



Summary of Benefits
BlueAdvantage Plus PFFSSM
Holston Defense Corporation

Section 1

Introduction to the Summary of Benefits for BlueAdvantage Plus PFFS January 1, 2008 – December 31, 2008

Thank you for your interest in BlueAdvantage Plus PFFS. Our plan is offered by BlueCross BlueShield of Tennessee, a Medicare Advantage Private Fee-For-Service organization. This Summary of Benefits tells you some of the features of our plan. It doesn't list every service that we cover, or list every limitation or every exclusion. To get a complete list of our benefits, please call BlueCross BlueShield of Tennessee and ask for the "Evidence of Coverage."

Who is Eligible to Join BlueAdvantage Plus PFFS?

You can join this plan if you are entitled to Medicare Part A and enrolled in Medicare Part B and eligible for your employer's retiree health plan.

Can I Choose My Doctors?

As a member of BlueAdvantage Plus PFFS you can go to any Medicare doctor, specialist, or hospital that accepts Medicare payment and accepts the terms, conditions and payment rate of the BlueCross BlueShield of Tennessee plan. BlueCross BlueShield of Tennessee has the right to determine if the service or treatment ordered by your health care provider is covered under the BlueCross BlueShield of Tennessee plan.

Does My Plan Cover Medicare Part B or Part D Drugs?

These plans do cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

Where Can I Get My Prescriptions If I Join BlueAdvantage Plus PFFS?

BlueAdvantage Plus PFFS has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a current Pharmacy Network List. Our Customer Service number is listed at the end of this introduction.

What is a Prescription Drug Formulary?

This plan uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you.

If you are currently taking a drug that is not on our formulary or subject to additional requirement or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

How Can I Get Extra Help With Prescription Drug Plan Costs?

If you qualify for extra help with your Medicare prescription drug plan costs, your premium and costs at the pharmacy will be lower. When you join BlueAdvantage Plus PFFS, Medicare will tell us how much extra help you are getting. Then we will let you know the amount you will pay. If you are not getting this extra help you can see if you qualify by calling 1-800-Medicare (1-800-633-4227), TTY users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

What Are My Protections in This Plan?

As a member of BlueAdvantage Plus PFFS, you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered.

An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug.

If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision.

Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug.

Please Call BlueCross BlueShield of Tennessee for more information about this plan.

Customer Service Hours:

Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8:00 a.m. - 9:00 p.m. Eastern Time. Between March 3 and September 30, you may be required to leave a message on holidays and weekends. Calls will be returned the next business day.

Members should call 1-800-841-7434 for questions related to the Medicare Advantage program. (TTY/TDD 1-888-423-9490)

For more information about Medicare, please call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, visit www.medicare.gov on the web.

If you have special needs, this document may be available in other formats.

Section 2

Summary of Benefits

If you have any questions about this plan's benefits or costs, please contact BlueCross BlueShield of Tennessee.

IMPORTANT INFORMATION

Benefit Category	Original Medicare	BlueAdvantage Plus PFFS
<p>1. Premium and Other Important Information</p>	<p>You pay the Medicare Part B Premium of \$96.40 each month.</p> <p>\$135 yearly Medicare Part B deductible.</p> <p>If a doctor or supplier does not accept assignment, their cost are often higher, which means you pay more.</p>	<p>Please see your Benefits Administrator for your premium information. You also continue to pay the Medicare Part B premium of \$96.40 per month.</p> <p>Balance billing means that a provider may charge and bill you more than the plan's payment amount for services. There is a limit on what providers may charge for Medicare-covered services.</p> <p>Balance billing doesn't count towards your out-of-pocket limit after the deductible is met.</p> <p>\$750 out-of-pocket limit. Contact the plan for services that apply.</p> <p>See page 16 for more information on out-of-pocket limits.</p>
<p>2. Doctor and Hospital Choice</p> <p>(For more information, see Emergency - #15 and Urgently Needed Care - #16.)</p>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p>You may have to pay a separate copay for certain doctor office visits.</p> <p>You may go to any doctor, specialist, or hospital that accepts the plan's payment.</p> <p>See page 15 for more information on doctor and hospital choice.</p>

