Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a member service representative at 1-800-292-5146 (TTY: 711).

Understanding the Benefits

❑ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit bcbstmedicare.com or call 1-800-292-5146 (TTY: 711) to view a copy of the EOC.

❑ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.

❑ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

❑ You must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.

❑ Benefits, premiums and/or copayments/coinsurance may change on January 1, 2021.

❑ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care.

BlueAdvantage is a PPO plan with a Medicare contract. Enrollment in BlueAdvantage depends on contract renewal.

H7917_20_PECFG_C (08/19)
THE BENEFIT INFORMATION PROVIDED IS A SUMMARY OF WHAT WE COVER AND WHAT YOU PAY. IT DOES NOT LIST EVERY SERVICE THAT WE COVER OR LIST EVERY LIMITATION OR EXCLUSION. TO GET A COMPLETE LIST OF SERVICES WE COVER, CALL US AND ASK FOR THE “EVIDENCE OF COVERAGE.”

**SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS**

**Sections in this booklet**

- Things to Know About BlueAdvantage Sapphire
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This document is available in other formats.

This document may be available in a non-English language. For additional information, call us at **1-800-831-2583** (TTY: **711**).

**Things to Know About BlueAdvantage Sapphire**

**Hours of Operation & Contact Information**

- From **Oct. 1 to March 31**, we’re open 8 a.m. – 9 p.m. ET, 7 days a week.
- From **April 1 to Sept. 30**, we’re open 8 a.m. – 9 p.m. ET, Monday through Friday.
- If you are a member of this plan, call us at 1-800-831-2583, TTY: 711.
- If you are not a member of this plan, call us at 1-800-292-5146, TTY: 711.
- Our website: [bcbstmedicare.com](http://bcbstmedicare.com).

**Who can join?**

To join BlueAdvantage Sapphire, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area. Our service area includes these Northeast counties in Tennessee: Carter, Greene, Hancock, Hawkins, Johnson, Sullivan, Unicoi and Washington.

**What do we cover?**

Like all Medicare Advantage health plans, we cover everything that Original Medicare covers – and more. Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs including chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, [bcbstmedicare.com](http://bcbstmedicare.com).
- Or, call us and we will send you a copy of the formulary.
### How will I determine my drug costs?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap and Catastrophic Coverage.

---

**If you have any questions about this plan's benefits or costs, please contact BlueCross BlueShield of Tennessee.**
# SECTION II - SUMMARY OF BENEFITS

**BlueAdvantage Sapphire**

## MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES

<table>
<thead>
<tr>
<th>Monthly Plan Premium</th>
<th>$0 per month. You must keep paying your Medicare Part B premiums.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>Medical Deductible: <strong>No Deductible</strong> Prescription Drug Deductible: <strong>No Deductible</strong></td>
</tr>
</tbody>
</table>
| Maximum Out-of-Pocket Responsibility | Your yearly limit(s) in this plan:  
  - **$5,100** for services you receive from in-network providers  
  - **$10,000** for services you receive from in and out-of-network providers  

If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.

## COVERED MEDICAL AND HOSPITAL BENEFITS

### Inpatient Hospital and Inpatient Mental Health Hospitalization

**Prior Authorization is required.**

| In-Network: | Days 1-5: **$300** copay per day  
Days 6+: **$0** copay per day |
| Out-of-Network: | **50%** of the Medicare-allowed amount per stay |

The amounts above apply per benefit period.

A benefit period begins the day you are admitted or transferred to a hospital and ends when you are discharged. If you are readmitted, a new benefit period begins.

Our plan covers an unlimited number of days for an inpatient hospital stay.

