



BlueCare Plus Tennessee, an Independent Licensee of the Blue Cross Blue Shield Association

**January 1 – December 31, 2024**

## **Evidence of Coverage:**

### **Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of BlueCare Plus Choice (HMO D-SNP) <sup>SM</sup>**

This document gives you the details about your Medicare and Medicaid health care, long-term care or home and community-based services, and prescription drug coverage from January 1 – December 31, 2024. **This is an important legal document. Please keep it in a safe place.**

**For questions about this document, please contact Member Service at 1-800-332-5762. (TTY users should call 711.) Hours are Oct. 1 to Mar. 31, you can call us seven days a week from 8 a.m. to 9 p.m. ET. From Apr. 1 to Sept. 30, you can call us Monday through Friday from 8 a.m. to 9 p.m. ET. Member Service also has free language interpreter services available for non-English speakers. This call is free.**

This plan, BlueCare Plus Choice, is offered by Volunteer State Health Plan, Inc. (BlueCare Plus Tennessee). (When this *Evidence of Coverage* says “we,” “us,” or “our,” it means Volunteer State Health Plan, Inc. (BlueCare Plus Tennessee) . When it says “plan” or “our plan,” it means BlueCare Plus Choice.)

This document is available in alternate formats.

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2025.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. We will notify affected enrollees about changes at least 30 days in advance.

**Notice:** TennCare (Medicaid) is not responsible for payment of these benefits except for appropriate cost sharing amounts. TennCare (Medicaid) is not responsible for guaranteeing the availability or quality of these benefits.

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

- Your plan premium and cost sharing;
- Your medical and prescription drug benefits;
- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us if you need further assistance; and,
- Other protections required by Medicare law.

---

---

**2024 Evidence of Coverage**

**Table of Contents**

**CHAPTER 1: *Getting started as a member* .....5**

SECTION 1 Introduction .....6

SECTION 2 What makes you eligible to be a plan member?.....8

SECTION 3 Important membership materials you will receive .....9

SECTION 4 Your monthly costs for BlueCare Plus Choice .....11

SECTION 5 More information about your monthly premium .....14

SECTION 6 Keeping your plan membership record up to date .....14

SECTION 7 How other insurance works with our plan .....15

**CHAPTER 2: *Important phone numbers and resources* .....17**

SECTION 1 BlueCare Plus Choice contacts (how to contact us, including how to reach Member Service).....18

SECTION 2 Medicare (how to get help and information directly from the Federal Medicare program).....26

SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare).....28

SECTION 4 Quality Improvement Organization .....29

SECTION 5 Social Security .....29

SECTION 6 TennCare (Medicaid) .....30

SECTION 7 Information about programs to help people pay for their prescription drugs ...32

SECTION 8 How to contact the Railroad Retirement Board .....33

SECTION 9 You can get assistance from the Area Agencies on Aging .....35

**CHAPTER 3: *Using the plan for your medical and other covered services* .....38**

SECTION 1 Things to know about getting your medical care and other services as a member of our plan .....39

SECTION 2 Use providers in the plan’s network to get your medical care and other services .....40

SECTION 3 How to get services when you have an emergency or urgent need for care or during a disaster .....45

SECTION 4 What if you are billed directly for the full cost of your covered services? .....47

---

SECTION 5	How are your medical services covered when you are in a clinical research study? .....	47
SECTION 6	Rules for getting care in a religious non-medical health care institution.....	49
SECTION 7	Rules for ownership of durable medical equipment .....	50
<b>CHAPTER 4: <i>Medical Benefits Chart (what is covered)</i></b> .....		<b>52</b>
SECTION 1	Understanding covered services.....	53
SECTION 2	Use the <i>Medical Benefits Chart</i> to find out what is covered.....	53
SECTION 3	What services are covered outside of Medicare.....	92
SECTION 4	What services are not covered by the plan? .....	108
<b>CHAPTER 5: <i>Using the plan’s coverage for Part D prescription drugs</i></b> .....		<b>112</b>
SECTION 1	Introduction .....	113
SECTION 2	Fill your prescription at a network pharmacy or through the plan’s mail-order service .....	114
SECTION 3	Your drugs need to be on the plan’s “Drug List”.....	117
SECTION 4	There are restrictions on coverage for some drugs .....	118
SECTION 5	What if one of your drugs is not covered in the way you’d like it to be covered? .....	120
SECTION 6	What if your coverage changes for one of your drugs? .....	122
SECTION 7	What types of drugs are <i>not</i> covered by the plan? .....	124
SECTION 8	Filling a prescription .....	125
SECTION 9	Part D drug coverage in special situations .....	126
SECTION 10	Programs on drug safety and managing medications.....	127
<b>CHAPTER 6: <i>What you pay for your Part D prescription drugs</i></b> .....		<b>129</b>
SECTION 1	Introduction .....	130
SECTION 2	What you pay for a drug depends on which drug payment stage you are in when you get the drug .....	132
SECTION 3	We send you reports that explain payments for your drugs and which payment stage you are in.....	133
SECTION 4	There is no deductible for BlueCare Plus Choice .....	134
SECTION 5	During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share .....	134
SECTION 6	There is no coverage gap for BlueCare Plus Choice.....	137

---

SECTION 7	During the Catastrophic Coverage Stage, the plan pays the full cost for your covered Part D drugs.....	137
SECTION 8	Additional benefits information.....	138
SECTION 9	Part D Vaccines. What you pay for depends on how and where you get them.....	138
<b>CHAPTER 7: Asking us to pay our share of a bill you have received for covered medical services or drugs .....</b>		<b>141</b>
SECTION 1	Situations in which you should ask us to pay for your covered services or drugs.....	142
SECTION 2	How to ask us to pay you back or to pay a bill you have received .....	144
SECTION 3	We will consider your request for payment and say yes or no .....	145
<b>CHAPTER 8: Your rights and responsibilities .....</b>		<b>146</b>
SECTION 1	Our plan must honor your rights and cultural sensitivities as a member of the plan.....	147
SECTION 2	You have some responsibilities as a member of the plan .....	152
<b>CHAPTER 9: What to do if you have a problem or complaint (coverage decisions, appeals, complaints) .....</b>		<b>158</b>
SECTION 1	Introduction .....	159
SECTION 2	Where to get more information and personalized assistance .....	159
SECTION 3	Understanding Medicare and TennCare (Medicaid) complaints and appeals in our plan.....	160
SECTION 4	Coverage decisions and appeals.....	161
SECTION 5	A guide to the basics of coverage decisions and appeals.....	161
SECTION 6	Your medical care: How to ask for a coverage decision or make an appeal of a coverage decision.....	164
SECTION 7	Your Part D prescription drugs: How to ask for a coverage decision or make an appeal .....	173
SECTION 8	How to ask us to cover a longer inpatient hospital stay if you think you are being discharged too soon.....	182
SECTION 9	How to ask us to keep covering certain medical services if you think your coverage is ending too soon.....	188
SECTION 10	Taking your appeal to Level 3 and beyond.....	194
SECTION 11	How to make a complaint about quality of care, waiting times, customer service, or other concerns.....	196

<b>CHAPTER 10: <i>Ending your membership in the plan</i></b> .....	<b>200</b>
SECTION 1 Introduction to ending your membership in our plan.....	201
SECTION 2 When can you end your membership in our plan?.....	201
SECTION 3 How do you end your membership in our plan? .....	204
SECTION 4 Until your membership ends, you must keep getting your medical items, services and drugs through our plan .....	205
SECTION 5 BlueCare Plus Choice must end your membership in the plan in certain situations .....	206
<b>CHAPTER 11: <i>Legal notices</i></b> .....	<b>208</b>
SECTION 1 Notice about governing law .....	209
SECTION 2 Notice about nondiscrimination .....	209
SECTION 3 Notice about Medicare Secondary Payer subrogation rights .....	209
SECTION 4 Coordination of Benefits .....	209
SECTION 5 Third Party Liability and Subrogation .....	211
SECTION 6 Nondiscrimination Notice and Multi-Language Insert .....	213
<b>CHAPTER 12: <i>Definitions of important words</i></b> .....	<b>215</b>

# CHAPTER 1:

*Getting started as a member*

---

## SECTION 1 Introduction

---

<b>Section 1.1</b>	<b>You are enrolled in BlueCare Plus Choice, which is a specialized Medicare Advantage Plan (Special Needs Plan)</b>
--------------------	--

You are covered by both Medicare and TennCare (Medicaid):

- **Medicare** is 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 (kidney failure).
- **TennCare (Medicaid)** is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. TennCare (Medicaid) coverage varies depending on the state and the type of TennCare (Medicaid) you have. Some people with TennCare (Medicaid) get help paying for their Medicare premiums and other costs. Other people also get coverage for additional services and drugs that are not covered by Medicare.

You have chosen to get your Medicare and TennCare (Medicaid) health care and your prescription drug coverage through our plan, BlueCare Plus Choice. We are required to cover all Part A and Part B services. However, cost sharing and provider access in this plan differ from Original Medicare.

BlueCare Plus Choice is a specialized Medicare Advantage Plan (a Medicare Special Needs Plan), which means its benefits are designed for people with special health care needs. BlueCare Plus Choice is designed for people who have Medicare, full TennCare (Medicaid) benefits enrolled in BlueCare as their Medicaid Managed Care Organization and who qualify for TennCare CHOICES program groups 1, 2 or 3.

Because you get assistance from TennCare (Medicaid) with your Medicare Part A and B cost sharing (deductibles, copayments, and coinsurance) you may pay nothing for your Medicare health care services. TennCare (Medicaid) may also provide other benefits to you by covering health care services and long-term care or home and community-based services that are not usually covered under Medicare. You will also receive “Extra Help” from Medicare to pay for the costs of your Medicare prescription drugs. BlueCare Plus Choice will help manage all of these benefits for you, so that you get the health care services and payment assistance that you are entitled to.

BlueCare Plus Choice is run by a private company. Like all Medicare Advantage Plans, this Medicare Special Needs Plan is approved by Medicare. The plan also has a contract with the Tennessee Medicaid program to coordinate your TennCare (Medicaid) benefits. We are pleased to be providing your Medicare and TennCare (Medicaid) health care coverage, including your prescription drug coverage, and long-term care or home and community-based services.

**Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act’s (ACA) individual shared responsibility



requirement. Please visit the Internal Revenue Service (IRS) website at: [www.irs.gov/Affordable-Care-Act/Individuals-and-Families](http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families) for more information.

## **Section 1.2 What is the *Evidence of Coverage* document about?**

This *Evidence of Coverage* document tells you how to get your Medicare and TennCare (Medicaid) medical care, long-term care, home and community-based services, and prescription drugs. It explains your rights and responsibilities, what is covered, what you pay as a member of the plan, and how to file a complaint if you are not satisfied with a decision or treatment.

The words coverage and covered services refer to the medical care, long-term care or home and community-based services and the prescription drugs available to you as a member of BlueCare Plus Choice.

It's important for you to learn what the plan's rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* document.

If you are confused, concerned or just have a question, please contact Member Service.

## **Section 1.3 Legal information about the *Evidence of Coverage***

This *Evidence of Coverage* is part of our contract with you about how BlueCare Plus Choice covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs (Formulary)*, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for months in which you are enrolled in BlueCare Plus Choice between January 1, 2024, and December 31, 2024.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of BlueCare Plus Choice after December 31, 2024. We can also choose to stop offering the plan in your service area, or to offer it in a different service area, after December 31, 2024.

Medicare (the Centers for Medicare & Medicaid Services) and TennCare (Medicaid) must approve BlueCare Plus Choice each year. You can continue each year to get Medicare and TennCare (Medicaid) coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare and TennCare (Medicaid) renews their approval of the plan.

---

## SECTION 2 What makes you eligible to be a plan member?

---

### Section 2.1 Your eligibility requirements

*You are eligible for membership in our plan as long as:*

- You have both Medicare Part A and Medicare Part B
- -- *and* -- You live in our geographic service area (Section 2.3 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- -- *and* -- you are a United States citizen or are lawfully present in the United States
- -- *and* -- You meet the special eligibility requirements described below.

#### Special eligibility requirements for our plan

Our plan is designed to meet the needs of people who receive certain TennCare (Medicaid) benefits. TennCare (Medicaid) is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources.) To be eligible for our plan you must be eligible for Medicare, full TennCare (Medicaid) benefits, enrolled in BlueCare as your Medicaid Managed Care Organization and qualify for TennCare CHOICES program groups 1, 2 or 3.

Please note: If you lose your eligibility but can reasonably be expected to regain eligibility within 6 months, then you are still eligible for membership in our plan (Chapter 4, Section 2.1 tells you about coverage and cost sharing during a period of deemed continued eligibility).

### Section 2.2 What is TennCare (Medicaid)?

TennCare (Medicaid) is a joint Federal and state government program that helps with medical and long-term care costs for certain people who have limited incomes and resources. Each state decides what counts as income and resources, who is eligible, what services are covered, and the cost for services. States also can decide how to run their program as long as they follow the Federal guidelines.

In addition, there are programs offered through TennCare (Medicaid) that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These “Medicare Savings Programs” help people with limited income and resources save money each year:

- **Full Benefit Dual Eligible (FBDE):** Eligible for full Medicaid benefits. Helps pay Medicare Part A and Part B premiums and cost sharing.
- **Qualified Medicare Beneficiary (QMB+):** Eligible for full Medicaid benefits. Helps pay Medicare Part A and Part B premiums and cost sharing.

- **Specified Low-Income Medicare Beneficiary (SLMB+):** Eligible for full Medicaid benefits. Helps pay Part B premiums.

### **Section 2.3 Here is the plan service area for BlueCare Plus Choice**

BlueCare Plus Choice is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes these states: Tennessee.

If you plan to move out of the service area, you cannot remain a member of this plan. Please contact Member Service to see if we have a plan in your new area. When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

### **Section 2.4 U.S. Citizen or Lawful Presence**

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify BlueCare Plus Choice if you are not eligible to remain a member on this basis. BlueCare Plus Choice must disenroll you if you do not meet this requirement.

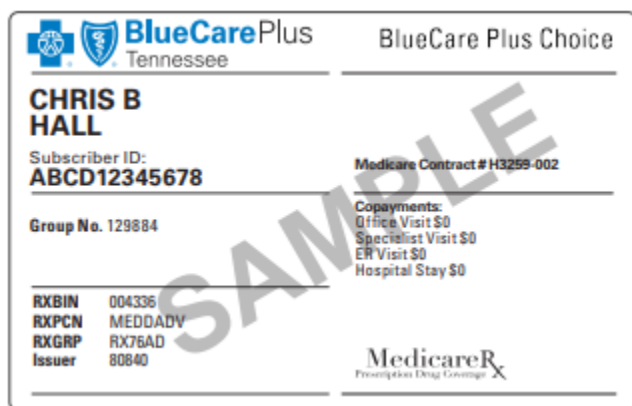
---

## **SECTION 3 Important membership materials you will receive**

---

### **Section 3.1 Your plan membership card**

While you are a member of our plan, you must use your BlueCare Plus Choice membership card whenever you get Medicare or TennCare (Medicaid) services covered by this plan and for prescription drugs you get at network pharmacies. Here's a sample membership card to show you what yours will look like:



Do NOT use your red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your BlueCare Plus Choice membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare approved clinical research studies also called clinical trials.

If your plan membership card is damaged, lost, or stolen, call Member Service right away and we will send you a new card.

### Section 3.2 Provider Directory

The *Provider Directory* lists our 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, CHOICES providers, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full.

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization you will have to pay in full. The only exceptions are emergencies, urgently needed services when the network is not available (that is, in situations when it is unreasonable or not possible to obtain services in-network), out-of-area dialysis services, and cases in which BlueCare Plus Choice authorizes use of out-of-network providers.

The most recent list of providers and suppliers is available on our website at [bluecareplus.bcbst.com](http://bluecareplus.bcbst.com).

If you don't have your copy of the *Provider Directory*, you can request a copy (electronically or in hardcopy form) from Member Service. Requests for hard copy Provider Directories will be mailed to you within three business days.

### Section 3.3 Pharmacy Directory

The pharmacy directory lists our network pharmacies. **Network pharmacies** are all of the pharmacies that have agreed to fill covered prescriptions for our plan members. You can use the

*Pharmacy Directory* to find the network pharmacy you want to use. See Chapter 5, Section 2.5 for information on when you can use pharmacies that are not in the plan's network.

If you don't have the *Pharmacy Directory*, you can get a copy from Member Service. You can also find this information on our website at [bluecareplus.bcbst.com](http://bluecareplus.bcbst.com).

### Section 3.4 The plan's List of Covered Drugs (*Formulary*)

The plan has a *List of Covered Drugs (Formulary)*. We call it the "Drug List" for short. It tells which Part D prescription drugs are covered under the Part D benefit included in BlueCare Plus Choice. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the BlueCare Plus Choice "Drug List."

The "Drug List" also tells you if there are any rules that restrict coverage for your drugs.

We will provide you a copy of the "Drug List." To get the most complete and current information about which drugs are covered, you can visit the plan's website [bluecareplus.bcbst.com](http://bluecareplus.bcbst.com) or call Member Service.