INPATIENT CARE

Benefit Category	Original Medicare	BlueAdvantage Plus PFFS
<p>3. Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)</p>	<p>For each benefit period: Days 1 - 60: \$1,024 deductible Days 61 - 90: \$256 per day Days 91 - 150: \$512 per lifetime reserve day</p> <p>Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.</p> <p>Lifetime reserve days can only be used once.</p> <p>A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>	<p>You may go to any doctor, specialist, or hospital that accepts the plan's payment.</p> <p>\$0 copay</p> <p>No limit to the number of days covered by the plan each benefit period.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>
<p>4. Inpatient Mental Health Care</p>	<p>Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care" above)</p> <p>190 day limit in a Psychiatric Hospital.</p>	<p>\$0 copay</p> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>When the 190-day benefit period is exhausted for Inpatient Mental Health Care services you will be responsible for 100% of the additional days.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>

INPATIENT CARE *continued*

Benefit Category	Original Medicare	BlueAdvantage Plus PFFS
<p>5. Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)</p>	<p>For each benefit period after at least a 3-day covered hospital stay:</p> <p>Days 1 - 20 \$0 per day Days 21 - 100 \$128 per day 100 days for each benefit period.</p> <p>A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>	<p>Authorization rules may apply.</p> <p>For SNF stays:</p> <p>Days 1 - 100: \$0 copay per day 100 days covered for each benefit period No prior hospital stay is required.</p> <p>When the 100-day benefit period is exhausted for SNF services you will be responsible for 100% of the additional days.</p>
<p>6. Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p>	<p>\$0 copay.</p>	<p>Authorization rules may apply.</p> <p>\$0 copay for Medicare-covered home health visits.</p>
<p>7. Hospice</p>	<p>You pay part of the cost for outpatient drugs and inpatient respite care.</p>	<p>You must get care from a Medicare-certified hospice.</p>

OUTPATIENT CARE

Benefit Category	Original Medicare	BlueAdvantage Plus PFFS
8. Doctor Office Visits	20% coinsurance	<p>You may go to any doctor, specialist, or hospital that accepts the plan's payment.</p> <p>See "Routine Physical Exams," for more information.</p> <p>\$10 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$10 copay for each specialist visit for Medicare-covered benefits.</p>
9. Chiropractic Services	<p>20% coinsurance</p> <p>Routine care not covered</p> <p>20% coinsurance for manual manipulation of the spine to correct subluxation if you get it from a chiropractor or other qualified provider.</p>	<p>\$10 copay for Medicare-covered visits.</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part.</p>
10. Podiatry Services	<p>20% coinsurance</p> <p>Routine care not covered.</p> <p>20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p>	<p>\$10 copay for each Medicare-covered visit.</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p>
11. Outpatient Mental Health Care	50% coinsurance for most outpatient mental health services.	\$10 copay for each Medicare-covered individual or group therapy visit.
12. Outpatient Substance Abuse Care	20% coinsurance	\$10 copay for Medicare-covered individual or group visits.
13. Outpatient Services/Surgery	<p>20% coinsurance for the doctor</p> <p>20% of outpatient facility</p>	<p>Authorization rules may apply.</p> <p>\$0 copay for each Medicare-covered ambulatory surgical center visit.</p> <p>\$0 copay for each Medicare-covered outpatient hospital facility visit.</p>
14. Ambulance Services (medically necessary ambulance services)	20% coinsurance	\$100 copay for Medicare-covered ambulance benefits.