### Outpatient Hospital Services

**Prior Authorization is required.**

| In-Network: | Ambulatory Surgical Center: **$250** copay  
Outpatient Hospital: **$300** copay |
| Out-of-Network: | Ambulatory Surgical Center: **50%** of the Medicare-allowed amount  
Outpatient Hospital: **50%** of the Medicare-allowed amount |
## SECTION II - SUMMARY OF BENEFITS

**BlueAdvantage Sapphire**

<table>
<thead>
<tr>
<th>Doctor's Office Visits</th>
<th><strong>In-Network:</strong></th>
<th><strong>Out-of-Network:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Primary Care Provider visit: $10 copay</td>
<td>Primary Care Provider visit: 50% of the Medicare-allowed amount</td>
</tr>
<tr>
<td></td>
<td>Specialist visit: $35 copay</td>
<td>Specialist visit: 50% of the Medicare-allowed amount</td>
</tr>
</tbody>
</table>

**Preventive Care**

*Our plan covers many preventive services, including:*

- Abdominal aortic aneurysm screening
- Alcohol misuse counseling
- Bone mass measurement
- Breast cancer screening (mammogram)
- Cardiovascular disease (behavioral therapy)
- Cardiovascular screenings
- Cervical and vaginal cancer screening
- Colorectal cancer screenings (colonoscopy, fecal occult blood test, flexible sigmoidoscopy)
- Depression screening
- HIV screening

**In-Network:**

$0 copay

Any additional preventive services approved by Medicare during the contract year will be covered.

**Out-of-Network:**

50% of the Medicare-allowed amount
## SECTION II - SUMMARY OF BENEFITS

**BlueAdvantage Sapphire**

<table>
<thead>
<tr>
<th>Preventive Care</th>
<th>In-Network:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medical nutrition therapy services</td>
<td></td>
</tr>
<tr>
<td>• Obesity screening and counseling</td>
<td></td>
</tr>
<tr>
<td>• Prostate cancer screenings (PSA)</td>
<td></td>
</tr>
<tr>
<td>• Sexually transmitted infections screening and counseling</td>
<td></td>
</tr>
<tr>
<td>• Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease)</td>
<td></td>
</tr>
<tr>
<td>• Vaccines, including flu shots, Hepatitis B shots, pneumococcal shots</td>
<td></td>
</tr>
<tr>
<td>• &quot;Welcome to Medicare&quot; preventive visit (one-time)</td>
<td></td>
</tr>
<tr>
<td>• Yearly &quot;Wellness&quot; visit</td>
<td></td>
</tr>
<tr>
<td><strong>Out-of-Network:</strong></td>
<td></td>
</tr>
<tr>
<td>50% of the Medicare-allowed amount</td>
<td></td>
</tr>
</tbody>
</table>

Any additional preventive services approved by Medicare during the contract year will be covered.

### Emergency Care

<table>
<thead>
<tr>
<th>In and Out-of-Network:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare-covered: $90 copay per visit</td>
</tr>
<tr>
<td>Worldwide Coverage: $90 copay per visit</td>
</tr>
</tbody>
</table>

If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.
# SECTION II - SUMMARY OF BENEFITS

## BlueAdvantage Sapphire

### Urgently Needed Services

<table>
<thead>
<tr>
<th>In and Out-of-Network:</th>
<th>Medicare-covered: $65 copay per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worldwide Coverage:</td>
<td>$90 copay per visit</td>
</tr>
<tr>
<td></td>
<td>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgently needed services.</td>
</tr>
</tbody>
</table>

### Diagnostic Services / Labs / Imaging

Prior Authorization may be required.

<table>
<thead>
<tr>
<th>In-Network:</th>
<th>Diagnostic tests and procedures:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$10 copay at a Primary Care Provider’s office</td>
</tr>
<tr>
<td></td>
<td>$35 copay at a Specialist’s office</td>
</tr>
<tr>
<td></td>
<td>$40 copay at a Free Standing Facility</td>
</tr>
<tr>
<td></td>
<td>$100 copay at an Outpatient Hospital</td>
</tr>
</tbody>
</table>

| Lab services: | $0 copay at a Primary Care Provider’s office |
|               | $0 copay at a Specialist’s office |
|               | $0 copay at a Free Standing lab |
|               | $40 copay at an Outpatient Hospital |

| X-rays: | $10 copay at a Primary Care Provider’s office |
|         | $35 copay at a Specialist’s office |
|         | $40 copay at a Free Standing Facility |
|         | $50 copay at an Outpatient Hospital |

| Genetic Testing: | 20% of the plan-allowed amount |

| Coumadin Services: | $0 copay at a Primary Care Provider’s office |
|                   | $0 copay at a Specialist’s office |
|                   | $0 copay at a Free Standing Facility |
|                   | $10 copay at an Outpatient Hospital |

| Sleep Studies: | $10 copay for In-Home |
|               | $40 copay at an Outpatient Hospital |

| Therapeutic Radiology Services: | $60 copay |

| Advanced Imaging (such as MRI, CT scans): | $225 copay |
### SECTION II - SUMMARY OF BENEFITS

