Services that are not covered under the Original Medicare Plan.

NOTE: The services listed in the remaining bullets are excluded from the Original Medicare benefit package.

1. Services that are not reasonable and necessary, according to the standards of the Original Medicare Plan, unless these services are otherwise listed by our Plan as a covered service.
2. Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by the Original Medicare Plan or unless, for certain services, the procedures are covered under an approved clinical trial. In 2008 CMS will continue to pay through Original Medicare for clinical trial items and services covered under the September 2000 National Coverage Determination that are provided to MA plan members. Experimental procedures and items are those items and procedures determined by our Plan and the Original Medicare Plan to not be generally accepted by the medical community.
3. Surgical treatment of morbid obesity *unless* Medically Necessary and covered under the Original Medicare plan.

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4. Private room in a hospital, *unless* Medically Necessary.
 5. Private duty nurses.
 6. Personal convenience items, such as a telephone or television in Your room at a hospital or skilled nursing facility.
 7. Nursing care on a full-time basis in Your home.
 8. Custodial care unless it is provided in conjunction with skilled nursing care and/or skilled rehabilitation services. “Custodial care” includes care that helps people with activities of daily living, like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
 9. Homemaker services.
 10. Charges imposed by immediate relatives or members of Your household.
 11. Meals delivered to Your home.
 12. Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: Weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance unless Medically Necessary.
 13. Cosmetic surgery or procedures, unless needed because of accidental injury or to improve the function of a malformed part of the body. All stages of reconstruction are covered for a breast after a mastectomy, as well as the unaffected breast, to produce a symmetrical appearance.
 14. Chiropractic care is generally not covered under the Plan, (with the exception of manual manipulation of the spine, as outlined in [Section 3](#)) and is limited according to Medicare guidelines.
 15. Routine foot care is generally not covered under the Plan and is limited according to Medicare guidelines.
 16. Orthopedic shoes unless they are part of a leg brace and are included in the cost of the leg brace. There is an exception: Orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
 17. Supportive devices for the feet. There is an exception: Orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
 18. Radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services.
 19. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmia or hyporgasmia.

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20. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices.
 21. Acupuncture.
 22. Naturopath services.
 23. Services provided to veterans in Veterans Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost-sharing is more than the cost-sharing required under our Plan, we will reimburse veterans for the difference. Members are still responsible for our Plan cost-sharing amount.
 24. Any of the services listed above that are not covered will remain not covered even if received at an emergency facility. For example, non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency are not covered if received at an emergency facility.

7 How to File a Grievance

What is a Grievance?

A grievance is any complaint, other than one that involves a request for an organization determination, a coverage determination, or an Appeal, as described in [Section 8](#) OR [Section 9](#) of this EOC, because grievances do not involve problems related to approving or paying for care OR Part D benefits, problems about having to leave the hospital too soon, and problems about having Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) services ending too soon.

If we will not give You the services You want, You believe that You are being released from the hospital or SNF too soon, or Your HHA or CORF services are ending too soon, You must follow the rules outlined in [Section 8](#) or [Section 9](#).

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

- Problems with the quality of the medical care You receive, including quality of care during a hospital stay.
- If You feel that You are being encouraged to leave (disenroll from) the Plan.
- Problems with the service You receive from Member Service.
- Problems with how long You have to wait on the phone, in the waiting room, or in the exam room.
- Problems getting appointments when You need them, or waiting too long for them.
- Rude behavior by doctors, nurses, receptionists, or other staff.
- Cleanliness or condition of doctor's offices, clinics, or hospitals.
- If You disagree with our decision not to give You a "fast" decision or a "fast" Appeal. We discuss these fast decisions and Appeals in more detail in section 8 OR section 9.
- You believe our notices and other written materials are hard to understand.
- We do not give You a decision within the required time frame (on time).
- We do not forward Your case to the independent review entity if we do not give You a decision on time.
- We do not give You required notices.

If You have one of these types of problems and want to make a complaint, it is called "filing a grievance." In certain cases, You have the right to ask for a "fast grievance," meaning we will answer Your grievance within 24 hours. We discuss fast grievances in more detail in Section 8 and/or Section 9.

Filing a grievance with our Plan

If You have a complaint, please call the phone number for **Part C Grievances** in Section 1 of this EOC. We will try to resolve Your complaint over the phone. If You ask for a written response, we will respond in writing to You. **If we cannot resolve Your complaint over the phone, we have a formal procedure to review Your complaints. We call this our Member Complaint and Grievance Process.** If You have a complaint or concern regarding anything not related to coverage decisions or claim payments, You may file a grievance. In order to file a formal written grievance, contact Member Services and we will assist You by sending You a grievance form, or we will direct You in what information should be included in Your letter to capture all of the important facts related to Your grievance. We will also take this over the phone if You wish. Please note that we will acknowledge receipt of Your grievance in writing within 10 working days. For standard grievances, we will formally respond to You within 30 calendar days from the date that we receive Your formal grievance request. In some cases it may be in Your best interest to ask for an extension up to 14 days in order to give us time to fully review all of the necessary information to make a final determination.

Call our Member Service Department if You have any questions about our grievance process. BlueCross BlueShield of Tennessee will also respond to grievances related to refusing to grant a request for an expedited organization determination or reconsideration within 24 hours. We must address Your grievance as quickly as Your case requires based on Your health status, but no later than 30 days after receiving Your complaint. We may extend the time frame by up to 14 days if You ask for the extension, or if we justify a need for additional information and the delay is in Your best interest.

For quality of care problems, You may also complain to Q-Source

You may complain about the quality of care received under Medicare, including care during a hospital stay. You may complain to us using the grievance process, to an independent review organization called the Quality Improvement Organization QIO, or both. If You file with Q-Source, we must help Q-Source resolve the complaint. See Section 1 for more information about Q-Source.

