



January 1 – December 31, 2026

Evidence of Coverage for 2026:

Your Medicare Health Benefits and Services as a Member of BlueAdvantage Freedom (PPO)SM

This document gives the details of your Medicare health coverage from January 1 – December 31, 2026. **This is an important legal document. Keep it in a safe place.**

This document explains your benefits and rights. Use this document to understand:

- Our plan premium and cost sharing
- Our medical benefits
- How to file a complaint if you're not satisfied with a service or treatment
- How to contact us
- Other protections required by Medicare law

For questions about this document, call Member Service at 1-800-831-2583 (TTY users should call 711). Hours are from Oct. 1 to March 31, you can call us seven days a week from 8 a.m. to 9 p.m. ET. From April 1 to Sept. 30, you can call us Monday through Friday from 8 a.m. to 9 p.m. ET. This call is free.

This plan, BlueAdvantage Freedom, is offered by BlueCross BlueShield of Tennessee, Inc. (When this *Evidence of Coverage* says “we,” “us,” or “our,” it means BlueCross BlueShield of Tennessee, Inc. When it says “plan” or “our plan,” it means BlueAdvantage Freedom.

This document is available for free in alternate formats (e.g., large print, audio, braille).

Benefits and/or copayments/coinsurance may change on January 1, 2027.

Our provider network may change at any time. You'll get notice about any changes that may affect you at least 30 days in advance.

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CHAPTER 1:

Get started as a member

SECTION 1 You're a member of BlueAdvantage Freedom

Section 1.1 You're enrolled in BlueAdvantage Freedom, which is a Medicare PPO

You're covered by Medicare, and you chose to get your Medicare health coverage through our plan, BlueAdvantage Freedom. Our plan covers all Part A and Part B services. However, cost sharing and provider access in this plan are different from Original Medicare.

BlueAdvantage Freedom is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company. This plan doesn't include Part D drug coverage.

Section 1.2 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how BlueAdvantage Freedom covers your care. Other parts of this contract include your enrollment form and any notices you get from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called *riders* or *amendments*.

The contract is in effect for the months you're enrolled in BlueAdvantage Freedom between January 1, 2026, and December 31, 2026.

Medicare allows us to make changes to plans we offer each calendar year. This means we can change the costs and benefits of BlueAdvantage Freedom after December 31, 2026. We can also choose to stop offering our plan in your service area, after December 31, 2026.

Medicare (the Centers for Medicare & Medicaid Services) must approve BlueAdvantage Freedom each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue offering our plan and Medicare renews approval of our plan.

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

You're eligible for membership in our plan as long as you meet all these conditions:

- You have both Medicare Part A and Medicare Part B

Chapter 1 Get started as a member

- You live in our geographic service area (described in Section 2.2). People who are incarcerated aren't considered to be in the geographic service area even if they're physically located in it.
- You're a United States citizen or lawfully present in the United States.

Section 2.2 Plan service area for BlueAdvantage Freedom

BlueAdvantage Freedom is only available to people who live in our plan service area. To stay a member of our plan, you must continue to live in our plan service area. The service area is described below.

Our service area includes these counties **in Tennessee**: Anderson, Bedford, Benton, Bledsoe, Blount, Bradley, Campbell, Cannon, Carroll, Carter, Cheatham, Chester, Claiborne, Clay, Cocke, Coffee, Crockett, Cumberland, Davidson, Decatur, DeKalb, Dickson, Dyer, Fayette, Fentress, Franklin, Gibson, Giles, Grainger, Greene, Grundy, Hamblen, Hamilton, Hancock, Hardeman, Hardin, Hawkins, Haywood, Henderson, Henry, Hickman, Houston, Humphreys, Jackson, Jefferson, Johnson, Knox, Lake, Lauderdale, Lawrence, Lewis, Lincoln, Loudon, Macon, Madison, Marion, Marshall, Maury, McMinn, McNairy, Meigs, Monroe, Montgomery, Moore, Morgan, Obion, Overton, Perry, Pickett, Polk, Putnam, Rhea, Roane, Robertson, Rutherford, Scott, Sequatchie, Sevier, Shelby, Smith, Stewart, Sullivan, Sumner, Tipton, Trousdale, Unicoi, Union, Van Buren, Warren, Washington, Wayne, Weakley, White, Williamson and Wilson; and **in Georgia**: Catoosa, Dade and Walker counties.

If you move out of our plan's service area, you can't stay a member of this plan. Call Member Service at 1-800-831-2583 (TTY users call 711) to see if we have a plan in your new area. When you move, you'll have a Special Enrollment Period to either switch to Original Medicare or enroll in a Medicare health or drug plan in your new location.

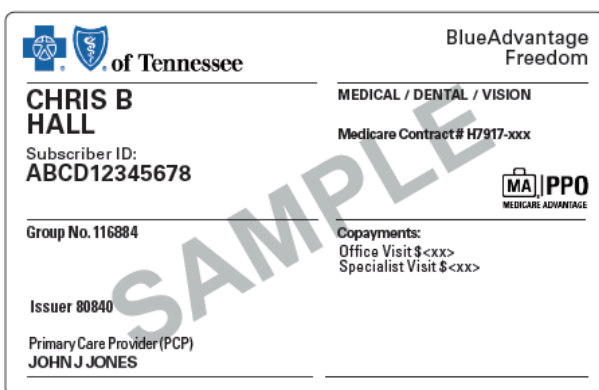
If you move or change your mailing address, it's also important to call Social Security. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

Section 2.3 U.S. citizen or lawful presence

You must be a U.S. citizen or lawfully present in the United States to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify BlueAdvantage Freedom if you're not eligible to stay a member of our plan on this basis. BlueAdvantage Freedom must disenroll you if you don't meet this requirement.

SECTION 3 Important membership materials**Section 3.1 Our plan membership card**

Use your membership card whenever you get services covered by our plan. You should also show the provider your Medicaid card, if you have one. Sample membership card:



DON'T use your red, white, and blue Medicare card for covered medical services while you're a member of this plan. If you use your Medicare card instead of your BlueAdvantage Freedom membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare-approved clinical research studies (also called clinical trials).

If our plan membership card is damaged, lost, or stolen, call Member Service at 1-800-831-2583. (TTY users call 711) right away and we'll send you a new card.

Section 3.2 Provider Directory

The *Provider Directory* bcbst.sapphirecareselect.com lists our current network providers and durable medical equipment suppliers. **Network providers** are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full.

As a member of our plan, you can choose to get care from out-of-network providers. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and medically necessary. However, if you use an out-of-network provider, your share of the costs for your covered services may be higher. Go to Chapter 3 for more specific information.

Get the most recent list of providers and suppliers on our website at bcbst.sapphirecareselect.com.

If you don't have a *Provider Directory*, you can ask for a copy (electronically or in paper form) from Member Service at 1-800-831-2583. (TTY users call 711). Requested paper *Provider Directories* will be mailed to you within 3 business days.

SECTION 4 Summary of Important Costs for 2026

	Your Costs in 2026
Monthly plan premium* * Your premium can be higher than this amount. Go to Section 4.1 for details.	\$0
Maximum out-of-pocket amount This is the most you'll pay out-of-pocket for covered Part A and Part B services. (Go to Chapter 4 Section 1 for details.)	From in-network providers: \$3,200 From in-network and out-of-network providers combined: \$5,750
Primary care office visits	In-Network \$0 per visit Out-of-Network \$10 copay per visit
Specialist office visits	In-Network \$25 copay per visit Out-of-Network \$30 copay per visit
Inpatient hospital stays	In-Network Medicare-covered stay \$175 copay per day for days 1-5 \$0 copay per day for additional days Non-Medicare covered stay

Your Costs in 2026	
	Non-Medicare covered stay is <u>not</u> covered
	Out-of-Network
	Medicare-covered stay
	\$225 copay per day for days 1-5
	\$0 copay per day for additional days
	Non-Medicare covered stay
	Non-Medicare covered stay is <u>not</u> covered

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)

Section 4.1 Plan premium

You don't pay a separate monthly plan premium for BlueAdvantage Freedom.

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums, check your copy of *Medicare & You* 2026 handbook in the section called 2026 *Medicare Costs*. Download a copy from the Medicare website (www.Medicare.gov/medicare-and-you) or order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

BlueAdvantage Freedom members whose Part B premium isn't paid by Medicaid (TennCare) can get a premium reduction. That means the plan will pay a maximum of **\$40** of your monthly Medicare Part B premium. As a result, your monthly Social Security check should increase by this amount. You don't need to do anything to get this benefit. We'll take care of it for you. If you leave this plan, you'll stop getting the premium reduction on the date you leave. It may take a few months for Social Security to start or end this benefit. But don't worry, you'll get full credit for the amount you've paid.

You must continue paying your Medicare premiums to stay a member of our plan. This

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includes your premium for Part B. You may also pay a premium for Part A if you aren't eligible for premium-free Part A.

SECTION 5 More information about your monthly premium

Section 5.1 Our monthly plan premium won't change during the year

We're not allowed to change our plan's monthly plan premium amount during the year. If the monthly plan premium changes for next year, we'll tell you in September and the new premium will take effect on January 1.

SECTION 6 Keep our plan membership record up to date

Your membership record has information from your enrollment form, including your address and phone number. It shows your specific plan coverage including your Primary Care Provider/Medical Group/IPA.

The doctors, hospitals, and other providers in our plan's network **use your membership record to know what services are covered and your cost-sharing amounts**. Because of this, it's very important to help us keep your information up to date.

If you have any of these changes, let us know:

- Changes to your name, address, or phone number
- Changes in any other health coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation, or Medicaid)
- Any liability claims, such as claims from an automobile accident
- If you're admitted to a nursing home
- If you get care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you participate in a clinical research study (**Note:** You're not required to tell our plan about clinical research studies you intend to participate in, but we encourage you to do so.)

If any of this information changes, let us know by calling Member Service at 1-800-831-2583. (TTY users call 711).

It's also important to contact Social Security if you move or change your mailing address. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

SECTION 7 How other insurance works with our plan

Medicare requires us to collect information about any other medical or drug coverage you have so we can coordinate any other coverage with your benefits under our plan. This is called **Coordination of Benefits**.

Once a year, we'll send you a letter that lists any other medical or drug coverage we know about. Read this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that is not listed, call Member Service at 1-800-831-2583 (TTY users call 711). You may need to give our plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

When you have other insurance (like employer group health coverage), Medicare rules decide whether our plan or your other insurance pays first. The insurance that pays first (the "primary payer") pays up to the limits of its coverage. The one that pays second (the "secondary payer") only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all uncovered costs. If you have other insurance, tell your doctor, hospital, and pharmacy.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
 - If you're under 65 and disabled and you (or your family member) are still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.
 - If you're over 65 and you (or your spouse or domestic partner) are still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)

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- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

CHAPTER 2:

Phone numbers and resources

SECTION 1 BlueAdvantage Freedom contacts

For help with claims, billing or member card questions, call or write to BlueAdvantage Freedom Member Service. We'll be happy to help you.

Member Service – Contact Information	
Call	1-800-831-2583 Calls to this number are free. From Oct. 1 to March 31 , you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From April 1 to Sept. 30 , you can call us Monday through Friday from 8 a.m. to 9 p.m. ET. Member Service 1-800-831-2583 (TTY users call 711) also has free language interpreter services for non-English speakers.
TTY	711 Calls to this number are free. From Oct. 1 to March 31 , you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From April 1 to Sept. 30 , you can call us Monday through Friday from 8 a.m. to 9 p.m. ET.
Fax	1-423-535-5498
Write	BlueCross BlueShield of Tennessee BlueAdvantage Operations 1 Cameron Hill Circle, Suite 0005 Chattanooga, TN 37402-0005
Website	bcbstmedicare.com

How to ask for a coverage decision or appeal about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services. An appeal is a formal way of asking us to review and change a coverage decision. For more information on how to ask for coverage decisions or appeals about your medical care, go to Chapter 7.

Chapter 2 Phone numbers and resources

Coverage Decisions and Appeals for Medical Care – Contact Information

Call	1-800-831-2583 Calls to this number are free. From Oct. 1 to March 31 , you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From April 1 to Sept. 30 , you can call us Monday through Friday from 8 a.m. to 9 p.m. ET.
TTY	711 Calls to this number are free. From Oct. 1 to March 31 , you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From April 1 to Sept. 30 , you can call us Monday through Friday from 8 a.m. to 9 p.m. ET.
Fax	1-423-535-5498
Write	BlueCross BlueShield of Tennessee BlueAdvantage Operations 1 Cameron Hill Circle, Suite 0005 Chattanooga, TN 37402-0005
Website	bcbstmedicare.com

Chapter 2 Phone numbers and resources**How to contact us when you are making an appeal about your medical care**

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making appeals about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Appeals For Medical Care – Contact Information

Call	1-800-831-2583 Calls to this number are free. From Oct. 1 to March 31 , you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From April 1 to Sept. 30 , you can call us Monday through Friday from 8 a.m. to 9 p.m. ET
TTY	711 Calls to this number are free. From Oct. 1 to March 31 , you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From April 1 to Sept. 30 , you can call us Monday through Friday from 8 a.m. to 9 p.m. ET
Fax	1-423-535-5270
Write	BlueCross BlueShield of Tennessee Medicare Advantage Appeals & Grievances 1 Cameron Hill Circle, Suite 0005 Chattanooga, TN 37402-0005
Website	bcbstmedicare.com

How to make a complaint about your medical care

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint doesn't involve coverage or payment disputes. For more information on how make a complaint about your medical care, go to Chapter 7.

Complaints about Medical Care – Contact Information

Call	1-800-831-2583 Calls to this number are free. From Oct. 1 to March 31 , you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From April 1 to Sept. 30 , you can call us Monday through Friday from 8 a.m. to 9 p.m. ET.
TTY	711

Chapter 2 Phone numbers and resources**Complaints about Medical Care – Contact Information**

	Calls to this number are free. From Oct. 1 to March 31 , you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From April 1 to Sept. 30 , you can call us Monday through Friday from 8 a.m. to 9 p.m. ET.
Fax	1-423-535-5270
Write	BlueCross BlueShield of Tennessee Medicare Advantage Appeals & Grievances 1 Cameron Hill Circle, Suite 0005 Chattanooga, TN 37402-0005
Medicare website	To submit a complaint about BlueAdvantage Freedom directly to Medicare, go to www.Medicare.gov/my/medicare-complaint .

How to ask us to pay our share of the cost for medical care you got

If you got a bill or paid for services (like a provider bill) you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill, go to Chapter 5 for more information.

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to Chapter 7 for more information.

Payment Requests – Contact Information

Call	1-800-831-2583 Calls to this number are free. From Oct. 1 to March 31 , you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From April 1 to Sept. 30 , you can call us Monday through Friday from 8 a.m. to 9 p.m. ET.
TTY	711 Calls to this number are free. From Oct. 1 to March 31 , you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From April 1 to Sept. 30 , you can call us Monday through Friday from 8 a.m. to 9 p.m. ET.
Fax	1-423-535-5498
Write	BlueCross BlueShield of Tennessee BlueAdvantage Operations 1 Cameron Hill Circle, Suite 0005 Chattanooga, TN 37402-0005
Website	bcbstmedicare.com

SECTION 2 Get help from Medicare

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (CMS). This agency contracts with Medicare Advantage organizations including our plan.

Medicare – Contact Information	
Call	1-800-MEDICARE (1-800-633-4227) Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free.
Chat Live	Chat live at www.Medicare.gov/talk-to-someone .
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044
Website	www.Medicare.gov <ul style="list-style-type: none">• Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide.• Find Medicare-participating doctors or other health care providers and suppliers.• Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly “Wellness” visits).• Get Medicare appeals information and forms.• Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals.• Look up helpful websites and phone numbers.

Medicare – Contact Information

You can also visit www.Medicare.gov to tell Medicare about any complaints you have about BlueAdvantage Freedom.

To submit a complaint to Medicare, go to www.Medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

SECTION 3 State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. In Tennessee, the SHIP is called Tennessee State Health Insurance Assistance Program.

The Tennessee State Health Insurance Assistance Program is an independent state program (not connected with any insurance company or health plan) that gets money from the federal government to give free local health insurance counseling to people with Medicare.

Tennessee State Health Insurance Assistance Program counselors can help you understand your Medicare rights, make complaints about your medical care or treatment, and straighten out problems, with your Medicare bills. Tennessee State Health Insurance Assistance Program counselors can also help you with Medicare questions or problems, help you understand your Medicare plan choices, and answer questions about switching plans.

Tennessee State Health Insurance Assistance Program – Contact Information

Call	1-877-801-0044
TTY	1-800-848-0298 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
Write	Tennessee State Health Insurance Assistance Program 502 Deaderick Street, 9th Floor Nashville, TN 37243-0860
Website	www.tn.gov/disability-and-aging/disability-aging-programs/information-assistance.html

Chapter 2 Phone numbers and resources

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. In Georgia, the SHIP is called Georgia State Health Insurance Assistance Program (or Georgia Cares).

The Georgia State Health Insurance Assistance Program is an independent state program (not connected with any insurance company or health plan) that gets money from the federal government to give free local health insurance counseling to people with Medicare.

Georgia State Health Insurance Assistance Program counselors can help you understand your Medicare rights, make complaints about your medical care or treatment, and straighten out problems, with your Medicare bills. Georgia State Health Insurance Assistance Program counselors can also help you with Medicare questions or problems, help you understand your Medicare plan choices, and answer questions about switching plans.

Georgia State Health Insurance Assistance Program – Contact Information	
Call	1-866-552-4464 (option 4) Calls to the number are free. Monday through Friday, 9 a.m. to 5 p.m. ET.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
Write	Georgia SHIP 47 Trinity Ave. SW, 1st Floor Atlanta, GA 30331
Website	aging.georgia.gov/georgia-ship

SECTION 4 Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state. For Tennessee and Georgia, the Quality Improvement Organization is called Acentra Health.

Acentra Health has a group of doctors and other health care professionals paid by Medicare to check on and help improve the quality of care for people with Medicare. Acentra Health is an independent organization. It's not connected with our plan.

Contact Acentra Health in any of these situations:

Chapter 2 Phone numbers and resources

- You have a complaint about the quality of care you got. Examples of quality-of-care concerns include getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services is ending too soon.

Acentra Health, Tennessee's and Georgia's Quality Improvement Organization - Contact Information

Call	1-888-317-0751 Calls to this number are free. Monday through Friday, 9 a.m. to 5 p.m.; Weekends and Holidays – 10:00 a.m. to 4:00 p.m.; in Eastern, Central, Mountain, Pacific, Alaska, and Hawaii-Aleutian time zones
TTY	711 Calls to this number are free. Monday through Friday, 9 a.m. to 5 p.m.; Weekends and Holidays – 10:00 a.m. to 4:00 p.m.; in Eastern, Central, Mountain, Pacific, Alaska, and Hawaii-Aleutian time zones
Write	Acentra Health 5201 W Kennedy Boulevard, Suite 900 Tampa, FL 33609
Website	www.acentraqio.com

SECTION 5 Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment.

If you move or change your mailing address, contact Social Security to let them know.

Social Security– Contact Information

Call	1-800-772-1213 Calls to this number are free. Available 8 am to 7 pm, Monday through Friday. Use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778

Chapter 2 Phone numbers and resources**Social Security– Contact Information**

	<p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p> <p>Available 8 am to 7 pm, Monday through Friday.</p>
Website	www.SSA.gov

SECTION 6 Medicaid

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid offers programs to help people with Medicare pay their Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualifying Individual (QI):** Helps pay Part B premiums
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums

To find out more about Medicaid and Medicare Savings Programs, contact TennCare Solutions.

Division of TennCare (Tennessee’s Medicaid program) – Contact Information

Call	<p>1-855-259-0701</p> <p>Monday through Friday, 7 a.m. to 6 p.m. CT. Closed on all State holidays.</p>
TTY	<p>1-877-779-3103</p> <p>This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.</p>
Write	<p>Division of TennCare</p> <p>310 Great Circle Road</p>

Chapter 2 Phone numbers and resources**Division of TennCare (Tennessee's Medicaid program) – Contact Information**

	Nashville, TN 37243
Website	www.tn.gov/tenncare

To find out more about Medicaid and its programs, contact Georgia Medicaid.

Georgia Medicaid – Contact Information

Call	1-877-423-4746 Monday through Friday from 8 a.m. to 5 p.m. ET.
TTY	711
Write	Georgia Medicaid 2 Martin Luther King Jr Dr. SE, East Tower Atlanta, GA 30334
Website	https://medicaid.georgia.gov/contact-georgia-medicaid

SECTION 7 Railroad Retirement Board (RRB)

The Railroad Retirement Board is an independent federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you get Medicare through the Railroad Retirement Board, let them know if you move or change your mailing address. For questions about your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board (RRB) – Contact Information

Call	1-877-772-5772 Calls to this number are free. Press “0” to speak with an RRB representative from 9 a.m. to 3 p.m. weekdays, except federal holidays. Press “1” to access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.