**BlueAdvantage Sapphire**

#### Out-of-Network:
Diagnostic tests and procedures, lab services, x-rays, genetic testing, Coumadin services, sleep studies, therapeutic radiology and advanced imaging:

50% of the Medicare-allowed amount

<table>
<thead>
<tr>
<th>Hearing Services</th>
<th>In-Network:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medicare-covered exam to diagnose and treat hearing and balance issues: $10 copay</td>
</tr>
<tr>
<td></td>
<td>Routine hearing exam (1 per year): $0 copay at TruHearing® provider</td>
</tr>
<tr>
<td></td>
<td>Hearing Aids: $599 or $899 copay depending on model</td>
</tr>
<tr>
<td></td>
<td>Limited to one per ear per year. Benefit is limited to TruHearing Advanced and Premium hearing aids, which come in various styles and colors. You must see a TruHearing provider to use this benefit.</td>
</tr>
<tr>
<td></td>
<td><strong>Out-of-Network:</strong></td>
</tr>
<tr>
<td></td>
<td>Medicare-covered exam to diagnose and treat hearing and balance issues: $10 copay</td>
</tr>
<tr>
<td></td>
<td>Routine hearing exam: Not covered</td>
</tr>
<tr>
<td></td>
<td>Hearing Aids: Not covered</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dental Services</th>
<th>In-Network:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medicare-covered: $40 copay</td>
</tr>
<tr>
<td></td>
<td>Combined preventive and comprehensive dental services: $2,750</td>
</tr>
<tr>
<td></td>
<td>Included as covered benefits with service limits in this plan, but not limited to:</td>
</tr>
<tr>
<td></td>
<td>• Standard diagnostic exam (limited to 2 per year)</td>
</tr>
<tr>
<td></td>
<td>• Emergency diagnostic exam (limited to 1 every year)</td>
</tr>
<tr>
<td></td>
<td>• Cleaning (limited to 2 per year)</td>
</tr>
<tr>
<td></td>
<td>• Bitewing x-ray (limited to 1 per year)</td>
</tr>
<tr>
<td></td>
<td>• Panoramic x-ray (limited to 1 per 36 months)</td>
</tr>
<tr>
<td></td>
<td>• Fillings (limited to 1 per tooth surface per year)</td>
</tr>
<tr>
<td></td>
<td>• Crowns (limited to 1 per tooth per 5 years)</td>
</tr>
<tr>
<td></td>
<td>• Extractions</td>
</tr>
<tr>
<td></td>
<td>• Bridges (limited to 1 per 5 years)</td>
</tr>
<tr>
<td></td>
<td>• Dentures (limited to 1 set every 5 years)</td>
</tr>
<tr>
<td></td>
<td>If the total covered cost for dental services is more than $2,750 or if you exceed a service limit, you are required to pay the difference.</td>
</tr>
<tr>
<td></td>
<td><strong>Out-of-Network:</strong></td>
</tr>
<tr>
<td></td>
<td>Medicare-covered: 50% of the Medicare-allowed amount</td>
</tr>
<tr>
<td></td>
<td>Combined preventive and comprehensive dental services: 50% of billed charges up to $2,750. You pay 100% of any charges over $2,750.</td>
</tr>
</tbody>
</table>
**SECTION II - SUMMARY OF BENEFITS**