How to file a quality of care complaint with Q-Source

You must write to Q-Source to file a quality of care complaint. You may file Your complaint with Q-Source at any time. See Section 1 for more information about how to file a quality of care complaint with Q-Source.

8 What to Do if You have Complaints about Your Part C Medical Services and Benefits

Introduction

This section gives the rules for making complaints about Part C services and payments in different types of situations. Federal law guarantees Your right to make complaints if You have concerns or problems with Your medical care as a plan member. If You make a complaint, we must be fair in how we handle it. You cannot be disenrolled or penalized in any way if You make a complaint.

Please refer to Original Medicare of Your 2008 Medicare & You Handbook for additional guidance on Your Appeal rights under Original Medicare. If You do not have a Medicare & You Handbook, please call 1-800 Medicare to get a copy.

How to make complaints in different situations

This section tells You how to make a complaint about services or payment disputes in each of the following situations:

Part 1. Complaints about what benefit or service we will approve or what we will pay for.

Part 2. Complaints if You think You are asked to leave the hospital too soon.

Part 3. Complaints if You think Your skilled nursing facility (SNF), home health (HHA) or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

If You want to make a complaint about any situation not listed above, You may file a **grievance**. For more information about grievances, see **Section 7**.

PART 1. Complaints about what benefit or service the Plan will approve or what the Plan will pay for

What are “complaints about Your services or payment for Your care?”

- If You are not getting the care You want, and You believe that this care is covered by the Plan.
- If we will not approve the medical treatment Your doctor or other medical provider wants to give You, and You believe that this treatment is covered by the Plan.
- If You are being told that a treatment or service You have been getting will be reduced or stopped, and You believe that this could harm Your health.

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- If You have received care that You believe should be covered by the Plan, but we have refused to pay for this care because we say it is not Medically Necessary or is not a plan benefit.

What is an organization determination?

An organization determination is our **initial decision** about whether we will provide the medical care or service You request, or pay for a service You have received.

If our initial decision is to deny Your request, You may **Appeal** the decision by going to Appeal Level 1 (see below). You may also Appeal if we fail to make a timely initial decision on Your request.

When we make an “organization determination,” we are giving our interpretation of how the benefits and services that are covered for members of the Plan apply to Your specific situation. This EOC and any amendments You may receive describe the benefits and services covered by the Plan, including any limits on these services. This EOC also lists services that are “not covered” by the Plan.

Who may ask for an “organization determination” about Your medical care or payment?

Your doctor or other medical provider may ask us whether we will approve the treatment. You may also ask us for an initial decision, or You can name (appoint) someone to do it for You. This person You name would be Your representative. You can name a relative, friend, advocate, doctor, or someone else to act for You. Other persons may already be authorized under state law to act for You. If You want someone to act for You, then You and the person You want to act for You must sign and date a statement that gives this person legal permission to be Your representative. This statement must be sent to us at the address listed under **Part C Organization Determinations** in **Section 1** of this EOC. Please call us at the phone number shown under **Part C Organization Determinations** for more information. You also have the right to have a lawyer act for You. You can get Your own lawyer, or find a lawyer from Your local bar association or other referral service. There are also groups that will give You free legal services if You qualify. You may want to call Legal Aid of East Tennessee at 1-865-637-0484.

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

A decision about whether we will pay for or approve medical care can be a “standard decision” that is made within the standard time frame (typically within 14 days), or it can be a “fast decision” that is made more quickly (typically within 72 hours). A fast decision is also called an “expedited organization determination.” You may ask for a fast decision **only** if You or any doctor believe that waiting for a standard decision could seriously harm Your health or Your ability to function.

Asking for a standard decision

To ask for a standard decision about providing medical care or payment for care, You or Your representative should mail or deliver a request in writing to the address listed under **Part C Organization Determinations** in **Section 1** of this EOC

Asking for a fast decision

You, any doctor, or Your representative can ask us to give a “fast” decision (rather than a “standard” decision) about medical care by calling us. Or You may send or fax us a written request to the fax number or address listed under **Part C Organization Determinations** in **Section 1** of this EOC. If You are asking for a fast decision after our regular business hours, a recorded voice message will instruct You to leave a detailed message with Your name, member ID number on the front of Your BlueAdvantage PFFS card, telephone number and information about Your medical condition in a secure voice mailbox. We will check the voice message mailbox to give You an answer within 72-hours. Our recorded message will also tell You how to contact Q-Source if You think the coverage for Your hospital, skilled nursing facility, home health agency, or a comprehensive outpatient rehabilitation services are ending too soon. We may need Your doctor to provide supporting documentation. Be sure to ask for a “fast” or “72-hour” review.

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

If You ask for a fast decision without support from a doctor, we will decide if Your health requires a fast decision. If we decide that You do not need a fast decision, we will send You a letter informing You that if You get a doctor’s support for a “fast” decision, we will automatically give You a fast decision. The letter will also tell You how to file a “grievance” if You disagree with our decision to deny Your request for a fast review. It will also tell You about Your right to ask for a “fast grievance.” If we deny Your request for a fast decision, we will give You a standard decision. For more information about grievances, see Section 8.

What happens next when You request an initial decision?

1. For a decision about payment for care You already received.

We have 30 days to make a decision after we receive Your request. However, if we need more information, we can take up to 30 more days. You will be told in writing if we extend the time frame for making a decision. If we do not approve Your request for payment, we must tell You why, and tell You how You can Appeal this decision. If You have not received an answer from us within 60 days of Your request, You can **Appeal** this decision. (An Appeal is also called a “reconsideration.”)