OUTPATIENT CARE *Continued*

Benefit Category	Original Medicare	BlueAdvantage Plus PFFS
<p>15. Emergency Care</p> <p>(You may go to any emergency room if you reasonably believe you need emergency care.)</p>	<p>20% coinsurance for the doctor</p> <p>You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit.</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p>\$50 for Medicare-covered emergency room visits.</p> <p>Worldwide coverage.</p> <p>If you are admitted to the hospital within 3-day(s) for the same condition, you pay \$0 for the emergency room visit</p> <p>See page 16 for more information on worldwide coverage</p>
<p>16. Urgently Needed Care</p> <p>(This is NOT emergency care, and in most cases, is out of the service area.)</p>	<p>20% coinsurance, or a set copay</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p>\$10 for Medicare-covered urgently needed care visits. If you are admitted to the hospital within 3-day(s) for the same condition, \$0 for the urgent-care visit.</p>
<p>17. Outpatient Rehabilitation Services</p> <p>(Occupational Therapy, Physical Therapy, Speech and Language Therapy)</p>	<p>20% coinsurance</p>	<p>Authorization rules may apply.</p> <p>\$10 copay for Medicare-covered Occupational Therapy visits.</p> <p>\$10 copay for Medicare-covered Physical and/or Speech/ Language Therapy visits.</p>

OUTPATIENT MEDICAL SERVICES AND SUPPLIES

Benefit Category	Original Medicare	BlueAdvantage Plus PFFS
18. Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	20% coinsurance	\$0 copay for each Medicare-approved item. Authorization rules may apply for services. Contact plan for more details.
19. Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	20% coinsurance	\$0 copay for each Medicare-approved item. Authorization rules may apply for services. Contact plan for more details.
20. Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)	20% coinsurance	\$0 copay for Diabetes self-monitoring training. \$0 copay for Diabetes supplies. See page 16 for more information on Diabetes monitoring and testing supplies.
21. Diagnostic Tests, X-Rays, and Lab Services	20% coinsurance for diagnostic tests and x-rays \$0 copay for Medicare-covered lab services Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.	\$0 copay for Medicare-covered: - lab services - diagnostic procedures and tests - X-rays. - diagnostic radiology services (not including X-rays) - therapeutic radiology service See page 16 for more information on diagnostic tests, x-rays and lab services.

PREVENTIVE SERVICES

Benefit Category	Original Medicare	BlueAdvantage Plus PFFS
22. Bone Mass Measurement (for people with Medicare who are at risk)	20% coinsurance Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.	\$0 copay
23. Colorectal Screening Exams (for people with Medicare age 50 and older)	20% coinsurance Covered when you are high risk or when you are age 50 and older.	\$0 copay for Medicare-covered colorectal screenings.
24. Immunizations (Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine)	\$0 copay for Flu and Pneumonia vaccines 20% coinsurance for Hepatitis B vaccine You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.	\$0 copay for Flu and Pneumonia vaccines. \$0 copay for Hepatitis B vaccine.
25. Mammograms (Annual Screening) (for women with Medicare age 40 and older)	20% coinsurance No referral needed. Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.	\$0 copay for Medicare-covered screening mammograms.
26. Pap Smears and Pelvic Exams (for women with Medicare)	\$0 copay for Pap smears Covered once every 2 years. Covered once a year for women with Medicare at high risk. 20% coinsurance for Pelvic Exams	\$0 copay for pap smears and pelvic exams.
27. Prostate Cancer Screening Exams (for men with Medicare age 50 and older)	20% coinsurance for the digital rectal exam. \$0 for the PSA test; 20% coinsurance for other related services. Covered once a year for all men with Medicare over age 50.	\$0 copay for Medicare-covered prostate cancer screening.
28. ESRD	20% coinsurance for dialysis	\$10 copay for in and out-of-area dialysis \$0 copay for Nutrition Therapy for Renal Disease