## SECTION 4 Your monthly costs for BlueCare Plus Choice

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Part D Late Enrollment Penalty (Section 4.4)
- Income Related Monthly Adjusted Amount (Section 4.5)

### **In some situations, your plan premium could be less**

The "Extra Help" program helps people with limited resources pay for their drugs. Chapter 2, Section 7 tells more about this program. If you qualify, enrolling in the program might lower your monthly plan premium.

If you are *already enrolled* and getting help from one of these programs, **the information about premiums in this Evidence of Coverage does not apply to you.** We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the Low-Income Subsidy Rider or the LIS Rider), which tells you about your drug coverage. If you don't have this insert, please call Member Service and ask for the LIS Rider.

Medicare Part B and Part D premiums differ for people with different incomes. If you have questions about these premiums review your copy of *Medicare & You 2024* handbook, the section called *2024 Medicare Costs*. If you need a copy you can download it from the Medicare

website ([www.medicare.gov](http://www.medicare.gov)). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

### **Section 4.1 Plan premium**

You do not pay a separate monthly plan premium for BlueCare Plus Choice. Because you are eligible for TennCare (Medicaid), you qualify for and are getting "Extra Help" from Medicare which covers your premium.

### **Section 4.2 Monthly Medicare Part B Premium**

#### **Many members are required to pay other Medicare premiums**

Some members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our plan, you must maintain your eligibility for TennCare (Medicaid) as well as have both Medicare Part A and Medicare Part B. For most BlueCare Plus Choice members, TennCare (Medicaid) pays for your Part A premium (if you don't qualify for it automatically) and for your Part B premium.

**If TennCare (Medicaid) is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan.** This includes your premium for Part B. It may also include a premium for Part A which affects members who aren't eligible for premium free Part A.

### **Section 4.3 Part D Late Enrollment Penalty**

Because you are dually-eligible, the LEP doesn't apply to you as long as you maintain your dually-eligible status, but if you lose your dually-eligible status, you may incur an LEP. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. Creditable prescription drug coverage is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

You **will not** have to pay it if:

- You receive "Extra Help" from Medicare to pay for your prescription drugs.
- You have gone less than 63 days in a row without creditable coverage.
- You have had creditable drug coverage through another source such as a former employer, union, TRICARE, or Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage.

This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.

- **Note:** Any notice must state that you had creditable prescription drug coverage that is expected to pay as much as Medicare's standard prescription drug plan pays.
- **Note:** The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.

**Medicare determines the amount of the penalty.** Here is how it works:

- First, count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2024, this average premium amount is \$34.70.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here, it would be 14% times \$34.70, which equals \$4.86. This rounds to \$4.90. This amount would be added to the monthly premium for someone with a Part D late enrollment penalty.

There are three important things to note about this monthly Part D late enrollment penalty:

- First, **the penalty may change each year**, because the average monthly premium can change each year.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- Third, if you are under 65 and currently receiving Medicare benefits, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

**If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review.** Generally, you must request this review **within 60 days** from the date on the first letter you receive stating you have to pay a late enrollment penalty. However, if you were paying a penalty before joining our plan, you may not have another chance to request a review of that late enrollment penalty.

#### **Section 4.4 Income Related Monthly Adjustment Amount**

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA. The extra charge is figured out using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this

amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit <https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans>.

If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. **You must pay the extra amount to the government. It cannot be paid with your monthly plan premium. If you do not pay the extra amount you will be disenrolled from the plan and lose prescription drug coverage.**

If you disagree about paying an extra amount, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

---

## SECTION 5 More information about your monthly premium

---

<b>Section 5.1 Can we change your monthly plan premium during the year?</b>
---

**No.** We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year, we will tell you in September and the change will take effect on January 1.

However, in some cases, you may be able to stop paying a late enrollment penalty, if owed. Or need to start paying a late enrollment penalty. (This could happen if you become eligible for the "Extra Help" program or if you lose your eligibility for the "Extra Help" program during the year:

- If you currently pay the Part D late enrollment penalty and become eligible for "Extra Help" during the year, you would be able to stop paying your penalty.
- If you lose Extra Help, you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.

You can find out more about the "Extra Help" program in Chapter 2, Section 7.

---

## SECTION 6 Keeping your plan membership record up to date

---

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage including your Primary Care Provider.

The doctors, hospitals, pharmacists, and other providers in the plan's network need to have correct information about you. **These network providers use your membership record to**



**know what services and drugs are covered and the cost sharing amounts for you.** Because of this, it is very important that you help us keep your information up to date.

**Let us know about these changes:**

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

If any of this information changes, please let us know by calling Member Service.

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

---

## **SECTION 7 How other insurance works with our plan**

---

### **Other insurance**

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. This is called **Coordination of Benefits**.

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Member Service. You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

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

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

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

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

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

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

# CHAPTER 2:

*Important phone numbers  
and resources*

---

## **SECTION 1 BlueCare Plus Choice contacts** (how to contact us, including how to reach Member Service)

---

### **How to contact our plan's Member Service**

For assistance with claims, billing, or member card questions, please call or write to BlueCare Plus Choice Member Service. We will be happy to help you.

<b>Method</b>	<b>Member Service – Contact Information</b>
<b>CALL</b>	<b>1-800-332-5762</b> Calls to this number are free. From <b>Oct. 1 to Mar. 31</b> , you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From <b>Apr. 1 to Sept. 30</b> , you can call us Monday through Friday from 8 a.m. to 9 p.m. ET. Member Service also has free language interpreter services available for non-English speakers.
<b>TTY</b>	<b>711</b> Calls to this number are free. From <b>Oct. 1 to Mar. 31</b> , you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From <b>Apr. 1 to Sept. 30</b> , you can call us Monday through Friday from 8 a.m. to 9 p.m. ET.
<b>FAX</b>	1-888-725-6849
<b>WRITE</b>	BlueCare Plus Tennessee 1 Cameron Hill Circle, Suite 0002 Chattanooga, TN 37402-0002 Email: <a href="mailto:BlueCarePlus_GM@bcbst.com">BlueCarePlus_GM@bcbst.com</a>
<b>WEBSITE</b>	<a href="http://bluecareplus.bcbst.com">bluecareplus.bcbst.com</a>

## How to contact us when you are asking for a coverage decision about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For more information on asking for coverage decisions about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

<b>Method</b>	<b>Coverage Decisions for Medical Care - Contact Information</b>
<b>CALL</b>	<b>1-800-332-5762</b> Calls to this number are free. From <b>Oct. 1 to Mar. 31</b> , you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From <b>Apr. 1 to Sept. 30</b> , you can call us Monday through Friday from 8 a.m. to 9 p.m. ET.
<b>TTY</b>	<b>711</b> Calls to this number are free. From <b>Oct. 1 to Mar. 31</b> , you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From <b>Apr. 1 to Sept. 30</b> , you can call us Monday through Friday from 8 a.m. to 9 p.m. ET.
<b>FAX</b>	1-888-725-6849
<b>WRITE</b>	BlueCare Plus Tennessee 1 Cameron Hill Circle, Suite 0002 Chattanooga, TN 37402-0002
<b>WEBSITE</b>	<a href="http://bluecareplus.bcbst.com">bluecareplus.bcbst.com</a>

## 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 asking for an appeal about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Appeals for Medical Care – Contact Information
<b>CALL</b>	<b>1-800-332-5762</b> Calls to this number are free. From <b>Oct. 1 to Mar. 31</b> , you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From <b>Apr. 1 to Sept. 30</b> , you can call us Monday through Friday from 8 a.m. to 9 p.m. ET.
<b>TTY</b>	<b>711</b> Calls to this number are free. From <b>Oct. 1 to Mar. 31</b> , you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From <b>Apr. 1 to Sept. 30</b> , you can call us Monday through Friday from 8 a.m. to 9 p.m. ET.
<b>FAX</b>	1-888-416-3026
<b>WRITE</b>	BlueCare Plus Tennessee Member Appeals 1 Cameron Hill Circle, Suite 0042 Chattanooga, TN 37402-0042
<b>WEBSITE</b>	<a href="http://bluecareplus.bcbst.com">bluecareplus.bcbst.com</a>

## How to contact us when you are making a complaint about your medical care

You can make a complaint about us or one of our network providers or pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. For more information on making a complaint about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

<b>Method</b>	<b>Complaints about Medical Care – Contact Information</b>
<b>CALL</b>	<b>1-800-332-5762</b> Calls to this number are free. From <b>Oct. 1 to Mar. 31</b> , you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From <b>Apr. 1 to Sept. 30</b> , you can call us Monday through Friday from 8 a.m. to 9 p.m. ET.
<b>TTY</b>	<b>711</b> Calls to this number are free. From <b>Oct. 1 to Mar. 31</b> , you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From <b>Apr. 1 to Sept. 30</b> , you can call us Monday through Friday from 8 a.m. to 9 p.m. ET.
<b>FAX</b>	1-888-416-3026
<b>WRITE</b>	BlueCare Plus Tennessee BlueCare Plus Operations 1 Cameron Hill Circle, Suite 0042 Chattanooga, TN 37402-0042
<b>MEDICARE WEBSITE</b>	You can submit a complaint about BlueCare Plus Choice directly to Medicare. To submit an online complaint to Medicare, go to <a href="http://www.medicare.gov/MedicareComplaintForm/home.aspx">www.medicare.gov/MedicareComplaintForm/home.aspx</a> .

---

## How to contact us when you are asking for a coverage decision about your Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your Part D prescription drugs. For more information on asking for coverage decisions about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

<b>Method</b>	<b>Coverage Decisions for Part D Prescription Drugs – Contact Information</b>
<b>CALL</b>	<b>1-800-332-5762</b> Calls to this number are free. From <b>Oct. 1. to Mar. 31</b> , you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From <b>Apr. 1 to Sept. 30</b> , you can call us Monday through Friday from 8 a.m. to 9 p.m. ET.
<b>TTY</b>	<b>711</b> Calls to this number are free. From <b>Oct. 1. to Mar. 31</b> , you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From <b>Apr. 1 to Sept. 30</b> , you can call us Monday through Friday from 8 a.m. to 9 p.m. ET.
<b>FAX</b>	1-423-591-9514
<b>WRITE</b>	BlueCare Plus Tennessee Medicare Part D Coverage Determinations and Appeals 1 Cameron Hill Circle, Suite 0051 Chattanooga, TN 37402-0051
<b>WEBSITE</b>	<a href="http://bluecareplus.bcbst.com">bluecareplus.bcbst.com</a>



## How to contact us when you are making an appeal about your Part D prescription drugs

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on asking for an appeal about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

<b>Method</b>	<b>Appeals for Part D Prescription Drugs – Contact Information</b>
<b>CALL</b>	<b>1-800-332-5762</b> Calls to this number are free. From <b>Oct. 1. to Mar. 31</b> , you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From <b>Apr. 1 to Sept. 30</b> , you can call us Monday through Friday from 8 a.m. to 9 p.m. ET.
<b>TTY</b>	<b>711</b> Calls to this number are free. From <b>Oct. 1. to Mar. 31</b> , you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From <b>Apr. 1 to Sept. 30</b> , you can call us Monday through Friday from 8 a.m. to 9 p.m. ET.
<b>FAX</b>	1-423-591-9514
<b>WRITE</b>	BlueCare Plus Tennessee Medicare Part D Coverage Determinations and Appeals 1 Cameron Hill Circle, Suite 0051 Chattanooga, TN 37402-0051
<b>WEBSITE</b>	<a href="http://bluecareplus.bcbst.com">bluecareplus.bcbst.com</a>

## How to contact us when you are making a complaint about your Part D prescription drugs

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. For more information on making a complaint about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Complaints about Part D Prescription Drugs – Contact Information
<b>CALL</b>	<b>1-800-332-5762</b> Calls to this number are free. From <b>Oct. 1 to Mar. 31</b> , you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From <b>Apr. 1 to Sept. 30</b> , you can call us Monday through Friday from 8 a.m. to 9 p.m. ET.
<b>TTY</b>	<b>711</b> Calls to this number are free. From <b>Oct. 1 to Mar. 31</b> , you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From <b>Apr. 1 to Sept. 30</b> , you can call us Monday through Friday from 8 a.m. to 9 p.m. ET.
<b>FAX</b>	1-888-416-3026
<b>WRITE</b>	BlueCare Plus Tennessee 1 Cameron Hill Circle, Suite 0042 Chattanooga, TN 37402-0042
<b>MEDICARE WEBSITE</b>	You can submit a complaint about BlueCare Plus Choice directly to Medicare. To submit an online complaint to Medicare go to <a href="http://www.medicare.gov/MedicareComplaintForm/home.aspx">www.medicare.gov/MedicareComplaintForm/home.aspx</a> .

## Where to send a request asking us to pay the cost for medical care or a drug you have received

BlueCare Plus Choice is not allowed to reimburse members for TennCare (Medicaid) cost sharing amounts. Please contact Member Service if you have questions (phone numbers are printed on the back cover of this booklet).

If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. See Chapter 7 (*Asking us to pay a bill you have received for covered medical services or drugs*).

**Please note:** If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) for more information.

<b>Method</b>	<b>Payment Requests – Contact Information</b>
<b>CALL</b>	<b>1-800-332-5762</b> Calls to this number are free. From <b>Oct. 1 to Mar. 31</b> , you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From <b>Apr. 1 to Sept. 30</b> , you can call us Monday through Friday from 8 a.m. to 9 p.m. ET.
<b>TTY</b>	<b>711</b> Calls to this number are free. From <b>Oct. 1 to Mar. 31</b> , you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From <b>Apr. 1 to Sept. 30</b> , you can call us Monday through Friday from 8 a.m. to 9 p.m. ET.
<b>FAX</b>	<b>Medical (Part C) Payment Requests:</b> 1-888-725-6849 <b>Prescription (Part D) Payment Requests:</b> 1-423-591-9495
<b>WRITE</b>	<b>Medical (Part C) Payment Requests:</b> BlueCare Plus Tennessee 1 Cameron Hill Circle, Suite 0002 Chattanooga, TN 37402-0002  <b>Prescription (Part D) Payments Requests:</b> BlueCare Plus Tennessee Medicare Part D Prescription Drug Claim Request 1 Cameron Hill Circle, Suite 48 Chattanooga, TN 37402-0048
<b>WEBSITE</b>	<a href="http://bluecareplus.bcbst.com">bluecareplus.bcbst.com</a>

---

## **SECTION 2 Medicare** (how to get help and information directly from the Federal Medicare program)

---

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

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called CMS). This agency contracts with Medicare Advantage organizations including us.

<b>Method</b>	<b>Medicare – Contact Information</b>
<b>CALL</b>	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
<b>TTY</b>	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.

Method	Medicare – Contact Information
<b>WEBSITE</b>	<p data-bbox="467 296 724 327"><a href="http://www.Medicare.gov">www.Medicare.gov</a></p> <p data-bbox="467 331 1382 541">This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state.</p> <p data-bbox="467 546 1382 619">The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:</p> <ul data-bbox="516 623 1382 877" style="list-style-type: none"><li data-bbox="516 623 1382 697">• <b>Medicare Eligibility Tool:</b> Provides Medicare eligibility status information.</li><li data-bbox="516 701 1382 877">• <b>Medicare Plan Finder:</b> Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an <i>estimate</i> of what your out-of-pocket costs might be in different Medicare plans.</li></ul> <p data-bbox="467 882 1382 955">You can also use the website to tell Medicare about any complaints you have about BlueCare Plus Choice:</p> <ul data-bbox="516 959 1382 1098" style="list-style-type: none"><li data-bbox="516 959 1382 1098">• <b>Tell Medicare about your complaint:</b> You can submit a complaint about BlueCare Plus Choice directly to Medicare. To submit a complaint to Medicare, go to <a href="http://www.medicare.gov/MedicareComplaintForm/home.aspx">www.medicare.gov/MedicareComplaintForm/home.aspx</a>.</li></ul> <p data-bbox="467 1102 1382 1176">Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.</p> <p data-bbox="467 1180 1382 1388">If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)</p>

---

### **SECTION 3 State Health Insurance Assistance Program** (free help, information, and answers to your questions about Medicare)

---

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Tennessee, the SHIP is called Tennessee State Health Insurance Assistance Program.

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

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

**METHOD TO ACCESS SHIP and OTHER RESOURCES:**

- Visit <https://www.shiphelp.org> (Click on SHIP LOCATOR in middle of page)
- Select your **STATE** from the list. This will take you to a page with phone numbers and resources specific to your state.

<b>Method</b>	<b>Tennessee State Health Insurance Assistance Program – Contact Information</b>
<b>CALL</b>	1-877-801-0044
<b>TTY</b>	1-800-848-0299 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
<b>WRITE</b>	Tennessee State Health Insurance Assistance Program 502 Deaderick Street, 9 <sup>th</sup> Floor Nashville, TN 37243-0860
<b>WEBSITE</b>	<a href="https://tn.gov/aging/our-programs/state-health-insurance-assistance-program--ship-.html">tn.gov/aging/our-programs/state-health-insurance-assistance-program--ship-.html</a>

---

## **SECTION 4 Quality Improvement Organization**

---

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For Tennessee, the Quality Improvement Organization is called Kepro.