2. For a standard decision about medical care.

We have 14 days to make a decision after we receive Your request. However, we can take up to 14 more days if You ask for additional time, or if we need more information (such as medical

records) that may benefit You. If we take additional days, we will notify You in writing. If You believe that we should not take additional days, You can make a specific type of complaint called a “fast grievance”. If we do not approve Your request, we must explain why in writing, and tell You of Your right to Appeal our decision. If You have not received an answer from us within 14 days of Your request (or by the end of any extended time period), You have the right to Appeal.

3. For a *fast* decision about medical care.

If You receive a “fast” decision, we will give You our decision about Your requested medical care within 72 hours after You or Your doctor ask for it – sooner if Your health requires. However, we can take up to 14 more days if we find that some information is missing that may benefit You, or if You need more time to prepare for this review. If You believe that we should not take any extra days, You can file a fast grievance.

We will call You as soon as we make the decision. If we deny any part of Your request, we will send You a letter that explains the decision within 3 days of calling You. If we do not tell You about our decision within 72 hours (or by the end of any extended time period), this is the same as denying Your request and You have the right to Appeal. If we deny Your request for a fast decision, You may file a fast grievance.

Appeal Level 1: If we deny any part of Your request for a service or payment of a service, You may ask us to reconsider our decision. This is called an “Appeal” or a “request for reconsideration.”

Please call us if You need help in filing Your Appeal. We give the request to different people than those who made the organization determination. This helps ensure that we will give Your request a fresh look.

If Your Appeal concerns a decision we made about a service You asked for, then You and/or Your doctor will first need to decide whether You need a “fast” Appeal. The procedures for deciding on a “standard” or a “fast” Appeal are the same as those described for a “standard” or “fast” initial decision.

Getting information to support Your Appeal

If we need Your help in gathering this information, we will contact You. You have the right to obtain and include additional information as part of Your Appeal. For example, You may already have documents related to the issue, or You may want to get Your doctor’s records or Your doctor’s opinion to support Your request. You may need to give Your doctor a written request to get information.

You can give us additional information to support Your Appeal by calling, faxing, or writing to the numbers or address listed under **Part C Appeals** in **Section 1** of this EOC. You can also deliver additional information in person to the address listed under **Part C Appeals** in **Section 1**

of this EOC. You also have the right to ask us for a copy of the information we have regarding Your Appeal. You may call or write us at the numbers or address listed under **Part C Appeals** in **Section 1** of this EOC. We are allowed to charge a fee for copying and sending this information to You.

How do You file Your Appeal of the organization determination?

The rules about who may file an Appeal are the same as the rules about who may ask for an organization determination. Follow the instructions under “Who may ask for an ‘organization determination’ about medical care or payment?” However, providers who do not have a contract with the Plan must sign a “waiver of payment” statement that says that they will not ask You to pay for the medical service under review, regardless of the outcome of the Appeal.

How soon must You file Your Appeal?

You must file Your Appeal within 60 days after we notify You of our decision. We can give You more time if You have a good reason for missing the deadline. To file Your Appeal, You may write us at the address listed under **Part C Appeals** in Section 1 of this EOC.

What if You want a “fast” Appeal?

The rules about asking for a “fast” Appeal are the same as the rules about asking for a “fast” decision.

How soon must we decide on Your Appeal?

1. For a decision about payment for care You already received.

After we receive Your Appeal, we have 60 days to decide. If we do not decide within 60 days, Your Appeal automatically goes to Appeal Level 2.

2. For a standard decision about medical care.

After we receive Your Appeal, we have 30 days to decide, but will decide sooner if Your health condition requires. However, if You ask for more time, or if we find that helpful information is missing, we can take up to 14 more days to make our decision. If we do not tell You our decision within 30 days (or by the end of the extended time period), Your request will automatically go to Appeal Level 2.

3. For a fast decision about medical care.

After we receive Your Appeal, we have 72 hours to decide, but will decide sooner if Your health requires. However, if You ask for more time, or if we find that helpful information is missing, we can take up to 14 more days to make our decision. If we do not decide within 72 hours (or by the end of the extended time period), Your request will automatically go to Appeal Level 2.

What happens next if we rule completely in Your favor?

1. For a decision about payment for care You already received.

We must pay within 60 days of the day we received Your Appeal.

2. For a standard decision about medical care.

We must authorize or provide Your requested care within 30 days of receiving Your Appeal. If we extended the time needed to decide Your Appeal, we will authorize or provide Your medical care immediately.

3. For a fast decision about medical care.

We must authorize or provide Your requested care within 72 hours of receiving Your Appeal – or sooner, if Your health requires it. If we extended the time needed to decide Your Appeal, we will authorize or provide Your medical care immediately.

Appeal Level 2: If on Your Level 1 Appeal, we do not rule completely in Your favor, Your Appeal will automatically be reviewed by an independent review entity

If we do not rule completely in Your favor, Your Appeal is automatically sent to Appeal Level 2 where an independent review entity that has a contract with CMS (Centers for Medicare & Medicaid Services), the government agency that runs the Medicare program, and is not part of the Plan, will review Your Appeal. We will tell You in writing that Your Appeal has been sent to this organization for review. How quickly we must forward Your Appeal depends on the type of Appeal:

1. For a decision about payment for care You already received.

We must forward Your Appeal to the independent review entity within 60 days of the date we received Your Level 1 Appeal.

2. For a standard decision about medical care.

We must forward Your Appeal to the independent review entity as quickly as Your health requires, but no later than 30 days after we received Your Level 1 Appeal.

3. For a fast decision about medical care.

We must forward Your Appeal to the independent review entity within 24 hours of our decision.

We will send the independent review entity a copy of Your case file. You also have the right to get a copy of Your case file from us by calling or writing us at the phone number or address listed under **Part C Appeals** in Section 1 of this EOC. We are allowed to charge You a fee for copying and sending this information to You.

How soon must the independent review entity decide?

1. For an Appeal about payment for care, the independent review entity has 60 days to make a

decision.