Chapter 2 Phone numbers and resources

Railroad Retirement Board (RRB) – Contact Information

	Calls to this number aren't free.
Website	https://RRB.gov

SECTION 8 If you have group insurance or other health insurance from an employer

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner's) employer or retiree group as part of this plan, call the employer/union benefits administrator or Member Service at 1-800-831-2583 (TTY users call 711) with any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Member Service are printed on the back cover of this document.) You can call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2048.

CHAPTER 3:

Using our plan for your medical services

SECTION 1 How to get medical care as a member of our plan

This chapter explains what you need to know about using our plan to get your medical care covered. For details on what medical care our plan covers and how much you pay when you get care, go to the Medical Benefits Chart in Chapter 4.

Section 1.1 Network providers and covered services

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term “providers” also includes hospitals and other health care facilities.
- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- **Covered services** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the Medical Benefits Chart in Chapter 4.

Section 1.2 Basic rules for your medical care to be covered by our plan

As a Medicare health plan, BlueAdvantage Freedom must cover all services covered by Original Medicare and follow Original Medicare’s coverage rules.

BlueAdvantage Freedom will generally cover your medical care as long as:

- **The care you get is included in our plan’s Medical Benefits Chart** in Chapter 4.
- **The care you get is considered medically necessary.** Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- **You get your care from a provider who is eligible to provide services under Original Medicare.** As a member of our plan, you can get care from either a network provider or an out-of-network provider (go to Section 2 for more information).
 - The providers in our network are listed in the *Provider Directory* bcbst.sapphirecareselect.com.
 - If you use an out-of-network provider, your share of the costs for your covered services may be higher.
 - While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we can't pay a provider who is not eligible to participate in Medicare. If you go to a provider who is not eligible to participate in Medicare, you'll be responsible for the full cost of the services you receive. Check with your provider before getting services to confirm that they're eligible to participate in Medicare.

SECTION 2 Use network and out-of-network providers to get medical care

Section 2.1 You must choose a Primary Care Provider (PCP) to provide and oversee your medical care

What is a PCP and what does the PCP do for you?

What is a PCP?

PCPs manage and coordinate your medical care. PCPs are generally either Family Medicine or Internal Medicine physicians, but other types of providers identified below can serve as your PCP. Family Medicine physicians treat patients of all ages. They are trained to treat the whole person, physically and emotionally. Internists treat adults and teens, focusing on both common and complex medical illnesses. Your PCP will help coordinate care for you when specialists, such as cardiologists or surgeons, are involved.

What types of providers may act as a PCP?

Physicians, Nurse Practitioners and Physician Assistants in the following specialties may serve as your PCP:

- Family Medicine
- Internal Medicine
- Pediatrics
- General Practice
- Geriatric Medicine

What is the role of a PCP?

In BlueAdvantage Freedom, you will generally go to one main healthcare provider for your medical care. He or she can be a doctor, a nurse practitioner or a physician's assistant. This person is called your PCP.

What is the role of the PCP in coordinating covered services?

Your PCP is responsible for the coordination of your health care and is also responsible for your routine health care needs. You may want to ask your PCP for assistance in selecting a network specialist and follow-up with your PCP after any specialist visits. It is important for you to develop and maintain a relationship with your PCP so that he or she can assist you with your health care needs.

What is the role of the PCP in making decisions about or getting a prior authorization, (PA) if applicable?

Your PCP is available to coordinate your care with specialists and other providers. If your PCP or other in-network provider orders a service that requires prior authorization, the ordering provider is responsible for obtaining a prior authorization from BlueAdvantage Freedom.

How to choose a PCP

All BlueAdvantage Freedom members must have a PCP. When you enrolled in BlueAdvantage Freedom, you were asked to pick a PCP and write the PCP's name on the enrollment form. The PCP's name will be printed on your BlueAdvantage Freedom member ID card. If you did not indicate a PCP on the form, we will automatically assign you to a PCP.

If your PCP is new to you, you should get to know him or her. Call to get an appointment with your PCP as soon as you can. This is important to do especially if you were getting care or treatment from a different doctor.

How to change your PCP

You can change your PCP for any reason, at any time. It's also possible that your PCP might leave our plan's network of providers, and you'd need to choose a new PCP. If you elect to continue to see a PCP or other provider who is not in the network, you'll pay more for covered services from that provider.

There are many reasons why you may need to change your PCP. You may want to change the PCP to whom you were automatically assigned if you did not choose one initially, see a PCP whose office is closer to you, or your PCP may stop working with BlueAdvantage Freedom. If your PCP stops working with BlueAdvantage Freedom, we will send a letter asking you to find a new PCP. If you do not select a new PCP, we will automatically assign you to a PCP in our network with an office that is close to you and who is accepting new patients.

To change your PCP:

Find a new PCP by using our Find a Doctor tool at bcbst.sapphirecareselect.com or by calling Member Service. The plan will make your PCP change after it is received, and the change will take effect immediately. If you need help finding a new PCP, call Member Service. They can help you designate a new PCP and order you a new ID card.

Section 2.2 Medical care you can get without a PCP referral

You can get the services listed below without getting approval in advance from your PCP.

- Routine women's health care, including breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams
- Flu shots, COVID-19 vaccines, hepatitis B vaccines, and pneumonia vaccines
- Emergency services from network providers or from out-of-network providers
- Urgently needed plan-covered services are services that require immediate medical attention (but not an emergency), if you're either temporarily outside our plan's service area or it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside the service area of our plan or our plan network is temporarily unavailable.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay our plan for dialysis can never exceed the cost sharing in Original Medicare. If you're outside our plan's service area and get the dialysis from a provider that is outside our plan's network, your cost sharing can't exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is available and you choose to get services inside the service area from a provider outside our plan's network, the cost sharing for the dialysis may be higher. If possible, let us know before you leave the service area so we can help arrange for you to have maintenance dialysis while you're away.
- Bone mineral density testing
- Colonoscopy

The above services are not all-inclusive.

Section 2.3 How to get care from specialists and other network providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. For example:

- Oncologists care for patients with cancer
- Cardiologists care for patients with heart conditions
- Orthopedists care for patients with certain bone, joint, or muscle conditions

How to access specialists and other network providers:

- You decide which specialists you see and to which hospitals you go. Your selection of a PCP does not limit which specialists you see or hospitals you go to. Your PCP may recommend specialists and hospitals, but may not have admitting privileges to all hospitals in your area. You may pay more to use specific specialists or hospitals not in the network.
- If you need to see a specialist or other provider, your PCP can refer you to an appropriate specialist. If you have a preference of a particular specialist or other provider in our network, you can discuss this with your PCP. Please note that if a specialist or other provider that you are referred to or that you select is not in the BlueAdvantage Freedom network, then your out-of-pocket costs may be higher.
- Network providers, physicians or other practitioners, are responsible for obtaining prior authorizations and/or requesting coverage or advance determinations of coverage from the plan. You or your authorized representative may also request prior authorizations or advance determinations. For services rendered by an out-of-network provider, you or the out-of-network provider may request a pre-determination or pre-visit coverage decision (see definition in Chapter 12). Requests for coverage, prior authorizations or for advance determinations should include supporting information and applicable medical records. See Chapter 4, Section 2.1 for information about which services require prior authorization.
- When we receive a request for coverage, prior authorization or an advance coverage determination from you or a network or out-of-network provider, registered nurses and licensed behavioral clinicians initially review information provided for the service or item requested. Medicare or other appropriate medical coverage criteria is used to determine medical necessity/appropriateness of the service.
- If coverage criteria are met for a requested service or item, the nurse/clinician will issue an approval, and we will send a letter to you and your provider indicating the approval.
- If coverage criteria are not met for a requested service or item, the nurse/clinician forwards the request to a plan physician reviewer for evaluation, and determination. Written notification is sent to you and your provider/facility indicating approval or denial. If the request for coverage of the service is denied, appeal rights and

instructions are included in the notification (see Chapter 9, Section 5 (*Your medical care: How to ask for a coverage decision or make an appeal of a coverage decision*)).

When a specialist or another network provider leaves our plan

We may make changes to the hospitals, doctors and specialists (providers) in our plan's network during the year. If your doctor or specialist leaves our plan, you have these rights and protections:

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.
- We'll notify you that your provider is leaving our plan so that you have time to choose a new provider.
 - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past 3 years.
 - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past 3 months.
- We'll help you choose a new qualified in-network provider for continued care.
- If you're undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- When an in-network provider or benefit is unavailable or inadequate to meet your medical needs, we'll arrange for any medically necessary covered benefit outside of our provider network at in-network cost sharing. Prior authorization may be required.
- If you find out your doctor or specialist is leaving our plan, contact us so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider or that your care isn't being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality-of-care grievance to our plan, or both (go to Chapter 7).

Section 2.4 How to get care from out-of-network providers

As a member of our plan, you can choose to get care from out-of-network providers. However, providers that don't contract with us are under no obligation to treat you, except in emergency situations. Our plan will cover services from either in-network or out-of-network

providers, as long as the services are covered benefits and are medically necessary. However, **if you use an out-of-network provider, your share of the costs for covered services may be higher.** Here are more important things to know about using out-of-network providers:

- You can get your care from an out-of-network provider, however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we can't pay a provider who isn't eligible to participate in Medicare. If you get care from a provider who isn't eligible to participate in Medicare, you'll be responsible for the full cost of the services you receive. Check with your provider before getting services to confirm that they're eligible to participate in Medicare.
- You don't need a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers, ask for a pre-visit coverage decision to confirm that the services you get are covered and medically necessary. (Go to Chapter 7, Section 4 for information about asking for coverage decisions.) This is important because:
 - Without a pre-visit coverage decision, and if our plan later determines that the services aren't covered or were not medically necessary, our plan may deny coverage and you'll be responsible for the entire cost. If we say we won't cover the services you got, you have the right to appeal our decision not to cover your care (go to Chapter 7 to learn how to make an appeal).
- It's best to ask an out-of-network provider to bill our plan first. But, if you've already paid for the covered services, we'll reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill you think we should pay, you can send it to us for payment (go to Chapter 5).
- If you're using an out-of-network provider for emergency care, urgently needed services, or out-of-area dialysis, you may not have to pay a higher cost-sharing amount (go to Section 3).

SECTION 3 How to get services in an emergency, disaster, or urgent need for care

Section 3.1 Get care if you have a medical emergency

A **medical emergency** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You don't need to get approval or a referral first from your PCP. You don't need to use a network doctor. You can get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they're not part of our network. Our plan also covers worldwide emergency medical care received outside the United States.
- **As soon as possible, make sure our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. You should contact Member Service to notify the plan (phone numbers are printed on the back cover of this booklet).

Covered services in a medical emergency

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency.

The doctors giving you emergency care will decide when your condition is stable, and when the medical emergency is over.

After the emergency is over, you're entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. Your follow-up care will be covered by our plan.

If you get your follow-up care from out-of-network providers, you'll pay the higher out-of-network cost sharing.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If it turns out that it wasn't an emergency, as long as you reasonably thought your health was in serious danger, we'll cover your care.

However, after the doctor says it wasn't an emergency, the amount of cost sharing that you pay will depend on whether you get the care from network providers or out-of-network providers. If you get the care from network providers, your share of the costs will usually be lower than if you get the care from out-of-network providers.

Section 3.2 Get care when you have an urgent need for services

A service that requires immediate medical attention (but isn't an emergency) is an urgently needed service if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

If you cannot obtain care from your PCP in a timely manner, use our Find a Doctor tool at bcbst.sapphirecareselect.com or call Member Service for help in finding an in-network provider for your urgently needed services. We also have a 24/7 Nurse Line that can provide guidance on where to go for care.

Our plan covers urgently needed services received outside the United States.

Section 3.3 Get care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you're still entitled to care from our plan.

Visit bcbstmedicare.com for information on how to get needed care during a disaster.

If you can't use a network provider during a disaster, our plan will allow you to get care from out-of-network providers at in-network cost sharing.

SECTION 4 What if you're billed directly for the full cost of covered services?

If you paid more than our plan cost sharing for covered services, or if you got a bill for the full cost of covered medical services, you can ask us to pay our share of the cost of covered services. Go to Chapter 5 for information about what to do.

Section 4.1 If services aren't covered by our plan, you must pay the full cost

BlueAdvantage Freedom covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4. If you get services that aren't covered by our plan, you're responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you use up your benefit for that type of covered service. 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.

SECTION 5 Medical services in a clinical research study?

Section 5.1 What is a clinical research study

A clinical research study (also called a *clinical trial*) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically ask for volunteers to participate in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for covered services you get as part of the study. If you tell us you're in a qualified clinical trial, you're only responsible for the in-network cost sharing for the services in that trial. If you paid more—for example, if you already paid the Original Medicare cost-sharing amount—we'll reimburse the difference between what you paid and the in-network cost sharing. You'll need to provide documentation to show us how much you paid.

If you want to participate in any Medicare-approved clinical research study, you don't need to tell us or get approval from us or your PCP. The providers that deliver your care as part of the clinical research study don't need to be part of our plan's network. (This doesn't apply to covered benefits that require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.)

While you don't need our plan's permission to be in a clinical research study, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

If you participate in a study not approved by Medicare, you'll be responsible for paying all costs for your participation in the study.

Section 5.2 Who pays for services in a clinical research study

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you get as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it's part of the research study.
- Treatment of side effects and complications of the new care.

After Medicare pays its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you'll pay the same amount for services you get as part of the study as you would if you got these services from our plan. However, you must submit documentation showing how much cost sharing you paid. Go to Chapter 5 for more information on submitting requests for payments.

Example of cost sharing in a clinical trial: Let's say you have a lab test that costs \$100 as part of the research study. Your share of the costs for this test is \$20 under Original Medicare, but the test would be \$10 under our plan. In this case, Original Medicare would pay \$80 for the test, and you would pay the \$20 copay required under Original Medicare. You would then notify our plan that you got a qualified clinical trial service and submit documentation (like a provider bill) to our plan. Our plan would then directly pay you \$10. This makes your net payment for the test \$10, the same amount you'd pay under our plan's benefits.

When you're in a clinical research study, **neither Medicare nor our plan will pay for any of the following:**

- Generally, Medicare won't pay for the new item or service the study is testing unless Medicare would cover the item or service even if you weren't in a study.
- Items or services provided only to collect data and not used in your direct health care. For example, Medicare won't pay for monthly CT scans done as part of a study if your medical condition would normally require only one CT scan.
- Items and services provided by the research sponsors free-of-charge for people in the trial.

Get more information about joining a clinical research study

Get more information about joining a clinical research study in the Medicare publication *Medicare and Clinical Research Studies*, available at www.Medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

SECTION 6 Rules for getting care in a religious non-medical health care institution

Section 6.1 A religious non-medical health care institution

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a

hospital or a skilled nursing facility is against a member's religious beliefs, we'll instead cover care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

Section 6.2 How to get care from a religious non-medical health care institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you're conscientiously opposed to getting medical treatment that is **non-excepted**.

- **Non-excepted** medical care or treatment is any medical care or treatment that's *voluntary* and *not required* by any federal, state, or local law.
- **Excepted** medical treatment is medical care or treatment you get that's *not* voluntary or *is required* under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan only covers *non-religious* aspects of care.
- If you get services from this institution provided to you in a facility, the following conditions apply:
 - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
 - – *and* – you must get approval in advance from our plan before you're admitted to the facility, or your stay won't be covered.

If you use inpatient services at a religious non-medical health care institution, Medicare Inpatient Hospital coverage limits will apply. Please reference the Medical Benefits Chart in Chapter 4.

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 You won't own some durable medical equipment after making a certain number of payments under our plan

Durable medical equipment (DME) includes items like oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for members to use in the home. The member always owns some DME items, like prosthetics. Other types of DME you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. **As a member of BlueAdvantage Freedom**, you will own certain types of rental DME after paying 10 months of continuous rental. Examples of rental DME items include CPAP machines, manual wheelchairs and hospital beds. Oxygen equipment (not the actual oxygen itself) must be rented for a period of 36 months. Items such as orthotics and prosthetics, power wheelchairs and bone growth stimulators are purchased initially and not rented. These are just a few examples and not an all-inclusive list. Call Member Service at 1-800-831-2583, TTY 711, for more information.

What happens to payments you made for durable medical equipment if you switch to Original Medicare?

If you didn't get ownership of the DME item while in our plan, you'll have to make 13 new consecutive payments after you switch to Original Medicare to own the DME item. The payments you made while enrolled in our plan don't count toward these 13 payments.

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare don't count. You'll have to make 13 payments to our plan before owning the item.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You didn't get ownership of the item while in our plan. You then go back to Original Medicare. You'll have to make 13 consecutive new payments to own the item once you rejoin Original Medicare. Any payments you already made (whether to our plan or to Original Medicare) don't count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

If you qualify for Medicare oxygen equipment coverage BlueAdvantage Freedom will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

If you leave BlueAdvantage Freedom or no longer medically require oxygen equipment, the oxygen equipment must be returned.

What happens if you leave our plan and return to Original Medicare?

Original Medicare requires an oxygen supplier to provide you services for 5 years. During the first 36 months, you rent the equipment. For the remaining 24 months, the supplier provides the equipment and maintenance (you're still responsible for the copayment for oxygen). After

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5 years, you can choose to stay with the same company or go to another company. At this point, the 5-year cycle starts over again, even if you stay with the same company, and you're again required to pay copayments for the first 36 months. If you join or leave our plan, the 5-year cycle starts over.

CHAPTER 4:

Medical Benefits Chart

(what's covered and what you pay)

SECTION 1 Understanding your out-of-pocket costs for covered services

The Medical Benefits Chart lists your covered services and shows how much you pay for each covered service as a member of BlueAdvantage Freedom. This section also gives information about medical services that aren't covered and explains limits on certain services.

Section 1.1 Out-of-pocket costs you may pay for covered services

Types of out-of-pocket costs you may pay for covered services include:

- **Copayment:** the fixed amount you pay each time you get certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart tells you more about your copayments.)
- **Coinsurance:** the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program don't pay deductibles, copayments or coinsurance. If you're in one of these programs, be sure to show your proof of Medicaid or QMB eligibility to your provider.

Section 1.2 What's the most you'll pay for Medicare Part A and Part B covered medical services?

Under our plan, there are 2 different limits on what you pay out-of-pocket for covered medical services:

- Your **in-network maximum out-of-pocket amount (MOOP)** is **\$3,200**. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from network providers. The amounts you pay for copayments and coinsurance for covered services from network providers count toward this in-network maximum out-of-pocket amount. (The amounts you pay for services from out-of-network providers don't count toward your in-network maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your in-network maximum out-of-pocket amount. These services are marked with an

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

asterisk in the Medical Benefits Chart.) If you pay \$3,200 for covered Part A and Part B services from network providers, you won't have any out-of-pocket costs for the rest of the year when you see our network providers. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

- Your **combined maximum out-of-pocket amount** is **\$5,750**. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from both in-network and out-of-network providers. The amounts you pay for copayments and coinsurance for covered services count toward this combined maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your combined maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart.) If you pay \$5,750 for covered services, you'll have 100% coverage and won't have any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Providers aren't allowed to balance bill you

As a member of BlueAdvantage Freedom, you have an important protection because you only have to pay your cost sharing amount when you get services covered by our plan. Providers can't bill you for additional separate charges, called **balance billing**. This protection applies even if we pay the provider less than the provider charges for a service, and even if there's a dispute and we don't pay certain provider charges.

Here's how protection from balance billing works:

- If your cost sharing is a copayment (a set amount of dollars, for example, \$15.00), you pay only that amount for any covered services from a network provider. You'll generally have higher copayments when you get care from out-of-network providers.
- If your cost sharing is a coinsurance (a percentage of the total charges), pay more than that percentage. However, your cost depends on which type of provider you see:
 - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (this is set in the contract between the provider and our plan).
 - If you get covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
 - If you get the covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

- If you think a provider has balance billed you, call Member Service at 1-800-831-2583 (TTY users call 711).

SECTION 2 The Medical Benefits Chart shows your medical benefits and costs

The Medical Benefits Chart on the next pages lists the services BlueAdvantage Freedom covers and what you pay out of pocket for each service. The services listed in the Medical Benefits Chart are covered only when these requirements are met:

- Your Medicare covered services must be provided according to Medicare coverage guidelines.
- Your services (including medical care, services, supplies, equipment, and Part B drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan may not require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- Some services listed in the Medical Benefits Chart are covered as in-network services only if your doctor or other network provider gets approval from us in advance (sometimes called prior authorization).
 - Covered services that need approval in advance to be covered as in-network services are marked by a footnote in the Medical Benefits Chart.
 - You never need approval in advance for out-of-network services from out-of-network providers.
 - While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.