PART D PRESCRIPTION DRUGS

Benefit Category	Original Medicare	BlueAdvantage Plus PFFS
29. Prescription Drugs	Most drugs not covered. (You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan.)	<p>Drugs Covered under Medicare Part D</p> <p>This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.bcbst-medicare.com on the web.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> - have limited incomes, - live in long term care facilities, or - have access to Indian/Tribal/Urban (Indian Health Service). <p>The plan offers national in-network prescription coverage. This means that you will pay the same amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel).</p> <p>Total yearly drug costs are the total drug costs paid by both you and the plan.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Your provider must get prior authorization from BlueAdvantage Plus PFFS for certain drugs.</p> <p>If the actual cost of a drug is less than the normal copay amount for that drug, you will pay the actual cost, not the higher copay amount.</p> <p>You may have to pay more than your copay if you choose to use a higher cost drug when a lower cost drug is available.</p> <p>\$0 deductible.</p> <p>Initial Coverage You pay the following until yearly drug costs reach \$4,050:</p> <p>Retail Pharmacy</p> <p>Tier 1</p> <ul style="list-style-type: none"> - \$7 copay for a one-month (30-day) supply of drugs - \$21 copay for a three-month (90-day) supply of drugs <p>Tier 2</p> <ul style="list-style-type: none"> - \$20 copay for a one-month (30-day) supply of drugs - \$60 copay for a three-month (90-day) supply of drugs <p>Tier 3</p> <ul style="list-style-type: none"> - \$35 copay for a one-month (30-day) supply of drugs - \$105 copay for a three-month (90-day) supply of drugs

PART D PRESCRIPTION DRUGS Continued

Benefit Category	Original Medicare	BlueAdvantage Plus PFFS
		<p>Tier 4</p> <ul style="list-style-type: none"> - \$35 coinsurance for a one-month (30-day) supply of drugs - \$105 coinsurance for a three-month (90-day) supply of drugs <p>Long Term Care Pharmacy</p> <p>Tier 1</p> <ul style="list-style-type: none"> - \$7 copay for a one-month (31-day) supply of drugs <p>Tier 2</p> <ul style="list-style-type: none"> - \$20 copay for a one-month (31-day) supply of drugs <p>Tier 3</p> <ul style="list-style-type: none"> - \$35 copay for a one-month (31-day) supply of drugs <p>Tier 4</p> <ul style="list-style-type: none"> - \$35 coinsurance for a one-month (31-day) supply of drugs <p>Mail Order</p> <p>Tier 1</p> <ul style="list-style-type: none"> - \$14 copay for a three-month (90-day) supply of drugs <p>Tier 2</p> <ul style="list-style-type: none"> - \$45 copay for a three-month (90-day) supply of drugs <p>Tier 3</p> <ul style="list-style-type: none"> - \$90 copay for a three-month (90-day) supply of drugs <p>Tier 4</p> <ul style="list-style-type: none"> - \$90 coinsurance for a three-month (90-day) supply of drugs

PART D PRESCRIPTION DRUGS Continued

Benefit Category	Original Medicare	BlueAdvantage Plus PFFS
		<p>Catastrophic Coverage</p> <p>After your yearly out-of-pocket drug costs reach \$4,050, you pay the greater of:</p> <ul style="list-style-type: none"> - \$2.25 copay for generic (including brand drugs treated as generic) and \$5.60 copay for all other drugs, or - 5% coinsurance. <p>Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may pay more than the copay if you get your drugs at an out-of-network pharmacy.</p> <p>Out-of-Network Initial Coverage</p> <p>You pay the following until total yearly drug costs reach \$2,510:</p> <p>Tier 1</p> <ul style="list-style-type: none"> - \$7 copay for a one-month (30-day) supply of drugs <p>Tier 2</p> <ul style="list-style-type: none"> - \$20 copay for a one-month (30-day) supply of drugs <p>Tier 3</p> <ul style="list-style-type: none"> - \$35 copay for a one-month (30-day) supply of drugs <p>Tier 4</p> <ul style="list-style-type: none"> - \$35 coinsurance for a one-month (30-day) supply of drugs <p>Out-of-Network Catastrophic Coverage</p> <p>After your yearly out-of-pocket drug costs reach \$4,050, you pay the greater of:</p> <ul style="list-style-type: none"> - \$2.25 copay for generic (including brand drugs treated as generic) and \$5.60 copay for all other drugs, or - 5% coinsurance.