2. For a standard Appeal about medical care, the independent review entity has 30 days to make a decision. However, it can take up to 14 more days if more information is needed and the extension will benefit You.
3. For a fast Appeal about medical care, the independent review entity has 72 hours to make a decision. However, it can take up to 14 more days if more information is needed and the extension will benefit You.

If the independent review entity decides completely in Your favor:

The independent review entity will tell You in writing about its decision.

1. For an Appeal about payment for care.

We must pay within 30 days after receiving the decision.

2. For a standard Appeal about medical care.

We must authorize the care You requested within 72 hours after receiving the decision, or provide the care no later than 14 days after receiving the decision.

We must authorize or provide the care no later than 14 days after receiving the decision. If it is not appropriate to provide the service within 14 calendar days, e.g., because of Your medical condition or You are outside of the service area, we must authorize the services within 72 hours from the date we receive notice that the independent review entity reversed the determination.

3. For a fast Appeal about medical care.

We must authorize or provide the care You requested within 72 hours after receiving the decision.

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

You must ask for a review by an Administrative Law Judge in writing within 60 days after the date You were notified of the decision made at Appeal Level 2. They may extend the deadline for good cause. You must send Your written request to the ALJ Field Office that is listed in the decision You received from the independent review organization. The Administrative Law Judge will not review the Appeal if the dollar value of the medical care does not meet the minimum requirement included in the independent review organization's decision. If the dollar value is less than the minimum requirement, You may not Appeal any further. During this review, You may present evidence, review the record, and be represented by a lawyer.

How soon will the Judge make a decision?

The Administrative Law Judge will hear Your case, weigh all of the evidence up to this point, and decide as soon as possible.

If the Judge decides in Your favor

We must pay for, authorize, or provide the service You have asked for within 60 days of the date we receive notice of the decision. However, we have the right to Appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4).

Appeal Level 4: If the Judge does not rule completely in Your favor, You may ask for a review by the Medicare Appeals Council

The Medicare Appeals Council does not review every case it receives. If they decide not to review Your case, then either You or we may ask for a review by a Federal Court Judge (Appeal Level 5). The Medicare Appeals Council will send a notice informing You of any action it has taken on Your request. The notice will tell You how to request a review by a Federal Court Judge.

How soon will the Council make a decision?

If the Medicare Appeals Council reviews Your case, they will decide as soon as possible.

If the Council decides in Your favor

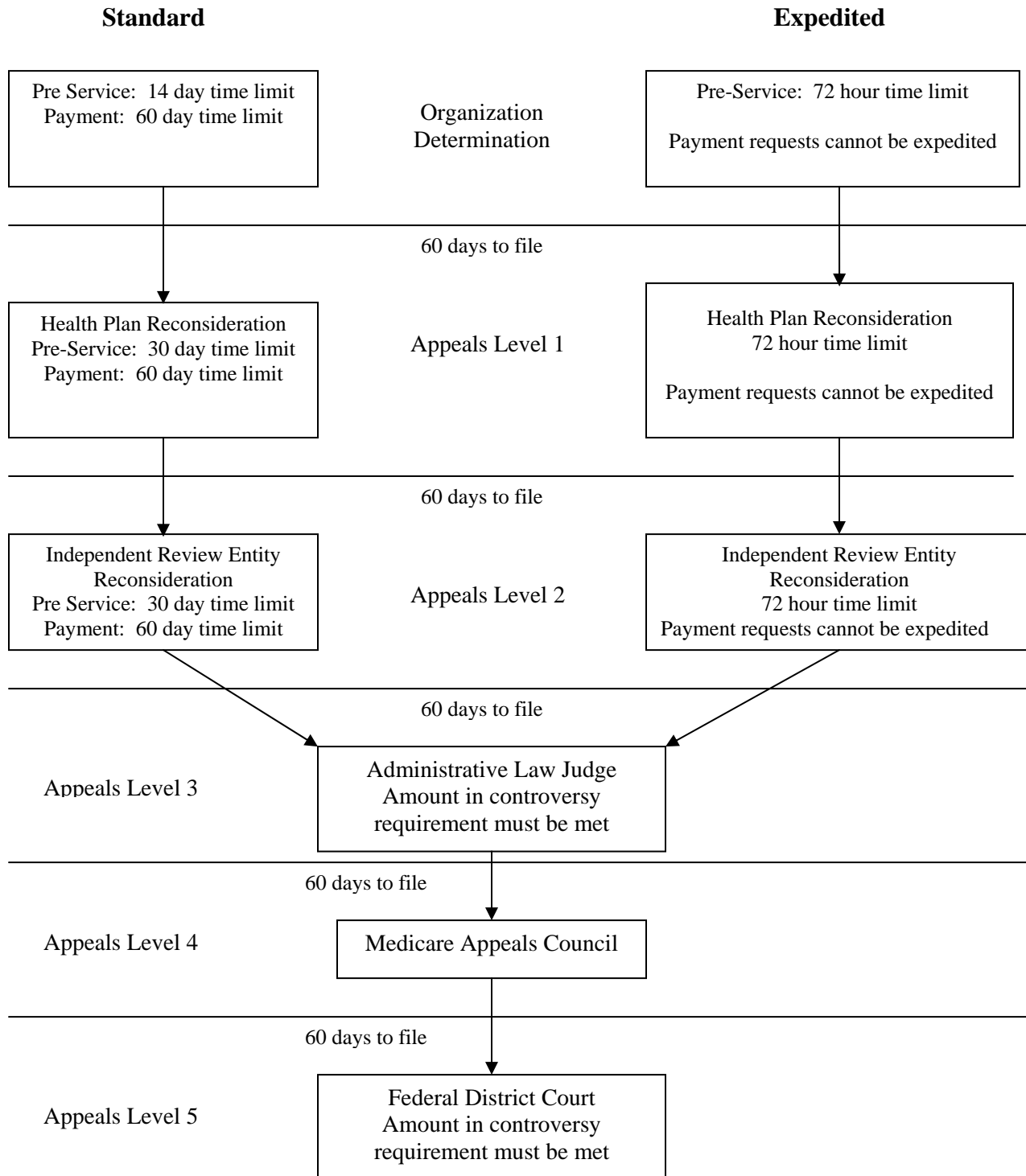
We must pay for, authorize, or provide the medical care You requested within 60 days of the date we receive the decision. However, we have the right to ask a Federal Court Judge to review the case (Appeal Level 5), as long as the dollar value of the care You asked for meets the minimum requirement.