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

You should contact Kepro in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

<b>Method</b>	<b>Kepro (Tennessee’s Quality Improvement Organization) – Contact Information</b>
<b>CALL</b>	1-888-317-0751 Calls to this number are free. Monday through Friday, 9 a.m. to 5 p.m.; Weekends and Holidays – 11:00 a.m. to 3:00 p.m.; in Eastern, Central, Mountain, Pacific, Alaska, and Hawaii-Aleutian time zones
<b>TTY</b>	711 Calls to this number are free. Monday through Friday, 9 a.m. to 5 p.m.; Weekends and Holidays – 11:00 a.m. to 3:00 p.m.; in Eastern, Central, Mountain, Pacific, Alaska, and Hawaii-Aleutian time zones
<b>WRITE</b>	Kepro 5201 W. Kennedy Boulevard, Suite 900 Tampa, FL 33609
<b>WEBSITE</b>	<a href="http://www.keproqio.com">www.keproqio.com</a>

---

## **SECTION 5 Social Security**

---

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If

you are not getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

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

<b>Method</b>	<b>Social Security – Contact Information</b>
<b>CALL</b>	1-800-772-1213 Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday. You can use Social Security’s automated telephone services to get recorded information and conduct some business 24 hours a day.
<b>TTY</b>	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday.
<b>WEBSITE</b>	<a href="http://www.ssa.gov">www.ssa.gov</a>

---

## **SECTION 6 TennCare (Medicaid)**

---

TennCare (Medicaid) is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. As a member of BlueCare Plus Choice, your Medicare and TennCare (Medicaid) benefits are covered under this plan.

In addition, there are programs offered through TennCare (Medicaid) that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These “Medicare Savings Programs” help people with limited income and resources save money each year:

- **Full Benefit Dual Eligible (FBDE):** Eligible for full TennCare (Medicaid) benefits. Helps pay Medicare Part A and Part B premiums and cost sharing.
- **Qualified Medicare Beneficiary (QMB+):** Eligible for full TennCare (Medicaid) benefits. Helps pay Medicare Part A and Part B premiums and cost sharing.
- **Specified Low-Income Medicare Beneficiary (SLMB+):** Eligible for full TennCare (Medicaid) benefits. Helps pay Part B premiums.



If you have questions about the assistance you get from Medicaid, contact TennCare (Medicaid).

<b>Method</b>	<b>TennCare (Medicaid) – Contact Information</b>
<b>CALL</b>	1-800-342-3145 Monday through Friday, 8 a.m. to 5 p.m., all time zones. Closed on state holidays.
<b>TTY</b>	1-877-779-3103 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
<b>WRITE</b>	Division of TennCare 310 Great Circle Drive Nashville, TN 37243
<b>WEBSITE</b>	<a href="http://www.tn.gov/tenncare">www.tn.gov/tenncare</a>

The Tennessee Commission on Aging and Disability, Office of the Ombudsman helps people enrolled in TennCare (Medicaid) with service or billing problems. They can help you file a grievance or appeal with our plan.

<b>Method</b>	<b>Tennessee Commission on Aging and Disability, Office of the Ombudsman – Contact Information</b>
<b>CALL</b>	1-877-236-0013 Monday through Friday, 8:30 a.m. to 5:00 p.m. ET
<b>TTY</b>	1-615-532-3893 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
<b>WRITE</b>	Tennessee Commission on Aging and Disability Office of the Ombudsman 502 Deaderick Street, 9 <sup>th</sup> Floor Nashville, TN 37243-0860
<b>WEBSITE</b>	<a href="http://www.tn.gov/aging/our-programs/long-term-care-ombudsman">www.tn.gov/aging/our-programs/long-term-care-ombudsman</a>

The Tennessee Ombudsman Program for Long-Term Care helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

<b>Method</b>	<b>Tennessee Ombudsman Program for Long-Term Care – Contact Information</b>
<b>CALL</b>	1-877-236-0013 Monday through Friday, 8:30 a.m. to 5:00 p.m. ET
<b>TTY</b>	1-615-532-3893 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
<b>WRITE</b>	Tennessee Ombudsman Program for Long-Term Care 502 Deaderick Street, 9 <sup>th</sup> Floor Nashville, TN 37243-0860
<b>WEBSITE</b>	<a href="http://www.tn.gov/aging/our-programs/long-term-care-ombudsman">www.tn.gov/aging/our-programs/long-term-care-ombudsman</a>

---

## **SECTION 7 Information about programs to help people pay for their prescription drugs**

---

The Medicare.gov website (<https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap/5-ways-to-get-help-with-prescription-costs>) provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, described below.

### **Medicare’s “Extra Help” Program**

Because you are eligible for TennCare (Medicaid), you qualify for and are getting “Extra Help” from Medicare to pay for your prescription drug plan costs. You do not need to do anything further to get this “Extra Help.”

If you have questions about “Extra Help,” call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048 (applications), 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 8 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778; or
- Your State TennCare (Medicaid) Office (applications) (See Section 6 of this chapter for contact information).

If you believe that you are paying an incorrect cost sharing amount when you get your prescription at a pharmacy, our plan has a process for you to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

- If you need assistance obtaining evidence of your proper copayment level, you can contact Member Service. BlueCare Plus Choice will contact CMS on your behalf to inquire about your eligibility. Once we receive a decision from CMS, we will contact you.
- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Member Service if you have questions.

Most of our members qualify for and are already getting "Extra Help" from Medicare to pay for their prescription drug plan costs.

**What if you have coverage from an AIDS Drug Assistance Program (ADAP)?**

**What is the AIDS Drug Assistance Program (ADAP)?**

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also on the ADAP formulary qualify for prescription cost sharing assistance through the Ryan White Program (Tennessee's AIDS Drug Assistance Program). **Note:** To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. If you change plans, please notify your local ADAP enrollment worker so you can continue to receive assistance. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call Ryan White Program (Tennessee's AIDS Drug Assistance Program) at 1-615-741-7500, from 9-5:30 ET .

---

## **SECTION 8 How to contact the Railroad Retirement Board**

---

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you receive your Medicare through the Railroad Retirement Board, it is important that you let them

know if you move or change your mailing address. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

<b>Method</b>	<b>Railroad Retirement Board – Contact Information</b>
<b>CALL</b>	<p>1-877-772-5772</p> <p>Calls to this number are free.</p> <p>If you press “0,” you may speak with an RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday.</p> <p>If you press “1”, you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.</p>
<b>TTY</b>	<p>1-312-751-4701</p> <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 <i>not</i> free.</p>
<b>WEBSITE</b>	<p><a href="http://rrb.gov/">rrb.gov/</a></p>

---

## **SECTION 9 You can get assistance from the Area Agencies on Aging**

---

<b>Method</b>	<b>First Tennessee Area Agency on Aging and Disability</b>
<b>CALL</b>	1-866-836-6678
<b>COUNTIES</b>	Carter, Greene, Hancock, Hawkins, Johnson, Sullivan, Unicoi, and Washington
<b>WRITE</b>	First TN Dev. District 3211 North Roane Street Johnson City, TN 37601
<b>WEBSITE</b>	<a href="http://www.ftaaad.org">www.ftaaad.org</a>

<b>Method</b>	<b>East Tennessee Area Agency on Aging and Disability</b>
<b>CALL</b>	1-865-691-2551
<b>COUNTIES</b>	Anderson, Blount, Campbell, Claiborne, Cocke, Grainger, Hamblen, Jefferson, Knox, Loudon, Monroe, Morgan, Roane, Scott, Sevier, and Union
<b>WRITE</b>	East TN Human Resource Agency 9111 Cross Park Drive, Suite D-100 Knoxville, TN 37923-4517
<b>WEBSITE</b>	<a href="http://www.ethra.org">www.ethra.org</a>

<b>Method</b>	<b>Southeast Tennessee Area Agency on Aging and Disability</b>
<b>CALL</b>	1-866-836-6678
<b>COUNTIES</b>	Bledsoe, Bradley, Grundy, Hamilton, Marion, McMinn, Meigs, Polk, Rhea, and Sequatchie
<b>WRITE</b>	Southeast TN Area Agencies on Aging & Disabilities PO Box 4757 Chattanooga, TN 37405
<b>WEBSITE</b>	<a href="http://www.setaad.org">www.setaad.org</a>

<b>Method</b>	<b>Upper Cumberland Area Agency on Aging and Disability</b>
<b>CALL</b>	1-931-432-4111
<b>COUNTIES</b>	Cannon, Clay, Cumberland, DeKalb, Fentress, Jackson, Macon, Overton, Pickett, Putnam, Smith, VanBuren, Warren and White
<b>WRITE</b>	Upper Cumberland Dev. District 1225 South Willow Avenue Cookeville, TN 38506-4194
<b>WEBSITE</b>	<a href="http://www.ucdd.org">www.ucdd.org</a>

<b>Method</b>	<b>Greater Nashville Area Agency on Aging and Disability</b>
<b>CALL</b>	1-615-862-8828
<b>COUNTIES</b>	Cheatham, Davidson, Dickson, Houston, Humphreys, Montgomery, Robertson, Rutherford, Stewart, Sumner, Trousdale, Williamson, and Wilson
<b>WRITE</b>	Greater Nashville Regional Council 220 Athens Way, Suite 200 Nashville, TN 37228
<b>WEBSITE</b>	<a href="http://www.gnrc.org">www.gnrc.org</a>

<b>Method</b>	<b>South Central Tennessee Area Agency on Aging and Disability</b>
<b>CALL</b>	1-931-379-2929
<b>COUNTIES</b>	Bedford, Coffee, Franklin, Giles, Hickman, Lawrence, Lewis, Lincoln, Marshall, Maury, Moore, Perry, and Wayne
<b>WRITE</b>	South Central TN Dev. District 101 Sam Watkins Boulevard Mount Pleasant, TN 38474
<b>WEBSITE</b>	<a href="http://www.sctdd.org">www.sctdd.org</a>

<b>Method</b>	<b>Northwest Tennessee Area Agency on Aging and Disability</b>
<b>CALL</b>	1-800-750-6866
<b>COUNTIES</b>	Benton, Carroll, Crockett, Dyer, Gibson, Henry, Lake, Obion, and Weakley
<b>WRITE</b>	Northwest TN Area Agency on Aging and Disability 124 Weldon Drive Martin, TN 38237-0963
<b>WEBSITE</b>	<a href="http://www.nwtdd.org/nwtdd">www.nwtdd.org/nwtdd</a>

<b>Method</b>	<b>Southwest Tennessee Area Agency on Aging and Disability</b>
<b>CALL</b>	1-731-668-7112
<b>COUNTIES</b>	Chester, Decatur, Hardeman, Hardin, Haywood, Henderson, McNairy, and Madison
<b>WRITE</b>	Southwest TN Area Agency on Aging and Disability 102 E. College Street Jackson, TN 38301
<b>WEBSITE</b>	<a href="http://www.swtdd.org">www.swtdd.org</a>

## CHAPTER 3:

*Using the plan for your medical and  
other covered services*



**Chapter 3. Using the plan for your medical and other covered services**

---

**SECTION 1 Things to know about getting your medical care and other services as a member of our plan**

---

This chapter explains what you need to know about using the plan to get your medical care and other services covered. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, equipment, prescription drugs, and other medical care that are covered by the plan.

For the details on what medical care and other services are covered by our plan, use the benefits chart in the next chapter, Chapter 4 (*Medical Benefits Chart, what is covered*).

**Section 1.1 What are network providers and covered services?**

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term providers also includes hospitals and other health care facilities.
- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay nothing for covered services.
- **Covered services** include all the medical care, health care services, supplies, equipment, and Prescription Drugs that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

**Section 1.2 Basic rules for getting your medical care and other services covered by the plan**

As a Medicare and TennCare (Medicaid) health plan, BlueCare Plus Choice must cover all services covered by Original Medicare and may offer other services in addition to those covered under Original Medicare, see Chapter 4, Section 2 and 3.

BlueCare Plus Choice will generally cover your medical care as long as:

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

**Chapter 3. Using the plan for your medical and other covered services**

---

- **You have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
  - Referrals from your PCP are not required for emergency care or urgently needed services. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 of this chapter).
- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. This means that you will have to pay the provider in full for the services furnished. *Here are three exceptions:*
  - The plan covers emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
  - If you need medical care that Medicare or TennCare (Medicaid) requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost sharing you normally pay in-network. You will need to obtain authorization from the plan prior to seeking this care. In this situation, we will cover these services as if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
  - The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay the plan for dialysis can never exceed the cost sharing in Original Medicare. If you are outside the plan's service area and obtain the dialysis from a provider that is outside the plan's network, your cost sharing cannot exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from a provider outside the plan's network the cost sharing for the dialysis may be higher.

---

**SECTION 2 Use providers in the plan's network to get your medical care and other services**

---

<b>Section 2.1 You must choose a Primary Care Provider (PCP) to provide and oversee your care</b>
---

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

**Chapter 3. Using the plan for your medical and other covered services**

---

*What is a PCP?*

A PCP provides and manages your care. A PCP should be your first contact for an undiagnosed health concern. PCPs also help coordinate care for you when specialists, such as cardiologists or surgeons, are involved.

*What types of providers may act as a PCP?*

PCPs can be physicians, nurse practitioners, or physician assistants in the following specialties:

- Family Practice
- General Practice
- Pediatric
- Internal Medicine
- Geriatric Medicine

*What is the role of a PCP?*

In BlueCare Plus Choice, you will go to one main person for your health care. He or she can be a doctor, nurse practitioner or a physician's assistant. This person is called your Primary Care Provider, or 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.

*What is the role of the PCP in making decisions about or obtaining prior authorization?*

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 BlueCare Plus Choice.

**How do you choose your PCP?**

All BlueCare Plus Choice members must have a PCP. When you enrolled in BlueCare Plus Choice, you were asked to pick a PCP and write the PCP's name on the enrollment form. If you did not choose a PCP, we will automatically assign you to a PCP who is located close to where you live.

**Changing your PCP**

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP.

**Chapter 3. Using the plan for your medical and other covered services**

---

There are many reasons why you may need to change your PCP. You may want to change the PCP to whom you were assigned if you did not choose one initially, or you may want to see a PCP whose office is closer to you, or your PCP may stop working with BlueCare Plus Choice. If your PCP stops working with BlueCare Plus Choice, we will send you 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 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 [bluecareplus.bcbst.com](http://bluecareplus.bcbst.com). We will make your PCP change after we receive your request, and the change will take effect immediately. What if you need help finding a PCP? Call Member Service at 1-800-332-5762 (TTY 711). We'll work with you to find a new PCP who is taking new patients.

<b>Section 2.2      What kinds of medical care and other services can you get without a referral from your PCP?</b>
---

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

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Flu shots, COVID-19 vaccinations, Hepatitis B vaccinations, and pneumonia vaccinations as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed services are covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. If possible, please call Member Service before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away.
- Bone mineral density testing every 24 months or more frequently, if medically necessary.
- Preventive Screening Colonoscopy (or screening barium enema as an alternative) for people at high risk of colorectal cancer every 24 months. We cover screening colonoscopy for people not at high risk of colorectal cancer every 10 years (120 months), except when performed within 48 months of a screening sigmoidoscopy.

The above services are not all-inclusive.

**Chapter 3. Using the plan for your medical and other covered services****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. Here are a few examples:

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

**How members access specialists and other network providers:**

*What is the role of the PCP in referring members to specialists and other providers?*

If you need to see a specialist, your PCP should be the one to recommend an appropriate specialist.

*For which services will your PCP, specialists and other providers need to get prior authorization from us?*

See Chapter 4, Section 2.1 for information about which services require prior authorization.

*What is the process for obtaining Prior Authorization (PA)?*

While participating network providers, including physicians or other practitioners, are responsible for obtaining prior authorizations and/or other coverage or advance determinations of coverage from the plan. You or your authorized representative(s) may also request authorizations or advance determinations. Requests for coverage, prior authorizations or for advance determinations should include supporting information and applicable medical records.

*Who makes the Prior Authorization (PA) decision?*

When we receive a request for coverage, prior authorization or for advance coverage determination from a network provider or out-of-network provider or you, registered nurses and licensed behavioral clinicians (for behavioral health services) initially review information provided for the service or item requested against Medicare or other appropriate medical coverage criteria to determine medical necessity of the service or item.

If coverage criteria are met for a requested item or service, 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 item or service, 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.

*Will your selection of a PCP result in being limited to specific specialists or hospitals to which that PCP refers (i.e. sub-network or referral circles)?*

You can see any specialist or visit any hospital in our network regardless of which PCP you choose. See Section 2.4 below for information about care from out-of-network providers.