MISCELLANEOUS SERVICES

Benefit Category	Original Medicare	BlueAdvantage Plus PFFS
30. Hearing Services	<p>Routine hearing exams and hearing aids not covered.</p> <p>20% coinsurance for diagnostic hearing exams.</p>	<p>\$0 copay for hearing aids.</p> <ul style="list-style-type: none"> - \$10 copay for diagnostic hearing exams - \$10 copay for up to 1 routine hearing test(s) every two years - \$10 copay for up to 1 hearing aid fitting evaluation(s) every two years <p>\$200 limit for routine hearing aids every two years.</p>
31. Vision Services	<p>20% coinsurance for diagnosis and treatment of diseases and conditions of the eye.</p> <p>Routine eye exams and glasses not covered.</p> <p>Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>Annual glaucoma screenings covered for people at risk.</p>	<p>\$0 copay for</p> <ul style="list-style-type: none"> - one pair of eyeglasses or contact lenses after each cataract surgery - glasses - contacts - lenses - frames - \$10 copay for exams to diagnose and treat diseases and conditions of the eye. - \$10 copay for up to 1 routine eye exam(s) every year <p>\$100 limit for eye wear every year.</p>
32. Physical Exams	<p>20% coinsurance for one exam within the first 6 months of your new Medicare Part B coverage</p> <p>When you get Medicare Part B, you can get a one time physical exam within the first 6 months of your new Part B coverage. The coverage does not include lab tests.</p>	<p>\$0 copay for routine exams.</p> <p>Limited to 1 exam(s) every year.</p>
Health/Wellness Education	Not covered.	<p>This plan covers health/wellness education benefits.</p> <ul style="list-style-type: none"> - Written health education materials, including Newsletters - Other Wellness Benefits
Transportation	Not covered.	<p>\$0 copay for air medical transportation when hospitalized more than 150 mile from home.</p> <p>See page 16 for more information on transportation.</p>
Custodial Care (Assistance walking, getting out of bed or other service performed by a non-professional)	Not covered	<p>Authorization rules apply.</p> <p>Custodial care must meet certain requirements.</p> <p>\$6,000 lifetime maximum benefit. (Includes previous custodial care services under prior benefit plans regardless of whether or not the benefits were administered by BlueCross BlueShield of Tennessee.</p>

Section 3

Summary of Benefits

How the BlueAdvantage Plus PFFS Plan Works

Selecting a Health Care Provider

With BlueAdvantage Plus PFFS, 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. However, you must present your BlueAdvantage Plus PFFS ID card before you receive services. Check with your doctors to see if they accept BlueAdvantage Plus PFFS.

You may also use providers who do not accept the Medicare payment in full from Original Medicare. These providers may charge you more for Medicare-covered services, up to the Medicare Limiting Charge. You will be responsible for these excess charges. In any case, your BlueAdvantage Plus PFFS ID card must be presented before you receive services.

Provider Accepts BlueAdvantage Plus PFFS

If your provider decides to accept BlueAdvantage Plus PFFS, the provider must bill BlueCross BlueShield of Tennessee for those services. As stated above, if your provider does not accept the Medicare payment in full from Original Medicare, you may be charged more for Medicare-covered services, up to the Medicare Limiting Charge. You will be responsible for these excess charges.

Providers have the right to decide if they will accept BlueAdvantage Plus PFFS each time they see you. This is why you must present your BlueAdvantage Plus PFFS member ID card every time you visit a health care provider.

Provider Does Not Accept BlueAdvantage Plus

If providers do not accept your card because the plan is unfamiliar, please ask them to call our provider service line at 1-800-841-7434 or visit www.bcbst.com for more information. A provider can decide at any time not to accept a BlueAdvantage Plus PFFS plan. If this happens, you will need to select another provider.

Important Information about PFFS Plans.