Appeal Level 5: If the Medicare Appeal Council does not rule completely in Your favor, You may ask for a review by a Federal Court

You may file an Appeal in Federal court if You receive a decision from the Medicare Appeals Council (MAC) that is not completely favorable to You or the MAC decided not to review Your case. The letter You get from the MAC will tell You how to ask for this review. The Federal Court Judge will first decide whether to review Your case. Your Appeal will not be reviewed by a Federal Court if the dollar value of the care You asked for does not meet the minimum requirement included in the MAC's decision.

How soon will the Judge make a decision?

The Federal judiciary controls the timing of any decision. The Judge's decision is final. Complaint process for what benefit or service the Plan will approve or what the Plan will pay for



PART 2. Complaints (Appeals) if You think You are being discharged from the hospital too soon

When You are admitted to the hospital, You have the right to get all the hospital care covered by the Plan that is necessary to diagnose and treat Your illness or injury. The day You leave the hospital (Your discharge date) is based on when Your stay in the hospital is no longer Medically Necessary. This part explains what to do if You believe that You are being discharged too soon.

Information You should receive during Your hospital stay

Within two days of admission as an inpatient, someone at the hospital must give You a notice called the Important Message from Medicare (call Member Services or 1-800 MEDICARE (1-800-633-4227) to get a sample notice or see it online at <http://www.cms.hhs.gov/BNI/>). This notice explains:

- Your right to get all Medically Necessary hospital services paid for by the Plan (except for any applicable co-payments or deductibles).
- Your right to be involved in any decisions that the hospital, Your doctor, or anyone else makes about Your hospital services and who will pay for them.
- Your right to get services You need after You leave the hospital.
- Your right to Appeal a discharge decision and have Your hospital services paid for by us during the Appeal (except for any applicable co-payments or deductibles).

You (or Your representative) will be asked to sign the Important Message from Medicare to show that You received and understood this notice. **Signing the notice does not mean that You agree that the coverage for Your services should end – only that You received and understand the notice.** If the hospital gives You the Important Message from Medicare more than 2 days before Your discharge day, it must give You a copy of Your signed Important Message from Medicare before You are scheduled to be discharged.

Review of Your hospital discharge by the Quality Improvement Organization

You have the right to request a review of Your discharge. You may ask a Quality Improvement Organization to review whether You are being discharged too soon.

What is the “Quality Improvement Organization”?

“QIO” stands for **Q**uality **I**mprovement **O**rganization. Q-Source is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of the Plan or the hospital. There is one QIO in each state. QIOs have different names, depending on which state they are in. The doctors and other health experts in Q-Source review certain types of complaints made by Medicare patients. These include complaints from Medicare patients who think their hospital stay is ending too soon.

Getting QIO review of Your hospital discharge

You must quickly contact Q-Source. The Important Message from Medicare gives the name and telephone number of Q-Source and tells You what You must do.

- You must ask Q-Source for a **“fast review”** of Your discharge. This “fast review” is also called an “immediate review.”
- You must request a review from Q-Source no later than the day You are scheduled to be discharged from the hospital. **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 Q-Source.**
- Q-Source will look at Your medical information provided to Q-Source by us and the hospital.
- During this process, You will get a notice giving our reasons why we believe that Your discharge date is medically appropriate.
- Q-Source will decide, within one day after receiving the medical information it needs, whether it is medically appropriate for You to be discharged on the date that has been set for You.

What happens if Q-Source decides in Your favor?

We will continue to cover Your hospital stay for as long as it is Medically Necessary (except for any applicable co-payments or deductibles).

What happens if Q-Source agrees with the discharge?

You will not be responsible for paying the hospital charges until noon of the day after Q-Source gives You its decision. However, You could be financially liable for any inpatient hospital services provided after noon of the day after Q-Source gives You its decision. You may leave the hospital on or before that time and avoid any possible financial liability.

If You remain in the hospital, You may still ask Q-Source to review its first decision if You make the request within 60 days of receiving Q-Source’s first denial of Your request. However, You could be financially liable for any inpatient hospital services provided after noon of the day after Q-Source gave You its first decision.

What happens if You Appeal Q-Source decision?

Q-Source has 14 days to decide whether to uphold its original decision or agree that You should continue to receive inpatient care. If Q-Source agrees that Your care should continue, we must pay for or reimburse You for any care You have received since the discharge date on the Important Message from Medicare, and provide You with inpatient care as long as it is Medically Necessary (except for any applicable co-payments or deductibles).

If Q-Source upholds its original decision, You may be able to Appeal its decision to the Administrative Law Judge. Please see Appeal Level 3 in Part 1 of this section for guidance on the Administrative Law Judge (ALJ) Appeal. If the ALJ upholds the decision, You may also be

able to ask for a review by the Medicare Appeals Council (MAC) or a Federal court. If any of these decision makers (Administrative Law Judge, Medicare Appeal Council, Federal Court) agree that Your stay should continue, we must pay for or reimburse You for any care You have received since the discharge date, and provide You with inpatient care as long as it is Medically Necessary (except for any applicable co-payments or deductibles).

What if You do not ask Q-Source for a review by the deadline?