**BlueAdvantage Sapphire**

<table>
<thead>
<tr>
<th>Vision Services</th>
<th><strong>In-Network:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Members are encouraged to use the defined vision care network to obtain routine eye exam and eyewear benefit coverage.</strong></td>
<td>Medicare-covered exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): <strong>$35</strong> copay</td>
</tr>
<tr>
<td>Routine eye exam (1 per year): <strong>$35</strong> copay</td>
<td>Routine eye exam (1 per year): <strong>$35</strong> copay</td>
</tr>
<tr>
<td>Eyeglasses or contact lenses after cataract surgery: <strong>$0</strong> copay</td>
<td>Eyeglasses or contact lenses after cataract surgery: <strong>$0</strong> copay</td>
</tr>
<tr>
<td>Our plan pays up to <strong>$150</strong> per year for eyewear</td>
<td>Our plan pays up to <strong>$150</strong> per year for eyewear</td>
</tr>
<tr>
<td>There is no copay for contact lenses or eyeglasses (frames and lenses). But if your total eyewear cost is more than <strong>$150</strong>, you will be required to pay the difference.</td>
<td>There is no copay for contact lenses or eyeglasses (frames and lenses). But if your total eyewear cost is more than <strong>$150</strong>, you will be required to pay the difference.</td>
</tr>
<tr>
<td><strong>For example:</strong> If your total cost for eyewear is <strong>$300</strong>, your plan will pay <strong>$150</strong> and you will pay <strong>$150</strong>.</td>
<td><strong>Out-of-Network:</strong></td>
</tr>
<tr>
<td>Medicare-covered exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): <strong>$35</strong> copay</td>
<td>Medicare-covered exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): <strong>$35</strong> copay</td>
</tr>
<tr>
<td>Routine eye exam (for up to 1 every year): <strong>$35</strong> copay</td>
<td>Routine eye exam (for up to 1 every year): <strong>$35</strong> copay</td>
</tr>
<tr>
<td>Eyeglasses or contact lenses after cataract surgery: <strong>$0</strong> copay</td>
<td>Eyeglasses or contact lenses after cataract surgery: <strong>$0</strong> copay</td>
</tr>
<tr>
<td>Our plan pays up to <strong>$150</strong> per year for eyewear.</td>
<td>Our plan pays up to <strong>$150</strong> per year for eyewear.</td>
</tr>
<tr>
<td>There is no copay for contact lenses or eyeglasses (frames and lenses). But if your total eyewear cost is more than <strong>$150</strong>, you will be required to pay the difference.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Health Services</th>
<th><strong>In-Network:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prior authorization is required.</strong></td>
<td>Individual therapy visit: <strong>$30</strong> copay</td>
</tr>
<tr>
<td></td>
<td>Outpatient group therapy visit: <strong>$20</strong> copay</td>
</tr>
<tr>
<td></td>
<td><strong>Out-of-Network:</strong></td>
</tr>
<tr>
<td></td>
<td>Individual therapy visit: <strong>50%</strong> of the Medicare-allowed amount</td>
</tr>
<tr>
<td></td>
<td>Outpatient group therapy visit: <strong>50%</strong> of the Medicare-allowed amount</td>
</tr>
</tbody>
</table>
## SECTION II - SUMMARY OF BENEFITS

**BlueAdvantage Sapphire**

### Skilled Nursing Facility (SNF)

**Prior authorization is required.**

**In-Network:**
- Days 1-20: $0 copay per day
- Days 21-100: $178 copay per day

The amounts above apply per benefit period. Our plan covers up to 100 days in a SNF per benefit period. A benefit period begins the day you go into a SNF. The benefit period will accumulate one day for each day you are inpatient at a SNF. The benefit period ends when you haven't received any inpatient hospital care or skilled care in a SNF for 60 days in a row. If you go into a SNF after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

**Out-of-Network:**
- 50% of the Medicare-allowed amount per stay

### Physical Therapy

**Prior authorization is required.**

**In-Network:**
- Occupational therapy visit: $35 copay
- Physical therapy and speech and language therapy visit: $35 copay

**Out-of-Network:**
- Occupational therapy visit: 50% of the Medicare-allowed amount
- Physical therapy and speech and language therapy visit: 50% of the Medicare-allowed amount

### Ambulance

**Prior authorization may be required.**

**In and Out-of-Network:**
- Ground Ambulance: $200 copay
- Air Ambulance: 20% of the Medicare-allowed amount.

### Transportation

Not covered

### Medicare Part B Drugs

**Prior authorization may be required.**

**In-Network:**
- Part B chemotherapy drugs: 20% of the plan-allowed amount
- Other Part B drugs: 20% of the plan-allowed amount

**Out-of-Network:**
- Part B chemotherapy drugs: 50% of the Medicare-allowed amount
- Other Part B drugs: 50% of the Medicare-allowed amount
Prescription Drug Benefits

1. Deductible Stage

This plan does not have a deductible for drug benefits. Prescription drug copays and coinsurance do not apply to the maximum out-of-pocket.