Other important things to know about our coverage:

- For benefits where your cost sharing is a coinsurance percentage, the amount you pay depends on what type of provider you get the services from:
 - If you get the covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (as determined in the contract between the provider and our plan).


Chapter 4 Medical Benefits Chart (what's covered and what you pay)

- If you get the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
 - If you get the covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You* 2026 handbook. View it online at www.Medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.)
- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you're also treated or monitored for an existing medical condition during the visit when you get the preventive service, a copayment will apply for the care you got for the existing medical condition.
- If Medicare adds coverage for any new services during 2026, either Medicare or our plan will cover those services.



This apple shows preventive services in the Medical Benefits Chart.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)**Medical Benefits Chart**

Covered Service	What you pay in-network	What you pay out-of-network
 Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist. Additional cost share may apply when other services are performed.	There is no coinsurance, copayment, or deductible for members eligible for this one-time preventive screening.	50% of the Medicare-allowed amount for this one-time preventive screening.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: <ul style="list-style-type: none"> • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and 	\$20 copay per visit	50% of the Medicare-allowed amount per visit

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<ul style="list-style-type: none"> not associated with pregnancy. <p>An additional 8 sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually.</p> <p>Treatment must be discontinued if the patient is not improving or is regressing.</p> <p>Provider Requirements:</p> <p>Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements.</p> <p>Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:</p> <ul style="list-style-type: none"> a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, 		

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<ul style="list-style-type: none"> a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. <p>Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.</p> <p>To get the most out of your benefit, you can always call Member Service. We'll be happy to assist you in finding a provider that meets the qualifications.</p> <p>Prior authorization is required.</p>		
<p>Allergy Shots and Serum</p> <p>You are covered for allergy shots and serum when medically necessary.</p>	<p>\$0 copay for Medicare-covered shots and serum at a PCP's office.</p> <p>\$25 copay for Medicare-covered shots and serum at a Specialist's office.</p>	<p>\$10 copay for Medicare-covered shots and serum at a PCP's office.</p> <p>\$30 copay for Medicare-covered shots and serum at a Specialist's office.</p>
<p>Ambulance services</p> <p>Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing,</p>	<p>Cost sharing applies to each one-way trip.</p> <p>Domestic ambulance:</p> <p>Ground: \$250 copay per one-way trip</p>	


Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>and ground ambulance services, to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.</p> <ul style="list-style-type: none"> • Non-emergency transportation by ambulance is only covered to the closest facility that can provide care. • Ambulance transportation outside the United States or its territories is only covered to the closest, most appropriate, facility that can provide care. Return to the United States by ambulance is not a covered service unless that is where the closest, most appropriate, facility is located. <p>Note: Prior authorization is required for non-emergency Medicare services (such as transport from home to a</p>	<p>Air: 20% of the Medicare-allowed amount per one-way trip</p> <p>Worldwide ambulance:</p> <p>Ground: \$250 copay per one-way trip</p> <p>Air: 20% of the Plan-allowed amount per one-way trip</p>	


Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
Medicare-certified dialysis facility for prescribed hemodialysis, or transport beyond the closest facility capable of providing care when transferring between facilities or levels of care).		


Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>Annual routine physical examination</p> <p>In addition to your annual wellness visit or your “Welcome to Medicare” preventive visit, you are covered for the following exam once per benefit year.</p> <ul style="list-style-type: none"> Comprehensive physical examination and evaluation of the status of chronic diseases. The exam does not include any laboratory, radiology or diagnostic testing. <p>Note: You will be responsible for cost sharing amounts for any separate PCP or Specialist visit, as well as any laboratory (such as blood work), radiology (such as a chest x-ray) or diagnostic (such as an electrocardiogram (EKG)) testing performed during the examination. These services are not covered as part of this specific benefit.</p>	\$0 copay	50% of the Plan-allowed amount
<p> Annual wellness visit</p> <p>If you’ve had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months.</p>	There is no coinsurance, copayment, or deductible for the annual wellness visit.	50% of the Medicare-allowed amount for the Medicare-covered annual wellness visit.



Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>Note: Your first annual wellness visit can't take place within 12 months of your <i>Welcome to Medicare</i> preventive visit. However, you don't need to have had a <i>Welcome to Medicare</i> visit to be covered for annual wellness visits after you've had Part B for 12 months.</p> <p>Note: You will be responsible for cost sharing amounts for any separate PCP or Specialist visit, as well as any laboratory (such as blood work), radiology (such as a chest x-ray film), or diagnostic (such as an electrocardiogram (EKG)) testing performed during the visit. These services are not covered as part of this specific benefit.</p>		
<p> Bone mass measurement</p> <p>For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months 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.</p>	<p>There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.</p>	<p>50% of the Medicare-allowed amount for the Medicare-covered bone mass measurement.</p>


Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>Additional cost share may apply when other services are performed at the same time.</p>		
<p> Breast cancer screening (mammograms)</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women aged 40 and older • Clinical breast exams once every 24 months <p>Additional cost share may apply when other services are performed.</p>	<p>There is no coinsurance, copayment, or deductible for covered screening mammograms.</p>	<p>50% of the Medicare-allowed amount for the Medicare-covered screening mammograms.</p>
<p>Cardiac rehabilitation services</p> <p>Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order.</p> <p>Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.</p> <p>These services are limited to two one-hour sessions per day</p>	<p>\$0 copay per day for Medicare-covered cardiac rehabilitation services.</p>	<p>50% of the Medicare-allowed amount for the Medicare-covered cardiac rehabilitation services.</p>


Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>with a limit of 36 sessions per year.</p> <p>Prior authorization is required.</p> <p>Additional cost share may apply when other services are performed.</p>		
<p> Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)</p> <p>We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.</p> <p>Additional cost share may apply when other services are performed.</p>	<p>There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.</p>	<p>50% of the Medicare-allowed amount for the Medicare-covered intensive behavioral therapy cardiovascular disease preventive benefit.</p>
<p> Cardiovascular disease screening tests</p> <p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).</p> <p>Additional cost share may apply when other services are performed.</p>	<p>There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.</p>	<p>50% of the Medicare-allowed amount for the Medicare-covered cardiovascular disease testing that is covered once every 5 years.</p>

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
 Cervical and vaginal cancer screening Covered services include: <ul style="list-style-type: none"> For all women: Pap tests and pelvic exams are covered once every 12 months If you're at high risk of cervical or vaginal cancer screening or you're of childbearing age and have had an abnormal Pap test with the past 3 years, one Pap test once every 12 months Additional cost share may apply when other services are performed.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.	50% of the Medicare-allowed amount for the Medicare-covered preventive Pap and pelvic exams.
Chiropractic services Covered services include: <ul style="list-style-type: none"> We cover only manual manipulation of the spine to correct subluxation Note: Only active therapy visits are covered. Visits for maintenance therapy are not covered. Prior authorization is required. Out-of-network services will be reviewed after the service is rendered to ensure it was medically and reasonably necessary.	\$20 copay for each Medicare-covered chiropractic visit.	50% of the Medicare-allowed amount for each Medicare-covered chiropractic visit.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>Chronic pain management and treatment services</p> <p>Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning.</p>	\$0 copay per service	50% of the Medicare-allowed amount per service
<p> Colorectal cancer screening</p> <p>The following screening tests are covered:</p> <ul style="list-style-type: none"> Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy. Computed tomography colonography for patients 45 year and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography 	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.	50% of the Medicare-allowed amount for the Medicare-covered colorectal cancer screening exam.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed.</p> <ul style="list-style-type: none"> • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 		

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>years of age and not meeting high risk criteria. Once every 3 years.</p> <ul style="list-style-type: none"> • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result. • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test. <p>Note: If you receive a colonoscopy without previous symptoms, this is considered preventive and there will be no copay or coinsurance. If your doctor is performing the colonoscopy because you have shown symptoms of a medical condition, this is considered outpatient surgery (see benefit description and cost share in this benefit chart) and a copay will apply.</p>		

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
Additional cost share may apply when other services are performed.		
<p>Dental services - Medicare-covered</p> <p>In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. In addition, we cover:</p> <ul style="list-style-type: none"> • If you have a disease that involves the jaw (like oral cancer) and need dental services that are necessary for radiation treatments, • If you need surgery to treat fractures of the jaw or face, 	<p>\$25 copay for Medicare-covered dental services in an office.</p> <p>If services are performed in other settings, the cost share for that place of service will apply (e.g., ambulatory surgery center or outpatient hospital).</p>	<p>50% of the Medicare-allowed amount for Medicare-covered dental services in any setting.</p>

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<ul style="list-style-type: none"> If you need dental splints and wiring as a result of jaw surgery 		
<p>Dental services* - Supplemental</p> <p>Supplemental dental services outlined below are covered until the annual allowance is met.</p> <p>Included as covered benefits with service limits in this plan, but not limited to:</p> <p>Diagnostic and Preventive:</p> <ul style="list-style-type: none"> Standard diagnostic exams (limited to 2 per year) Problem-focused oral evaluations Cleanings (limited to 2 per year) Bitewing x-ray (limited to 1 set per 12-month period) Panoramic or full mouth x-ray (limited to 1 per 36-month period) <p>Endodontics:</p> <ul style="list-style-type: none"> Root canals (limited to 1 per 60 month period) Apicoectomy (limited to 1 per lifetime) 	<p>\$2,500 annual allowance for all of the covered dental services listed.</p> <p>Diagnostic and Preventive:</p> <p>\$0 copay through the annual allowance</p> <p>Endodontics:</p> <p>\$0 copay through the annual allowance</p>	<p>\$2,500 annual allowance for all of the covered dental services listed.</p> <p>Diagnostic and Preventive:</p> <p>50% of billed charges through the annual allowance</p> <p>Endodontics:</p> <p>50% of billed charges through the annual allowance</p>


Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<ul style="list-style-type: none"> Retrograde filling (limited to 1 per lifetime) 		
Oral and Maxillofacial Surgery: <ul style="list-style-type: none"> Simple extractions and surgical extractions (including removal of impacted teeth), coronectomy, and other oral surgical procedures typically not covered by a medical plan 	Oral and Maxillofacial Surgery: <p>20% of the Plan-allowed amount through the annual allowance</p>	Oral and Maxillofacial Surgery: <p>50% of billed charges through the annual allowance</p>
Periodontics: <ul style="list-style-type: none"> Periodontal exam (limited to 1 per 36 months) Periodontal maintenance (limited to 2 per year) Scaling and root planning (limited to 1 per 24 months for any quadrant) Full mouth debridement (limited to 1 per lifetime) 	Periodontics: <p>\$0 copay through the annual allowance</p>	Periodontics: <p>50% of billed charges through the annual allowance</p>
Prosthodontics, removable and fixed: <ul style="list-style-type: none"> Complete dentures (limited to 1 in any 5 year period) Partial dentures (limited to 1 in 5 years) Denture restorations (limited to 1 in 5 years) <p>Other limitations apply.</p>	Prosthodontics: <p>20% of the Plan-allowed amount through the annual allowance</p>	Prosthodontics: <p>50% of billed charges through the annual allowance</p>


Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>Restorative</p> <ul style="list-style-type: none"> • Fillings (limited to 1 per tooth surface per year) • Crowns (limited to 1 per tooth per 5 years) • Bridges (limited to 1 per 5 years) • Denture repair and adjustments (limited to 1 per 36 month period) <p>Please inform the provider that you are a BlueAdvantage PPO member with access to Dental Network M. When using an out-of-network provider, you will be responsible for costs above the Plan-approved allowance.</p> <p>You are responsible for submitting a Dental Network M out-of-network claim form, with itemized receipts, when seeing an out-of-network provider. Dental services rendered by a provider who has formally "opted out" of the Medicare program are not covered or payable by the plan.</p> <p>If you use an out-of-network provider and need the claim form, call Dental Member Service at 1-866-206-8274, TTY 711 (Monday through Friday, 8 a.m. to 9 p.m. ET.)</p>	<p>Restorative:</p> <p>20% of the Plan-allowed amount through the annual allowance</p>	<p>Restorative:</p> <p>50% of billed charges through the annual allowance</p>


Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>Supplemental dental benefits do not apply to the maximum out-of-pocket amount.</p> <p>Service limits and exclusions apply. All allowable charges and treatments will be based on generally accepted standards of care.</p> <p>If you change from one BlueAdvantage plan to another during the same benefit year, the annual dental allowance would not start over. The allowance used would remain with you from one plan to another.</p> <p>Facility and/or facility anesthesia services associated with a dental procedure are covered only if the primary dental procedure is covered under the guidelines of Original Medicare.</p> <p>If you would like to obtain more details about these limitations, exclusions or standards of care, please contact Dental Member Service at 1-866-206-8274, TTY 711. (Monday through Friday, 8 a.m. to 9 p.m. ET.)</p>		
 Depression screening We cover one screening for depression per year. The screening must be done in a	There is no coinsurance, copayment, or deductible for an annual depression screening visit.	50% of the Medicare-allowed amount for the Medicare-covered annual depression screening visit.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>primary care setting that can provide follow-up treatment and/or referrals.</p> <p>Additional cost share may apply when other services are performed.</p>		
<p> Diabetes screening</p> <p>We cover this screening (includes fasting glucose tests) if you have any of these risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.</p> <p>You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test.</p> <p>Additional cost share may apply when other services are performed.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.</p>	<p>50% of the Medicare-allowed amount for the Medicare-covered diabetes screening tests.</p>

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
 Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: <ul style="list-style-type: none"> Supplies to monitor your blood glucose: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. The following diabetic testing supplies are limited to: <ul style="list-style-type: none"> Calibration Solution: 1 per 365 days Glucometer: 1 per 365 days Lancets: 600 per 90 days Lancet Device: 1 per 365 days Test Strips: 300 per 90 days (100 per month) Preferred diabetic testing supplies covered under Part B are Ascencia's Contour and Roche Accu-Chek products. Other products are covered only with prior authorization. The supplies listed above are only available through a durable medical equipment (DME) supplier.	\$0 copay for preferred Medicare-covered diabetic monitoring products/supplies. 20% of the Plan-allowed amount for other (non-preferred) diabetic testing products/supplies. Covered only with prior authorization.	50% of the Medicare-allowed amount for Medicare-covered diabetic monitoring products/supplies.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>Talking monitors are covered for members with severe visual impairment with prior authorization.</p> <ul style="list-style-type: none"> Supplies to monitor your blood glucose: continuous glucose monitors (CGMs) <p>Currently covered under Part B, Dexcom product CGMs with a prior authorization. These supplies are only available through a DME supplier.</p>	<p>20% of the Plan-allowed amount for Dexcom products</p> <p>50% of the Plan-allowed amount for other CGM brands with prior authorization</p>	<p>50% of the Medicare-allowed amount for CGMs</p>
<ul style="list-style-type: none"> For people with diabetes who have severe diabetic foot disease: one pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts, or one pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. 	<p>\$10 copay for Medicare-covered diabetic therapeutic shoes and inserts.</p>	<p>50% of the Medicare-allowed amount for Medicare-covered diabetic therapeutic shoes and inserts.</p>
<ul style="list-style-type: none"> Diabetes self-management training is covered under certain conditions. 	<p>\$0 copay for Medicare-covered diabetes self-management training.</p>	<p>20% of the Medicare-allowed amount for Medicare-covered diabetes self-management training.</p>
<p>Note: Please see the "Durable medical equipment (DME) and related supplies" section in this</p>	<p>You may pay an additional PCP or Specialist copay if a separate office visit is</p>	<p>You may pay an additional PCP or Specialist copay if a separate office visit is</p>

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>chart for more information on external insulin pumps and related supplies.</p> <p>Out-of-network services will be reviewed after the service is rendered to ensure it was medically and reasonably necessary.</p>	<p>billed when you receive Medicare-covered services.</p>	<p>billed when you receive Medicare-covered services.</p>
<p>Durable medical equipment (DME) and related supplies</p> <p>(For a definition of durable medical equipment, go to Chapter 10 and Chapter 3)</p> <p>Covered items include, but aren't limited to, wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers.</p> <p>DME, such as an insulin pump with integrated adjunctive continuous glucose monitor, requires prior authorization.</p> <p>We cover all medically necessary DME covered by Original Medicare. If our supplier in your area doesn't carry a particular brand or manufacturer, you can ask them if they can special order it for you. The most recent list of</p>	<p>20% of the Plan-allowed amount for Medicare-covered durable medical equipment</p> <p>Your cost sharing for Medicare oxygen equipment coverage is 20% of the Plan-allowed amount, every month for 36 months.</p> <p>Once oxygen equipment rental payments have been made for 36 months, there are no further payments for oxygen equipment during the following five (5) year reasonable use lifetime of the equipment. The supplier(s) who provided the equipment during the 36-month rental period is required to continue providing the equipment during the 5-year reasonable use lifetime of the equipment.</p> <p>If prior to enrolling in BlueAdvantage Freedom</p>	<p>50% of the Medicare-allowed amount for Medicare-covered durable medical equipment.</p> <p>Your cost sharing for Medicare oxygen equipment coverage is 50% of the Medicare-allowed amount, every month for 36 months.</p> <p>Once oxygen equipment rental payments have been made for 36 months, there are no further payments for oxygen equipment during the following five (5) year reasonable use lifetime of the equipment. The supplier(s) who provided the equipment during the 36-month rental period is required to continue providing the equipment during the 5-year reasonable use lifetime of the equipment.</p>

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>suppliers is available on our website at bcbst.sapphirecareselect.com.</p> <p>Prior authorization may be required. The total rental price cannot exceed the purchase price, if applicable.</p> <p>Out-of-network services will be reviewed after the service is rendered to ensure it was medically and reasonably necessary.</p>	<p>you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in BlueAdvantage Freedom is \$0.</p>	<p>If prior to enrolling in BlueAdvantage Freedom you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in BlueAdvantage Freedom is \$0.</p>
<p>Emergency care</p> <p>Emergency care refers to services that are:</p> <ul style="list-style-type: none"> • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. <p>A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.</p>	<p>Domestic</p> <p>\$150 copay for each emergency room visit</p> <p>Copay is waived if you are admitted to the hospital within 24 hours for the same condition.</p> <p>Worldwide</p> <p>\$60 copay for each emergency room visit</p>	

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
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Self-administered drugs in an emergency room setting are not covered under this plan.

Cost sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital in order to pay the in-network cost sharing amount for the part of your stay after you're stabilized. If you stay at the out-of-network hospital, your stay will be covered but you'll pay the out-of-network cost sharing amount for the part of your stay after you're stabilized.

Scenarios for Emergency Care Services	What You Will Pay
ER and/or Outpatient Observation with Advanced Imaging	Advanced Imaging cost share

Chapter 4 Medical Benefits Chart (what's covered and what you pay)


Covered Service		What you pay in-network	What you pay out-of-network
ER and/or Outpatient Observation with Outpatient Surgery	Outpatient Surgery cost share		
ER and/or Outpatient Observation with Outpatient Surgery and Advanced Imaging	Outpatient Surgery & Advanced Imaging cost share		
ER and Observation	Observation cost share		

For more information on other cost share, see *Outpatient diagnostic tests and therapeutic services and supplies for Advanced Imaging, Outpatient hospital observation for outpatient observation and Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers for outpatient surgery.*

This plan includes worldwide emergency care.