If You do not ask Q-Source for a fast review of Your discharge by the deadline, You may ask us for a “fast Appeal” of Your discharge, which is discussed in Part 1 of this section.

If You ask us for a fast Appeal of Your discharge and You stay in the hospital past Your discharge date, You may have to pay for the hospital care You receive past Your discharge date. Whether You have to pay or not depends on the decision we make.

- If we decide, based on the fast Appeal, that You need to stay in the hospital, we will continue to cover Your hospital care for as long as it is Medically Necessary (except for any applicable co-payments or deductibles).
- If we decide that You should not have stayed in the hospital beyond Your discharge date, we will not cover any hospital care You received after the discharge date.

If we uphold our original decision, we will forward our decision and case file to the independent review organization within 24 hours. Please see Appeal Level 2 in Part 1 of this section for guidance on the Independent Review Organization (IRO) Appeal. If the IRO upholds our decision, You may also be able to ask for a review by an ALJ, MAC, or a Federal court. If any of these decision makers (Independent Review Organization, Administrative Law Judge, Medicare Appeal Council, Federal Court) agree that Your stay should continue, we must pay for or reimburse You for any care You have received since the discharge date on the notice You got from Your provider, and provide You with any services You asked for as long as they are Medically Necessary (except for any applicable co-payments or deductibles).

PART 3. Complaints (Appeals) if You think coverage for Your skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility services is ending too soon

When You are a patient in a **S**killed **N**ursing **F**acility (SNF), **H**ome **H**ealth **A**gency (HHA), or **C**omprehensive **O**utpatient **R**ehabilitation **F**acility (CORF), You have the right to get all the SNF, HHA or CORF care covered by the Plan that is necessary to diagnose and treat Your illness or injury. The day we end coverage for Your SNF, HHA or CORF services is based on when these services are no longer Medically Necessary. This part explains what to do if You believe that coverage for Your services is ending too soon.

Information You will receive during Your SNF, HHA or CORF stay

Your provider will give You written notice called the Notice of Medicare Non-Coverage at least 2 days before coverage for Your services ends (call Member Services or 1-800 Medicare to get a sample notice or see it online at <http://www.cms.hhs.gov/BNI/>). You (or Your representative)

will be asked to sign and date this notice to show that You received it. **Signing the notice does not mean that You agree that coverage for Your services should end – only that You received and understood the notice.**

Getting QIO review of our decision to end coverage

You have the right to Appeal our decision to end coverage for Your services. As explained in the notice You get from Your provider, You may ask the **Quality Improvement Organization** (the “QIO”) to do an independent review of whether it is medically appropriate to end coverage for Your services.

How soon do You have to ask for QIO review?

You must quickly contact Q-Source. The written notice You got from Your provider gives the name and telephone number of Your QIO and tells You what You must do.

- If You get the notice 2 days before Your coverage ends, You must contact Q-Source no later than noon of the day after You get the notice.
- If You get the notice more than 2 days before Your coverage ends, You must make Your request no later than noon of the day before the date that Your Medicare coverage ends.

What will happen during Q-Source’s review?

Q-Source will ask why You believe coverage for the services should continue. You do not have to prepare anything in writing, but You may do so if You wish. Q-Source will also look at Your medical information, talk to Your doctor, and review information that we have given to Q-Source. During this process, You will get a notice called the Detailed Explanation of Non-Coverage giving the reasons why we believe coverage for Your services should end (call Member Services or 1-800-Medicare to get a sample notice or see it online at <http://www.cms.hhs.gov/BNI/>).

Q-Source will make a decision within one full day after it receives all the information it needs.

What happens if Q-Source decides in Your favor?

We will continue to cover Your SNF, HHA or CORF services for as long as they are Medically Necessary (except for any applicable co-payments or deductibles).

What happens if Q-Source agrees that Your coverage should end?

You will not be responsible for paying for any SNF, HHA, or CORF services provided before the termination date on the notice You get from Your provider. You may stop getting services on or before the date given on the notice and avoid any possible financial liability. If You continue receiving services, You may still ask Q-Source to review its first decision if You make the request within 60 days of receiving Q-Source’s first denial of Your request.

What happens if You Appeal Q-Source decision?

Q-Source has 14 days to decide whether to uphold its original decision or agree that You should continue to receive services. If Q-Source agrees that Your services should continue, we must pay for or reimburse You for any care You have received since the termination date on the notice You got from Your provider, and provide You with any services You asked for as long as they are Medically Necessary (except for any applicable co-payments or deductibles).

If Q-Source upholds its original decision, You may be able to Appeal its decision to the Administrative Law Judge (ALJ). Please see Appeal Level 3 in Part 1 of this section for guidance on the ALJ Appeal. If the ALJ upholds our decision, You may also be able to ask for a review by the Medicare Appeals Council or a Federal Court. If either the Medicare Appeal Council or Federal Court agrees that Your stay should continue, we must pay for or reimburse You for any care You have received since the termination date on the notice You got from Your provider, and provide You with any services You asked for as long as they are Medically Necessary (except for any applicable co-payments or deductibles).

What if You do not ask Q-Source for a review by the deadline?

If You do not ask Q-Source for a review by the deadline, You may ask us for a fast Appeal, which is discussed in Part 1 of this section.

If You ask us for a fast Appeal of Your coverage ending and You continue getting services from the SNF, HHA, or CORF, You may have to pay for the care You get after Your termination date. Whether You have to pay or not depends on the decision we make.

- If we decide, based on the fast Appeal, that coverage for Your services should continue, we will continue to cover Your SNF, HHA, or CORF services for as long as they are Medically Necessary.
- If we decide that You should not have continued getting services, we will not cover any services You received after the termination date.