**Chapter 3. Using the plan for your medical and other covered services**

---

**What if a specialist or another network provider leaves our plan?**

We may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. If your doctor or specialist leaves your plan you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will notify you that your provider is leaving our plan so that you have time to select a new provider.
  - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.
  - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.
- We will assist you in selecting a new qualified in-network provider that you may access for continued care.
- If you are currently undergoing medical treatment or therapies with your current provider, you have the right to request, and we will work with you to ensure, that the medically necessary treatment or therapies you are receiving continues.
- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- We will arrange for any medically necessary covered benefit outside of our provider network, but at in-network cost sharing, when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. Prior authorization is required.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file a quality of care complaint to the QIO, a quality of care grievance to the plan, or both. Please see Chapter 9.

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

Care that you receive from out-of-network providers will not be covered unless the care meets one of the three exceptions described in Section 1.2 of this chapter. For information about getting out-of-network care when you have a medical emergency or urgent need for care, please see Section 3 in this chapter.

Services you obtain from out-of-network providers may be covered in the following situations:

## Chapter 3. Using the plan for your medical and other covered services

---

- You require emergency or urgent care. You do not need to obtain prior authorization.
- You require dialysis treatment and you are not in our service area. Prior authorization is required.
- If a provider of specialized services is not available in our network within a reasonable distance from your home, you can ask us to see an out-of-network provider with a prior authorization.

To request a prior authorization for an out-of-network provider, please refer to Section 5.1 of Chapter 9, *Asking for coverage decisions and making appeals: the big picture*.

---

### SECTION 3 How to get services when you have an emergency or urgent need for care or during a disaster

---

<b>Section 3.1 Getting care if you have a medical emergency</b>
---

#### What is a medical emergency and what should you do if you have one?

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

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP. You do not need to use a network doctor. You may get covered emergency medical care whenever you need it, anywhere in the United States.
- **As soon as possible, make sure that 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. The Member Service number is located on the back of this booklet. The Member Service number can also be found on the back of your member ID card.

#### What is covered if you have a medical emergency?

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

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

After the emergency is over, you are entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us

**Chapter 3. Using the plan for your medical and other covered services**

---

and make plans for additional care. Your follow-up care will be covered by our plan. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

**What if it wasn't a medical emergency?**

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

However, after the doctor has said that it was *not* an emergency, we will cover additional care *only* if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care.
- – *or* – The additional care you get is considered urgently needed services and you follow the rules for getting this urgent care (for more information about this, see Section 3.2 below).

**Section 3.2 Getting care when you have an urgent need for services****What are urgently needed services?**

An urgently needed service is a non-emergency, situation requiring immediate medical care but, given your circumstances, it is not possible or not reasonable to obtain these services from a network provider. The plan must cover urgently needed services provided out of network. Some examples of urgently needed services are i) a severe sore throat that occurs over the weekend or ii) an unforeseen flare-up of a known condition when you are temporarily outside the service area.

You should always try to obtain urgently needed services from network providers. However, if providers are temporarily unavailable or inaccessible and it is not reasonable to wait to obtain care from your network provider until they are available, we will cover urgently needed services that you get from an out-of-network provider.

BlueCare Plus Choice provides access to a 24-hour nurse hotline to all members. The nurse hotline phone number is 1-888-747-8951. BlueCare Plus Choice has urgent care centers in our provider network that can provide urgently needed services.

Our plan does not cover emergency services, urgently needed services, or any other services for care outside of the United States and its territories.



**Chapter 3. Using the plan for your medical and other covered services****Section 3.3 Getting care during a disaster**

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

Please visit the following website: [bluecareplus.bcbst.com](http://bluecareplus.bcbst.com) for information on how to obtain needed care during a disaster.

If you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost sharing. If you cannot use a network pharmacy during a disaster, you may be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5, Section 2.5 for more information.

**SECTION 4 What if you are billed directly for the full cost of your covered services?****Section 4.1 You can ask us to our share of the cost for covered services**

If you have paid more than your plan cost-sharing for covered services or if you have received a bill for the full cost of covered medical services, go to Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*) for information about what to do.

**Section 4.2 What should you do if services are not covered by our plan?**

BlueCare Plus Choice covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4 of this document. If you receive services not covered by our plan or services obtained out-of-network and were not authorized, you are responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you have used up your benefit for that type of covered service. These kinds of costs are not counted toward any plan out-of-pocket maximum. You can call Member Service to learn how much of your benefit limit you have already used.

**SECTION 5 How are your medical services covered when you are in a clinical research study?****Section 5.1 What is a clinical research study?**

A clinical research study (also called a *clinical trial*) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies

**Chapter 3. Using the plan for your medical and other covered services**

---

are approved by Medicare. Clinical research studies approved by Medicare typically request volunteers to participate in the study.

Once Medicare approves the study, and you express interest, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study *and* you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. If you tell us that you are in a qualified clinical trial, then you are only responsible for the in-network cost sharing for the services in that trial. If you paid more, for example, if you already paid the Original Medicare cost-sharing amount, we will reimburse the difference between what you paid and the in-network cost sharing. However, you will need to provide documentation to show us how much you paid. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in any Medicare-approved clinical research study, you do *not* need to tell us or to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers. Please note that this does not include benefits for which our plan is responsible that include, as a component, a clinical trial or registry to assess the benefit. These include certain benefits specified under national coverage determinations (NCDs) and investigational device trials (IDE) and may be subject to prior authorization and other plan rules.

Although you do not need to get our plan's permission to be in a clinical research study, covered for Medicare Advantage enrollees by Original Medicare, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study.*

<b>Section 5.2</b>	<b>When you participate in a clinical research study, who pays for what?</b>
--------------------	--

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

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

### Chapter 3. Using the plan for your medical and other covered services

---

After Medicare has paid its share of the cost for these services, our plan will pay the rest. Like for all covered services, you will pay nothing for the covered services you get in the clinical research study.

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

- Generally, Medicare will *not* pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.

#### Do you want to know more?

You can get more information about joining a clinical research study by visiting the Medicare website to read or download the publication “Medicare and Clinical Research Studies.” (The publication is available at: ([www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf](http://www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf).) You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

---

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

---

<b>Section 6.1</b>	<b>What is a religious non-medical health care institution?</b>
--------------------	---

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member’s religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

<b>Section 6.2</b>	<b>Receiving care from a religious non-medical health care institution</b>
--------------------	--

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

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

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

**Chapter 3. Using the plan for your medical and other covered services**

---

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

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

---

**SECTION 7 Rules for ownership of durable medical equipment**

---

<b>Section 7.1 Will you own the durable medical equipment after making a certain number of payments under our plan?</b>
---

Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of BlueCare Plus Choice, however, you will own certain types of rental DME after paying for the item for 10 months. These items must be ordered by a healthcare provider and must meet CMS medical necessity criteria. Some examples of rented items are CPAP machines, manual wheelchairs and hospital beds. However, oxygen equipment is rented for 36 months; oxygen itself is always rented. Some items such as orthotics and prosthetics, power wheelchairs and bone growth stimulators are purchased initially and not rented. These are just a few examples, not an all-inclusive list. Call Member Service (phone numbers are printed on the back cover of this booklet) to find out about the requirements you must meet and the documentation you need to provide.

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

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. The payments made while enrolled in your plan do not count.

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare do not count. You will have to make 10 payments to our plan before owning the item.

**Chapter 3. Using the plan for your medical and other covered services**

---

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You were in our plan but did not obtain ownership while in our plan. You then go back to Original Medicare. You will have to make 13 consecutive new payments to own the item once you join Original Medicare again. All previous payments (whether to our plan or to Original Medicare) do not count.

**Section 7.2 Rules for oxygen equipment, supplies, and maintenance****What oxygen benefits are you entitled to?**

If you qualify for Medicare oxygen equipment coverage BlueCare Plus Choice 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 BlueCare Plus Choice or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

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

Original Medicare requires an oxygen supplier to provide you services for five years. During the first 36 months you rent the equipment. The remaining 24 months the supplier provides the equipment and maintenance (you are still responsible for the copayment for oxygen). After five years you may choose to stay with the same company or go to another company. At this point, the five-year cycle begins again, even if you remain with the same company, requiring you to pay copayments for the first 36 months. If you join or leave our plan, the five-year cycle starts over.

# CHAPTER 4:

*Medical Benefits Chart (what is covered)*

---

## **SECTION 1 Understanding covered services**

---

This chapter provides a Medical Benefits Chart that lists your covered services as a member of BlueCare Plus Choice. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

### **Section 1.1 You pay nothing for your covered services**

Because you get assistance from TennCare (Medicaid), you pay nothing for your covered services as long as you follow the plan's rules for getting your care. (See Chapter 3 for more information about the plan's rules for getting your care.)

### **Section 1.2 What is the most you will pay for Medicare Part A and Part B covered medical services?**

**Note:** Because our members also get assistance from TennCare (Medicaid), very few members ever reach this out-of-pocket maximum. You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

Because you are enrolled in a Medicare Advantage Plan, there is a limit on the amount you have to pay out-of-pocket each year for medical services that are covered under Medicare Part A and Part B. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. For calendar year 2024 this amount is \$8,850.

The amounts you pay for covered services count toward this maximum out-of-pocket amount. The amounts you pay for your Part D prescription drugs do not count toward your maximum out-of-pocket amount. If you reach the maximum out-of-pocket amount of \$8,850, you will not have to pay 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 TennCare (Medicaid) or another third party).

---

## **SECTION 2 Use the *Medical Benefits Chart* to find out what is covered**

---

### **Section 2.1 Your medical, long-term care or home and community-based services benefits as a member of the plan**

The Medical Benefits Chart on the following pages lists the services BlueCare Plus Choice covers. Part D prescription drug coverage is in Chapter 5. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare and TennCare (Medicaid) covered services must be provided according to the coverage guidelines established by Medicare and TennCare (Medicaid).

- Your services (including medical care, services, supplies, equipment, and Part B prescription 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.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered unless it is emergent or urgent care or unless your plan or a network provider has given you a referral. This means that you will have to pay the provider in full for the services furnished.
- You have a primary care provider (a PCP) who is providing and overseeing your care.
- Some of the services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval in advance (sometimes called prior authorization) from us. **Covered services that need approval in advance are marked in the Medical Benefits Chart by an asterisk.**

Other important things to know about our coverage:

- You are covered by both Medicare and TennCare (Medicaid). Medicare covers health care and prescription drugs. TennCare (Medicaid) covers your cost sharing for Medicare services, including deductible, copay and coinsurance. TennCare (Medicaid) also covers services Medicare does not cover, like long-term care and home and community-based services.
- Like all Medicare health plans, we cover everything that Original Medicare covers. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2024* handbook. View it online at [www.medicare.gov](http://www.medicare.gov) or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you.
- If Medicare adds coverage for any new services during 2024, either Medicare or our plan will cover those services.
- As a member of our plan, your Medicare and TennCare (Medicaid) covered services are provided under this plan.
- **If you are within our plan's 6-month period of deemed continued eligibility, we will continue to provide all Medicare Advantage plan-covered Medicare benefits. However, during this period, BlueCare Plus Choice will not continue to cover TennCare (Medicaid) benefits that are included under TennCare (Medicaid), nor will we pay the Medicare cost sharing for which the state would otherwise be liable had you not lost your TennCare (Medicaid) eligibility.**


You do not pay anything for the services listed in the Medical Benefits Chart, as long as you meet the coverage requirements described above.










You will see this apple next to the preventive services in the benefits chart.

## Medical Benefits Chart

Services that are covered for you	What you must pay when you get these services
<p> <b>Abdominal aortic aneurysm screening</b></p> <p>A one-time screening ultrasound for people at risk. The 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.</p>	<p><b>In-Network:</b>  <b>Medicare-covered</b></p> <p>There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.</p>
<p><b>Acupuncture for chronic low back pain*</b></p> <p>Covered services include:</p> <p>Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances:</p> <p>For the purpose of this benefit, chronic low back pain is defined as:</p> <ul style="list-style-type: none"> <li>• Lasting 12 weeks or longer;</li> <li>• nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, disease, etc.);</li> <li>• not associated with surgery; and</li> <li>• not associated with pregnancy.</li> </ul> <p>An additional eight sessions will be covered for those 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"> <li>• a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the</li> </ul>	<p><b>Prior authorization is required.</b></p> <p><b>In-Network:</b>  <b>Medicare-covered</b></p> <p>There is no coinsurance, copayment or deductible for covered acupuncture visits.</p>

Services that are covered for you	What you must pay when you get these services
<p>Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and,</p> <ul style="list-style-type: none"> <li>• 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.</li> </ul> <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><b>Ambulance services*</b></p> <p>Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person’s health or if authorized by the plan. If the covered ambulance services are not 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> <p><b>Note:</b> All prior authorized non-emergency transportation/ ambulance transport should be scheduled through Verida. You may contact Verida by calling 1-855-681-5032. Services may include the following: transport from home to your doctor’s office for routine visits, transport from home to a Medicare-certified dialysis facility for prescribed hemodialysis, or transport beyond the closest appropriate facility when transferring between facilities or levels of care.</p>	<p>There is no coinsurance, copayment or deductible for Medicare-covered ambulance services.</p>
<p> <b>Annual wellness visit</b></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>	<p><b>In-Network:</b>  <b>Medicare-covered</b></p> <p>There is no coinsurance, copayment, or deductible for the annual wellness visit.</p>

Services that are covered for you	What you must pay when you get these services
<p><b>Note:</b> 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> <b>Bone mass measurement</b></p> <p>For qualified individuals (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><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.</p>
<p> <b>Breast cancer screening (mammograms)</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• One baseline mammogram between the ages of 35 and 39</li> <li>• One screening mammogram every 12 months for women age 40 and older</li> <li>• Clinical breast exams once every 24 months</li> </ul>	<p><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment, or deductible for covered screening mammograms.</p>
<p><b>Cardiac rehabilitation services</b></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. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. These services are limited to 2 one-hour sessions per day for 36 sessions per service per year.</p>	<p><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment, or deductible for Medicare-covered cardiac rehabilitation services.</p>
<p> <b>Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)</b></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),</p>	<p><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment, or deductible for the intensive behavioral therapy</p>

Services that are covered for you	What you must pay when you get these services
<p>check your blood pressure, and give you tips to make sure you're eating healthy.</p>	<p>cardiovascular disease preventive benefit.</p>
<p> <b>Cardiovascular disease testing</b></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><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.</p>
<p> <b>Cervical and vaginal cancer screening</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• For all women: Pap tests and pelvic exams are covered once every 24 months</li> <li>• If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months</li> </ul>	<p><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.</p>
<p><b>Chiropractic services</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Manual manipulation of the spine to correct subluxation</li> <li>• Additionally, a limit of 20 supplemental routine visits per year for the relief of pain and neuromusculoskeletal disorders.</li> </ul>	<p><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment or deductible for covered chiropractic services.</p>

**Services that are covered for you**

**What you must pay when you get these services**

 **Colorectal cancer screening**

The following screening tests are covered:

- 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 are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema.
- Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema.
- 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 years of age and not meeting high risk criteria. Once every 3 years.
- Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy.
- Barium Enema as an alternative to flexible sigmoidoscopy for patient not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy.

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.

**In-Network:**

**Medicare-covered**

There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam, excluding barium enemas, for which coinsurance applies.



 **Depression screening**

We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.