2. Initial Coverage Stage

What you pay for: **Preferred** Retail and Mail Order Pharmacy OR **Standard** Retail Pharmacy

You pay the following until total yearly drug cost (including what our plan paid and what you have paid) reaches $4,020.

Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at preferred retail pharmacies and through the mail order pharmacy program managed by Express Scripts®. Or you can get your drugs from standard retail pharmacies. Your prescription drug copay will typically be less at a preferred network pharmacy because it has an agreement with BlueAdvantage. Some medications may require prior authorization, step therapy and/or quantity limits. Please see the formulary (drug list).

<table>
<thead>
<tr>
<th>PRESCRIPTION DRUG BENEFITS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Coverage Stage</strong></td>
</tr>
<tr>
<td>30 / 90 Day Supply</td>
</tr>
<tr>
<td>Tier 1: Preferred Generic</td>
</tr>
<tr>
<td>Tier 2: Generic</td>
</tr>
<tr>
<td>Tier 3: Preferred Brand</td>
</tr>
<tr>
<td>Tier 4: Non-Preferred Drugs</td>
</tr>
<tr>
<td>Tier 5: Specialty Drugs</td>
</tr>
</tbody>
</table>
3. Coverage Gap Stage (Donut Hole)

What you pay for: **Preferred** Retail and Mail Order Pharmacy OR **Standard** Retail Pharmacy

The coverage gap begins after the total yearly cost of your drugs (including what our plan has paid and what you have paid) reaches **$4,020**.

After you enter the coverage gap, you pay **25%** of the plan’s cost for covered brand name and generic drugs until your costs total **$6,350**, which is the end of the coverage gap. With this plan you may pay less than **25%** of the cost of some preferred generic drugs through the gap.

<table>
<thead>
<tr>
<th>PRESCRIPTION DRUG BENEFITS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coverage Gap Stage</strong></td>
</tr>
<tr>
<td><strong>Tier 1: Preferred Generic</strong></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

4. Catastrophic Coverage Stage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach **$6,350**, until 12/31/20, you pay the greater of:

- **5%** of the cost, or
- **$3.60** copay for generic (including brand drugs treated as generic) and an **$8.95** copay for all other drugs.
<table>
<thead>
<tr>
<th><strong>ADDITIONAL HEALTH BENEFITS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>24/7 Nurseline</strong></td>
</tr>
</tbody>
</table>
| **Chiropractic** | **Prior Authorization is required.** Manual manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position).  
**In-Network:** $20 copay  
**Out-of-Network:** 50% of the Medicare-allowed amount |
| **Diabetes Supplies and Services** | **In-Network:** Diabetes self-management training: $0 copay  
Diabetes *preferred* monitoring supplies: $0 copay  
Diabetes *non-preferred* monitoring supplies: 20% of the plan-allowed amount  
Therapeutic shoes or inserts: $10 copay  
**Out-of-Network:** Diabetes monitoring supplies, diabetic self-management training and therapeutic shoes or inserts: 20% of the Medicare-allowed amount |
| **Durable Medical Equipment** | **Prior authorization may be required.**  
**In-Network:** 20% of the plan-allowed amount  
**Out-of-Network:** 50% of the Medicare-allowed amount |
| **Foot Care (podiatry services)** | **If you have diabetes-related nerve damage and/or meet certain conditions.**  
**In-Network:** Foot exams: $25 copay  
**Out-of-Network:** Foot exams: 50% of the Medicare-allowed amount  
Routine foot care is not covered. |
| **Home Health Care** | **Prior Authorization is required.**  
**In-Network:** $0 copay  
**Out-of-Network** 50% of the Medicare-allowed amount |
<table>
<thead>
<tr>
<th>Service Description</th>
<th>In-Network:</th>
<th>Out-of-Network:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac (heart) rehab services</td>
<td>$20 copay</td>
<td>50% of the Medicare-allowed amount</td>
</tr>
<tr>
<td>Pulmonary (lung) rehab services</td>
<td>$20 copay</td>
<td>50% of the Medicare-allowed amount</td>
</tr>
<tr>
<td>Prosthetic Devices (braces, artificial limbs, etc.)</td>
<td>Prosthetic devices: 20% of the plan-allowed amount</td>
<td>Prosthetic devices: 50% of the Medicare-allowed amount</td>
</tr>
<tr>
<td></td>
<td>Related medical supplies: 20% of the plan-allowed amount</td>
<td>Related medical supplies: 50% of the Medicare-allowed amount</td>
</tr>
<tr>
<td>Renal Dialysis</td>
<td>In-and Out-of-Network:</td>
<td>20% of the Medicare-allowed amount</td>
</tr>
<tr>
<td>Wellness Program - Fitness Membership</td>
<td>These plans include a Fitness Membership through SilverSneakers®: You pay nothing</td>
<td>20% of the Medicare-allowed amount</td>
</tr>
</tbody>
</table>