If we uphold our original decision, we will forward our decision and case file to the independent review entity within 24 hours. Please see Appeal Level 2 in Part 1 of this section for guidance on the Independent Review Entity (IRE) Appeal. If the IRE upholds our decision, You may also be able to ask for a review by an ALJ, MAC, or a Federal court. If any of these decision makers (Independent Review Entity, Administrative Law Judge, Medicare Appeal Council, Federal Court) agree that Your stay should continue, we must pay for or reimburse You for any care You have received since the discharge date on the notice You got from Your provider, and provide You with any services You asked for as long as they are Medically Necessary (except for any applicable co-payments or deductibles).

9 Ending Your Membership

Ending Your membership in our Plan 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.
- There are also limited situations where we are required to end Your membership.

Voluntarily ending Your membership

In general, there are only certain times during the year when You may voluntarily end Your membership in our Plan.

Every year, from November 15 through December 31, during the Annual Coordinated Election Period (AEP), anyone with Medicare may switch from one way of getting Medicare to another for the following year. Your change will take effect on January 1.

There may be other limited times during which You may make changes. For more information about these times and the options available to You, please refer to the “Medicare & You” handbook You receive each fall. You may also call 1-800-MEDICARE (1-800-633-4227), or visit www.medicare.gov to learn more about Your options.

Your Group may Voluntarily End its Program

The Plan or the Group may modify or terminate the Group Agreement. Notice to the Group of the termination or modification of the Group Agreement is deemed to be notice to all Members of the Group. The Group is responsible for notifying You of such a termination or modification of Your Coverage.

All Members’ Coverage through the Agreement will change or terminate at 12:00 midnight on the date of such modification or termination. The Group’s failure to notify You of the modification or termination of Your Coverage shall not be deemed to continue or extend Your Coverage beyond the date that the Group Agreement is modified or terminated. You have no vested right to Coverage under this EOC following the date of the termination of the Group Agreement.

Until Your membership ends, You must keep getting Your Medicare services through our Plan or You will have to pay for them Yourself.

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

If You must get services from plan providers and doctors or other medical providers who are not plan providers before your membership in our Plan ends, neither we nor the Medicare program will pay for these services, with just a few exceptions. The exceptions are urgently needed care, care for a medical emergency, out-of-area renal (kidney) dialysis services, and care that has been approved by us. There is another possible exception, if You happen to be hospitalized on the day Your membership ends. If this happens to you, call Member Services to find out if Your hospital care will be covered by our Plan. If you have any questions about leaving our Plan, please call us at Member Services.

We cannot ask You to leave the Plan because of Your health.

We *cannot* ask You to leave Your health plan for any health-related reasons. If You ever feel that You are being encouraged or asked to leave our Plan because of Your health, You should call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Involuntarily ending Your membership

If any of the following situations occur, we will end Your membership in our Plan.

- If You do *not* stay continuously enrolled in “Medicare A and B”;
- If You give us information on Your enrollment request that You know is false or deliberately misleading, and it affects whether or not You can enroll in our Plan.
- If You behave in a way that is disruptive, to the extent that Your continued enrollment seriously impairs our ability to arrange or provide medical care for You or for others who are members of our Plan. We cannot make You leave our Plan for this reason unless we get permission first from Medicare.
- If You let someone else use Your plan membership ID card to get medical care. If You are disenrolled for this reason, CMS may refer Your case to the Inspector General for additional investigation.
- If You do not pay the Plan premiums, Your group will tell You in writing that You have a 60-day grace period during which You may pay the Plan premiums before Your membership ends.

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 will tell You our reasons in writing and explain how You may file a complaint against us if You want to.

10 Legal Notices

Notice about governing law

Many laws apply to this EOC and some additional provisions may apply because they are required by law. This may affect Your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the State(s) of Tennessee may apply.

Notice about nondiscrimination

We do not discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans or Medicare Prescription Drug 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, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

11 Definition of Some Words Used in This EOC

Defined terms are capitalized. When defined words are used in this EOC, they have the meaning set forth in this section. Words that are defined in Our Medical Policies and Procedures have the same meaning as if they were used in this EOC.

Advance Determination – A member or provider has the opportunity to seek a determination of coverage by requesting an Advance Determination. An Advance Determination will be reviewed for medical appropriateness to ensure members are receiving medically necessary services in the most appropriate settings.

Appeal – An Appeal is a special kind of complaint You make if You disagree with a decision to deny a request for health care services or payment for services You already received. You may also make a complaint if You disagree with a decision to stop services that You are receiving. For example, You may ask for an Appeal if Medicare does not pay for an item or service You think You should be able to get. There is a specific process that Your Part D Plan Sponsor must use when You ask for an Appeal. Sections 8 and 9 explain about Appeals, including the process involved in making an Appeal.

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

You are an inpatient in a SNF only if Your care in the SNF meets certain standards for skilled level of care. Specifically, in order to be an inpatient in a SNF, You must need daily skilled-nursing or skilled-rehabilitation care, or both. (Section 6 tells what is meant by skilled care.)

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

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that runs the Medicare program. Section 1 explains how to contact CMS.

Cost-sharing - Cost-sharing refers to amounts that a member has to pay when services are received. It includes any combination of the following three types of payments: (1) any deductible amount the plan may impose before services are covered; (2) any fixed “copayment” amounts that a plan may require be paid when specific services are received; or (3) any “coinsurance” amount that must be paid as a percentage of the total amount paid for a service.

Coverage Determination - The Plan has made a coverage determination when it makes a decision about the benefits You can receive under the Plan, and the amount that You must pay for those benefits. You need to call or write to Your plan to ask for a formal decision about the coverage if You disagree.

Covered Services – The general term we use in this EOC to mean all of the health care services and supplies that are covered by our Plan. Covered Services are listed in the Benefits Chart in [Section 3](#).