**In-Network:**

**Medicare-covered**

There is no coinsurance, copayment, or deductible for an

Services that are covered for you	What you must pay when you get these services
	annual depression screening visit.
<p> <b>Diabetes screening</b></p> <p>We cover this screening (includes fasting glucose tests) if you have any of the following 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>Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.</p>	<p><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.</p>
<p> <b>Diabetes self-management training, diabetic services and supplies</b></p> <p>For all people who have diabetes (insulin and non-insulin users). Covered services include:</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• 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 two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.</li> <li>• Diabetes self-management training is covered under certain conditions.</li> <li>• The following diabetic testing supplies are limited to: <ul style="list-style-type: none"> <li>○ Calibration Solution: 1 per 365 days</li> <li>○ Glucometer: 1 per 365 days</li> <li>○ Lancets: 600 per 90 days</li> <li>○ Lancet Device: 1 per 365 days</li> <li>○ Test Strips: 300 per 90 days (100 per month)</li> </ul> </li> <li>• Talking monitors are covered for members with severe visual impairment with prior authorization. Diabetic test</li> </ul>	<p><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment or deductible for Medicare-covered diabetes self-management training, diabetic services and supplies.</p> <p>(Note: This does not include continuous glucose monitor coverage which is described under Durable medical equipment (DME) and related supplies.)</p> <p>Diabetic testing supplies covered under Part B: Ascencia’s Contour and Johnson &amp; Johnson’s Lifescan OneTouch products are both preferred brands. All other products are covered only with a prior authorization. Approved exceptions will be treated as in-network benefits.</p>

Services that are covered for you	What you must pay when you get these services
<p>strips are only available through the pharmacy (rather than a DME supplier).</p>	
<p><b>Durable medical equipment (DME) and related supplies*</b></p> <p>(For a definition of durable medical equipment, see Chapter 12 as well as Chapter 3, Section 7 of this document.)</p> <p>Covered items include, but are not 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>Continuous glucose monitors are covered under Part B with a prior authorization. Continuous glucose monitoring systems supplied only through the pharmacy and not a DME provider include Dexcom G6, G7 and Abbott Freestyle Libre 14-day and Libre 2. DME such as insulin pumps with integrated adjunctive CGMs require authorization.</p> <p>We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you.</p> <ul style="list-style-type: none"> <li>• Incontinence Supplies are covered by TennCare (Medicaid)</li> </ul>	<p><b>Prior authorization is required for all rentals or if the purchase price is greater than \$500.</b></p> <p><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment or deductible for Medicare-covered durable medical equipment and related supplies.</p> <p><b>TennCare (Medicaid)-covered</b></p> <p>TennCare will consider benefits for any service not covered by Medicare or after Medicare coverage has been exhausted.</p> <p>Your cost sharing for Medicare oxygen equipment coverage is \$0, every month.</p> <p>Your cost sharing will not change after being enrolled for 36 months.</p> <p>If prior to enrolling in BlueCare Plus Choice you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in BlueCare Plus Choice is \$0.</p>
<p><b>Emergency care</b></p> <p>Emergency care refers to services that are:</p> <ul style="list-style-type: none"> <li>• Furnished by a provider qualified to furnish emergency services, and</li> <li>• Needed to evaluate or stabilize an emergency medical condition.</li> </ul>	<p><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment or deductible for</p>



Services that are covered for you	What you must pay when you get these services
<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 are 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 is quickly getting worse.</p> <p>Self-administered drugs in an emergency room setting are not covered under this plan.</p> <p>Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.</p>	<p>Medicare-covered emergency care.</p> <p>If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost sharing you would pay at a network hospital.</p>
<p><b>Flex Card</b></p> <p>This combined allowance is loaded on an easy-to-use flex card. The card comes prepaid by the plan, and you can use it to pay for extra vision and hearing services not covered by Medicare.</p> <p>The Flex Card is only for your personal use, cannot be sold or transferred, and has no cash value.</p> <p>You will receive an easy-to-use pre-loaded debit card. Your allowances will be reloaded at the start of each benefit period. Depending on the benefit, that'll be at the start of the month or the start of the plan year. Remember: Unused funds don't roll over. They expire at the end of each benefit period. You can use it to pay for services not covered by Medicare.</p> <p>Use one card for the following supplemental benefits:</p> <ul style="list-style-type: none"> <li>• Over-The-Counter (OTC) items</li> <li>• Healthy Food</li> <li>• Housing Utilities</li> <li>• Hearing Services -(See the "Hearing" section in the chapter 4 Medical Benefit Chart for additional details).</li> </ul>	<p><b>In-Network: Plan Covered</b></p> <p>There is no coinsurance, copayment or deductible for covered OTC, Healthy Food, Housing Utilities, Hearing and Vision.</p> <p>The maximum combined coverage for covered OTC and Healthy Food <b>\$280</b> every month. Any unused amount will expire at the end of each month.</p> <p>The maximum coverage amount for covered Housing Utilities is <b>\$100</b> every month. Any unused amount will expire at the end of each month.</p> <p>The maximum combined coverage for covered vision and hearing services is <b>\$3300</b> annually. Any unused amount will expire at the end of the year.</p>

**Services that are covered for you**

**What you must pay when you get these services**

- Vision Services - (See the "Vision" section in the **chapter 4 Medical Benefit Chart for additional details**).

If you need help activating your card, need help placing an order, check your balance or have questions about your Flex Card you can call Member Service at 1-800-384-2038, TTY 711, Monday to Friday, 8 a.m. to 8 p.m. ET or visit

[bcptncard.com](http://bcptncard.com).

**OTC, Healthy Food and Housing Utilities**

OTC items, Healthy Food and Housing utilities is a monthly allowance to give you more flexibility.

**OTC items**

- Your coverage includes non-prescription OTC health and wellness items like vitamins, sunscreen, pain relievers, cough and cold medicine, and bandages.
- You can shop at participating retail stores, place an order for OTC products online, over the phone, or by mail through the OTC catalog that will be sent to you. Your items will ship directly to you.

• **Healthy Food**

- Your coverage may include healthy food like fruits, vegetables, and select canned goods.
- You can shop at participating retail stores, place an order online, over the phone, or by mail through the OTC catalog that will be sent to you. Your food items will ship directly to you.


• **Housing Utilities**

- Your coverage provides an allowance to help with housing utilities, such as your electric, water, or natural gas bill. Simply visit or call your utility provider and use your Flex Card to pay your bill.



The monthly allowance cannot be used to purchase firearms, ammunition, weaponry, tobacco or alcohol.

If the services you receive exceed the available funds on your Flex Card, you'll be responsible for the additional charges. Value of the Flex Card is preloaded with certain amounts, according to benefits. Value of card may be zero. Card may not be used at all merchants or providers.

Merchants and providers must accept major credit cards.


<b>Services that are covered for you</b>	<b>What you must pay when you get these services</b>
<p>Purchases may be restricted to certain types of items and services.</p>	
<p> <b>Health and wellness education programs</b></p> <p>Our health and wellness programs are available to all members at no additional cost. They are designed to assist members with improving healthy behaviors.</p> <p><b>Health Education:</b></p> <p><i>Wellness Services:</i></p> <p>Interactive wellness services include general preventive education and reminders for certain preventive screening tests appropriate for age, sex, and claims history. This is through web-based coaching and telephonic based coaching provided by population health staff.</p> <p><b>Fitness Program:</b></p> <p><i>The Silver&amp;Fit® Healthy Aging and Exercise Program</i></p> <p>As a member, you have the following choices available at no cost to you:</p> <ul style="list-style-type: none"><li>• Fitness center membership: To enroll you can:<ul style="list-style-type: none"><li>○ Visit a standard Silver&amp;Fit participating fitness center near you.</li><li>○ Visit <a href="https://www.silverandfit.com">SilverandFit.com</a>.</li><li>○ Or, you can call 1-888-797-8091, TTY 711 (Monday to Friday 8 a.m. to 9 p.m. ET).</li></ul></li><li>• A customized program for your exercise of choice, including instructions on how to get started and suggested online workout videos</li><li>• On-demand videos through the website digital library</li><li>• Healthy Aging resources tailored to your interests and healthy habit goals</li></ul> <p><b>Enhanced Disease Management</b></p> <p>If you have CHF, COPD, diabetes, hypertension, hypercholesterolemia, or Stage 4 or 5 chronic kidney disease, you may have access to enhanced disease management. In this program, members are assessed and coached by certified case management nurses in compliance</p>	<p><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment or deductible for health and wellness education programs.</p>

<b>Services that are covered for you</b>	<b>What you must pay when you get these services</b>
<p>with their doctor’s plan of care and educated in ways to control and manage their chronic diseases. Members are monitored relative to prescription medication compliance, ER and inpatient utilization and PCP/Specialist visits. This information is shared with the treating provider as it is necessary to help coordinate services.</p> <p><b>Remote Access Technology:</b></p> <p><i>Nurse Hotline:</i> You have access to a 24-hour telephonic nurse hotline, where an R.N. level nurse can assist with general health information, referral guidance to a local clinician or triage some conditions for immediate evaluation versus next day follow-up with your PCP or specialist.</p> <p><i>Tele-Monitoring:</i> 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. Frequency of monitoring is based on condition severity. Abnormal results are appropriately shared with the treating physician, while normal results are shared monthly. This monitoring does not include blood glucose monitoring devices covered by Original Medicare.</p>	
<p><b>Hearing services - Medicare covered</b></p> <p>Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.</p> <p><b>Hearing services - Supplemental</b></p> <p>1 routine hearing exam per year (exam must be obtained from a TruHearing® provider) Up to two TruHearing-branded hearing aids every year (one per ear, per year).</p> <p>You must see a TruHearing provider to use this benefit. Call <b>1-833-414-8998</b>, TTY <b>711</b> (Monday to Friday 8 am to 8 pm ET) to schedule an appointment.</p> <p>Hearing aid purchase includes:</p>	<p><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment or deductible for each Medicare-covered hearing exam.</p> <p><b>Plan-covered</b></p> <p><b>\$3300</b> combined yearly allowance. <b>(See the "FlexCard" section in the chapter 4 Medical Benefit Chart for additional details).</b> The annual allowance is a coverage limit</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> <li>• First year of follow-up provider visits</li> <li>• 60-day trial period</li> <li>• 3-year extended warranty</li> <li>• 80 batteries per aid for non-rechargeable models</li> </ul> <p>Benefit does not include or cover any of the following:</p> <ul style="list-style-type: none"> <li>• Additional fee for optional hearing aid rechargeability</li> <li>• Ear molds</li> <li>• Hearing aid accessories</li> <li>• Additional provider visits</li> <li>• Additional batteries; batteries when a rechargeable hearing aid is purchased</li> <li>• Hearing aids that are not TruHearing-branded hearing aids</li> <li>• Costs associated with loss and damage warranty claims</li> <li>• Additional fee for optional hearing aid rechargeability</li> </ul> <p>Costs associated with excluded items are the responsibility of the member and are not covered by the plan.</p>	
<p> <b>Hepatitis C screening</b></p> <p>We cover a Hepatitis C screening test if your Primary Care Provider (PCP) orders it and you meet one or more of these conditions; a) at high risk due to illicit injection drug use, b) had a blood transfusion prior to 1992, or c) born between 1945 - 1965. If you are at high risk, we also cover annual screening. We cover a one-time Hepatitis C screening test. We also cover repeat screening annually for certain people at high risk.</p>	<p><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment or deductible for each Medicare-covered Hepatitis C screening.</p>
<p> <b>HIV screening</b></p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</p>	<p><b>In-Network:</b></p> <p><b>Medicare-covered</b></p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> <li>• One screening test every 12 months</li> </ul> <p>For women who are pregnant, we cover:</p> <ul style="list-style-type: none"> <li>• Up to three screening exams during a pregnancy</li> </ul>	<p>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.</p>
<p><b>Home health agency care*</b></p> <p>Prior to receiving 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 are not limited to:</p> <ul style="list-style-type: none"> <li>• Part-time or intermittent skilled nursing and home health aide services (To be covered under the home 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)</li> <li>• Physical therapy, occupational therapy, and speech therapy</li> <li>• Medical and social services</li> <li>• Medical equipment and supplies</li> <li>• Home health services are limited to 8 hours per day and 27 hours per week of nursing care, with a limit of 30 hours per week for enrollees who qualify for Level 2 Nursing Facility care.</li> <li>• Home health aide and home health nursing services combined are limited to 8 hours per day and 35 hours per week, with a limit of 40 hours per week for enrollees who qualify for Level 2 Nursing Facility Care.             <ul style="list-style-type: none"> <li>○ Private Duty Nursing is covered under TennCare (Medicaid) for people who are ventilator dependent for at least 12 hours each day or have a functioning tracheotomy along with the need of certain nursing care.</li> </ul> </li> </ul>	<p><b>Prior authorization is required.</b></p> <p><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment or deductible for Medicare-covered home health agency care.</p> <p><b>TennCare (Medicaid)-covered</b></p> <p>TennCare will consider benefits for any service not covered by Medicare or after Medicare coverage has been exhausted.</p>
<p><b>Home infusion therapy</b></p> <p>Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals or</p>	<p><b>Prior authorization may be required.</b></p> <p><b>In-Network:</b></p> <p><b>Medicare-covered</b></p>

<b>Services that are covered for you</b>	<b>What you must pay when you get these services</b>
<p>immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters).</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"><li>• Professional services, including nursing services, furnished in accordance with the plan of care</li><li>• Patient training and education not otherwise covered under the durable medical equipment benefit</li><li>• Remote monitoring</li><li>• Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier</li></ul>	<p>There is no coinsurance, copayment or deductible for home infusion therapy.</p>
<p><b>Hospice care</b></p> <p>You are 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 may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>Covered services include:</p> <ul style="list-style-type: none"><li>• Drugs for symptom control and pain relief</li><li>• Short-term respite care</li><li>• Home care</li></ul> <p><u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis:</u> Original Medicare (rather than our plan) will pay your hospice provider for your hospice services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost sharing.</p> <p><u>For services that are covered by Medicare Part A or B and are not related to your terminal prognosis:</u> If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on</p>	<p><b>Medicare-covered</b></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 BlueCare Plus Choice.</p> <p>You must get care from a Medicare-certified hospice provider. The Plan will pay for a consultative visit before you select hospice.</p> <p>There is no coinsurance, copayment or deductible for this 1 consultative visit.</p>

<b>Services that are covered for you</b>	<b>What you must pay when you get these services</b>
<p>whether you use a provider in our plan’s network and follow plan rules (such as if there is a requirement to obtain prior authorization).</p> <ul style="list-style-type: none"><li>• If you obtain the covered services from a network provider and follow plan rules for obtaining service, you only pay the plan cost-sharing amount for in-network services</li><li>• If you obtain the covered services from an out-of-network provider, you pay the cost sharing under Fee-for-Service Medicare (Original Medicare)</li></ul> <p><u>For services that are covered by BlueCare Plus Choice but are not covered by Medicare Part A or B:</u> BlueCare Plus Choice will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost sharing amount for these services.</p> <p><u>For drugs that may be covered by the plan’s Part D benefit:</u> If these drugs are unrelated to your terminal hospice condition you pay cost sharing. If they are related to your terminal hospice condition then you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.3 (<i>What if you’re in Medicare-certified hospice</i>).</p> <p><b>Note:</b> If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.</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> <b>Immunizations</b></p> <p>Covered Medicare Part B services include:</p> <ul style="list-style-type: none"><li>• Pneumonia vaccines are limited to two (2) per lifetime; the initial immunization and one booster. There must be at least 11 months between the initial and booster vaccinations.</li><li>• Flu shots, once each flu season in the fall and winter with additional flu shots if medically necessary</li></ul>	<p><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines.</p>






Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> <li>• Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B</li> <li>• COVID-19 vaccine</li> <li>• Other vaccines if you are at risk and they meet Medicare Part B coverage rules</li> </ul> <p>We also cover some vaccines under our Part D prescription drug benefit.</p> <ul style="list-style-type: none"> <li>• Tdap (Tetanus, Diphtheria and Pertussis (Whooping Cough))</li> <li>• Shingles</li> </ul>	<p>Please see Chapter 6, Section 9.1, for more information on Part D covered vaccines.</p>
<p><b>Inpatient hospital care*</b></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 are formally admitted to the hospital with a doctor’s order. The day before you are discharged is your last inpatient day.</p> <p>We cover 90 days of care each benefit period. Our plan also covers 60 lifetime reserve days. These are days available to you once you use your 90 inpatient hospital days. Additional coverage may be available under your TennCare (Medicaid) benefits.</p> <p>Covered services include but are not limited to:</p> <ul style="list-style-type: none"> <li>• Semi-private room (or a private room if medically necessary)</li> <li>• Meals including special diets</li> <li>• Regular nursing services</li> <li>• Costs of special care units (such as intensive care or coronary care units)</li> <li>• Drugs and medications</li> <li>• Lab tests</li> <li>• X-rays and other radiology services</li> <li>• Necessary surgical and medical supplies</li> <li>• Use of appliances, such as wheelchairs</li> <li>• Operating and recovery room costs</li> <li>• Physical, occupational, and speech language therapy</li> <li>• Inpatient substance abuse services</li> <li>• Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow,</li> </ul>	<p><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment or deductible for Medicare-covered inpatient hospital care.</p> <p>A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility (SNF). The benefit period ends when you haven’t been inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital or SNF after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.</p> <p>If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital.</p> <p><b>TennCare (Medicaid)-covered</b></p> <p>TennCare (Medicaid) will consider benefits for any service not covered by Medicare or after</p>

<b>Services that are covered for you</b>	<b>What you must pay when you get these services</b>
<p>stem cell, and intestinal/ multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are 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 BlueCare Plus Choice provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion.</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• Physician services</li> <li>• Self-administered drugs in a hospital setting are not covered under this plan.</li> </ul> <p><b>Note:</b> 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 outpatient. If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called <i>Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!</i> This fact sheet is available on the Web at <a href="https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf">https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf</a> or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p> <p>Self-administered drugs in a hospital setting are not covered under this plan.</p>	<p>Medicare coverage has been exhausted.</p>
<p><b>Inpatient services in a psychiatric hospital</b></p> <p>Covered services include mental health care services that require a hospital stay. There is a 190-day lifetime limit for</p>	<p><b>Prior authorization is required.</b></p>

<b>Services that are covered for you</b>	<b>What you must pay when you get these services</b>
<p>inpatient services in a psychiatric hospital. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital.</p>	<p><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment or deductible for Medicare-covered inpatient mental health care.</p> <p><b>TennCare (Medicaid)-covered</b></p> <p>TennCare (Medicaid) will consider benefits for any service not covered by Medicare or after Medicare coverage has been exhausted.</p>
<p><b>Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay*</b></p> <p>If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• Physician services</li> <li>• Diagnostic tests (like lab tests)</li> <li>• X-ray, radium, and isotope therapy including technician materials and services</li> <li>• Surgical dressings</li> <li>• Splints, casts and other devices used to reduce fractures and dislocations</li> <li>• 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</li> <li>• 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</li> <li>• Physical therapy, speech therapy, and occupational therapy</li> </ul>	<p><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment or deductible for each covered service received in a hospital or SNF during a non-covered inpatient stay.</p> <p><b>TennCare (Medicaid)-covered</b></p> <p>TennCare will consider benefits for any service not covered by Medicare or after Medicare coverage has been exhausted.</p>