Note: If radiopharmaceuticals are used as part of your advanced imaging services, the Part B Drug Benefit will also apply. See Medicare Part

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
B prescription drugs for cost share information.		
 Health and wellness education programs Fitness Program: <i>The Silver&Fit® Healthy Aging and Exercise Program</i> As a member, you have the following choices available at no cost to you: <ul style="list-style-type: none"> • Fitness center membership: To enroll you can: <ul style="list-style-type: none"> ○ Visit a standard Silver&Fit participating fitness center near you. ○ Visit SilverandFit.com. ○ Or, you can call 1-888-797-8091, TTY 711 (Monday to Friday 8 a.m. to 9 p.m. ET). • A customized program for your exercise of choice, including instructions on how to get started and suggested online workout videos • On-demand videos through the website digital library 	\$0 copay for health and wellness education programs Must use designated plan vendor(s).	Not covered

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<ul style="list-style-type: none"> • Healthy Aging resources tailored to your interests and healthy habit goals <p>Remote Access Technologies:</p> <p><i>Nurse Hotline:</i></p> <p>Members will have access to a 24-hour nurse hotline, where a nurse can assist with general health information, referral to a local provider or triage some conditions for immediate evaluation versus next day follow-up with the member's PCP or specialist.</p> <p><i>Tele-Monitoring:</i></p> <p>Plan utilizes home based monitoring when medically necessary for members with chronic conditions who are participating in condition management programs and are at increased risk for medical interventions or hospitalization. For example, remote monitoring scales to assess weight changes in members with congestive heart failure. Frequency of monitoring is based on condition severity. Abnormal results are appropriately shared with the treating physician, while normal results are shared monthly. This tele-monitoring benefit does not include blood glucose</p>		


Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
monitoring devices covered by Original Medicare.		
Hearing services - Medicare-covered Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.	\$10 copay per Medicare-covered visit	
Hearing services* - Supplemental Services include: One routine hearing exam per year (exam must be obtained from a TruHearing® provider) Limit of two TruHearing-branded hearing aids per year (one per ear, per year). Benefit is limited to the TruHearing Standard, Advanced and Premium hearing aids, which come in various styles and colors. Advanced and Premium hearing aids are available in rechargeable style options (for an additional fee). You must see a TruHearing provider to use this benefit. Call 1-855-205-6376 , TTY 711 , Monday through Friday to schedule an appointment.	Must use designated plan vendor. Routine hearing exam: \$0 copay Hearing aids: \$199 copay per aid for Standard model (one hearing aid per ear, per year). or \$399 copay per aid for Advanced model (one hearing aid per ear, per year). or	Not covered

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>Hearing aid purchase includes:</p> <ul style="list-style-type: none"> • First year of follow-up provider visits • 60-day trial period • 3-year extended warranty • 80 batteries per aid for non-rechargeable models <p>Benefit does not include or cover any of the following:</p> <ul style="list-style-type: none"> • Additional fee for optional hearing aid rechargeability • Ear molds • Hearing aid accessories • Additional provider visits • Additional batteries; batteries when a rechargeable hearing aid is purchased • Hearing aids that are not TruHearing-branded hearing aids • Costs associated with loss and damage warranty claims <p>Costs associated with excluded items are the responsibility of the member and are not covered by the Plan.</p> <p>* Routine hearing exam and</p>	<p>\$699 copay per aid for Premium model (one hearing aid per ear, per year).</p> <p>\$50 additional fee per hearing aid for rechargeable style options for Premium and Advanced hearing aids.</p>	

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>hearing aid copayments do not count toward your in-network or combined maximum out-of-pocket amount.</p>		
<p> HIV screening</p> <p>For people who ask for an HIV screening test or are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none"> One screening exam every 12 months <p>If you are pregnant, we cover:</p> <ul style="list-style-type: none"> Up to 3 screening exams during a pregnancy <p>Additional cost share may apply when other services are performed.</p>	<p>There's no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.</p>	<p>50% of the Medicare-allowed amount for members eligible for Medicare-covered preventive HIV screening.</p>
<p>Home health agency care</p> <p>Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort.</p> <p>Covered services include, but aren't limited to:</p> <ul style="list-style-type: none"> Part-time or intermittent skilled nursing and home health aide services (To be covered under the home 	<p>\$0 copay for each Medicare-covered home health visit.</p>	<p>50% of the Medicare-allowed amount for each Medicare-covered home health visit.</p>

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week)</p> <ul style="list-style-type: none"> Physical therapy, occupational therapy and speech therapy Medical and social services Medical equipment and supplies <p>Prior authorization is required.</p> <p>Out-of-network services will be reviewed after the service is rendered to ensure it was medically and reasonably necessary.</p>		
<p>Home infusion therapy</p> <p>Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters).</p> <p>Covered services include, but aren't limited to:</p>	<p>20% of the Plan-allowed amount</p>	<p>50% of the Medicare-allowed amount</p>

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<ul style="list-style-type: none"> Professional services, including nursing services, furnished in accordance with our plan of care Patient training and education not otherwise covered under the durable medical equipment benefit Remote monitoring Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier <p>Prior authorization is required.</p>		
<p>Hospice care</p> <p>You're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider.</p>		<p>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not BlueAdvantage Freedom.</p> <p>\$0 copay for one consultative visit before you select hospice.</p> <p>You must get care from a Medicare-certified hospice.</p>


Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>Covered services include:</p> <ul style="list-style-type: none"> • Drugs for symptom control and pain relief • Short-term respite care • Home care <p>When you're admitted to a hospice, you have the right to stay in our plan; if you stay in our plan you must continue to pay plan premiums.</p> <p>For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis: Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost sharing.</p> <p>For services covered by Medicare Part A or B not related to your terminal prognosis: If you need non-emergency, non-urgently needed services covered under Medicare Part A or B that aren't related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's</p>		

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>network and follow plan rules (like if there's a requirement to get prior authorization).</p> <ul style="list-style-type: none"> • If you get the covered services from a network provider and follow plan rules for getting service, you pay only our plan cost sharing amount for in-network services • If you get the covered services from an out-of-network provider, you pay the cost sharing under Original Medicare <p>For services covered by BlueAdvantage Freedom but not covered by Medicare Part A or B: BlueAdvantage Freedom will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our plan cost sharing amount for these services.</p> <p>Note: If you need non-hospice care (care that's not related to your terminal prognosis), contact us to arrange the services.</p> <p>The Plan will pay for a consultative visit from a Medicare-certified hospice to help you determine if you should select hospice. Once</p>		

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>enrolled in hospice, these services are covered by Original Medicare and not your BlueAdvantage plan.</p> <p>Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.</p>		
<p> Immunizations</p> <p>Covered Medicare Part B services include:</p> <ul style="list-style-type: none"> • Pneumonia vaccines (limited to two per lifetime; the initial immunization and one booster. There must be at least 11 months between the initial and booster.) • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you're at high or intermediate risk of getting Hepatitis B • COVID-19 vaccine • Other vaccines if you're at risk and they meet the Medicare Part B coverage rules <p>Additional cost share may apply when other services are performed.</p>	<p>There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines.</p>	<p>50% of the Medicare-allowed amount for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines.</p>

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>Inpatient hospital care</p> <p>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.</p> <p>No limit to the number of days covered by the plan. Covered services include but aren't limited to:</p> <ul style="list-style-type: none"> • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care 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, occupational, and speech language therapy 	<p>Medicare-covered stays at an inpatient hospital:</p> <p>\$175 copay per day for days 1-5</p> <p>\$0 copay per day for additional days</p> <p>Cost sharing (copayment or coinsurance) applies on the date of admission each time you are admitted or transferred to a specific facility type, including Inpatient Rehabilitation facilities, Inpatient Acute Care facilities, Inpatient Long Term Acute Care hospitals and Inpatient Psychiatric facilities.</p>	<p>Medicare-covered stays at an inpatient hospital:</p> <p>\$225 copay per day for days 1-5</p> <p>\$0 copay per day for additional days</p> <p>Cost sharing (copayment or coinsurance) applies on the date of admission each time you are admitted or transferred to a specific facility type, including Inpatient Rehabilitation facilities, Inpatient Acute Care facilities, Inpatient Long Term Acute Care hospitals and Inpatient Psychiatric facilities.</p>

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<ul style="list-style-type: none"> • Inpatient substance abuse services • 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. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. • If BlueAdvantage Freedom covers transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion. Travel 		

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>reimbursement requires that you must be an approved transplant candidate who is actively listed by the transplant center, and the center is a minimum of 100 miles one-way from your legal residence to the transplant center. Travel, meals and lodging (TML) expense reimbursement is limited to \$10,000 per covered transplant. This benefit only covers TML expenses for you and one companion for the initial and annual evaluation, stem cell injection and cell collection, and transplant. TML is not covered for follow-up or post-operative visits or transplant related inpatient admissions after you receive your transplant, except for re-admissions occurring during sequestering (time required to be near a facility and away from your home) immediately after a transplant. A transplant case manager will provide you instructions on how to submit your claim for TML reimbursement, if eligible. Original itemized receipts (please keep a copy for your records), including all pertinent information (member name and subscriber ID), must be</p>		

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>submitted with your claim for reimbursement within 90 days of your evaluation that resulted in an active transplant listing or when a transplant has been completed.</p> <ul style="list-style-type: none"> ○ Reimbursable TML expenses include: mileage (at the IRS mileage rate) for a personal vehicle; cost of public transportation; coach rate airfare (if approved); parking; food and non-alcoholic drinks; and hotel fees including taxes. ○ Non-reimbursable TML expenses: expenses related to a transplant Donor (transportation, meals and lodging); member evaluations at a facility where the member is not on an active transplant list; or, doctor or follow-up visits after a transplant. Other items the plan doesn't cover are: gasoline; car rental; paper products; over-the-counter medications; personal hygiene products; magazines; gratuities; alcoholic beverages; clothing; cleaning products; appliances; furniture; telephone or internet access charges; 		

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>movies or any other type of entertainment.</p> <ul style="list-style-type: none"> • Blood - including storage and administration. Coverage of whole blood, packed red cells and all other components of blood are covered starting with the first pint. • Physician services <p>Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an <i>outpatient</i>. If you're not sure if you're an inpatient or an outpatient, ask the hospital staff.</p> <p>Get more information in the Medicare fact sheet <i>Medicare Hospital Benefits</i>. This fact sheet is available at www.Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.</p> <p>Prior authorization is required.</p> <p>A facility provider must obtain an authorization for a member for an elective inpatient admission. A facility provider must notify plan of an</p>		

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>unplanned, emergency admission within 24 hours, or the next business day if over the weekend or holiday.</p> <p>If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the highest cost sharing you would pay at a network hospital.</p> <p>Out-of-network services will be reviewed after the service is rendered to ensure it was medically and reasonably necessary.</p>		
<p>Inpatient services in a psychiatric hospital</p> <p>Covered services include mental health care services that require a hospital stay. Our plan covers a maximum of 190 days (a lifetime limit) for inpatient services at a psychiatric hospital.</p> <ul style="list-style-type: none"> The 190-day limit doesn't apply to inpatient mental health services provided in a psychiatric unit of a general hospital. Includes Medicare Part A covered services provided at a religious non-medical health care institution. 	<p>Medicare-covered stays at a psychiatric hospital:</p> <p>\$175 copay per day for days 1-5</p> <p>\$0 copay per day for days 6-190</p>	<p>Medicare-covered stays at a psychiatric hospital:</p> <p>\$225 copay per day for days 1-5</p> <p>\$0 copay per day for days 6-190</p>


Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>Prior authorization may be required.</p> <p>Cost sharing (copayment or coinsurance) applies on the date of admission each time you are admitted or transferred to an Inpatient Psychiatric facility.</p> <p>Out-of-network services will be reviewed after the service is rendered to ensure it was medically and reasonably necessary.</p>		
<p>Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay</p> <p>If you've used up your inpatient benefits or if the inpatient stay isn't reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you get while you're in the hospital or the skilled nursing facility (SNF). Covered services include, but aren't limited to:</p> <ul style="list-style-type: none"> • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings 		<p>Copayments and/or coinsurance may apply for these services. Please review the benefits in this chart for information on these covered services. For example, see "Prosthetic devices and related supplies" section for braces and artificial limbs.</p>


Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<ul style="list-style-type: none"> 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 <p>Prior authorization may be required.</p> <p>Out-of-network services will be reviewed after the service is rendered to ensure it was medically and reasonably necessary.</p>		
Meals	\$0 copay	Not covered

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>This benefit provides 14 meals after discharge from an acute inpatient hospital, skilled nursing facility, or observation stay to a home setting. This should be handled during the discharge planning process. There is no limit to the number of times you may access this benefit.</p> <p>Members are eligible to request and receive these meals within 21 days after discharge. If you would like assistance, please call Member Service at 1-800-831-2583, TTY 711.</p>	<p>Must use designated plan vendor.</p>	
<p> Medical nutrition therapy</p> <p>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor.</p> <p>We cover 3 hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage Plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a physician's order. A physician must prescribe these services and</p>	<p>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.</p>	<p>50% of the Medicare-allowed amount for members eligible for Medicare-covered medical nutrition therapy services.</p>

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>renew their order yearly if your treatment is needed into the next calendar year.</p> <p>Additional cost share may apply when other services are performed.</p>		
<p> Medicare Diabetes Prevention Program (MDPP)</p> <p>MDPP services are covered for eligible people under all Medicare health plans.</p> <p>MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.</p> <p>Additional cost share may apply when other services are performed.</p>	<p>There is no coinsurance, copayment, or deductible for the MDPP benefit.</p> <p>Must use designated plan vendor.</p>	Not covered
<p>Medicare Part B drugs</p> <p>These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include:</p> <ul style="list-style-type: none"> Drugs that usually aren't self-administered by the patient and are injected or infused while you get 	<p>Medicare Part B-covered drugs:</p> <p>20% of the Plan-allowed amount</p> <p>Medicare Part B-covered chemotherapy drugs:</p> <p>20% of the Plan-allowed amount</p> <p>Medicare Part B-covered gene therapy drugs:</p>	<p>Medicare Part B-covered drugs:</p> <p>50% of the Medicare-allowed amount</p> <p>Medicare Part B-covered chemotherapy drugs:</p> <p>50% of the Medicare-allowed amount</p> <p>Medicare Part B-covered gene therapy drugs:</p>

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>physician, hospital outpatient, or ambulatory surgical center services</p> <ul style="list-style-type: none"> Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan The Alzheimer's drug, Leqembi®, (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment Clotting factors you give yourself by injection if you have hemophilia Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must 	<p>20% of the Plan-allowed amount - Prior authorization is required even in an inpatient setting.</p> <p>Medicare Part B-covered insulin drugs: You will pay 20% of the Medicare-allowed amount, but no more than \$35, for a one-month supply of each insulin product covered by our plan.</p>	<p>50% of the Medicare-allowed amount</p> <p>Medicare Part B-covered insulin drugs: You will pay 20% of the Medicare-allowed amount, but no more than \$35, for a one-month supply of each insulin product covered by our plan.</p>


Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>have Part B at the time you get immunosuppressive drugs.</p> <ul style="list-style-type: none"> • Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug • Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're 		

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug</p> <ul style="list-style-type: none"> • Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B • Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv®, and the oral medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin, when medically necessary and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa Mircera®, or Methoxy 		

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>polyethylene glycol-epoetin beta)</p> <ul style="list-style-type: none"> • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) • Gene therapy, such as chimeric antigen receptor (CAR) T-cell therapy <p>Out-of-network services will be reviewed after the service is rendered to ensure it was medically and reasonably necessary.</p>		
<p> Obesity screening and therapy to promote sustained weight loss</p> <p>If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan.</p> <p>Talk to your primary care doctor or practitioner to find out more.</p>	<p>There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.</p>	<p>50% of the Medicare-allowed amount for preventive obesity screening and therapy.</p>

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
Additional cost share may apply when other services are performed.		
<p>Opioid treatment program services</p> <p>Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:</p> <ul style="list-style-type: none"> • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments <p>Prior authorization is required.</p>	<p>Medicare-covered group therapy visit: \$0 copay</p> <p>Medicare-covered individual therapy visit: \$0 copay</p>	<p>Medicare-covered group or individual therapy visit: 50% of the Medicare-allowed amount for each Medicare-covered visit</p>
Outpatient diagnostic tests and therapeutic services and supplies	Cost share may be based on the service received and the setting where it is performed.	Cost share may be based on the service received and the setting where it is performed.

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>Covered services include, but aren't limited to:</p> <ul style="list-style-type: none"> • X-rays (such as plain film x-rays like a chest x-ray or bone x-ray) • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood, packed red cells and all other components of blood are 	<p>X-rays:</p> <p>\$0 copay - PCP's office</p> <p>\$25 copay - Specialist's office</p> <p>\$25 copay - Free-Standing Radiology Facility</p> <p>\$35 copay - Outpatient Hospital</p> <p>Radiation (radium and isotope) therapy service:</p> <p>\$50 copay</p> <p>Laboratory tests:</p> <p>\$0 copay - PCP's office</p> <p>\$0 copay - Specialist's office</p> <p>\$0 copay - Free-Standing Lab</p> <p>\$30 copay - Outpatient Hospital</p> <p>Blood services:</p> <p>\$0 copay for Medicare-covered blood services</p>	<p>X-rays:</p> <p>50% of the Medicare-allowed amount</p> <p>Radiation (radium and isotope) therapy service:</p> <p>50% of the Medicare-allowed amount</p> <p>Laboratory tests:</p> <p>50% of the Medicare-allowed amount</p> <p>Blood services:</p> <p>\$0 copay for Medicare-covered blood services</p>

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
covered beginning with the first pint used		
<ul style="list-style-type: none"> • Diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem (such as nerve conduction studies, electroencephalogram (EEG) and electromyography) • Other outpatient diagnostic tests (such as nerve conduction studies, electroencephalogram (EEG) and electromyography) • Molecular Diagnostic/ Genetic Testing: Genetic tests will only be covered once per the member's lifetime unless the test is specifically approved by the U.S. Food and Drug Administration (FDA) to be performed more than once. • Advanced imaging (Services such as: CT, CTA, MRI, MRA, nuclear stress test, PET scans, SPECT.) Note: If radiopharmaceuticals are used as part of your advanced imaging services, the Part B Drug Benefit will also apply. See Medicare Part B prescription drugs for cost share information. 	<p>Diagnostic procedures and tests:</p> <p>\$0 copay - PCP's office</p> <p>\$25 copay - Specialist's office</p> <p>\$25 copay - Free Standing Facility</p> <p>\$35 copay - Outpatient Hospital</p> <p>Genetic test:</p> <p>20% of the plan-allowed amount in all service settings - All genetic testing requires prior authorization.</p> <p>Advanced imaging service (not including x-rays):</p> <p>\$110 copay</p>	<p>Diagnostic procedures and tests:</p> <p>50% of the Medicare-allowed amount</p> <p>Genetic test:</p> <p>50% of the Medicare-allowed amount</p> <p>Advanced imaging service (not including x-rays):</p> <p>50% of the Medicare-allowed amount</p>

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<ul style="list-style-type: none"> • Sleep studies Note: Home-based polysomnography sleep studies do not require a prior authorization. Facility-based sleep studies (polysomnogram or PSG), CPAP titration and split night sleep studies require prior authorization. • Coumadin clinic services Prior authorization may be required. You can contact Member Service with questions about how a specific setting would be classified for these benefits. All out-of-network services will be reviewed after the service is rendered to ensure it was medically and reasonably necessary. 	<p>Sleep study: \$0 copay for each home-based sleep study \$30 copay for each facility-based sleep study</p> <p>Coumadin testing: \$0 copay - PCP's office \$0 copay - Specialist's office \$0 copay - Free-Standing Lab \$10 copay - Outpatient Hospital</p> <p>You may pay an additional copay (PCP or Specialist) if a separate office visit is billed when you receive Medicare-covered services.</p>	<p>Sleep study: 50% of the Medicare-allowed amount for each sleep study</p> <p>Coumadin testing: 50% of the Medicare-allowed amount</p> <p>You may pay an additional copay (PCP or Specialist) if a separate office visit is billed when you receive Medicare-covered services.</p>
<p>Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet Medicare criteria and be considered reasonable and</p>	<p>\$200 copay</p>	<p>50% of the Medicare-allowed amount</p>

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>necessary. Observation services are covered only when provided by the order of a physician or another people authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.</p> <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff.</p> <p>Get more information in the Medicare fact sheet <i>Medicare Hospital Benefits</i>. This fact sheet is available at www.Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.</p>		
<p>Outpatient hospital services</p> <p>We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</p>	<p>Copayments and/or coinsurance may apply for these services. Please review the benefits in this Medical Benefits Chart for information on these covered services. For example, see "Outpatient diagnostic tests and therapeutic services and supplies" section for laboratory and diagnostic tests.</p>	

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>Covered services include, but aren't limited to:</p> <ul style="list-style-type: none"> • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals you can't give yourself <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff.</p>		

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>Outpatient mental health care</p> <p>Covered services include:</p> <p>Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.</p> <p>Out-of-network services will be reviewed after the service is rendered to ensure it was medically and reasonably necessary.</p>	<p>Medicare-covered group therapy visit:</p> <p>\$15 copay per visit</p> <p>Medicare-covered individual therapy visit:</p> <p>\$25 copay per visit</p>	<p>Medicare-covered group or individual therapy visit:</p> <p>50% of the Medicare-allowed amount for each Medicare-covered visit</p>
<p>Outpatient rehabilitation services</p> <p>Covered services include physical therapy, occupational therapy, and speech language therapy.</p> <p>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient</p>	<p>Medicare-covered therapy visit:</p> <p>\$25 copay per visit</p>	<p>Medicare-covered therapy visit:</p> <p>50% of the Medicare-allowed amount for each physical, speech or occupational therapy visit.</p>

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>Rehabilitation Facilities (CORFs).</p> <p>Prior authorization is required.</p> <p>Out-of-network services will be reviewed after the service is rendered to ensure it was medically and reasonably necessary.</p>		
<p>Outpatient substance use disorder services</p> <p>Coverage under Medicare Part B is available for treatment services that are provided in the outpatient department of a hospital to patients who, for example, have been discharged from an inpatient stay for the treatment of drug substance abuse or who require treatment but do not require the availability and intensity of services found only in the inpatient hospital setting.</p> <p>Out-of-network services will be reviewed after the service is rendered to ensure it was medically and reasonably necessary.</p>	<p>Medicare-covered group therapy visit:</p> <p>\$15 copay per visit</p> <p>Medicare-covered individual therapy visit:</p> <p>\$25 copay per visit</p>	<p>Medicare-covered group or individual therapy visit:</p> <p>50% of the Medicare-allowed amount for each Medicare-covered visit</p>
<p>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</p> <p>Note: If you're having surgery in a hospital facility, you should</p>	<p>Cost share is based per date of service on each service received and the setting where it is performed.</p>	<p>Cost share is based per date of service on each service received and the setting where it is performed.</p>