DISCLAIMERS

This document is available in other formats. BlueAdvantage is a PPO plan with a Medicare contract. Enrollment in BlueAdvantage depends on contract renewal. Out-of-network/non-contracted providers are under no obligation to treat BlueCross BlueShield of Tennessee members, except in emergency situations. Please call Member Service or see your “Evidence of Coverage” for more information, including the cost-sharing that applies to out-of-network services.

This is a summary of drugs and health services covered by BlueAdvantage Preferred Provider Organization (PPO) Northeast health plans January 1, 2020 through December 31, 2020.
Nondiscrimination Notice

BlueCross BlueShield of Tennessee (BlueCross), including its subsidiaries SecurityCare of Tennessee, Inc. and Volunteer State Health Plan, Inc. also doing business as BlueCare Tennessee, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BlueCross does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

BlueCross:

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

If you need these 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 Compliance Coordinator; 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), 8:30 a.m. to 8 p.m. ET. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Multi Language Services

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-831-2583 (TTY: 711).

注意力: 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-831-2583 (TTY: 711)。

注意：如果您使用繁体中文，您可以免费获得语言援助服务。请致电 1-800-831-2583 (TTY: 711)。

ATENTION : Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez le 1-800-831-2583 (ATS : 711).

注意：如果您使用简体中文，您可以免费获得语言援助服务。请致电 1-800-831-2583 (TTY: 711)。


注意：如果您使用日语，可以免费获得语言援助服务。请致电 1-800-831-2583 (TTY: 711)。

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-831-2583 (TTY: 711) まで、お電話にてご連絡ください。

PAUNAWA: Kung nagasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-831-2583 (TTY:711).

注意：如果您使用菲律宾语，可以免费获得语言援助服务。请致电 1-800-831-2583 (TTY: 711)。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-831-2583 (телетайп: 711).

注意：如果您使用俄语，可以免费获得语言援助服务。请致电 1-800-831-2583 (TTY:711)。

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis àd pou lang ki disponib gratis pou ou. Rele 1-800-831-2583 (TTY: 711).

注意：如果您使用克里奥尔语，可以免费获得语言援助服务。请致电 1-800-831-2583 (TTY: 711)。

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-831-2583 (TTY: 711).


注意：如果您使用葡萄牙语，可以免费获得语言援助服务。请致电 1-800-831-2583 (TTY: 711)。

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-831-2583 (TTY: 711).

注意：如果您使用意大利语，可以免费获得语言援助服务。请致电 1-800-831-2583 (TTY: 711)。
For more information

If you are a member, call toll-free 1-800-831-BLUE (2583) (TTY: 711).

If you are not a member, call toll-free 1-800-292-5146 (TTY: 711).

Visit us at bcbstmedicare.com.

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. If you call us outside these hours or on a holiday, our automated system will answer your call. You can leave a message for us, and we will call you back the next business day.

If you are a member, call toll-free 1-800-831-BLUE (2583) (TTY: 711).

If you are not a member, call toll-free 1-800-292-5146 (TTY: 711).

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