<b>Services that are covered for you</b>	<b>What you must pay when you get these services</b>
<p><b>Meals</b> You will receive 56 meals following discharge from an acute inpatient hospital or skilled nursing facility stay.</p> <p><b>TennCare-Covered</b> Choices Groups 2 &amp; 3 - Home-delivered meals (1 meal per day).</p>	<p><b>Notification is required.</b></p> <p><b>In-Network:</b></p> <p><b>Plan Covered</b> There is no coinsurance, copayment or deductible for covered meals.</p> <p><b>TennCare-Covered</b> Offered for Choices Groups 2 &amp; 3 if qualify.</p>

Services that are covered for you	What you must pay when you get these services
<p> <b>Medical nutrition therapy</b></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 your first year that you receive 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 receive more hours of treatment with a physician’s order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.</p>	<p><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.</p>
<p> <b>Medicare Diabetes Prevention Program (MDPP)</b></p> <p>MDPP services will be covered for eligible Medicare beneficiaries 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><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment, or deductible for the MDPP benefit.</p>
<p><b>Medicare Part B prescription drugs*</b></p> <p>These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:</p> <ul style="list-style-type: none"> <li>• Drugs that usually aren’t self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services</li> <li>• Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump)</li> <li>• Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan</li> <li>• Clotting factors you give yourself by injection if you have hemophilia</li> <li>• Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant</li> </ul>	<p><b>Prior authorization or step therapy through Part B or Part D medications may be required.</b></p> <p><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment or deductible for Medicare Part B-covered drugs (including insulin and chemotherapy drugs).</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> <li>• Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug</li> <li>• Antigens</li> <li>• Certain oral anti-cancer drugs and anti-nausea drugs</li> <li>• Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)</li> <li>• Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases</li> <li>• Gene therapy, such as chimeric antigen receptor (CAR) T-cell therapy</li> <li>• Self-administered drugs in a hospital setting are not covered under this plan.</li> </ul> <p>The following link will take you to a list of Part B Drugs that may be subject to Step Therapy:  <a href="http://bcbstmedicare.com/ST">bcbstmedicare.com/ST</a>.</p> <p>We also cover some vaccines under our Part B and Part D prescription drug benefit.</p> <p>Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.</p>	
<p> <b>Obesity screening and therapy to promote sustained weight loss</b></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. Talk to your primary care doctor or practitioner to find out more.</p>	<p><b>In-Network: Medicare-covered</b></p> <p>There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.</p>
<p><b>Opioid treatment program services</b></p> <p>Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an</p>	<p><b>In-Network: Medicare-covered</b></p>

Services that are covered for you	What you must pay when you get these services
<p>Opioid Treatment Program (OTP) which includes the following services:</p> <ul style="list-style-type: none"> <li>• U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications.</li> <li>• Dispensing and administration of MAT medications (if applicable)</li> <li>• Substance use counseling</li> <li>• Individual and group therapy</li> <li>• Toxicology testing</li> <li>• Intake activities</li> <li>• Periodic assessments</li> </ul>	<p>There is no coinsurance, copayment or deductible for Medicare-covered opioid treatment program services.</p> <p><b>TennCare (Medicaid)-covered</b></p> <p>TennCare (Medicaid) will consider benefits for any service not covered by Medicare or after Medicare coverage has been exhausted.</p>
<p><b>Outpatient diagnostic tests and therapeutic services and supplies*</b></p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• X-rays</li> <li>• Radiation (radium and isotope) therapy including technician materials and supplies</li> <li>• Surgical supplies, such as dressings</li> <li>• Splints, casts and other devices used to reduce fractures and dislocations</li> <li>• Laboratory tests</li> <li>• 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.</li> <li>• Other outpatient diagnostic tests</li> </ul>	<p><b>Prior authorization may be required.</b></p> <p><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment or deductible for Medicare-covered outpatient diagnostic tests or therapeutic services and supplies.</p> <p><b>TennCare (Medicaid)-covered</b></p> <p>TennCare (Medicaid) will consider benefits for any service not covered by Medicare or after Medicare coverage has been exhausted.</p>
<p><b>Outpatient hospital observation</b></p> <p>Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged.</p> <p>For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital</p>	<p><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment or deductible for Medicare-covered outpatient hospital observation.</p> <p><b>TennCare (Medicaid)-covered</b></p>

Services that are covered for you	What you must pay when you get these services
<p>staff bylaws to admit patients to the hospital or order outpatient tests.</p> <p>Self-administered drugs in a hospital setting are not covered under this plan.</p> <p><b>Note:</b> Unless the provider has written an order to admit you as an inpatient to the hospital, you are 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 are not sure if you are an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called <i>Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!</i> This fact sheet is available on the Web at <a href="https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf">https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf</a> or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	<p>TennCare (Medicaid) will consider benefits for any service not covered by Medicare or after Medicare coverage has been exhausted.</p>
<p><b>Outpatient hospital services*</b></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>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery</li> <li>• Laboratory and diagnostic tests billed by the hospital</li> <li>• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it</li> <li>• X-rays and other radiology services billed by the hospital</li> <li>• Medical supplies such as splints and casts</li> <li>• Certain drugs and biologicals that you can't give yourself</li> <li>• Certain screenings and preventive services</li> <li>• Self-administered drugs in a hospital setting are not covered under this plan.</li> </ul> <p><b>Note:</b> Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost sharing amounts for outpatient hospital services.</p>	<p><b>Prior authorization may be required.</b></p> <p><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment or deductible for Medicare-covered outpatient hospital services.</p>




Services that are covered for you	What you must pay when you get these services
<p>Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called <i>Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!</i> This fact sheet is available on the Web at <a href="https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf">https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf</a> or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	
<p><b>Outpatient mental health care</b></p> <p>Covered services include:                      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><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment or deductible for Medicare-covered outpatient mental health care.</p> <p><b>TennCare (Medicaid)-covered</b></p> <p>TennCare (Medicaid) will consider benefits for any service not covered by Medicare or after Medicare coverage has been exhausted.</p>
<p><b>Outpatient rehabilitation services*</b></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 Rehabilitation Facilities (CORFs).</p>	<p><b>Prior authorization is required.</b></p> <p><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment or deductible for Medicare-covered outpatient rehabilitation services.</p> <p><b>TennCare (Medicaid)-covered</b></p> <p>TennCare (Medicaid) will consider benefits for any service not covered by Medicare or after</p>




Services that are covered for you	What you must pay when you get these services
	Medicare coverage has been exhausted.
<p><b>Outpatient substance abuse services</b></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><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment or deductible for Medicare-covered outpatient substance abuse services.</p> <p><b>TennCare (Medicaid)-covered</b></p> <p>TennCare (Medicaid) will consider benefits for any service not covered by Medicare or after Medicare coverage has been exhausted.</p>
<p><b>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers*</b></p> <p><b>Note:</b> If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are 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><b>Prior authorization may be required.</b></p> <p><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment or deductible for Medicare-covered outpatient surgeries.</p> <p><b>TennCare (Medicaid) -covered</b></p> <p>TennCare (Medicaid) will consider benefits for any service not covered by Medicare or after Medicare coverage has been exhausted.</p>
<p><b>Partial hospitalization services and Intensive outpatient services*</b></p> <p>Partial hospitalization is a structured program of active psychiatric treatment provided as a hospital outpatient</p>	<p><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment or deductible for</p>

Services that are covered for you	What you must pay when you get these services
<p>service or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.</p> <p>Intensive outpatient service 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 is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization.</p>	<p>Medicare-covered partial hospitalization program services.</p> <p><b>TennCare (Medicaid)-covered</b></p> <p>TennCare (Medicaid) will consider benefits for any service not covered by Medicare or after Medicare coverage has been exhausted.</p>
<p><b>Physician/Practitioner services, including doctor's office visits</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location</li> <li>• Consultation, diagnosis, and treatment by a specialist</li> <li>• Basic hearing and balance exams performed by your PCP <i>or</i> specialist, if your doctor orders it to see if you need medical treatment</li> <li>• Certain telehealth services, including: specific urgently needed medical services and individual sessions for specific mental health specialty services.             <ul style="list-style-type: none"> <li>○ You have the option of getting these services either through an in-person visit or by telehealth. If you choose to receive one of these services by telehealth, then you must use a network provider that currently offers the service by telehealth.</li> </ul> </li> <li>• 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</li> <li>• Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location</li> <li>• Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location</li> <li>• Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if:</li> </ul>	<p><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment or deductible for each Medicare-covered visit with a primary care provider, specialist or other health care professional.</p> <p><b>TennCare (Medicaid)-covered</b></p> <p>TennCare (Medicaid) will consider benefits for any service not covered by Medicare or after Medicare coverage has been exhausted.</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"><li>○ You have an in-person visit within 6 months prior to your first telehealth visit</li><li>○ You have an in-person visit every 12 months while receiving these telehealth services</li><li>○ Exceptions can be made to the above for certain circumstances</li><li>● Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers</li><li>● 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 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.</li><li>● 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.</li><li>● Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes <b>if</b>:<ul style="list-style-type: none"><li>○ You're not a new patient <b>and</b></li><li>○ The check-in isn't related to an office visit in the past 7 days <b>and</b></li><li>○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment</li></ul></li><li>● Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours <b>if</b>:<ul style="list-style-type: none"><li>○ You're not a new patient <b>and</b></li><li>○ The evaluation isn't related to an office visit in the past 7 days <b>and</b></li><li>○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment</li></ul></li><li>● Consultation your doctor has with other doctors by phone, internet, or electronic health record <b>if</b> you're not a new patient</li><li>● Second opinion by another network provider prior to surgery</li></ul>	

<b>Services that are covered for you</b>	<b>What you must pay when you get these services</b>
<ul style="list-style-type: none"><li>• Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)</li></ul>	


Services that are covered for you	What you must pay when you get these services
<p><b>Podiatry services</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs)</li> <li>• Routine foot care for members with certain medical conditions affecting the lower limbs</li> <li>• Additionally, a limit of 6 supplemental routine visits per year for treatment which is generally considered preventive, i.e., cutting or removal of corns, warts, calluses or nails.</li> </ul>	<p><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment or deductible for each Medicare-covered podiatry visit.</p>
<p> <b>Prostate cancer screening exams</b></p> <p>For men age 50 and older, covered services include the following - once every 12 months:</p> <ul style="list-style-type: none"> <li>• Digital rectal exam</li> <li>• Prostate Specific Antigen (PSA) test</li> </ul>	<p><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment, or deductible for an annual digital rectal exam or PSA test.</p>
<p><b>Prosthetic devices and related supplies*</b></p> <p>Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see <b>Vision Care</b> later in this section for more detail.</p>	<p><b>Prior authorization is required if the purchase price is greater than \$200.</b></p> <p><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment or deductible for Medicare-covered prosthetic devices and related supplies.</p>
<p><b>Pulmonary rehabilitation services</b></p> <p>Comprehensive programs of pulmonary rehabilitation are covered for members who have 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><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment or deductible for Medicare-covered pulmonary rehabilitation services.</p>

Services that are covered for you	What you must pay when you get these services
<p> <b>Screening and counseling to reduce alcohol misuse</b></p> <p>We cover one alcohol misuse screening for adults with Medicare (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><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.</p>
<p> <b>Screening for lung cancer with low dose computed tomography (LDCT)</b></p> <p>For qualified individuals, a LDCT is covered every 12 months.</p> <p><b>Eligible members are:</b> people aged 50 – 77 years 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 receive a written 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 member must receive a written 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 subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.</p>	<p><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision-making visit or for the LDCT.</p>
<p> <b>Screening for sexually transmitted infections (STIs) and counseling to prevent STIs</b></p> <p>We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests</p>	<p><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening for</p>


Services that are covered for you	What you must pay when you get these services
<p>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 two 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 will 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>STIs and counseling for STIs preventive benefit.</p>
<p><b>Services to treat kidney disease</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime.</li> <li>• 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)</li> <li>• Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care)</li> <li>• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)</li> <li>• Home dialysis equipment and supplies</li> <li>• 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)</li> </ul> <p>Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, <b>Medicare Part B prescription drugs</b>.</p>	<p><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment or deductible for covered services to treat kidney disease.</p> <p><b>TennCare (Medicaid)-covered</b></p> <p>TennCare (Medicaid) will consider benefits for any service not covered by Medicare or after Medicare coverage has been exhausted.</p>
<p><b>Skilled nursing facility (SNF) care*</b></p> <p>(For a definition of skilled nursing facility care, see Chapter 12 of this document. Skilled nursing facilities are sometimes called SNFs.)</p>	<p><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>For Medicare-covered SNF care, there is no coinsurance, copayment or deductible for</p>




Services that are covered for you	What you must pay when you get these services
<p>You are covered for 100 days of medically necessary care per benefit period when authorized by BlueCare Plus Choice. Covered services include but are not limited to:</p> <ul style="list-style-type: none"> <li>• Semiprivate room (or a private room if medically necessary)</li> <li>• Meals, including special diets</li> <li>• Skilled nursing services</li> <li>• Physical therapy, occupational therapy, and speech therapy</li> <li>• Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.)</li> <li>• 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.</li> <li>• Medical and surgical supplies ordinarily provided by SNFs</li> <li>• Laboratory tests ordinarily provided by SNFs</li> <li>• X-rays and other radiology services ordinarily provided by SNFs</li> <li>• Use of appliances such as wheelchairs ordinarily provided by SNFs</li> <li>• Physician/Practitioner services</li> </ul> <p>Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to get your care from 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"> <li>• 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)</li> <li>• A SNF where your spouse or domestic partner is living at the time you leave the hospital</li> </ul>	<p>days 1-100 for each benefit period.</p> <p>A benefit period begins on the first day you go to a Medicare-participating inpatient hospital or SNF. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital or SNF after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.</p> <p><b>TennCare (Medicaid)-covered</b></p> <p>TennCare (Medicaid) will consider benefits for any service not covered by Medicare or after Medicare coverage has been exhausted.</p>

Services that are covered for you	What you must pay when you get these services
<p> <b>Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)</b></p> <p><u>If you use tobacco, but do not have signs or symptoms of tobacco-related disease:</u> We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits.</p> <p><u>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</u> We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits.</p>	<p><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.</p>
<p><b>Supervised Exercise Therapy (SET)</b></p> <p>SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for SET from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must:</p> <ul style="list-style-type: none"> <li>• Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication</li> <li>• Be conducted in a hospital outpatient setting or a physician’s office</li> <li>• Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD</li> <li>• 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</li> </ul> <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><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment, or deductible for the Medicare-covered supervised exercise therapy.</p>
<p><b>Tennessee Health Link</b></p>	<p><b>In-Network:</b></p>

<b>Services that are covered for you</b>	<b>What you must pay when you get these services</b>
<p>Tennessee Health Link is a team of professionals who work at a mental health clinic or behavioral health provider that can help these members with their healthcare. They provide whole-person, patient centered, and coordinated care for assigned members with behavioral health conditions.</p> <p>Members who are eligible for Health Link services are identified based on:</p> <ul style="list-style-type: none"> <li>• Your diagnosis,</li> <li>• certain health care services you use, or</li> <li>• functional need.</li> </ul> <p>Health Link professionals will use care coordination and other services to help members with your behavioral and physical health. This includes:</p> <ul style="list-style-type: none"> <li>• Comprehensive care management (e.g., creating care coordination and treatment plans)</li> <li>• Care coordination (e.g., proactive outreach and follow up with primary care and behavioral health providers)</li> <li>• Health promotion (e.g., educating the patient and his/her family on independent living skills)</li> <li>• Transitional care (e.g., participating in the development of discharge plans)</li> <li>• Patient and family support (e.g., supporting adherence to behavioral and physical health treatment)</li> <li>• Referral to social supports (e.g., helping to find access to community supports including scheduling and follow through)</li> </ul>	<p>TennCare (Medicaid) Covered</p> <p>There is no coinsurance, copayment or deductible for TennCare (Medicaid) covered services.</p>
<p><b>Transportation Services</b></p> <p>This benefit is for transportation access to Medicare covered benefit locations not covered by member's TennCare (Medicaid) benefit</p> <p>Plan covers <b>60</b> one-way trips to plan-approved locations every year.</p> <p>To schedule a pick-up, please call 1-855-681-5032 (TTY/TDD: 711), 24/7. Request for pick-up should be made at least 3 days in advance of the appointment.</p> <p>Travel is limited to 50 miles from pick-up location.</p>	<p><b>In-Network:</b></p> <p>There is no coinsurance, copayment, or deductible for plan-approved transportation.</p> <p><b>Plan-covered</b></p> <p>Our plan provides transportation for one-way plan-approved medical, vision, hearing appointments, pharmacy and fitness visits and non-emergency ambulance rides that are not</p>