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.</p> <p>Prior authorization may be required.</p> <p>Out-of-network services will be reviewed after the service is rendered to ensure it was medically and reasonably necessary.</p>	<p>Ambulatory Surgical Center:</p> <p>\$125 copay for surgical services</p> <p>Outpatient Hospital Facility:</p> <p>\$175 copay for surgical services</p>	<p>Ambulatory Surgical Center:</p> <p>50% of the Medicare-allowed amount</p> <p>Outpatient Hospital Facility:</p> <p>\$225 copay for surgical services</p>
<p>Over-the-counter (OTC) benefit*</p> <p>This plan gives you a fixed dollar amount each quarter to buy over-the-counter (OTC) medications and products you need to stay well – things like bandages, pain relievers, cold remedies, toothpaste and more. This benefit is limited to specific items listed in the online catalog available at the link listed below.</p> <p>You can access your benefit so items can be shipped for free to your home by:</p>	<p>\$0 copay</p> <p>The maximum benefit allowance is \$100 per quarter. The amount of an order, including any applicable sales tax, will count toward this allowance. Any unused amounts will expire at the end of each quarter.</p> <p>Must use designated plan vendor.</p>	<p>Not Covered</p>

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<ul style="list-style-type: none"> Placing an order online at bcbstmedicare.com/OTC; Calling 1-844-995-5834, TTY 711 (Monday to Friday, 9 a.m. to 8 p.m. ET) to place an order; or Mailing the catalog order form <p>Purchases are limited to the available benefit allowance. All orders must be placed through the designated vendor. Quantity limits may apply. Unused OTC amounts do not roll over from quarter to quarter or from one calendar year to the next. This quarterly benefit does not apply toward any out-of-pocket maximums.</p>		
<p>Partial hospitalization services and Intensive outpatient services</p> <p><i>Partial hospitalization</i> is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization.</p>	<p>\$40 copay per day for Medicare-covered partial hospitalization services.</p>	<p>50% of the Medicare-allowed amount per day for Medicare-covered partial hospitalization services.</p>

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p><i>Intensive outpatient service</i> is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a federally qualified health center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.</p> <p>Prior authorization is required.</p> <p>Out-of-network services will be reviewed after the service is rendered to ensure it was medically and reasonably necessary.</p>		
<p>Physician/Practitioner services, including doctor's office visits</p> <p>Covered services include:</p> <ul style="list-style-type: none"> Medically necessary medical care or surgery services you get in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location including telehealth 	<p>Primary care provider office or telehealth visit for Medicare-covered services:</p> <p>\$0 copay per visit</p>	<p>Primary care provider office or telehealth visit for Medicare-covered services:</p> <p>\$10 copay per visit</p>

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<ul style="list-style-type: none"> Consultation, diagnosis, and treatment by a specialist 	Specialist office or telehealth visit for Medicare-covered services: \$25 copay per visit	Specialist office or telehealth visit for Medicare-covered services: \$30 copay per visit
<ul style="list-style-type: none"> Basic hearing and balance exams performed by your PCP or Specialist, if your doctor orders it to see if you need medical treatment 	See "Hearing services - Medicare-covered" in this chart for cost share information.	
<ul style="list-style-type: none"> Certain telehealth services, including those for specific urgently needed medical services and individual sessions for specific mental health specialty services. <ul style="list-style-type: none"> You have the option of getting these services either through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, then you must use a network provider that currently offers the service by telehealth. This plan utilizes a vendor that offers telephonic and web-based access to a licensed provider for the medical consultation, diagnosis and/or treatment of urgent conditions when the 	Telephonic and web-based medical consultation, diagnosis and/or treatment of urgent conditions provided by the designated telehealth vendor \$0 copay per visit Telephonic access to a licensed clinical social worker and certified health coach for mood and adjustment disorders provided by the designated telehealth vendor \$0 copay per visit	Telehealth: Not covered

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Covered Service	What you pay in-network	What you pay out-of-network
<p>member's treating provider is not available (e.g. after hours and weekends). This telehealth program is not intended to replace the PCP relationship but rather to reduce the utilization of the emergency room and urgent care centers.</p> <ul style="list-style-type: none"> • This plan also uses a vendor that offers telephonic access to a licensed clinical social worker and certified health coach for the short-term management with lifestyle skills development to better adapt to mood and adjustment disorders. • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke regardless of your location • Telehealth services for members with a substance use disorder or co-occurring 		


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Covered Service	What you pay in-network	What you pay out-of-network
<p>mental health disorder, regardless of their location</p> <ul style="list-style-type: none"> • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: <ul style="list-style-type: none"> • You have an in-person visit within 6 months prior to your first telehealth visit • You have an in-person visit every 12 months while getting these telehealth services • Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: <ul style="list-style-type: none"> • You're not a new patient and • The check-in isn't related to an office visit in the past 7 days and • The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation 		


Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>and follow-up by your doctor within 24 hours if:</p> <ul style="list-style-type: none"> You're not a new patient and The evaluation isn't related to an office visit in the past 7 days and The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment <ul style="list-style-type: none"> Consultation your doctor has with other doctors by phone, internet, or electronic health record Second opinion by another network provider prior to surgery 		
<ul style="list-style-type: none"> Wound care services (including clinic) are provided to manage acute and chronic wounds through debridement, local wound care and specialized dressings. <p>Note: Services provided by a Mid-Level provider (such as a Nurse Practitioner or Physician Assistant) will have a copay based on the supervising physician's specialty. For example, if you are seeing a Nurse Practitioner and the supervising physician is a PCP,</p>	<p>Wound care: \$25 copay</p>	<p>Wound care: \$30 copay</p>

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Covered Service	What you pay in-network	What you pay out-of-network
<p>your copay amount will be the PCP copay. If you are seeing a Nurse Practitioner and the supervising physician is a Specialist, your copay amount will be the Specialist copay.</p> <p>Additional cost share may apply when other services are performed.</p>		
<p>Podiatry services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Diagnosis and the medical or surgical 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 • Additional routine foot care (limited to 6 visits per year) 	<p>\$25 copay for each podiatry visit</p>	<p>50% of the Medicare-allowed amount for each podiatry visit</p>
<p> Pre-exposure prophylaxis (PrEP) for HIV prevention</p> <p>If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services.</p> <p>If you qualify, covered services include:</p>	<p>There is no coinsurance, copayment, or deductible for the PrEP benefit.</p>	<p>50% of the Medicare-allowed amount</p>



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Covered Service	What you pay in-network	What you pay out-of-network
<ul style="list-style-type: none"> FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug. Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. Up to 8 HIV screenings every 12 months. <p>A one-time hepatitis B virus screening.</p>		
 Prostate cancer screening exams <p>For men age 50 and older, covered services include the following once every 12 months:</p> <ul style="list-style-type: none"> Digital rectal exam Prostate Specific Antigen (PSA) test <p>Additional cost share may apply when other services are performed.</p>	There is no coinsurance, copayment, or deductible for an annual PSA test.	50% of the Medicare-allowed amount for an annual PSA test
Prosthetic and orthotic devices and related supplies <p>Devices (other than dental) that replace all or part of a body part or function. These include but aren't limited to testing, fitting, or training in the use of prosthetic and orthotic devices;</p>	20% of the Plan-allowed amount for Medicare-covered prosthetic devices and medical supplies.	50% of the Medicare-allowed amount for Medicare-covered prosthetic devices and medical supplies.

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Covered Service	What you pay in-network	What you pay out-of-network
<p>as well as 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 and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery– go to <i>Vision Care</i> later in this table for more detail.</p> <p>Prior authorization may be required.</p> <p>Medical supply quantities will be reviewed to ensure they are medically and reasonably necessary.</p> <p>Total monthly quantity limits may apply for medical supplies.</p> <p>Out-of-network services will be reviewed after the service is rendered to ensure it was medically and reasonably necessary.</p>		
<p>Pulmonary rehabilitation services</p> <p>Comprehensive programs of pulmonary rehabilitation are covered for members who have</p>	<p>\$15 copay per day for Medicare-covered pulmonary rehabilitation services.</p>	<p>50% of the Medicare-allowed amount for Medicare-covered pulmonary rehabilitation services.</p>



Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.</p> <p>These services are limited to two one-hour sessions per day with a limit of 36 sessions per year.</p> <p>Prior authorization is required.</p>		
<p> Screening and counseling to reduce alcohol misuse</p> <p>We cover one alcohol misuse screening for adults (including pregnant women) who misuse alcohol but aren't alcohol dependent.</p> <p>If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.</p> <p>Additional cost share may apply when other services are performed.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.</p>	<p>50% of the Medicare-allowed amount for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.</p>
<p> Screening for lung cancer with low dose computed tomography (LDCT)</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared</p>	<p>50% of the Medicare-allowed amount for the Medicare-covered counseling and shared</p>

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>For qualified people, a LDCT is covered every 12 months.</p> <p>Eligible members are people age 50 – 77 who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who get an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner.</p> <p><i>For LDCT lung cancer screenings after the initial LDCT screening:</i> the members must get an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.</p> <p>Additional cost share may apply when other services are performed.</p>	<p>decision-making visit or for the LDCT.</p>	<p>decision-making visit or for the LDCT.</p>

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
 Screening for Hepatitis C Virus infection <p>We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions:</p> <ul style="list-style-type: none"> • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. <p>If you were born between 1945-1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus.</p>	<p>50% of the Medicare-allowed amount</p>
 Screening for sexually transmitted infections (STIs) and counseling to prevent STIs <p>We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.</p>	<p>50% of the Medicare-allowed amount for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.</p>

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy.</p> <p>We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.</p> <p>Additional cost share may apply when other services are performed.</p>		
<p>Services to treat kidney disease</p> <p>Covered services include:</p> <ul style="list-style-type: none"> Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV or V chronic kidney disease when referred by their doctor, we cover up to 6 sessions of kidney disease education services per lifetime 	<p>Medicare-covered kidney disease education services:</p> <p>\$0 copay</p>	<p>Medicare-covered kidney disease education services:</p> <p>50% of the Medicare-allowed amount</p>

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<ul style="list-style-type: none"> • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you're admitted as an inpatient 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>Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, go to Medicare Part B drugs in this table.</p> <p>Prior authorization may be required.</p>	<p>Medicare-covered ESRD benefits, including renal dialysis and related medications, equipment and supplies :</p> <p>20% of the Plan-allowed amount</p>	<p>Medicare-covered ESRD benefits, including renal dialysis and related medications, equipment and supplies:</p> <p>20% of the Medicare-allowed amount</p>


Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>Skilled nursing facility (SNF) care</p> <p>(For a definition of skilled nursing facility care, go to Chapter 10. Skilled nursing facilities are sometimes called SNFs.)</p> <p>We cover 100 days per benefit period if medically necessary. A prior hospital stay is not required before admittance.</p> <p>Covered services include but aren't limited to:</p> <ul style="list-style-type: none"> • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy and speech therapy • Drugs administered to you as part of our plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood, packed red cells and all other components of blood are covered beginning with the first pint used. 	<p>Cost sharing (copayment or coinsurance) applies on the date of admission. As a member, a new benefit period will begin on day one when you first enter a SNF, or when you have been discharged from a SNF (or not received inpatient skilled level of care) for 60 consecutive days. 100 days per benefit period are covered if medically necessary. Please see the definition of a Benefit Period in Chapter 12 for more information.</p> <p>Inpatient hospital stay is not required prior to admission.</p> <p>Medicare-covered skilled nursing facility stays:</p> <p>\$0 copay per day for days 1-20</p> <p>\$218 copay per day for days 21-100</p>	<p>Cost sharing (copayment or coinsurance) applies on the date of admission. As a member, a new benefit period will begin on day one when you first enter a SNF, or when you have been discharged from a SNF (or not received inpatient skilled level of care) for 60 consecutive days. 100 days per benefit period are covered if medically necessary. Please see the definition of a Benefit Period in Chapter 12 for more information.</p> <p>Inpatient hospital stay is not required prior to admission.</p> <p>Medicare-covered skilled nursing facility stays:</p> <p>50% of the Medicare-allowed amount per admission</p>

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<ul style="list-style-type: none"> • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services <p>Generally, you get SNF care from network facilities. Under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment.</p> <ul style="list-style-type: none"> • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital <p>Prior authorization is required.</p> <p>Your skilled nursing care</p>		

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>benefits are based on the date of admission. If you are admitted in 2025 and are discharged in 2026, the 2025 copay amount will apply until you have not had any inpatient care in an acute hospital, a SNF, or an inpatient mental health facility for 60 days in a row.</p> <p>Out-of-network services will be reviewed after the service is rendered to ensure it was medically and reasonably necessary.</p>		
<p> Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)</p> <p>Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria:</p> <ul style="list-style-type: none"> • Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • Are competent and alert during counseling • A qualified physician or other Medicare-recognized practitioner provides counseling <p>We cover 2 cessation attempts per year (each attempt may include a maximum of 4</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.</p>	<p>50% of the Medicare-allowed amount for the Medicare-covered smoking and tobacco use cessation preventive benefits.</p>

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>intermediate or intensive sessions, with the patient getting up to 8 sessions per year.)</p> <p>Additional cost share may apply when other services are performed.</p>		
<p>Supervised Exercise Therapy (SET)</p> <p>SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment.</p> <p>Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.</p> <p>The SET program must:</p> <ul style="list-style-type: none"> • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms and who are trained in exercise therapy for PAD 	<p>\$10 copay for Medicare-covered SET</p>	<p>50% of the Medicare-allowed amount for Medicare-covered SET.</p>

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<ul style="list-style-type: none"> Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques <p>SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.</p> <p>Prior authorization is required</p> <p>Out-of-network services will be reviewed after the service is rendered to ensure it was medically and reasonably necessary.</p>		
<p>Urgently needed services</p> <p>A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or, even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of</p>	<p>Domestic services:</p> <p>\$45 copay for urgently needed services</p> <p>Worldwide services:</p> <p>\$60 copay for urgently needed services</p> <p>Copay is waived if you are admitted to the hospital within 24 hours for the same condition.</p>	

This plan includes worldwide urgently needed services.

Covered services include:

- Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. **Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts.**
- For people who are at high risk for glaucoma, we cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African-Americans

\$0 copay

\$0 copay

\$0 copay

50% of the Medicare-allowed amount


Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>who are age 50 and older and Hispanic Americans who are 65 or older.</p> <ul style="list-style-type: none"> For people with diabetes, screening for diabetic retinopathy is covered once per year (Additional cost share may apply when other services are performed.) One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. If you have 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. <p>Additional cost share may apply when other services are performed.</p> <p>Benefit only covers standard frames and lenses (or contacts) and will not cover any enhanced eyewear options (including but not limited to, anti-reflective lenses, tinted lenses, scratch-proof lenses, etc.).</p>	<p>Annual diabetic retinopathy screening:</p> <p>\$0 copay</p> <p>Eyewear after cataract surgery:</p> <p>\$0 copay for 1 pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery</p>	<p>Annual diabetic retinopathy screening:</p> <p>50% of the Medicare-allowed amount</p> <p>Eyewear after cataract surgery:</p> <p>\$0 copay for 1 pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery</p>

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>Vision care* - Supplemental</p> <p>Supplemental vision benefits include:</p> <ul style="list-style-type: none"> One routine vision exam per year (including eye refraction for eyeglasses/contact lenses). Eyewear allowance <p>Members are limited to one pair of eyeglasses (lenses and frames) or contact lenses (conventional or disposable) every two years, not to exceed the allowance.</p> <p>Please inform the network provider that you are a BlueAdvantage PPO member (with access to the EyeMed® network). When using an out-of-network provider, you will be responsible for costs above the Plan-approved amount.</p> <p>You are responsible for submitting an EyeMed Vision Care out-of-network claim form with itemized receipt when seeing an out-of-network vision provider. Vision services rendered by a provider who has formally “opted out” of the Medicare program are not covered or payable by the plan.</p> <p>If you use an out-of-network vision provider, you can locate a reimbursement claim form and information for submitting</p>	<p>Routine vision care:</p> <p>\$0 copay</p> <p>Supplemental routine eyewear:</p> <p>\$225 plan coverage limit for routine eyewear (in- and out-of-network)</p> <p>You must pay the difference between the plan’s benefit and the cost of the eyewear.</p> <p>For example: If your total cost for eyewear is \$350, your plan will pay \$225 and you will pay \$125.</p>	

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Covered Service	What you pay in-network	What you pay out-of-network
<p>that form to EyeMed on our website (bcbst-medicare.com/manage-my-plan/vision-plans/index.page) or call Member Service (phone numbers are listed on the back cover of this booklet) for assistance.</p> <p>Benefit only covers standard frames and lenses or contacts and will not cover any enhanced eyewear options (including but not limited to, anti-reflective lenses, tinted lenses, scratch-proof lenses, etc.).</p> <p>* Routine vision care copayments and eyewear cost share do not count toward your in-network or combined maximum out-of-pocket amount.</p>		
<p> Welcome to Medicare preventive visit</p> <p>Our plan covers the one-time <i>Welcome to Medicare</i> preventive visit. The visit includes a review of your health, as well as education and counseling about preventive services you need (including certain screenings and shots), and referrals for other care if needed.</p> <p>Important: We cover the <i>Welcome to Medicare</i></p>	<p>There is no coinsurance, copayment, or deductible for the <i>Welcome to Medicare</i> preventive visit.</p>	<p>50% of the Medicare-allowed amount for the Medicare-covered Welcome to Medicare preventive visit</p>

Covered Service	What you pay in-network	What you pay out-of-network
<p>preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor’s office know you want to schedule your <i>Welcome to Medicare</i> preventive visit.</p> <p>Additional cost share may apply when other services are performed.</p>		

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Section 2.1 Get care using our plan's optional visitor/traveler benefit

If you don't permanently move, but you're continuously away from our plan's service area for more than 6 months, we usually must disenroll you from our plan. However, we offer a visitor/traveler program as described below, that will allow you to stay enrolled when you're outside of our service area for less than 6 months. Under our visitor/traveler program you can get all plan covered services at in-network cost sharing. Contact our plan for help locating a provider when using the visitor/traveler benefit.

If you're in the visitor/traveler area, you can stay enrolled in our plan up to 6 months. If you don't return to our plan's service area within 6 months, you'll be disenrolled from our plan.

The Visitor/Traveler program will include Blue Medicare Advantage PPO network coverage of all Part A, Part B and Supplemental benefits offered by your plan outside your service area in 48 states and 2 territories: Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin and West Virginia. For some of the states listed, MA PPO networks are only available in portions of the state.

Your Member Liability Calculation

When you receive covered services outside of the BlueAdvantage service area from a Medicare Advantage PPO network provider, the cost of the service, on which your member liability (copayment/coinsurance) is based, will be either:

- The Medicare allowed amount for covered services; or
- The amount either BlueAdvantage negotiates with the provider or the local Blue Medicare Advantage plan negotiates with its provider on behalf of BlueAdvantage members, if applicable. The amount negotiated may be either higher than, lower than, or equal to the Medicare allowed amount.

Nonparticipating healthcare providers outside the BlueAdvantage service area

When covered services are provided outside of the BlueAdvantage service area by nonparticipating healthcare providers, the amount(s) you pay for such services will be based on either the payment arrangements, described above, for Medicare Advantage PPO network providers, Medicare's limiting charge where applicable or the provider's billed charge. Payments for out-of-network emergency services will be governed by applicable federal and state law.

If you are receiving inpatient facility services from a MA PPO network provider outside of

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Tennessee, and those services require a Prior Authorization, the MA PPO network provider is responsible for obtaining Prior Authorization. If the MA PPO network provider fails to obtain Prior Authorization, you will not be held liable for any cost share.

If you are receiving any services, other than inpatient facility services, from a MA PPO network provider outside of Tennessee, and those services require a Prior Authorization, you are responsible for obtaining Prior Authorization. If you fail to obtain Prior Authorization, you will be held liable for higher cost share.

SECTION 3 Services that aren't covered by our plan (exclusions)

This section tells you what services are *excluded* from Medicare coverage and therefore, aren't covered by this plan.

The chart below lists services and items that either aren't covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you get the excluded services at an emergency facility, the excluded services are still not covered, and our plan won't pay for them. The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we made to not cover a medical service, go to Chapter 7, Section 5.3.)