A Medicare Advantage Private Fee-for-Service plan works differently than your existing plan. Your doctor or hospital is not required to agree to accept the plan's terms and conditions, and thus may choose not to treat you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, or otherwise agree to treat you, you will not be able to receive covered services from them under this plan. Providers can find the plan's terms and conditions on our website at: <http://www.bcbst.com/providers/bcbst-medicare/>

BlueAdvantage Plus PFFS Features an Out-of-Pocket Maximum

Once your out-of-pocket expenses for most Medicare-covered services reaches your plan's out-of-pocket amount of \$750 in a calendar year, you will no longer be required to pay any copays for those services for the remainder of the year. Most of your expenses will apply toward this out-of-pocket maximum. Expenses that do not apply include: plan premiums, expenses for Medicare-covered diabetic supplies, health expenses incurred during foreign travel and prescription drug expenses including copays.

Worldwide Coverage for Urgently Needed Care and Emergency Care

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 pay 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 days of foreign travel.

Diagnostic Tests, X-rays and Lab Services

You may be required to pay on office visit copay if these services are provided during a doctor's office visit.

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.
- Service must be arranged through AirMed International.

Diabetes Monitoring and Testing Supplies

Some diabetic monitoring and testing supplies fall under Medicare Part B coverage and some fall under Medicare Part D coverage. BlueAdvantagePlus PFFS covers Medicare Part B approved items at 100 percent. Items that are covered under Medicare Part D are subject to your prescription drug copays and benefits.

Medicare Part B Items include insulin pumps and blood glucose self-testing equipment. Examples: glucose monitors, glucose control solutions, test strips, lancets and lancet devices.

Medicare Part D Items include diabetic supplies for administering insulin. Examples: alcohol swabs, needles, syringes, gauze, insulin inhalers and insulin.

To avoid having to pay up front for your Medicare Part B diabetic monitoring and testing supplies, please contact our Customer Service Department assistance in locating a supplier who has agreed to file these claims electronically. If you use a supplier that is not able to file a claim electronically, you will have to pay for your supplies up front and submit a paper claim for reimbursement.

Care Management

When you need care, our staff of registered nurses will be there to help coordinate the care that is right for you with your health care providers. Through education, care planning and follow-up phone calls from your care management nurse, you and your family will be able to better manage your health care.

Medical Grievances, Coverage Determination/Exceptions and Appeals Processes

What is a Grievance?

If you have a problem with any of our medical or prescription drug policies and procedures, you may file a grievance. You cannot be dropped from the plan for making a complaint.

What is an Appeal?

If we deny a claim, service or coverage for a prescription drug, we will explain why. If you disagree with our decision regarding the handling of your claim or a denial of a service or prescription drug, you have the right to file an appeal. Your claim will be reviewed again. If we cannot overturn the decision, your appeal will be reviewed by an independent organization that works for Medicare.

Appointing a Representative to Act on Your Behalf

You may assign someone such as a relative, friend, advocate, an attorney or any physician to act as your representative and file an appeal for you. A representative may:

- Obtain information about the enrollee's claim to the extent consistent with current Federal and state law;
- Submit evidence;
- Make statements of fact and law; and
- Make any request, or give or receive any notice about the appeal proceedings.

Both you and your representative must sign, date and complete the Appointment of Representative form found on our Web site. If you want to assign a representative to ask for an appeal for you, this signed form must be filed with your appeal. Unless you decide you no longer want to have a representative, the form will be good for one year after the date you and your representative sign the form. If future appeals are filed during this time, your representative must file a photocopy of the signed representative form for each appeal. If your physician agrees to act as your representative and files an appeal for you, you cannot be charged by your physician for filing the appeal.

How to File a Medical Grievance or Appeal

Call Customer Service to file or check on the status of a medical grievance or appeal
1-800-841-7434
Hearing impaired TTY/TDD: 1-888-423-9490
8 a.m. to 9 p.m. Eastern Time, 7 days a week

From March 3 to September 30, you may be required to leave a message on weekends and holidays. Calls will be returned on the next business day.