Services that are covered for you	What you must pay when you get these services
	<p>covered by the member's Medicaid plan every year.</p> <p><b>TennCare (Medicaid)-covered</b></p> <p>TennCare (Medicaid) provides transportation for unlimited plan-approved non-emergent medical appointments within 90 miles from pick-up location.</p>
<p><b>Urgently needed services</b></p> <p>Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but, given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. If it is unreasonable given your circumstances to immediately obtain the medical care from a network provider, then your plan will cover the urgently needed services from a provider out-of-network. Services must be immediately needed and medically necessary. Examples of urgently needed services that the plan must cover out of network occur if: You are temporarily outside the service area of the plan and require medically needed immediate services for an unforeseen condition but it is not a medical emergency; or it is unreasonable given your circumstances to immediately obtain the medical care from a network provider. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network.</p> <p>Coverage is limited to within the United States.</p>	<p><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment, or deductible for Medicare-covered urgently needed services.</p>
<p> <b>Vision care</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• 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.</li> </ul>	<p><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment or deductible for Medicare-covered exams to diagnose and treat diseases/conditions of the eye,</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> <li>• For people who are at high risk of glaucoma, we will 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 who are age 50 and older, and Hispanic Americans who are 65 or older</li> <li>• For people with diabetes, screening for diabetic retinopathy is covered once per year</li> <li>• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.</li> </ul> <p><b>Vision care - Supplemental</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• routine vision exams</li> <li>• glasses (lens and/or frames)</li> <li>• contact lenses</li> <li>• <b>\$800</b> plan coverage limit for supplemental vision care</li> </ul>	<p>glaucoma screening, eyeglasses/contact lenses after cataract surgery.</p> <p><b>Plan-covered</b></p> <p><b>\$3300</b> combined yearly allowance. (See the "FlexCard" section in the chapter 4 Medical Benefit Chart for additional details).</p>
<p> <b>Welcome to Medicare preventive visit</b></p> <p>The 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 the preventive services you need (including certain screenings and shots), and referrals for other care if needed.</p> <p><b>Important:</b> We cover the <i>Welcome to Medicare</i> 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 would like to schedule your <i>Welcome to Medicare</i> preventive visit.</p>	<p><b>In-Network:</b></p> <p><b>Medicare-covered</b></p> <p>There is no coinsurance, copayment, or deductible for the <b>Welcome to Medicare</b> preventive visit.</p>

---

## **SECTION 3 What services are covered outside of Medicare**

---

<b>Section 3.1 Services covered by BlueCare Plus Choice</b>
---

The following services are covered by BlueCare Plus Choice through the Choices Program:

### **CHOICES**

#### **1 What is CHOICES?**

TennCare CHOICES in Long-Term Services and Supports (or CHOICES for short) is for adults (age 21 and older) with a physical disability and seniors (age 65 and older). CHOICES offers services to help a person live in their own home or in the community. These services are called **Home and Community Based Services** or HCBS. These services can be provided in the home, on the job, or in the community to assist with daily living activities and allow people to work and be actively involved in their local community. CHOICES also provides care in a nursing home if it is needed.

#### **2 Receiving Services in the CHOICES Program**

The covered long-term services and supports you can receive in CHOICES depend on the CHOICES Group you're enrolled in. If you enroll in CHOICES, TennCare will tell you which CHOICES Group you're in. **There are three (3) CHOICES Groups.**

People in **CHOICES Group 1** receive **nursing home care**.

People in **CHOICES Group 2** need the level of care provided in a nursing home but receive **home care** (or HCBS) instead of nursing home care. Everyone in CHOICES Group 2 has an individual cost neutrality cap which is usually related to the average cost of nursing home care. This amount is updated every year.

People in **CHOICES Group 3** receive **home care** (or HCBS) to prevent or delay the need for nursing home care. There is an \$18,000 per year limit on services in CHOICES Group 3.

The **kinds** of home care covered in CHOICES Group 2 and Group 3 are in Part 9 of this handbook. Some of these services have limits. This means that TennCare will pay for only a certain amount of these services. The kind and amount of care you get in CHOICES depends on your needs.

- **Personal care visits** (2 visits per day, lasting no more than 4 hours per visit; there must be at least 4 hours between each visit.) – Someone will help you with personal care needs and support in the home, on the job, or in the community. Do you need this kind of personal care? If you do, the worker giving your personal care visits can also help with household chores like fixing meals, cleaning, or laundry. And they can run errands like grocery shopping or picking up your medicine.
  - They can only help with those things for you, not for other family members who aren't in CHOICES. And they can only do those things if there's no one else that can do them for you.
- **Attendant care** (1,080 hours per calendar year) – The same kinds of help you'd get with personal care visits, but for longer periods of time (more than 4 hours per visit or visits less than 4 hours apart). You can only get attendant care when your needs

can't be met with shorter personal care visits.

- o Do you need help with personal care **and also** need help with household chores or errands? If so, your attendant care limit increases to 1,400 hours per calendar year. This higher limit is **only** for people who **also** need help with household chores or errands. How much attendant care you get depends on your needs.
- **Home-delivered meals** (1 meal per day).
- **Personal Emergency Response System** - A call button so you can get help in an emergency when your caregiver is not around. Limit of 1 per month.
- **Adult day care** (2,080 hours per calendar year) - A place that provides supervised care and activities during the day.
- **In-home respite care** (216 hours per calendar year) - Someone to come and stay with you in your home for a short time so your caregiver can get some rest.
- **In-patient respite care** (9 days per calendar year) – A short stay in a nursing home or assisted care living facility so your caregiver can get some rest.
- **Assistive technology** (\$900 per calendar year) – Certain low-cost items or devices that help you do things easier or safer in your home like grabbers to reach things.
- **Minor home modifications** (a maximum of \$6,000 per project; \$10,000 per calendar year; and \$20,000 per lifetime) – Certain changes to your home that will help you get around easier and safer in your home like grab bars or a wheelchair ramp.
- **Pest control** (9 units per calendar year) - Spraying your home for bugs or mice.
- **Assisted Care Living Facility** - A place you live that helps with personal care needs, homemaker services and taking your medicine. You must pay for your room and board.
- **Critical Adult Care Home** – A home where you and no more than 4 other people live with a health care professional that takes care of special health and long-term care needs. (Under state law, available only for people who are ventilator dependent or who have traumatic brain injury. You must pay for your room and board.) Critical Adult Care Homes are available for Group 2 members **ONLY**.
- **Companion Care** – Someone you hire who lives with you in your home to help with personal care or light housekeeping whenever you need it. (Available only for people in Consumer Direction who are in Group 2 and who need care off and on during the day and night that can't be provided by unpaid caregivers. And only when it costs no more than other kinds of home care that would meet your needs.)
- **Community Living Supports (CLS)** – A shared home or apartment where you and no more than 3 other people live. The level of support provided depends on your needs and can include hands-on assistance, supervision, transportation and other supports needed to remain in the community.
- **Community Living Supports – Family Model (CLS-FM)** – A shared home or apartment where you and no more than 3 other people live with a trained host family. The level of support provided depends on your needs and can include hands-on assistance, supervision, transportation and other supports needed to remain in the community.
- **Transition Allowance** - (a maximum of \$2,000 lifetime benefit) Allowance to obtain essential household items to establish a community residence for members transitioning from a nursing facility to community or from one HCBS setting to another HCBS setting.
- **Enabling technology is a new service** (\$5,000 per calendar year) and

is the use of various forms of devices and technology to support independent living such as sensors, mobile applications, remote support systems and other smart devices. Enabling Technology can support a person in navigating their jobs and communities, gain more control of their environment, and provide remote support and reminders to assist a person in independent living.

#### **Prior Authorization of Long-Term Services and Supports**

Sometimes you may have to get an **OK** from us for your physical or behavioral health (mental health or substance use disorder) services before you receive them even if a doctor says you need the services. This is called prior authorization. Services that must have a prior authorization before you receive them will only be paid for if we say **OK before** the services are provided.

**All** long-term services and supports must be approved before we will pay for them. **All home care services** must be approved in your support plan **before you receive them**. Nursing home care may sometimes start before you get an **OK**, but you still need an **OK** before we will pay for it. We will not pay for any long-term services and supports unless you have an **OK**.

#### **Using Long-Term Services and Supports Providers Who Work with BlueCare**

Just like physical and behavioral health services, you must use providers who work with us for most long-term services and supports. You can find the Provider Directory online at [bluecare.bcbst.com](http://bluecare.bcbst.com). Or call us at **800-468-9698** to get a list. Providers may have signed up or dropped out after the list was printed. But, the online Provider Directory is updated every week. You can also call us at **800-468-9698** to find out if a provider is in our network.

In most cases, you must receive services from a long-term services and supports provider on this list so that TennCare will pay for your long-term services and supports. However, there are times when TennCare will pay for you to get care from a long-term services and supports provider who does not usually work with us. But, we must first say that it is **OK** to use a long-term services and supports provider who does not usually work with BlueCare.

#### **Consumer Direction**

Consumer Direction is a way of getting some of the kinds of home care you need. It offers more choice and control over **who** gives your home care and **how** your care is given. In CHOICES, the services available through Consumer Direction are:

- Personal care visits;
- Attendant care;
- In-home respite; and



- Companion care (Only if you qualify for and are enrolled in CHOICES Group 2)

In Consumer Direction, you actually employ the people who give some of your home care services—they work **for you** (instead of a provider). You must be able to do the things that an employer would do. These include things like:

1. Hiring and training your workers
  - Find, interview and hire workers to provide care for you.
  - Define workers' job duties.
  - Develop a job description for your workers.
  - Train workers to deliver your care based on your needs and preferences.
2. Setting and managing your workers' schedule
  - Set the schedule at which your workers will give your care.
  - Make sure your workers clock in and out using an EVV system **every** time they work.
  - Make sure your workers provide *only* as much care as you are approved to receive.
  - Make sure that no hourly worker gives you more than 40 hours of care in a week.
3. Supervising your workers
  - Supervise your workers.
  - Evaluate your workers' job performance.
  - Address problems or concerns with your workers' performance.
  - Fire a worker when needed.
4. Overseeing workers' pay and service notes
  - Decide how much your workers will be paid (within limits set by the State).
  - Review the time your workers report to be sure it's right.
  - Ensure there are good notes kept in your home about the care your workers provide.
5. Having and using a back-up plan when needed
  - Develop a back-up plan to address times that a scheduled worker doesn't show up (you can't decide to just go without services).
  - Activate the back-up plan when needed.

**What if you can't do some or all of these things? Then you can choose a family member, friend, or someone close to you to do these things for you. It's called a "Representative for Consumer Direction." It's important that you pick someone who knows you very well that you can depend on. To be your Representative for Consumer Direction, the person must:**

- Be at least 18 years of age.
- Know you very well.
- Understand the kinds of care you need and how you want care to be given.
- Know your schedule and routine.
- Know your health care needs and the medicine you take.
- Be willing and able to do **all** of the things that are required to be in Consumer Direction.
- Live with you in your home **or** be present in your home often enough to supervise staff. This usually means at least part of every worker's shift. But, it may be less as long as it's enough to be sure you're getting the quality of care you need.
- Be willing to sign a Representative Agreement, saying they agree to do these things.

**Your Representative cannot get paid for doing these things.**

You or your Representative will have help doing some of the things you must do as an employer. The help will be provided by a Fiscal Employer Agent (also called FEA).

There are 2 kinds of help you will receive:

1. The FEA will help you and your workers fill out all of the paperwork that you must complete. They will pay your workers for the care they give. And, they will fill out and file the payroll tax forms that you must fill out as an employer.
2. The FEA will hire or contract with a Supports Broker for you. A Supports Broker is a person who will help you with the other kinds of things you must do as an employer. These are things like:
  - Writing job descriptions.
  - Helping you and your workers with paperwork and training
  - Scheduling workers based on your support plan; and
  - Developing an initial back-up plan to address times when a scheduled worker doesn't show up.

**But**, your Supports Broker **can't** help you supervise your workers. You or your Representative must be able to do that by yourself.

The kind and amount of care you'll get depends on what you need. Those services are listed in your support plan. You won't be able to get more services by choosing to be in Consumer Direction. You can only get the services you need that are listed in your support plan.

You can choose to get some of these services through Consumer Direction **and** get some home care from providers that work with your TennCare health plan. But, you must use providers that work with BlueCare for care that you can't get through Consumer Direction.

**Can you pay a family member or friend to provide care in Consumer Direction?**

**Yes, you can pay a family member, but you cannot:**

**Chapter 4. Medical Benefits Chart (what is covered)**

---

- Pay your spouse to provide care;
- Pay someone who lives with you to provide Attendant Care, Personal Care, or In-home Respite services;
- Pay an immediate family member to provide Companion Care. An immediate family member is a spouse, parent, grandparent, child, grandchild, sibling, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law, and son-in-law. Adopted and step members are included in this definition;
- Pay someone who lives with you now or in the last 5 years to provide Companion Care.

**And**, CHOICES can't pay family members or others to provide care they would have given for free. CHOICES only pays for care to meet needs that **can't** be met by family members or others who help you. The services you need are listed in your support plan.

If you're in CHOICES and need services that can be consumer directed your Care Coordinator will talk with you about Consumer Direction. If you want to be in Consumer Direction, your Care Coordinator will work with you to decide which of the services you will direct and start the process to enroll you in Consumer Direction. Until Consumer Direction is set up, you will get the services that are in your support plan from a provider who works with BlueCare, unless **you choose** to wait for your Consumer Directed workers to start. If you choose to wait for your Consumer Directed workers to start, you must have supports in place to give you the care you need.

You can decide to be in Consumer Direction at any time. If you are directing one or more services and decide not to be in Consumer Direction anymore, you will **not** stop getting long-term services and supports. You will still be in CHOICES. You'll get the services you need from a provider who works with BlueCare instead.

**Self-Direction of Health Care Tasks**

If you're in Consumer Direction, you may also choose to have consumer directed workers perform certain kinds of health care tasks for you. Health care tasks are routine things like taking prescribed drugs that most people do for themselves every day. Usually, if you can't perform health care tasks yourself and don't have a family member to do them for you, they must be performed by a licensed nurse.

But, in Consumer Direction, if your doctor says it's OK, you can have your consumer directed workers do certain kinds of health care tasks for you. You (or your Representative) must be able to train your workers on how to do each health care task and must supervise them in performing the task.

Please talk with your Care Coordinator if you have any questions about self-direction of health care tasks.

**Chapter 4. Medical Benefits Chart (what is covered)**

---

**Electronic Visit Verification**

Federal law says that any person that gives certain types of care paid for by Medicaid **MUST** use an electronic system to log the care they provide. This is called EVV (which stands for Electronic Visit Verification). Some of the services in CHOICES must use EVV. The EVV system collects and records information every time your worker comes to give your care. The law says that an **EVV system MUST be used to record ALL of these things:**

- Your name (the name of the person who received care)
- The service you received
- Your worker (the name of the person who provided your care)
- The date you got the care
- Where the care was provided
- The time it started
- The time it ended

ALL of this information must be recorded electronically at the time of EACH service you receive. If it isn't, BlueCare may not be able to pay for the care you receive.

BlueCare can give you a tablet for your workers to use. If we do, it's important to keep your tablet charged and ready for your workers. You shouldn't use it for other reasons.

If you don't want a tablet, your workers can use a smart phone or a phone in your home. But, **to comply with the federal law, they MUST check in and check out EVERY time they come to your home.** Please remind your workers to use the EVV system when they come to your home every day. If they don't, TennCare may not be able to pay for your care.

**3 Care Coordination and Role of the Care Coordinator**

In CHOICES, we are responsible for managing all of your physical health, behavioral health (mental health or substance use disorder) and long-term services and supports needs, and the services that you receive to address these needs. This is called care coordination.

These functions are carried out by a Care Coordinator. We will assign you a Care Coordinator when you enroll in CHOICES. Your Care Coordinator will play a very important role. Your Care Coordinator is your primary contact person and is the first person that you should go to if you have any questions about your services.

**Not sure who your Care Coordinator is or how to contact them?** You can call us at **800-468-9698**.

**Your Care Coordinator will:**

- Provide information about CHOICES and answer your questions.
- Help you get the right kind of long-term services and supports in the right setting for you to address your needs.
- Coordinate all of your physical health, behavioral health (mental health or substance use disorder) and long-term services and supports needs.
- Help to fix problems and answer questions that you have about your care.
- Check at least once a year to make sure that you continue to need the level of care provided in a nursing home or, for Group 3, continue to be "at risk" of going into a nursing home.
- Communicate with your providers to make sure they know what's happening with your health care and to coordinate your service delivery.

Other tasks performed by the Care Coordinator will vary slightly depending on the CHOICES Group you're enrolled in.

**If you receive nursing home care in CHOICES Group 1, your Care Coordinator will:**

- Be part of the care planning process with the nursing home where you live.
- Perform any additional needs assessment that may be helpful in managing your health and long-term services and supports needs.
- Supplement (or add to) the nursing home's plan of care if there are things BlueCare can do to help manage health problems or coordinate other kinds of physical and behavioral health (mental health or substance use disorder) care you need.
- Conduct face-to-face visits at least every 6 months.
- Coordinate with the nursing home when you need services the nursing home isn't responsible for providing.
- Determine if you're interested and able to move from the nursing home to the community and if so, help make sure this happens timely.