Services not covered by Medicare	Covered only under specific conditions
Acupuncture	Available for people with chronic low back pain under circumstances
Cosmetic surgery or procedures	Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member
	Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Custodial care Custodial care is personal care that doesn't require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities	Not covered under any condition

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Services not covered by Medicare	Covered only under specific conditions
of daily living, such as bathing or dressing.	
Experimental medical and surgical procedures, equipment and medications Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.	May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan (Go to Chapter 3, Section 5 for more information on clinical research studies)
Fees charged for care by your immediate relatives or members of your household	Not covered under any condition
Full-time nursing care in your home	Not covered under any condition
Home-delivered meals	14 meals after discharge from an acute inpatient hospital, skilled nursing facility, or observation stay to a home setting.
Homemaker services include basic household help, including light housekeeping or light meal preparation.	Not covered under any condition
Naturopath services (uses natural or alternative treatments)	Not covered under any condition
Orthopedic shoes or supportive devices for the feet	Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with, diabetic foot disease
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	Not covered under any condition
Private room in a hospital	Covered only when medically necessary

Chapter 4 Medical Benefits Chart (what's covered and what you pay)

Services not covered by Medicare	Covered only under specific conditions
Radial keratotomy, LASIK surgery, and other low vision aids	Not covered under any condition
Reversal of sterilization procedures and or non-prescription contraceptive supplies	Not covered under any condition
Routine chiropractic care	Manual manipulation of the spine to correct a subluxation is covered
Routine foot care	Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes)
Services considered not reasonable and necessary, according to Original Medicare standards	Not covered under any condition

CHAPTER 5:

Asking us to pay our share of a bill for covered medical services

SECTION 1 Situations when you should ask us to pay our share for covered services

Sometimes when you get medical care, you may need to pay the full cost. Other times, you may pay more than you expected under the coverage rules of our plan, or you may get a bill from a provider. In these cases, you can ask our plan to pay you back (reimburse you). It's your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services covered by our plan. There may be deadlines that you must meet to get paid back. Go to Section 2 of this chapter.

There may also be times when you get a bill from a provider for the full cost of medical care you got or for more than your share of cost sharing. First, try to resolve the bill with the provider. If that doesn't work, send the bill to us instead of paying it. We'll look at the bill and decide whether the services should be covered. If we decide they should be covered, we'll pay the provider directly. If we decide not to pay it, we'll notify the provider. You should never pay more than plan-allowed cost-sharing. If this provider is contracted, you still have the right to treatment.

Examples of situations in which you may need to ask our plan to pay you back or to pay a bill you got:

1. When you got medical care from a provider who isn't in our plan's network

When you get care from a provider who is not part of our network, you're only responsible for paying your share of the cost. (Your share of the cost may be higher for an out-of-network provider than for a network provider.) Ask the provider to bill our plan for our share of the cost.

- Emergency providers are legally required to provide emergency care. You're only responsible for paying your share of the cost for emergency or urgently needed services. If you pay the entire amount yourself at the time you get the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you made.

Chapter 5 Asking us to pay our share of a bill for covered medical services

- You may get a bill from the provider asking for payment you think you don't owe. Send us this bill, along with documentation of any payments you already made.
 - If the provider is owed anything, we'll pay the provider directly.
 - If you already paid more than your share of the cost of the service, we'll determine how much you owed and pay you back for our share of the cost.
- While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we can't pay a provider who is not eligible to participate in Medicare. If the provider is not eligible to participate in Medicare, you'll be responsible for the full cost of the services you got.

2. When a network provider sends you a bill you think you shouldn't pay

Network providers should always bill our plan directly and ask you only for your share of the cost. But sometimes they make mistakes and ask you to pay more than your share.

- You only have to pay your cost-sharing amount when you get covered services. We don't allow providers to add additional separate charges, called *balance billing*. This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there's a dispute and we don't pay certain provider charges.
- Whenever you get a bill from a network provider you think is more than you should pay, send us the bill. We'll contact the provider directly and resolve the billing problem.
- If you already paid a bill to a network provider, but feel you paid too much, send us the bill along with documentation of any payment you made and ask us to pay you back the difference between the amount you paid and the amount you owed under our plan.

3. If you're retroactively enrolled in our plan

Sometimes a person's enrollment in our plan is retroactive. This means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.

If you were retroactively enrolled in our plan and you paid out of pocket for any covered services after your enrollment date, you can ask us to pay you back for our share of the costs. You need to submit paperwork such as receipts and bills for us to handle the reimbursement.

When you send us a request for payment, we'll review your request and decide whether the service or drug should be covered. This is called making a **coverage decision**. If we decide it should be covered, we'll pay for our share of the cost for the service or drug. If we deny your

Chapter 5 Asking us to pay our share of a bill for covered medical services

request for payment, you can appeal our decision. Chapter 7 has information about how to make an appeal.

SECTION 2 How to ask us to pay you back or pay a bill you got

You can ask us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records. **You must submit your claim to us within one year** of the date you got the service or item.

To make sure you're giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it'll help us process the information faster. The following information is required for a decision: Member ID number, Member Name, Provider NPI number, Provider Name, Date(s) of Service, Procedure Code, itemization of the charge for each service and proof of payment.
- Download a copy of the form from our website ([bcbstmedicare.com](https://www.bcbstmedicare.com)) or call Member Service at 1-800-831-2583 (TTY users call 711) and ask for the form.

Mail your request for payment together with any bills or paid receipts to us at this address:

BlueCross BlueShield of Tennessee
Medicare Advantage Operations
1 Cameron Hill Circle, Suite 0005
Chattanooga, TN 37405-0005

SECTION 3 We'll consider your request for payment and say yes or no

When we get your request for payment, we'll let you know if we need any additional information from you. Otherwise, we'll consider your request and make a coverage decision.

- If we decide the medical care is covered and you followed all the rules, we'll pay for our share of the cost. If you already paid for the service, we'll mail your reimbursement of our share of the cost to you. If you haven't paid for the service yet, we'll mail the payment directly to the provider.
- If we decide the medical care is *not* covered, or you did *not* follow all the rules, we won't pay for our share of the cost. We'll send you a letter explaining the reasons why we aren't sending the payment and your right to appeal that decision.

Section 3.1 If we tell you we won't pay for all or part of the medical care, you can make an appeal

If you think we made a mistake in turning down your request for payment or the amount we're paying, you can make an appeal. If you make an appeal, it means you're asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For details on how to make this appeal, go to Chapter 7.

CHAPTER 6:

Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities

Section 1.1 We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, braille, large print, or other alternate formats, etc.)

Our plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how our plan may meet these accessibility requirements include, but aren't limited to, provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English speaking members. We can give you information in a language other than English if requested. We can also give you materials in braille, in large print, or other alternate formats at no cost if you need it. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Member Service at 1-800-831-2583 (TTY users call 711).

Our plan is required to give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

If providers in our plan's network for a specialty aren't available, it's our plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you'll only pay in-network cost sharing. If you find yourself in a situation where there are no specialists in our plan's network that cover a service you need, call our plan for information on where to go to get this service at in-network cost sharing.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with 1-800-831-2583, TTY 711. You can also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

Section 1.2 We must ensure you get timely access to covered services

You have the right to choose a provider in our plan's network. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral and still pay the in-network cost-sharing amount.

You have the right to get appointments and covered services from your providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care.

If you think you aren't getting your medical care within a reasonable amount of time, Chapter 7 tells what you can do.

Section 1.3 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your personal health information includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a *Notice of Privacy Practice*, that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we're required to get written permission from you or someone you have given legal power to make decisions for you first*.
- There are certain exceptions that don't require us to get your written permission first. These exceptions are allowed or required by law.
 - We're required to release health information to government agencies that are checking on quality of care.
 - Because you're a member of our plan through Medicare, we're required to give Medicare your health information. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

Chapter 6 Your rights and responsibilities

You can see the information in your records and know how it's been shared with others

You have the right to look at your medical records held by our plan, and to get a copy of your records. We're allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we'll work with your health care provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that aren't routine.

If you have questions or concerns about the privacy of your personal health information, call Member Service at 1-800-831-2583 (TTY users call 711).

Section 1.4 We must give you information about our plan, our network of providers, and your covered services

As a member of BlueAdvantage Freedom, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, call Member Service at 1-800-831-2583 (TTY users call 711):

- **Information about our plan.** This includes, for example, information about our plan's financial condition.
- **Information about our network providers.** You have the right to get information about the qualifications of the providers in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services.
- **Information about why something is not covered and what you can do about it.** Chapter 7 provides information on asking for a written explanation on why a medical service isn't covered or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 You have the right to know your treatment options and participate in decisions about your care

You have the right to get full information from your doctors and other health care providers. Your providers must explain your medical condition and your treatment choices *in a way that you can understand*.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

Chapter 6 Your rights and responsibilities

- **To know about all your choices.** You have the right to be told about all treatment options recommended for your condition, no matter what they cost or whether they're covered by our plan.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say “no.”** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. If you refuse treatment, you accept full responsibility for what happens to your body as a result.

You have the right to give instructions about what's to be done if you can't make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you're in this situation. This means, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

Legal documents you can use to give your directions in advance of these situations are called **advance directives**. Documents like a **living will** and **power of attorney for health care** are examples of advance directives.

How to set up an advance directive to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also call Member Service at 1-800-831-2583 (TTY users call 711) to ask for the forms.
- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people.** Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

Chapter 6 Your rights and responsibilities

If you know ahead of time that you're going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital.**

- The hospital will ask whether you signed an advance directive form and whether you have it with you.
- If you didn't sign an advance directive form, the hospital has forms available and will ask if you want to sign one.

Filling out an advance directive is your choice (including whether you want to sign one if you're in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you signed an advance directive.

If your instructions aren't followed

If you sign an advance directive and you believe that a doctor or hospital didn't follow the instructions in it, you can file a complaint with the Tennessee Department of Health at www.tn.gov/health/health-professionals/hcf-main/filing-a-complaint.html or, in Georgia, with the Georgia Department of Health at dch.georgia.gov/divisionsoffices/facility-licensure/hfrd-file-complaint.

Section 1.6 You have the right to make complaints and ask us to reconsider decisions we made

If you have any problems, concerns, or complaints and need to ask for coverage, or make an appeal, Chapter 7 of this document tells what you can do. Whatever you do — ask for a coverage decision, make an appeal, or make a complaint — **we're required to treat you fairly.**

Section 1.7 If you believe you're being treated unfairly, or your rights aren't being respected

If you believe you've been treated unfairly or your rights haven't been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY users call 1-800-537-7697), or call your local Office for Civil Rights.

If you believe you've been treated unfairly or your rights haven't been respected, *and it's not* about discrimination, you can get help dealing with the problem you're having from these places:

- **Call Member Service at 1-800-831-2583 (TTY users call 711)**
- **Call your local SHIP** at 1-877-801-0044 in Tennessee or 1-866-552-4464 (option 4) in Georgia

- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

Section 1.8 How to get more information about your rights

Get more information about your rights from these places:

- **Call Member Service at 1-800-831-2583 (TTY users call 711).**
- **Call your local SHIP** at 1-877-801-0044 in Tennessee or 1-866-552-4464 (option 4) in Georgia
- **Contact Medicare**
 - Visit www.Medicare.gov to read the publication *Medicare Rights & Protections* (available at [Medicare Rights & Protections](#))
 - Call 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048).

SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, call Member Service at 1-800-831-2583 (TTY users call 711).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* to learn what's covered and the rules you need to follow to get covered services.
 - Chapters 3 and 4 give details about medical services.
- **If you have any other health coverage in addition to our plan, or separate drug coverage, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show our plan membership card whenever you get your medical care.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
 - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions you and your doctors agree on.
 - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
 - If you have questions, be sure to ask and get an answer you can understand.

Chapter 6 Your rights and responsibilities

- **Be considerate.** We expect our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you're responsible for these payments:
 - You must continue to pay your Medicare Part B premiums to stay a member of our plan.
 - For some of your medical services covered by our plan, you must pay your share of the cost when you get the service.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* of our plan service area, you can't stay a member of our plan.**
- **If you move, tell Social Security (or the Railroad Retirement Board).**

CHAPTER 7:

If you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 What to do if you have a problem or concern

This chapter explains 2 types of processes for handling problems and concerns:

- For some problems, you need to use the **process for coverage decisions and appeals**.
- For other problems, you need to use the **process for making complaints** (also called grievances).

Both processes have been approved by Medicare. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

The information in this chapter will help you identify the right process to use and what to do.

Section 1.1 Legal terms

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people. To make things easier, this chapter uses more familiar words in place of some legal terms.

However, it's sometimes important to know the correct legal terms. To help you know which terms to use to get the right help or information, we include these legal terms when we give details for handling specific situations.

SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Member Service at 1-800-831-2583 (TTY users call 711) for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help are:

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you're having. They can also answer questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. SHIP contact information is available in Chapter 2, Section 3.

Medicare

You can also contact Medicare for help:

- Call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.
- Visit www.Medicare.gov

SECTION 3 Which process to use for your problem

Is your problem or concern about your benefits or coverage?

This includes problems about whether medical care (medical items, services and/or Part B drugs) are covered or not, the way they're covered, and problems related to payment for medical care.

Yes.

Go to **Section 4, A guide to coverage decisions and appeals.**

No.

Go to **Section 9, How to make a complaint about quality of care, waiting times, customer service or other concerns.**

Coverage decisions and appeals

SECTION 4 A guide to coverage decisions and appeals

Coverage decisions and appeals deal with problems related to your benefits and coverage for your medical care (services, items, and Part B drugs, including payment). To keep things simple, we generally refer to medical items, services, and Medicare Part B drugs as **medical care**. You use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions before you get services

If you want to know if we'll cover a medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical care. For example, if our plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either you or your network doctor can show that you got a standard denial notice for this medical specialist, or the *Evidence of Coverage* makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we'll cover a particular medical service or refuses to provide medical care you think you need.

In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we might decide medical care isn't covered or is no longer covered for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after you get a benefit, and you aren't satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we made. Under certain circumstances, you can ask for an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

Chapter 7 If you have a problem or complaint (coverage decisions, appeals, complaints)

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we properly followed the rules. When we complete the review, we give you our decision.

In limited circumstances a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we say no to all or part of your Level 1 appeal for medical care, your appeal will automatically go on to a Level 2 appeal conducted by an independent review organization not connected to us.

- You don't need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we don't fully agree with your Level 1 appeal.
- Go to **Section 5.4** of this chapter for more information about Level 2 appeals for medical care.

If you aren't satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.1 Get help when asking for a coverage decision or making an appeal

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- **Call Member Service at 1-800-831-2583 (TTY users call 711)**
- **Get free help** from your State Health Insurance Assistance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call Member Service at 1-800-831-2583 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at bcbstmedicare.com.)
 - For medical care or Part B drugs, your doctor can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
- **You can ask someone to act on your behalf.** You can name another person to act for you as your *representative* to ask for a coverage decision or make an appeal.

Chapter 7 If you have a problem or complaint (coverage decisions, appeals, complaints)

- If you want a friend, relative, or another person to be your representative, call Member Service at 1-800-831-2583 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at bcbstmedicare.com.) This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.
- We can accept an appeal request from a representative without the form, but we can't begin or complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.2 Rules and deadlines for your different situations

There are 3 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give the details for each one of these situations in this chapter:

- **Section 5:** Medical care: How to ask for a coverage decision or make an appeal
- **Section 6:** How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon
- **Section 7:** How to ask us to keep covering certain medical services if you think your coverage is ending too soon (*Applies only to these services:* home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which information applies to you, call Member Service at 1-800-831-2583 (TTY users call 711). You can also get help or information from your SHIP.

SECTION 5 Medical care: How to ask for a coverage decision or make an appeal

Section 5.1 What to do if you have problems getting coverage for medical care or want us to pay you back for our share of the cost of your care

Your benefits for medical care are described in Chapter 4 in the Medical Benefits Chart. In some cases, different rules apply to ask for a Part B drug. In those cases, we'll explain how the rules for Part B drugs are different from the rules for medical items and services.

This section tells what you can do if you're in any of the 5 following situations:

1. You aren't getting certain medical care you want, and you believe that this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**
2. Our plan won't approve the medical care your doctor or other medical provider wants to give you, and you believe this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**
3. You got medical care that you believe should be covered by our plan, but we said we won't pay for this care. **Make an Appeal. Section 5.3.**
4. You got and paid for medical care that you believe should be covered by our plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5.**
5. You're told that coverage for certain medical care you've been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an Appeal. Section 5.3.**

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, go to Sections 6 and 7 of this Chapter. Special rules apply to these types of care.

Section 5.2 How to ask for a coverage decision

Legal Terms:

A coverage decision that involves your medical care is called an **organization determination**.

A fast coverage decision is called an **expedited determination**.

Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

A standard coverage decision is usually made within 7 calendar days when the medical item or service is subject to our prior authorization rules, 14 calendar days for all other medical items and services, or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. To get a fast coverage decision, you must meet 2 requirements:

- You may *only ask* for coverage for medical care items and/or services (not requests for payment for items and/or services you already got).
- You can get a fast coverage decision *only* if using the standard deadlines could cause serious harm to your health or hurt your ability to regain function.

If your doctor tells us that your health requires a fast coverage decision, we'll automatically agree to give you a fast coverage decision.

If you ask for a fast coverage decision on your own, without your doctor's support, we'll decide whether your health requires that we give you a fast coverage decision. If we don't approve a fast coverage decision, we'll send you a letter that:

- Explains that we'll use the standard deadlines.
- Explains if your doctor asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
- Explains that you can file a *fast complaint* about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for.

Step 2: Ask our plan to make a coverage decision or fast coverage decision

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this. Chapter 2 has contact information.

Step 3: We consider your request for medical care coverage and give you our answer.

For standard coverage decisions we use the standard deadlines.

This means we'll give you an answer within 7 calendar days after we get your request for a medical item or service that is subject to our prior authorization rules. If your requested medical item or service is not subject to our prior authorization rules, we'll give you an answer within 14 calendar days after we get your request. If your request is for a Part B drug, we'll give you an answer within 72 hours after we get your request.

- **However**, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or

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service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.

- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. We'll give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. Go to Section 9 of this chapter for information on complaints.)

For fast coverage decisions we use an expedited timeframe.

A fast coverage decision means we'll answer within 72 hours if your request is for a medical item or service. If your request is for a Part B drug, we'll answer within 24 hours.

- **However**, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days**. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. (Go to Section 9 for information on complaints.) We'll call you as soon as we make the decision.
- If our answer is no to part or all of what you asked for, we'll send you a written statement that explains why we said no.

Step 4: If we say no to your request for coverage for medical care, you can appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the medical care coverage you want. If you make an appeal, it means you're going on to Level 1 of the appeals process.

Section 5.3 How to make a Level 1 appeal

Legal Terms:

An appeal to our plan about a medical care coverage decision is called a plan **reconsideration**.

A fast appeal is also called an **expedited reconsideration**.

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 30 calendar days or 7 calendar days for Part B drugs. A fast appeal is generally made within 72 hours.

- If you're appealing a decision we made about coverage for care, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we'll give you a fast appeal.

- The requirements for getting a *fast appeal* are the same as those for getting a *fast coverage decision* in Section 5.2 of this chapter.

Step 2: Ask our plan for an appeal or a fast appeal

- **If you're asking for a standard appeal, submit your standard appeal in writing.** Chapter 2 has contact information.
- **If you're asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.**

Step 3: We consider your appeal, and we give you our answer.

- When our plan is reviewing your appeal, we take a careful look at all the information. We check to see if we were following all the rules when we said no to your request.
- We'll gather more information if needed and may contact you or your doctor.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
 - If you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time if your request is for a Part B drug.
 - If we don't give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we're required to automatically send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage we agreed to within 72 hours after we get your appeal.

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- **If our answer is no to part or all of what you asked for**, we'll send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if your health condition requires us to.
 - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
 - If you believe we shouldn't take extra days, you can file a fast complaint. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (Go to Section 9 of this chapter for information on complaints.)
 - If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Part B drug.
- **If our plan says no to part or all of your appeal**, we'll automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 5.4 The Level 2 appeal process**Legal Term:**

The formal name for the independent review organization is the **Independent Review Entity**. It's sometimes called the **IRE**.

The **independent review organization is an independent organization hired by Medicare**. It isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: The independent review organization reviews your appeal.

- We'll send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file.**

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- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all the information related to your appeal.

If you had a fast appeal at Level 1, you'll also have a fast appeal at Level 2.

- For the fast appeal, the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it gets your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

If you had a standard appeal at Level 1, you'll also have a standard appeal at Level 2.

- For the standard appeal, if your request is for a medical item or service, the independent review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it gets your appeal. If your request is for a Part B drug, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it gets your appeal.
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

Step 2: The independent review organization gives you its answer.

The independent review organization will tell you it's decision in writing and explain the reasons for it.