Disenroll or disenrollment – The process of ending Your membership. Disenrollment can be voluntary (Your own choice) or involuntary (not Your own choice). [Section 10](#) tells about disenrollment.

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

Emergency care – Covered Services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition. [Section 2](#) tells about emergency services.

Evidence of coverage and disclosure information – This document along with Your enrollment form which explains Your coverage, and what we must do, and explains Your rights and what You have to do as a member of our Plan.

Grievance – A type of complaint You make about us or one of our Plan providers, including a complaint concerning the quality of Your care. This type of complaint does not involve payment or coverage disputes. See [Section 7](#) for more information about grievances.

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

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

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 permanent kidney failure (who need dialysis or a kidney transplant).

Medicare Advantage Organization – Medicare Advantage Plans are run by private companies. They give You more options, and sometimes, extra benefits. These plans are still

part of the Medicare Program and are also called “Part C.” They provide all Your Part A (Hospital) and Part B (Medical) coverage.

Medicare Advantage Plan – A benefit package offered by a Medicare Advantage Organization that offers a specific set of health benefits at the same premium and level of cost-sharing to all people with Medicare who live in the service area covered by the Plan. Medicare Advantage Organizations can offer one or more Medicare Advantage Plans in the same service area. We are a Medicare Advantage Organization.

Medicare Health Plan – A Medicare Advantage Plan (such as an HMO, PPO, or Private Fee-for-Service Plan) or other plan such as a Medicare Cost Plan. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Health Plans that are offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

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

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

“Medigap” (Medicare supplement insurance) policy – Medicare Supplement Insurance sold by private insurance companies to fill “gaps” in the Original Medicare Plan coverage. Medigap policies only work with the Original Medicare Plan.

Member, Member of our Plan, or Plan Member, You, Your – A person with Medicare who is eligible to get covered services, who qualifies for coverage under the Group’s requirements, who has enrolled in our Plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services – A department within our Plan responsible for answering Your questions about Your membership, benefits, grievances, and Appeals. See Section 1 for information about how to contact Member Services.

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

Original Medicare – Some people call it “traditional Medicare” or “fee-for-service” Medicare. The Original Medicare plan is the way many people get their health care coverage. It is the national pay-per-visit program that lets You go to 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.

Plan provider – “**Provider**” is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them “**plan providers**” when they accept our payment as payment in full, and in some cases to coordinate as well as provide Covered Services to Members of our Plan. .

Prior authorization – Approval in advance to get services. In an HMO with a referral model and in the network portion of a PPO, some in-network services are covered only if Your doctor or other plan provider gets “prior authorization” from our Plan. Covered Services that need prior authorization are marked in the Benefits Chart in Section 2 In a PPO and PFFS plan You do not need prior authorization to obtain out-of-network services. However, You may want to check with Your plan before obtaining services out-of-network to confirm that the service is covered by Your plan and what Your cost share responsibility is. Check with Your plan.

Private Fee-for-Service Plan – An MA private fee-for-service plan is an MA plan that pays providers of services at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk. An MA Organization wishing to offer a PFFS plan must meet general requirements for MA Organizations required by law including:

- Providing for all original Medicare covered services;
- Providing for emergency and urgent care;
- Allowing beneficiary Appeals for services that are limited, not provided, not paid for, or not allowed and
- Disclosing its terms and conditions of payment and a list of services it provides.

An MA Organization offering a PFFS plan:

- Does not vary the rates for a provider based on the utilization of that provider's services;
- Does not restrict enrollees' choices among providers that (a) agree to accept the plan's terms and conditions of payment and (b) are lawfully authorized to provide services; and
- Does not limit enrollees to a provider network (no“lock in”).

Special access rules apply to PFFS plans.

Members of a PFFS plan may go to any doctor or hospital in the U.S. that is:

- Eligible to be paid by Medicare (that is (a) the provider is state licensed, (b)is eligible to receive, or has received, a Medicare billing number, and, (c) for Institutional providers, such as hospitals and skilled nursing facilities, is certified to treat Medicare beneficiaries); and
- Is willing to accept the plan’s terms and conditions of payment.

PFFS plans may offer supplemental benefits. Additionally a PFFS plan offered by an MA Organization has the option of offering a Part D prescription drug benefit.

Terms and conditions of participation (payment) – The PFFS terms and conditions of participation establish the rules that providers must follow if they choose to furnish services to an enrollee of a PFFS plan. At a minimum the terms and conditions will specify:

- A list of all services that the plan provides;
- The amount the PFFS organization will pay for all plan-covered services;
- Provider billing procedures;
- The amount the provider is permitted to collect from the enrollee including balance billing; and

The PFFS plan is not required to reimburse providers for services to PFFS plan enrollees, if these services are not covered by the plan.

A private fee-for-service organization is required to make its terms and conditions of participation reasonably available--through phone, fax, email, or websites-- to providers in the U.S. from whom its enrollees seek health care services.

Quality Improvement Organization (QIO) – Groups of practicing doctors and other health care experts that are paid by the federal government to check and improve the care given to Medicare patients. They must review Your complaints about the quality of care given by Medicare Providers. See Section 1 for information about how to contact Q-Source in Your state and Section 8 for information about making complaints to Q-Source.

Referral – You do not need a referral to obtain care in a private fee-for-service plan. If You have any question whether BlueAdvantage PFFS will pay for a service, including inpatient hospital services, You have the right under law to have a written / binding advance coverage determination made for the service. Call BlueAdvantage PFFS at 1-800-841-7434 and tell us You would like a decision if the service will be covered.

Rehabilitation services – These services include physical therapy, cardiac rehabilitation, speech and language therapy, and occupational therapy that are provided under the direction of a plan provider.

Service area – Section 1 tells about our Plan’s service area. “Service area” is the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a Medicare Health Plan.

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

Urgently needed care – Section 2 explains urgently needed services. These are different from emergency services.



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