To file a medical grievance or appeal in writing please call the number above the appropriate form. Complete, sign and mail the form to:

BlueCross BlueShield of Tennessee
Attn: BlueAdvantage Operations Appeals/Grievance Coordinator
P.O. Box 180205
Chattanooga, TN 37402
Or fax to: (423) 296-5498

More Detailed Information is Available

This information is a brief overview of the BlueAdvantage Plus PFFS medical grievance and appeals processes. More details are provided in your Evidence of Coverage.

Pharmacy Grievances, Coverage Determinations and Appeals

What is a grievance?

A grievance is any complaint other than one that involves a coverage determination. You would file a grievance if you have any type of problem with Blue Advantage Plus PFFS or one of our network pharmacies that does not relate to coverage for a prescription drug. You may file a grievance with us either orally or in writing no later than 60 days after the event or incident that precipitates the grievance. We will respond to your grievance within 30 days after receiving your request.

What is a coverage determination?

A coverage determination is a decision whether or not we provide or pay for a Part D drug and what your share of the cost is for the drug. Coverage determinations also include exception requests. These will be reviewed within 72 hours of receiving all the information required to review your request.

What is an appeal?

An appeal is the review of an unfavorable coverage determination. You would file an appeal if you want us to reconsider and change a decision we have made about what Part D prescription drug benefits are covered for you or what we will pay for a prescription drug. You must request an appeal within 60 days from the date of the notice of the coverage determination. Appeals are reviewed and determinations returned within 7 days upon receiving all necessary information.

What if I need my request expedited?

If you or your health care provider believe that waiting for a decision under the standard time frame may place your life, health, or ability to regain maximum function in serious jeopardy, an expedited appeal may be requested. Once all necessary information is received, your request will be reviewed and a determination sent to you and all necessary parties within 24 hours.

How to submit a grievance, coverage determination or appeal

The first step to filing grievance, appeal, or seeking a coverage determination is to call Member Services.

1-800-841-7434

Hearing impaired TTY/TDD: 1-888-423-9490

Sunday through Saturday, 8 a.m. to 9 p.m. Eastern Time

From March 3 to September 30, you may be required to leave a message on holidays and weekends. Calls will be returned the next business day.

To file a pharmacy grievance or appeal in writing please call the number above for a copy of the appropriate form. Complete, sign and mail the form to:

BlueCross BlueShield of Tennessee

Attn: BlueAdvantage Operations

Appeals/Grievance Coordinator

P.O. Box 180205

Chattanooga, TN 37402

Or fax to: (423) 296-5498

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Notice of Prescription Drug Plan Transition Policy

If you were previously enrolled in a Medicare Part D plan, you may be taking drugs that are not on your new plan's formulary. Or you may be taking drugs that require trying other drugs first (step therapy) or prior authorization. The following transition policy has been developed to help you make a smooth change to a new prescription drug plan.

You may receive a one-time 30-day temporary supply of any non-formulary drug at any time during the first 90 days of your enrollment in the new plan.

If you are refilling a medication covered by your previous prescription drug plan and that medication is not on your new plan's formulary, you will receive up to a 30-day supply to ensure that you do not experience interruption in medically necessary medication therapy or do not inappropriately pay additional cost sharing. A 30-day refill will also be provided for refills of Medicare Part D drugs that are on your new plan's formulary but require prior authorization or step therapy under a plan's utilization management rules.

You may pay a Tier 3 copay for a temporary supply. However, if you qualify for the low income subsidy, your copay for this temporary supply will not exceed the maximum copay amounts that apply to you.

If you received a temporary supply of a non-formulary medication (including Medicare Part D drugs that are on a plan's formulary but require prior authorization or step therapy), you will be sent notice in writing within three business days of the temporary fill to give you time to talk with your doctor about switching to a therapeutically equivalent medication on your new plan's formulary. The notification may include:

- An explanation of the temporary nature of the transition supply you have received.
- Instructions for working with your plan and your doctor to identify appropriate therapeutic alternatives on the formulary list.
- An explanation of your right to request formulary exception and a description of the procedure to request a formulary exception.



A health plan with a Medicare contract.
This document is available in alternative formats.

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