- **If the independent review organization says yes to part or all of a request for a medical item or service**, we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we get the decision from the independent review organization for **standard requests**. For **expedited requests**, we have **72 hours** from the date we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of a request for a Part B drug**, we must authorize or provide the Part B prescription drug within **72 hours** after we get the decision from the independent review organization for **standard requests**. For **expedited requests** we have **24 hours** from the date we get the decision from the independent review organization.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care shouldn't be

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approved. (This is called **upholding the decision** or **turning down your appeal**.) In this case, the independent review organization will send you a letter:

- Explains the decision.
- Lets you know about your right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
- Tells you how to file a Level 3 appeal.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 explains the Level 3, 4, and 5 appeals processes.

Section 5.5 If you're asking us to pay you for our share of a bill you got for medical care

Chapter 5 describes when you may need to ask for reimbursement or to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you're asking for a coverage decision. To make this coverage decision, we'll check to see if the medical care you paid for is covered. We'll also check to see if you followed the rules for using your coverage for medical care.

- **If we say yes to your request:** If the medical care is covered and you followed the rules, we'll send you the payment for the cost typically within 30 calendar days, but no later than 60 calendar days after we get your request. If you haven't paid for the medical care, we'll send the payment directly to the provider.
- **If we say no to your request:** If the medical care is not covered, or you did not follow all the rules, we won't send payment. Instead, we'll send you a letter that says we won't pay for the medical care and the reasons why.

If you don't agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you're asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals in Section 5.3. For appeals concerning reimbursement, note:

- We must give you our answer within 60 calendar days after we get your appeal. If you're asking us to pay you back for medical care you have already received and paid for, you aren't allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you asked for to you or the provider within 60 calendar days.

SECTION 6 How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon

When you're admitted to a hospital, you have the right to get all covered hospital services necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day you leave the hospital. They'll help arrange for care you may need after you leave.

- The day you leave the hospital is called your **discharge date**.
- When your discharge date is decided, your doctor or the hospital staff will tell you.
- If you think you're being asked to leave the hospital too soon, you can ask for a longer hospital stay, and your request will be considered.

Section 6.1 During your inpatient hospital stay, you'll get a written notice from Medicare that tells you about your rights

Within 2 calendar days of being admitted to the hospital, you'll be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice. If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Member Service at 1-800-831-2583 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

1. Read this notice carefully and ask questions if you don't understand it. It tells you:

- Your right to get Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be involved in any decisions about your hospital stay.

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- Where to report any concerns, you have about the quality of your hospital care.
- Your right to **request an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date, so we'll cover your hospital care for a longer time.

2. You'll be asked to sign the written notice to show that you got it and understand your rights.

- You or someone who is acting on your behalf will be asked to sign the notice.
- Signing the notice shows *only* that you got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date.

3. Keep your copy of the notice so you'll have the information about making an appeal (or reporting a concern about quality of care) if you need it.

- If you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
- To look at a copy of this notice in advance, call Member Service at 1-800-831-2583 (TTY users call 711) or 1-800 MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can also get the notice online at www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Section 6.2 How to make a Level 1 appeal to change your hospital discharge date

To ask us to cover inpatient hospital services for a longer time, use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help, call Member Service at 1-800-831-2583 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you. The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts aren't part of our plan.

Step 1: Contact the Quality Improvement Organization for your state and ask for an immediate review of your hospital discharge. You must act quickly.

How can you contact this organization?

- The written notice you got (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge**.
 - **If you meet this deadline**, you can stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
 - **If you don't meet this deadline, contact us.** If you decide to stay in the hospital after your planned discharge date, *you may have to pay all the costs* for hospital care you get after your planned discharge date.
- Once you ask for an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we're contacted, we'll give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it's right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling Member Service at 1-800-831-2583 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227). (TTY users call 1-877-486-2048.) Or you can get a sample notice online at www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

- Health professionals at the Quality Improvement Organization (the *reviewers*) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want.
- The reviewers will also look at your medical information, talk with your doctor, and review information that we and the hospital gave them.
- By noon of the day after the reviewers told us of your appeal, you'll get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it's right (medically appropriate) for you to be discharged on that date.

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the independent review organization says **yes**, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You'll have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

- If the independent review organization says *no*, they're saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the independent review organization says *no* to your appeal and you decide to stay in the hospital, **you may have to pay the full cost** of hospital care you get after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, you can make another appeal. Making another appeal means you're going to *Level 2* of the appeals process.

Section 6.3 How to make a Level 2 appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at its decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you stay in the hospital after the date your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you it's decision.***If the independent review organization says yes:***

- **We must reimburse you** for our share of the costs of hospital care you got since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it's medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

If the independent review organization says no:

- It means they agree with the decision they made on your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you want to continue with the review process.

Step 4: If the answer is no, you need to decide whether you want to take your appeal further by going to Level 3.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

When you're getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it's time to stop covering any of these 3 types of care for you, we're required to tell you in advance. When your coverage for that care ends, *we'll stop paying our share of the cost for your care.*

If you think we're ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 7.1 We'll tell you in advance when your coverage will be ending

Legal Term:

Notice of Medicare Non-Coverage. It tells you how you can ask for a **fast-track appeal**. Asking for a fast-track appeal is a formal, legal way to ask for a change to our coverage decision about when to stop your care.

- 1. You get a notice in writing** at least 2 calendar days before our plan is going to stop covering your care. The notice tells you:
 - The date when we'll stop covering the care for you.
 - How to ask for a fast-track appeal to ask us to keep covering your care for a longer period of time.
- 2. You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you got it.** Signing the notice shows *only* that you got the information about when your coverage will stop. **Signing it doesn't mean you agree** with our plan's decision to stop care.

Section 7.2 How to make a Level 1 appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you'll need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help, call Member Service at 1-800-831-2583 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate. The **Quality Improvement Organization** is a group of doctors and other health care experts who are paid by the federal government to check on and improve the quality of care for people with Medicare. This

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includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts aren't part of our plan.

Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a *fast-track appeal*. You must act quickly.

How can you contact this organization?

- The written notice you got (*Notice of Medicare Non-Coverage*) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the *Notice of Medicare Non-Coverage*.
- If you miss the deadline, and you want to file an appeal, you still have appeal rights. Contact the Quality Improvement Organization using the contact information on the *Notice of Medicare Non-coverage*. The name, address, and phone number of the Quality Improvement Organization for your state may also be found in Chapter 2.

Step 2: The Quality Improvement Organization conducts an independent review of your case.**Legal Term:**

Detailed Explanation of Non-Coverage. Notice that gives details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization (the *reviewers*) will ask you, or your representative, why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want.
- The independent review organization will also look at your medical information, talk with your doctor, and review information our plan gives them.
- By the end of the day the reviewers tell us of your appeal, you'll get the *Detailed Explanation of Non-Coverage* from us that explains in detail our reasons for ending our coverage for your services.

Step 3: Within one full day after they have all the information they need; the reviewers will tell you it's decision.***What happens if the reviewers say yes?***

- If the reviewers say yes to your appeal, then **we must keep providing your covered services for as long as it's medically necessary.**
- You'll have to keep paying your share of the costs (such as deductibles or copayments if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say *no*, then **your coverage will end on the date we told you.**
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, **you'll have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If reviewers say *no* to your Level 1 appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make a Level 2 appeal.

Section 7.3 How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day when the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you continued getting care after the date your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your appeal request, reviewers will decide on your appeal and tell you it's decision.

What happens if the independent review organization says yes?

- **We must reimburse you** for our share of the costs of care you got since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it's medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the independent review organization says no?

- It means they agree with the decision made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you want to continue with the review process. It will give you details about how to go to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you need to decide whether you want to take your appeal further.

- There are 3 additional levels of appeal after Level 2, for a total of 5 levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 Taking your appeal to Levels 3, 4, and 5

Section 8.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

This section may be right for you if you made a Level 1 appeal and a Level 2 appeal, and both of your appeals were turned down.

If the dollar value of the item or medical service you appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you can't appeal any further. The written response you get to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way at the first 2 levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

An **Administrative Law Judge** or an attorney adjudicator who works for the federal government will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may or may not* be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that's favorable to you. If we decide to appeal, it will go to a Level 4 appeal.
 - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision.
 - If we decide to appeal the decision, we'll send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may or may not* be over.**

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- If you decide to accept the decision that turns down your appeal, the appeals process is over.
- If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal

The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may or may not* be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We'll decide whether to appeal this decision to Level 5.
 - If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after getting the Council's decision.
 - If we decide to appeal the decision, we'll let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may or may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal

A judge at the **Federal District Court** will review your appeal.

- A judge will review all the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Making complaints

SECTION 9 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 9.1 What kinds of problems are handled by the complaint process?

The complaint process is *only* used for certain types of problems. This includes problems related to quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	<ul style="list-style-type: none"> Are you unhappy with the quality of the care you got (including care in the hospital)?
Respecting your privacy	<ul style="list-style-type: none"> Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	<ul style="list-style-type: none"> Has someone been rude or disrespectful to you? Are you unhappy with our Member Service? Do you feel you're being encouraged to leave our plan?
Waiting times	<ul style="list-style-type: none"> Are you having trouble getting an appointment, or waiting too long to get it? Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Service or other staff at our plan? <ul style="list-style-type: none"> Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	<ul style="list-style-type: none"> Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?

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Complaint	Example
Information you get from us	<ul style="list-style-type: none"> • Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all related to the <i>timeliness</i> of our actions about coverage decisions and appeals)	If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples: <ul style="list-style-type: none"> • You asked us for a <i>fast coverage decision</i> or a <i>fast appeal</i>, and we said no; you can make a complaint. • You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we aren't meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 9.2 How to make a complaint**Legal Terms:**

A **complaint** is also called a **grievance**.

Making a complaint is called **filing a grievance**.

Using the process for complaints is called **using the process for filing a grievance**.

A **fast complaint** is called an **expedited grievance**.

Step 1: Contact us promptly – either by phone or in writing.

- **Calling Member Service at 1-800-831-2583 (TTY users call 711) is usually the first step.** If there's anything else you need to do, Member Service will let you know.
- **If you don't want to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing.
- **You may file a complaint by calling, writing or faxing our plan.** See Chapter 2, *"Important phone numbers and resources"*, Section 1 for contact information. You must file a grievance no later than 60 days after the event or incident occurred that brought about the complaint. We will investigate all grievances that we receive within 30 calendar days from the date we receive the grievance. If the grievance was not resolved during your call to the plan or it was receiving in writing, we will notify you of our decision within 30 calendar days from the date we receive the grievance. We may extend the 30-day timeframe by up to 14 days if you request an extension, or if we need additional information and an extension is in your best interest. We will respond to expedited grievances involving our decision to extend a timeframe related to an organization determination or reconsideration, or our decision not to grant an enrollee's request for an expedited initial organization/coverage determination or reconsideration/redetermination within 24 hours of receipt.
- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

Step 2: We look into your complaint and give you our answer.

- **If possible, we'll answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, **we can take up to 14 more calendar days** (44 calendar days total) to answer your complaint. If we decide to take extra days, we'll tell you in writing.
- **If you're making a complaint because we denied your request for a fast coverage decision or a fast appeal, we'll automatically give you a fast complaint.** If you have a fast complaint, it means we'll give you **an answer within 24 hours.**
- **If we don't agree** with some or all of your complaint or don't take responsibility for the problem you're complaining about, we'll include our reasons in our response to you.

Section 9.3 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you have 2 extra options:

- **You can make your complaint directly to the Quality Improvement Organization.**
The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time.**

Section 9.4 You can also tell Medicare about your complaint

You can submit a complaint about BlueAdvantage Freedom directly to Medicare. To submit a complaint to Medicare, go to www.Medicare.gov/my/medicare-complaint. You can also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048.

CHAPTER 8:

Ending membership in our plan

SECTION 1 Ending your membership in our plan

Ending your membership in BlueAdvantage Freedom may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you decide you *want* to leave. Sections 2 and 3 give information on ending your membership voluntarily.
- There are also limited situations where we're required to end your membership. Section 5 tells you about situations when we must end your membership.

If you're leaving our plan, our plan must continue to provide your medical care, and you'll continue to pay your cost share until your membership ends.

SECTION 2 When can you end your membership in our plan?

Section 2.1 You can end your membership during the Open Enrollment Period

You can end your membership in our plan during the **Open Enrollment Period** each year. During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- **The Open Enrollment Period** is from **October 15 to December 7**.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans:
 - Another Medicare health plan, with or without drug coverage,
 - Original Medicare *with* a separate Medicare drug plan,
 - Original Medicare *without* a separate Medicare drug plan.
- **Your membership will end in our plan** when your new plan's coverage starts on January 1.

Section 2.2 You can end your membership during the Medicare Advantage Open Enrollment Period

You can make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period each year**.

- **The Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and also for new Medicare enrollees who are enrolled in an MA plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.
- **During the Medicare Advantage Open Enrollment Period** you can:
 - Switch to another Medicare Advantage Plan with or without drug coverage.
 - Disenroll from our plan and get coverage through Original Medicare. If you switch to Original Medicare during this period, you can also join a separate Medicare drug plan at the same time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan, or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare drug plan, your membership in the drug plan will start the first day of the month after the drug plan gets your enrollment request.

Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of BlueAdvantage Freedom may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

- **You may be eligible to end your membership during a Special Enrollment Period** if any of the following situations apply to you. These are just examples. For the full list you can contact our plan, call Medicare, or visit www.Medicare.gov.
 - Usually, when you move
 - If you have TennCare (Medicaid)
 - If we violate our contract with you
 - If you're getting care in an institution, such as a nursing home or long-term care (LTC) hospital
 - If you enroll in the Program of All-inclusive Care for the Elderly (PACE)

Enrollment time periods vary depending on your situation.

To find out if you're eligible for a Special Enrollment Period, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. If you're eligible to end your

membership because of a special situation, you can choose to change both your Medicare health coverage and drug coverage. You can choose:

- Another Medicare health plan with or without drug coverage.
- Original Medicare *with* a separate Medicare drug plan.
- Original Medicare *without* a separate Medicare drug plan.

Your membership will usually end on the first day of the month after we get your request to change our plan.

Section 2.4 Get more information about when you can end your membership

If you have questions about ending your membership you can:

- **Call Member Service at 1-800-831-2583 (TTY users call 711)**
- Find the information in the **Medicare & You 2026** handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227) TTY users call 1-877-486-2048.

SECTION 3 How to end your membership in our plan?

The table below explains how you can end your membership in our plan.

To switch from our plan to:	Here's what to do:
Another Medicare health plan	<ul style="list-style-type: none"> • Enroll in the new Medicare health plan. • You'll automatically be disenrolled from BlueAdvantage Freedom when your new plan's coverage starts.
Original Medicare <i>with</i> a separate Medicare drug plan.	<ul style="list-style-type: none"> • Enroll in the new Medicare drug plan. • You'll automatically be disenrolled from BlueAdvantage Freedom when your new plan's coverage starts.
Original Medicare <i>without</i> a separate Medicare drug plan.	<ul style="list-style-type: none"> • Send us a written request to disenroll. Contact Member Service at 1-800-831-2583 (TTY users call 711) if you need more information on how to do this. • You can also contact Medicare, at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users call 1-877-486-2048. • You'll be disenrolled from BlueAdvantage Freedom when your coverage in Original Medicare starts.

Note: If you also have creditable drug coverage (e.g., a separate Medicare drug plan) and disenroll from that coverage, you may have to pay a Part D late enrollment penalty if you join

a Medicare drug plan later after going without creditable drug coverage for 63 days or more in a row.

SECTION 4 Until your membership ends, you must keep getting your medical items and services through our plan

Until your membership ends, and your new Medicare coverage starts, you must continue to get your medical items, services through our plan.

- **Continue to use our network providers to get medical care.**
- **If you're hospitalized on the day your membership ends, your hospital stay will be covered by our plan until you're discharged** (even if you're discharged after your new health coverage starts).

SECTION 5 BlueAdvantage Freedom must end our plan membership in certain situations

BlueAdvantage Freedom must end your membership in our plan if any of the following happen:

- If you no longer have Medicare Part A and Part B
- If you move out of our service area
- If you're away from our service area for more than 6 months.
 - If you move or take a long trip, call Member Service at 1-800-831-2583 (TTY users call 711) to find out if the place you're moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison)
- If you're no longer a United States citizen or lawfully present in the United States
- If you intentionally give us incorrect information when you're enrolling in our plan, and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)

Chapter 8 Ending membership in our plan

- If you let someone else use your membership card to get medical care. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
 - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

If you have questions or want more information on when we can end your membership call Member Service at 1-800-831-2583 (TTY users call 711).

Section 5.1 We can't ask you to leave our plan for any health related reason

BlueAdvantage Freedom isn't allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel you're being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 5.2 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

CHAPTER 9:

Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, (CMS). In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws aren't included or explained in this document.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at www.HHS.gov/ocr/index.html.

If you have a disability and need help with access to care, call Member Service at 1-800-831-2583 (TTY users call 711). If you have a complaint, such as a problem with wheelchair access, Member Service can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, BlueAdvantage Freedom, as a Medicare Advantage Organization, will exercise

the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

SECTION 4 Coordination of Benefits

The Medicare Program has rules and requirements – called Medicare Secondary Payer rules – that address financial responsibility for health care claims when an individual has Medicare coverage and other coverage also may be available to pay for such claims. For example, if you have health benefits under a group health plan sponsored by your employer in addition to the Medicare benefits you receive from us, we will coordinate your Medicare benefits with this other group health plan according to the Medicare Secondary Payer rules. Or, if you suffer from a job-related injury or illness and workers' compensation benefits are available to you, or if you have been in an accident or suffered an injury, the Medicare Secondary Payer rules will direct whether another person or coverage should pay for your health care expenses before we apply your Medicare benefits.

We coordinate benefits in accordance with the Medicare Secondary Payer rules and shall have all of the rights of the Medicare Program under the Medicare Secondary Payer rules.

When you have other coverage in addition to your Medicare benefits, and when other coverage (such as automobile insurance) may be available to pay for your health care claims, we will coordinate your Medicare benefits with these other coverages in accordance with the Medicare Secondary Payer rules. You will often get your health care through our provider network, and the other coverage may help pay for the care you receive. In some instances, such as when you have employer-sponsored coverage in addition to your Medicare benefits from us, you may be able to maximize your coverage by receiving health care from a provider that participates in our provider network and also participates in the provider network for your other coverage.

We will always apply your Medicare benefits after payment is made or is reasonably expected to be made under:

- A workers' compensation law or plan;
- Any non-fault based insurance, including automobile and non-automobile no-fault and medical payments insurance;
- Any liability insurance policy or plan (including a self-insured or self-funded plan) issued under an automobile or other type of policy or coverage; and
- Any automobile insurance policy or plan (including a self-insured plan) including, but not limited to, uninsured and underinsured motorist coverages.

We may make conditional payments while a determination of who is a responsible third party is being made or while a liability claim is pending. In some instances, we may receive claims and pay claims without knowing that a liability or claim with another carrier, plan or

Chapter 9 Legal notices

responsible third party is pending. In these instances, any payments we make for your claims are conditional. Conditional payments must be reimbursed to us upon receipt of the insurance settlement or liability payment.

If you receive payment from another person or entity, we have the right to recover from you and be reimbursed by you for all conditional payments we make or will make.

We will automatically have a lien upon any recovery, whether by settlement, judgement or otherwise, for any conditional payments. The lien may be enforced against any person or entity who possesses funds or proceeds in the amount of the conditional payments, including without limitation, you, your representatives, agents, any person, entity or insurer responsible for causing your injury, illness or condition, or any person, entity or insurer identified as a primary payer.

We will not make a duplicate payment of claims covered by, or apply your Medicare benefits on top of benefits you receive under, any automobile, accident, liability or other coverage. It is your responsibility to take whatever action is necessary to receive payment or benefits under such automobile, accident, liability or other coverage. By enrolling in our plan, you agree to notify us when such coverage is available to you, and further cooperate with us in obtaining reimbursement for the amount of any conditional payments made by us. If we provide benefits before any other type of health coverage or benefits you may have, we may seek recovery of the benefits we provide in accordance with the Medicare Secondary Payer rules, including recovery of the amount paid for your claims. Please refer to Third Party Liability and Subrogation for more information on our recovery rights.

This is a brief summary of how the Medicare Secondary Payer rules work and how we will apply them to claims for health care services you receive. Whether we pay first, second, or not at all depends on what types of additional insurance or coverage you have or that may apply to your claim and how the Medicare Secondary Payer rules apply to your situation. The Medicare Secondary Payer rules are published in the Code of Federal Regulations.

For general information on the Medicare Secondary Payer program, Medicare has available a booklet entitled *Medicare and Other Health Benefits: Your Guide to Who Pays First* (publication number 02179). You can get a copy by calling 1-800-MEDICARE (TTY, 1-877-486-2048), or by visiting the www.medicare.gov website.

SECTION 5 Third Party Liability and Subrogation

Consistent with your rights and obligations and our rights and obligations under the Medicare Secondary Payer rules, you must promptly notify us if you have an injury, illness or condition for which any third party is or may be responsible. This includes, without limitation, benefits you may have under automobile (including no-fault), property, accident or liability coverage and includes situations when another party is alleged or perceived to be responsible. If it is

Chapter 9 Legal notices

determined that the plan is not the primary payer, any claim received without the primary payer's explanation of benefits will be denied requesting this information be submitted.

We have the right to recover the amount(s) we paid for your claims from any third party responsible for payment of health care expenses or benefits related to an injury you incur or related to your illness or condition, including without limitation when a responsible third party pays you directly for health care expenses or benefits as part of a judgement, settlement or other payment. References to "health expenses or benefits" include without limitation any medical, pharmacy and/or dental service benefits.

As a member of our plan, you acknowledge that our recovery rights are a first priority claim and are to be paid to us before any other claim for your damages. Our rights of recovery and reimbursement have priority over other claims and apply even if a responsible third party has not or will not pay for all costs related to your injury, illness or condition.

As a member of our plan, you also agree to assign to us your right to take legal action against responsible third parties for amounts we paid for your claims and agree not to further assign your right to legal action to another person or entity without our written consent. You may be required to, and agree to, execute documents and provide information necessary for any such legal action.

You, and your legal representatives, agree to provide us with information we request regarding responsible third parties, and agree to cooperate with, and if needed to participate in, administrative and/or legal action taken to recover amounts we paid for your claims. If you interfere with our rights, or elect not to cooperate with us or our representatives in actions to recover amounts we paid for your claims from responsible third parties, we may take legal action against you.

If you are paid directly by a third party for health care expenses or benefits as part of a judgment, settlement or other payment, you must reimburse us amounts we paid for your claims.

While we may pursue recovery for amounts paid for your claims from responsible third parties, we are not obligated or required to take any administrative or legal action against a third party, or to participate in any administrative or legal action you take related to your injury, illness or condition. We are not required to participate in or pay court costs or attorneys' fees to any attorney you hire to pursue your claims. Our rights under Medicare law and this Evidence of Coverage will not be affected if we elect not to participate in any administrative or legal action you may pursue related to your injury, illness or condition.

If you disagree with our recovery efforts, you have the right to file a complaint or to appeal, as explained in Chapters 7 and 9.

SECTION 6 Nondiscrimination and Notice of Availability



1 Cameron Hill Circle | Chattanooga, TN 37402 | bcbstmedicare.com

Nondiscrimination Notice

BlueCross BlueShield of Tennessee (BlueCross), including its subsidiaries, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex¹. BlueCross does not exclude people or treat them less favorably because of race, color, national origin, age, disability or sex.

BlueCross:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as: (1) qualified sign language interpreters and (2) written information in other formats, such as large print, audio and accessible electronic formats.
- Provides free language assistance services to people whose primary language is not English, such as: (1) qualified interpreters and (2) information written in other languages.

If you need these reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Member Service at the number on the back of your Member ID card or call **1-800-831-2583**, TTY **711**. From **Oct. 1 to March 31**, you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From **April 1 to Sept. 30**, you can call us Monday through Friday from 8 a.m. to 9 p.m. ET. Our automated phone system may answer your call outside of these hours and during holidays.

If you believe that BlueCross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance ("Nondiscrimination Grievance").

For help with preparing and submitting your Nondiscrimination Grievance, contact Member Service at the number on the back of your Member ID card or call **1-800-831-2583**, TTY **711**. They can provide you with the appropriate form to use in submitting a Nondiscrimination Grievance. You can file a Nondiscrimination Grievance in person or by mail, fax or email. Address your Nondiscrimination Grievance to: Nondiscrimination Grievance; c/o Manager, Operations, Member Benefits Administration; 1 Cameron Hill Circle, Suite 0019, Chattanooga, TN 37402-0019; 423-591-9208 (fax); Nondiscrimination_OfficeGM@bcbst.com (email).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD), Monday through Friday, 8 a.m. to 6 p.m. ET. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

You can contact BlueCross's Nondiscrimination Coordinator at 423-535-1010 (phone), Nondiscrimination_CoordinatorGM@bcbst.com (email), or Corporate Compliance, 1 Cameron Hill Circle, 1.4, Chattanooga, TN 37402.

This notice is available at BlueCross's website: bcbst.com.

BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association

¹ Consistent with the scope of sex discrimination described at 45 CFR 92.101(a)(2)

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-831-2583 (TTY: 711) or speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-831-2583 (TTY: 711) o hable con su proveedor.

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-831-2583 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-831-2583 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.

注意: 如果您说[中文], 我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务, 以无障碍格式提供信息。致电 1-800-831-2583 (文本电话: 711) 或咨询您的服务提供商。

ध्यान आपो: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય આક્રમણીય સહાય અને એક્સિસિબલ ફોર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-800-831-2583 (TTY: 711) પર કોલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-831-2583 (TTY : 711) ou parlez à votre fournisseur.

ማሳሰቢያ:- እማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርባል፡፡ ማረጋገጥ በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ አገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ፡፡ በስልክ ቁጥር 1-800-831-2583 (TTY: 711) ይደውሉ ወይም አገልግሎት አቅርቦት ያናግሩ፡፡

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-800-831-2583 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-831-2583 (TTY: 711) или обратитесь к своему поставщику услуг.

تنبيه: إذا كنت تتحدث اللغة العربية، فستوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجاناً. اتصل على الرقم 1-800-831-2583 (الهاتف النصي: 711) أو تحدث إلى مقدم الخدمة.

توجه: اگر [وارد کردن زبان] صحبت می کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب های قابل دسترس، به طور رایگان موجود می باشند. با شماره 1-800-831-2583 (تله تایپ: 711) تماس بگیرید یا با ارائه دهنده خود صحبت کنید.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-831-2583 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

注: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル(誰もが利用できるような配慮された)な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-800-831-2583 (TTY: 711) までお電話ください。または、ご利用の事業者にご相談ください。

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang a dispozisyon w gratis. Ed ak sèvis oksilyè apwopriye pou bay enfòmasyon nan fòm aksesib yo a dispozisyon gratis tou. Rele nan 1-800-831-2583 (TTY: 711) oswa pale avèk founisè swen w lan.

ATENÇÃO: Se você fala [Português], serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-831-2583 (TTY: 711) ou fale com seu provedor.

ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍເຫຼືອພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ, ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-800-831-2583 (TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyonang tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-831-2583 (TTY: 711) o makipag-usap sa iyong provider.

SECTION 7 Notice of Privacy Practices



Notice of Privacy Practices (NOPP)

THIS NOTICE DESCRIBES HOW INFORMATION WE HAVE ABOUT YOU MAY BE USED AND SHARED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

LEGAL OBLIGATIONS

The law requires BlueCross BlueShield of Tennessee, Inc., SecurityCare of Tennessee and certain subsidiaries and affiliates of BlueCross BlueShield of Tennessee, Inc. ("we," "us," "our") to give this notice of privacy practices to all our members. This notice lets you know about our legal duties and your rights when it comes to your information and privacy.

The law requires us to keep private all of the information we have about you, including your name, address, other demographic information, claims information, financial information (including Social Security number), diagnosis information, other health information and other information that can identify you (your "information"). The law requires us to follow all the privacy practices in this notice from the date on the cover until we change or replace it.

We have the right to make changes to our privacy practices and this notice at any time, but we will send you a new notice any time we do. Any changes we make to this notice will apply to all information we keep, including information created or received before we made changes.

Please review this notice carefully and keep it on file for reference. You may ask us for a copy of this notice at any time. To get one, please contact us at:

You may reach out to us at this address or phone number to ask questions or make a complaint about this notice or how we've handled your privacy rights. You may also submit a written complaint to the U.S. Department of Health and Human Services (HHS). Just ask us for their address, and we will give it to you.

We support your right to protect the privacy of the information we have about you. We won't retaliate against you if you file a complaint with HHS or us.

ORGANIZATIONS THIS NOTICE COVERS

This notice applies to BlueCross BlueShield of Tennessee, Inc. and SecurityCare of Tennessee. We may share your information with any of the following subsidiaries and affiliates as set forth below: Shared Health, Inc., Group Insurance Services, Inc., Volunteer State Health Plan, Inc., Golden Security Insurance Co., Shared Health Mississippi, Inc., and BlueCross BlueShield of Tennessee, Inc. as outlined in this notice.

These entities support us in providing health insurance and related products and services. If we buy or create new affiliates or subsidiaries, they may also be required to follow the privacy practices outlined in this notice.

CONNECT WITH US

Privacy Office
BlueCross BlueShield of Tennessee
1 Cameron Hill Circle
Chattanooga, TN 37402
Phone: 888-455-3824 | Fax: 423-535-1976
E-mail: privacy_office@bcbst.com

For additional information, including TTY/TDD users, please call the Privacy Office at **1-888-455-3824**. Para obtener ayuda en español, llame al **1-888-455-3824**.

HOW WE MAY USE AND SHARE YOUR INFORMATION

We typically use your information for treatment, payment, or health care operations. Sometimes we are allowed, and sometimes we are required, to use or share your information in other ways. This is usually to contribute to the public good, such as public health and research.

Some states may have more stringent laws. When those laws apply to your information, we follow the more stringent law. Specifically, Tennessee law and other state and federal laws may require us to obtain your consent for uses and disclosures of behavioral health information, alcohol and other substance use disorder information, and genetic information.

Information about members and former members may be used and shared for treatment, payment, and health care operations.

We restrict access to information about you to those employees or contractors who need to know that information to run our business. We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your information.

SOURCES OF INFORMATION WE COLLECT AND SHARE

We collect information about you from the following sources:

1. Information we receive from you: We collect information directly from you. For example, we collect information like your name, address, and Social Security number when you apply for insurance or complete other forms, and we collect information like your name and contact information when you contact us for customer service requests.

2. Information about your transactions with us and our affiliates: We collect information about your relationship with us and with our affiliates. For example, we collect information about the claims we process like when you received health care, what services are covered and how much we've paid. We sometimes use affiliates and related entities to provide administrative services to process those claims, and they provide us with the same type of information about you.

3. Information about your transactions with nonaffiliated third-parties: We collect information about your relationship with nonaffiliated third-parties such as healthcare providers. For example, when your healthcare provider submits claims to us, it includes information about your encounter like diagnostic information, procedures you've had and the date of service.

As permitted by law and this notice, we may use and share all of the information we have about you as described above.

WAYS WE MAY USE AND SHARE YOUR INFORMATION

We may use and share any of the information we have about you, including to nonaffiliated third-parties, in accordance with federal and state laws. The following are examples of how we may use or share your information — and the types of third-parties to whom we may share your information.

For your treatment: We may use or share your information with health care professionals who are treating you. For example, a doctor may send us information about your diagnosis and treatment plan so we can arrange additional care for you from other health care providers.

To make payments: We may use or share your information to pay claims for your care or to coordinate benefits covered under your health care coverage. For example, we may share your information with your dental provider to coordinate payment for dental services.

For health care operations: We may use or share your information to run our organization. For example, we may use or share it to measure quality, provide you with care management or wellness programs, and to conduct audit and other oversight activities.

To work with plan sponsors: We may share your information with your employer-sponsored group health plan (if applicable) for plan administration. Please see your plan documents for all ways a plan sponsor may use this information. For example, we may use or share your information to help verify your identity or to give you more information about your health insurance options.

For underwriting: We may use or share your information for underwriting, premium rating or other activities relating to the creation, renewal, or replacement of a health plan contract. We're not allowed to use or share genetic information for underwriting purposes.

Research: We may use or share your information in connection with lawful research purposes. For example, we may share your information as part of a limited data set given to a researcher for clinical research.

In the event of your death: If you die, we may share your information with a coroner, medical examiner, funeral director, or organ procurement organization.

To help with public health and safety issues: We can share information about you in certain situations, such as:

- Preventing disease
- Assisting public health authorities in controlling the spread of disease such as during pandemics
- Helping with product recalls
- Reporting negative reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

As required by law: We may use or share your information as required by state or federal law.

To comply with a court or administrative order: Under certain circumstances, we may share your information in response to a court or administrative order, subpoena, discovery request or other lawful process.

To address workers' compensation, law enforcement and other government requests: We can use or share information about you:

- For workers' compensation claims
- For law enforcement purposes, or with a law enforcement official
- With health oversight agencies for legal activities
- To comply with requests from the military or other authorized federal officials

With your permission: Some uses and disclosures of information require your written authorization, including certain instances if you want us to share your information with anyone. You may cancel your authorization in writing at any time, but doing so won't affect any use or disclosure that happened while your authorization was valid.

For example, we would need your written authorization for:

- Most uses and disclosures of psychotherapy notes
- Uses and disclosures of your information for marketing
- Sale of your information
- Other uses and disclosures not described in this notice
We will let you know if any of these circumstances arise.
- We cannot use or share information except as described in this notice without your written authorization.

YOUR INDIVIDUAL RIGHTS

To access your records: You have the right to view and get copies of your information that we maintain, with some exceptions. You must make a written request, using a form available from the Privacy Office, to get access to your information.

If you ask for copies of your information, we may charge you a reasonable, cost-based fee for staff time and postage if you want us to mail the copies to you. If you ask for this information in another format, this charge will reflect the cost of giving you the information in that format. If you prefer, you may request a summary or explanation of your information, which may also result in a fee. For details about fees we may charge, please contact the Privacy Office.

To see who we've shared your information to: You have the right to receive a list of most disclosures we (or a business associate on our behalf) made of your information within the last six years, other than those made for the purpose of treatment, payment, or health care operations, and certain other disclosures. This list will include the date of the disclosure, what information was shared, the name of the person or entity it was shared to, the reason for the disclosure and some other information.

If you ask for this list of disclosures more than once in a 12-month period, we may charge you based on the cost of responding to those additional requests. Please contact the Privacy Office for a more detailed explanation of these charges.

To ask for restrictions: You have the right to ask for restrictions on how we use or share your information. We're not required to agree to these requests except in limited circumstances. If we agree to a restriction, you and we will agree to the restriction in writing. Please contact the Privacy Office for more information.

To get notified of a breach: We will notify you after an unauthorized acquisition, access, use or disclosure of your unsecured health information that compromises the security or privacy of the information.

To ask for confidential communications: You have the right to ask us in writing to send your information to you at a different address or by a different method if you believe that sending information to you in the normal manner will put you in danger. We have to grant your request if it's reasonable. We will also need information from you, including how and where to communicate with you. Your request must not interfere with payment of your premiums.

If there's an immediate threat, you may make your request by calling the Member Service number on the back of your Member ID card or the Privacy Office. Please follow up your call with a written request as soon as possible.

To ask for changes to your personal information: You have the right to request in writing that we revise your information. Your request must be in writing and explain why the information should be revised. We may deny your request, for example, if we received (but didn't create) the information you want to amend. If we deny your request, we will write to let you know why. If you disagree with our denial, you may send us a written statement that we will include with your information.

If we grant your request, we will make reasonable efforts to notify people you name about this change. Any future disclosures of that information will be revised.

To request another copy of this notice: You can ask for a paper copy of this notice at any time, even if you got this notice by email or from our website. Please contact the Privacy Office at the address on the previous page.

To choose a personal representative: You may choose someone to exercise your rights on your behalf, such as a power of attorney. You may also have a legal guardian exercise your rights. We will work with you if you'd like to make this effective.

CHAPTER 10:

Definitions

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center doesn't exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or payment for services you already got. You may also make an appeal if you disagree with our decision to stop services that you're getting.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than our plan's allowed cost-sharing amount. As a member of BlueAdvantage Freedom, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We don't allow providers to **balance bill** or otherwise charge you more than the amount of cost sharing our plan says you must pay.

Benefit Period – The way that Original Medicare measures your use of skilled nursing facility (SNF) services. A benefit period begins the day you go into a skilled nursing facility. The benefit period ends when you have not received any skilled care in a SNF for 60 days in a row. If you go into a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Centers for Medicare & Medicaid Services (CMS) – The federal agency that administers Medicare.

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services.

Combined Maximum Out-of-Pocket Amount – This is the most you'll pay in a year for all Part A and Part B services from both network (preferred) providers and out-of-network (non-preferred) providers. Go to Chapter 4, Section 1.2 for information about your combined maximum out-of-pocket amount.

Complaint – The formal name for making a complaint is **filing a grievance**. The complaint process is used *only* for certain types of problems. This includes problems about quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or

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psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or copay) – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor’s visit, hospital outpatient visit, or a prescription. A copayment is a set amount (for example \$10), rather than a percentage.

Cost-Sharing – Cost-sharing refers to amounts that a member has to pay when services are gotten. Cost-sharing includes any combination of the following 3 types of payments: 1) any deductible amount a plan may impose before services are covered; 2) any fixed *copayment* amount that a plan requires when a specific service is gotten; or 3) any *coinsurance* amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is gotten.

Covered Services – The term we use to mean all the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you don’t need skilled medical care or skilled nursing care. Custodial care provided by people who don’t have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn’t pay for custodial care.

Deductible – The amount you must pay for health care before our plan pays.

Disenroll or Disenrollment – The process of ending your membership in our plan.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you’re a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious

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impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are: 1) provided by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Grievance – A type of complaint you make about our plan or providers including a complaint concerning the quality of your care. This doesn't involve coverage or payment disputes.

Home Health Aide – A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. Our plan must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you're still a member of our plan. You can still get all medically necessary services as well as the supplemental benefits we offer.

Hospital Inpatient Stay – A hospital stay when you've been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an outpatient.

Initial Enrollment Period – When you're first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

In-Network Maximum Out-of-Pocket Amount – The most you'll pay for covered Part A and Part B services gotten from network (preferred) providers. After you have reached this limit, you won't have to pay anything when you get covered services from network providers for the rest of the contract year. However, until you reach your combined out-of-pocket amount, you must continue to pay your share of the costs when you seek care from an out-of-network (non-preferred) provider.

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Low Income Subsidy (LIS) –Go to Extra Help.

Medicaid (or Medical Assistance) – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Open Enrollment Period – The time period from January 1 to March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan or get coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after a person is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all the services that are covered by Medicare Part A and B. The term Medicare-Covered Services doesn't include the extra benefits, such as vision, dental, or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in our plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

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

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Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill *gaps* in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or Plan Member) – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Service – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Network Provider – Provider is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. **Network providers** have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called **plan providers**.

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called coverage decisions in this document.

Original Medicare (Traditional Medicare or Fee-for-Service Medicare) – Original Medicare is offered by the government, and not a private health plan such as Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that doesn't have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that aren't employed, owned, or operated by our plan.

Out-of-Pocket Costs – Go to the definition for cost-sharing above. A member's cost-sharing requirement to pay for a portion of services gotten is also referred to as the member's out-of-pocket cost requirement.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care (LTC) services and support (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long

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as possible. People enrolled in PACE plans get both their Medicare and Medicaid benefits through our plan.

Part C – Go to Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they're received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are gotten from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Preventive services – Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

Primary Care Provider (PCP) – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization – Approval in advance to get covered services based on specific criteria. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other network provider gets prior authorization from our plan. In a PPO, you don't need prior authorization to get out-of-network services. However, you may want to check with our plan before getting services from out-of-network providers to confirm that the service is covered by our plan and what your cost-sharing responsibility is. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4.

Prosthetics and Orthotics – Medical devices including, but not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.

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Referral – A written order from your primary care doctor for you to visit a specialist or get certain medical services. Without a referral, our plan may not pay for services from a specialist.

Rehabilitation Services – These services include inpatient rehabilitation care, physical therapy (outpatient), speech and language therapy, and occupational therapy.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. Our plan must disenroll you if you permanently move out of our plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you move into a nursing home, or if we violate our contract with you.

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

Urgently Needed Services – A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

BlueAdvantage Freedom Member Service

Method	Member Service – Contact Information
Call	1-800-831-2583 Calls to this number are free. We can be reached between the hours of 8 a.m. to 9 p.m. ET, seven days a week from Oct. 1 to March 31. From April 1 to Sept. 30, you can call us Monday through Friday from 8 a.m. to 9 p.m. ET. Member Service 1-800-831-2583 (TTY users call 711) also has free language interpreter services available for non-English speakers.
TTY	(711)- Calls to this number are free. We can be reached between the hours of 8 a.m. to 9 p.m. ET, seven days a week from Oct. 1 to March 31. From April 1 to Sept. 30, you can call us Monday through Friday from 8 a.m. to 9 p.m. ET.
Fax	1-423-535-5498
Write	BlueCross BlueShield of Tennessee BlueAdvantage Operations 1 Cameron Hill Circle, Suite 0005 Chattanooga, TN 37402-0005
Website	bcbstmedicare.com

State Health Insurance Assistance Program

A State Health Insurance Assistance Program (SHIP) is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare. You can call the SHIP in your state at the number listed in Chapter 2, Section 3 of this *Evidence of Coverage*.

PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.