**If you receive home care in CHOICES Group 2 or Group 3, your Care Coordinator will work with you to:**

- Do a comprehensive, individual assessment of your health and long-term services and supports needs; and
- Develop a **Person-Centered Support Plan**.

**Your Care Coordinator will also:**

- Make sure your plan of care is carried out and working the way that it needs to.
- Monitor to make sure you are getting what you need and that gaps in care are addressed right away.
- Contact you by telephone at least once every month and visit you in person at least

once every 3 months if you are in Group 2 or contact you by telephone at least once every 3 months and visit you in person at least once every 6 months if you are in Group 3. These visits may occur more often if you get residential services or based on your needs.

- Make sure the home care services you receive are based on your goals, needs and preferences and do not cost more than nursing home care, if you are in Group 2, or more than \$18,000 if you are in Group 3.

#### **Changing Care Coordinators**

If you're unhappy with your Care Coordinator and would like a different one, you can ask us. You can have a new Care Coordinator if one is available. That doesn't mean you can pick whoever you want to be your Care Coordinator. We must be able to meet the needs of all CHOICES members and assign staff in a way that allows us to do that. To ask for a different Care Coordinator, call us at **800-468-9698**. Tell us why you want to change Care Coordinators. If we can't give you a new Care Coordinator, we'll tell you why. And, we'll help to address any problems or concerns you have with your Care Coordinator.

There may be times when we will have to change your Care Coordinator.

This may happen if your Care Coordinator is no longer with BlueCare, is temporarily not working, or has too many members to give them the attention they need. If this happens, we will send you a letter that says who your new Care Coordinator will be and how to contact them.

If you're in CHOICES, you can contact your Care Coordinator anytime you have a question or concern about your health care – you do not need to wait until a home visit or a phone call. You should contact your Care Coordinator anytime you have a change in your health condition or other things that may affect the kind or amount of care you need. If you need help after regular business hours that won't wait until the next day, you can call us at **800-262-2873**.

#### **4 Your Person-Centered Support Plan**

In CHOICES, you must have a **Person-Centered Support Plan (PCSP** or "support plan" for short). This is your plan that helps guide the services and supports you will receive. Your support plan tells the people who will support you:

- **what is important to you**—the things that really matter to you
- **what is important for you**—the supports you need to stay healthy and safe, and achieve your goals, and
- **how to support you** to have those things in your life.

#### **Your support plan must include:**

- your strengths and needs
  - the goals you want to reach
-

- the services and supports (paid and unpaid) you will receive to help you meet your goals
- how often you will receive those service and supports
- who will provide them, and
- the settings (or places) they will be provided.

**Your Care Coordinator helps develop your support plan. They will help you to:**

- Identify the services and supports you need.
- Explore employment options and ways to be part of your community and build relationships,
- Decide what services and supports you will need to meet your needs and reach your goals,
- Develop and access other services and unpaid supports to help too,
- Understand all of the services, providers and settings you can choose from,
- Choose the services you will receive, your provider for each service, and settings (places) where you will receive those services,
- Write your support plan based on your choices, preferences, and support needs, and
- Make sure you get the services in your support plan.

Your support plan and how it's developed is very important. CHOICES can only pay for covered services that are part of an approved support plan.

**Your support plan should be developed in a way that makes sure:**

- You get to lead the planning process.
- You receive the help you need to lead the planning process.
- You get to make choices and to have the information you need to make those choices.
- You have help from family, friends, advocates or anyone else you choose.
- You get to speak for yourself.
- You can have someone to speak for you and choose that person.
- You have and use an interpreter if the language you speak or understand is not English.

**Your support plan should also be developed in a way that makes sure:**

- You get to talk with your Care Coordinator before the planning meeting if you want to.
- You get to pick who to invite to the meeting (and decide if you **don't** want someone there).
- The planning meeting is set at times and places that work best for you.
- You get to help choose service providers **before** services begin, and at any time during the year if you want to change providers. BlueCare will try to give you the providers you want. (The provider must be contracted with your MCO and willing and

able to provide your services.)

- You can choose to direct (or stop directing) some or all of the services that are part of Consumer Direction at any time.
- You sign your support plan.
- And, everyone who will provide services and supports (paid and unpaid) signs your support plan saying they are committed to implement your plan as written.



**What if your needs change and you need more support?**

Your support plan is usually in effect for a year. But you can ask to change your support plan anytime during the year if your needs change or your situation changes.

**5 Requesting a TennCare Review**

If you're in CHOICES Group 2 or Group 3, you can ask TennCare to review your needs assessment or support plan if you have concerns and think you're not getting the services you need. TennCare will review the assessment or plan of care and the information gathered by your Care Coordinator. If TennCare thinks you're right, they'll work with us to fix the problem. If TennCare thinks you are getting the services you need, they'll send you a letter that says why.

To request an objective review of your needs assessment and support plan, you must submit a written request.

<b>Requesting a TennCare Review</b>	
	<p><b>MAIL:</b> TennCare Division of Long Term Services and Supports c/o CHOICES Review 310 Great Circle Rd. Nashville, TN 37243</p> <p><b>Keep a copy</b> of your request. Write down the date that you sent it to TennCare.</p>
	<p><b>FAX: 615-532-9140</b></p> <p><b>Keep the page</b> that shows your fax went through.</p>



**6 You also have the right to file an appeal.** Here are some of your appeal rights:

- You can appeal if you think an assessment doesn't really match your needs and you think you should get more and/or different services.
- You can appeal if you don't agree with the services in your support plan.
- You can appeal if a covered service that you want and need isn't in your support plan.
- You can appeal if your request to have your support plan changed is denied, or your support plan is not changed enough to meet your needs.
- And, you can appeal if a service is in your approved support plan, but you don't receive it, or there is a delay in getting it.

If you file an appeal, it doesn't mean that you will get the services you want. But, TennCare will take another look at what you're asking for. If TennCare agrees that the service is covered **and** that you need it, you will get the service.

What if TennCare decides the service isn't covered or that you don't need it? You may get a fair hearing. To get a fair hearing, the service(s) you want must be covered in the CHOICES benefit group you're in. That includes any limits on the service(s) and on the total cost of services you can receive—your yearly cost cap.

TennCare can only pay for services that are covered in the CHOICES benefit group you're in. If a service isn't covered, or if you want more of a service than is covered, TennCare can't pay for it.

If you file an appeal to keep a service you've been getting, you *may* be able to keep it during the appeal. To keep getting a service during your appeal, it must be a covered benefit. And, you must have an approved support plan. TennCare can only pay for services that are part of an approved support plan.

You can't get a service during your appeal:

- If the service isn't covered.
- You don't have an approved support plan that includes the service.
- Or, you want to start getting a new service.

**Go to Part 6 of this handbook for more information on filing appeals.**

**7 CHOICES Consumer Advocate**

In addition to your Care Coordinator, there is another person at BlueCare to help you. This person is the CHOICES Consumer Advocate. The CHOICES Consumer Advocate is available to:

- Provide information about the CHOICES program.
- Help you figure out how things work at BlueCare, like filing a complaint, changing Care Coordinators or getting the care you need.

- Make referrals to the right BlueCare staff.
- Help fix problems with your care.

To reach the BlueCare CHOICES Consumer Advocate, call us at **800-468-9698**. Ask to speak with the CHOICES Consumer Advocate.

### **8 Freedom of Choice**

In CHOICES, if you need the level of care provided in a nursing home, you have the right to choose to get care:

- In your home,
- Or in another place in the community (like an assisted living facility or critical adult care home),
- Or in a nursing home.

To get care in your home or in the community, you must qualify and be able to enroll in CHOICES Group 2 or CHOICES Group 3. (See ***Who can qualify to enroll in CHOICES?***)

If you're in a nursing home, you may be able move from your nursing home to your own home and receive services if you want to. If you're interested in moving out of the nursing home into the community, talk with your Care Coordinator.

To get care in your home or in the community, we must be able to safely meet your needs in that setting. And, for CHOICES Group 2 the cost of your care can't be more than the cost of your care in a nursing home. That includes the cost of your home care **and** any home health or nursing care you may need. For CHOICES Group 3, the cost of your care can't be more than \$18,000 per year. Minor home modifications, and any home health or nursing care you might need don't count against the \$18,000 limit. The actual kind and amount of care you will receive depends on your needs.

What if you qualify for nursing home care but don't want to leave the nursing home and move to the community? Then, we won't make you, even if we think care in the community would cost less. As long as you qualify for nursing home care, you can choose to receive it.

You can change your choice at any time as long as you qualify and can enroll to receive care in the setting you pick.

In CHOICES, you can also help choose the providers who will give your care. This could be an assisted living or nursing home, or the agency who will give your care at home. You may also be able to hire your own workers for some kinds of care (called Consumer Direction).

The provider you choose must be willing and able to give you care. Your Care Coordinator will try to help you get the provider you pick. But, if you don't get the **provider** you want, you can't appeal and get a fair hearing. If you don't get the **services** you think you need, then you can file an appeal.

### **9 Paying for your CHOICES Long-Term Services and Supports**

You may have to pay part of the cost of your care in CHOICES. It's called "**patient liability**." The amount you pay depends on your income and countable expenses. If you have patient liability, you **must** pay it in CHOICES. If you get care in an assisted living or adult care home, or in a nursing home, you will pay your patient liability to that home. If you get care in your own home, you will pay your patient liability to BlueCare.

**If you have patient liability, it's very important that you pay it.**

#### **What if you DON'T pay the patient liability you owe? 4 things could happen:**

1. Your CHOICES care provider could decide not to provide your care anymore. If you get care in an assisted living or adult care home, or in a nursing home, they could discharge you. Before they do, they must send you a letter that says why you're being discharged. If you think they're wrong about owing them money, you can appeal.
2. **And** if you don't pay your patient liability, other providers may not be willing to give your care either. If that happens, BlueCare could decide not to be your health plan for CHOICES anymore. We can't meet your needs if we can't find any providers willing to give you care. We must send you a letter that says why we can't be your health plan for CHOICES anymore. If you think we're wrong, you can appeal.
3. **And** if you don't pay your patient liability, other TennCare health plans may not be willing to be your health plan for CHOICES either. If that happens, you may not be able to stay in CHOICES. You may not get any long-term services and supports from TennCare. If you can't stay in CHOICES, TennCare will send you a letter that says why. If you think they're wrong, you can appeal.
4. **And** if you can't stay in CHOICES, you may not qualify for TennCare anymore. If the only way you qualify for TennCare is because you get long-term services and supports, you could lose your TennCare too. Before your TennCare ends, you'll get a letter that says how to appeal if you think it's a mistake.

**Do you have medical bills for care you got before your TennCare started? This includes care in a nursing home, or Medicare co-pays or deductibles.**

**Or, do you have medical bills for care you got after TennCare started that TennCare doesn't cover?** This includes eyeglasses and hearing aids for adults.

We may be able to subtract those bills from the patient liability you owe each month. This means your patient liability will be less. (It can even be zero.) We'll keep subtracting those bills until the total cost of your medical bills has been subtracted.

The bills must be for care you got in the 3 months before the month you applied to TennCare. For example, if you apply for TennCare in April, the bills must be for January, February, March.

These can be bills you've already paid. Or they can be bills you haven't paid yet. But you must be expected to pay them. (You don't have other insurance to pay for them.) What if a family member or someone else paid these bills? Send them only if they expect you to pay them back.

If you have medical bills like this, send them to TennCare. There are 2 ways to get them to us.



**Mail to:**

TennCare Connect  
P.O. Box 305240  
Nashville, TN 37230-5240



**Fax to:**

**855-315-0669**

On each page you send, be sure to write "for patient liability" and include your name and social security number.

**Do you have Medicare or other insurance** that helps pay for your long-term services and supports? If you do, that insurance must pay **first**. TennCare can't pay for care that's covered by Medicare or other insurance.

What if you have long-term services and supports insurance that pays **you**? Then you must pay the amount you get to help cover the cost of your care. If you live in an assisted living or adult care home, or in a nursing home, you'll pay the amount you get to that home. If you get care in your own home, your Care Coordinator will tell you how to pay the insurance money you get. This **won't** lower the amount of any patient liability you owe.

You must pay any long-term services and supports insurance you get **and** your patient liability to help cover the cost of your care. But, you won't pay more than the total cost of long-term services and supports you receive that month.

What if you receive Aid and Attendance Benefits through the Department of Veterans Affairs? If you do, it is important that you tell your Care Coordinator. Your Care Coordinator will give you important information that will help you make choices about how you will receive the long-term services and supports that you need.

#### **10 Disenrollment from CHOICES**

Your enrollment in CHOICES and receipt of long-term services and supports can end for several reasons and may vary depending on the CHOICES Group that you are enrolled in. We can recommend a member's disenrollment from CHOICES but TennCare will make the final decision. Some of the reasons you could be disenrolled from CHOICES include:

- You no longer qualify for Medicaid.
- You no longer need the level of care provided in a nursing home and you're not at risk of going into a nursing home.
- You no longer need and aren't receiving **any** long-term services and supports.
- You do not pay your patient liability.

#### **If you're in Group 2 or Group 3, your enrollment in CHOICES can also end if:**

We decide we can no longer safely meet your needs in the home or community, and you refuse to move to a nursing home. Reasons we may not be able to safely meet your needs include things like:

- You refuse to allow a Care Coordinator into your home. If a Care Coordinator can't visit you in your home, we can't be sure that you're safe and healthy.
- The risk of harm to you or to people providing care in your home is too great.
- Even though there are providers available to provide care, none of those providers are willing to provide your care.
- You refuse to receive services that are identified in your person-centered support plan as needed services.

#### **If you're in Group 2, you can also be disenrolled if:**

The cost of care you need in the home or community will be more than the cost of nursing home care. The cost of care includes any home health or private duty nursing you may need.

Your Care Coordinator will check regularly to make sure that the care you receive in your own home or in the community (including the cost of home health and private duty nursing) does not exceed the cost of nursing home care.

If we decide that home care will cost more than nursing home care, your Care Coordinator will work with you to try to put together a support plan that will safely and cost-effectively meet your needs. If we decide it's not possible to safely serve you in your home or in the community for no more than the cost of nursing home care, your Care Coordinator will help you move to a nursing home of your choice who works with BlueCare. If you choose not to move to a nursing home, you'll no longer be able to receive services in your own home or in the community. You'll be disenrolled from CHOICES.

**If you're in Group 3:**

We must be able to safely meet your needs with the care you can get in CHOICES Group 3. **This** includes CHOICES home care with a maximum of \$18,000 per year (not counting minor home modifications), other Medicaid services you qualify to receive from your MCO, services you can get through Medicare, private insurance or other funding sources, and unpaid care provided by family members and friends. If we decide your needs can't be met with the care you can get in Group 3, TennCare will see if you qualify to move to CHOICES Group 2 for more home care or CHOICES Group 1 for nursing home care. What if your needs can't be met at home or in the community (even with home care up to the cost of nursing home care) and you choose not to move to a nursing home? Then, you will be disenrolled from CHOICES.

If you're disenrolled from CHOICES, you'll stay on TennCare as long as you still qualify for Medicaid. However, you'll no longer receive **any** long-term services and supports paid for by TennCare. You'll get a letter that says why your CHOICES is ending and how to appeal if you think it's a mistake.

If the **only** way you qualify for Medicaid is because you receive long-term services and supports and you're disenrolled from CHOICES, your TennCare may end too. Before it does, you'll get a letter that says why. You'll get a chance to qualify in another one of the groups that Medicaid covers.

**11 Redetermination**

As with all Medicaid programs, we are required to make sure that everyone still qualifies every year—called redetermination. We must make sure you still meet the medical and financial rules for CHOICES. Be sure TennCare has your current address. If you move, tell us right away. Open your mail and watch for requests for information from TennCare so your coverage can continue. Your TennCare health plan can help, if you ask them. If you lose CHOICES, there must be an open slot for you to enroll again.

---

## **SECTION 4 What services are not covered by the plan?**

---

<b>Section 4.1 Services <i>not</i> covered by the plan (exclusions)</b>
---

This section tells you what services are excluded.

The chart below describes some services and items that aren't covered by the plan under any conditions or are covered by the plan only under specific conditions.

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

**Chapter 4. Medical Benefits Chart (what is covered)**

appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 6.3 in this document.)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Acupuncture		<ul style="list-style-type: none"> <li>Available for people with chronic low back pain under certain circumstances.</li> </ul>
Cosmetic surgery or procedures		<ul style="list-style-type: none"> <li>Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member.</li> <li>Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.</li> </ul>
<p>Custodial care.</p> <p>Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.</p>		<p>May be covered by TennCare (Medicaid)</p>
Dental		<p>May be covered by TennCare (Medicaid)</p>
<p>Experimental medical and surgical procedures, equipment and medications.</p> <p>Experimental procedures and items are those items and procedures determined by Original Medicare to not be</p>		<ul style="list-style-type: none"> <li>May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan</li> </ul>

**Chapter 4. Medical Benefits Chart (what is covered)**

<b>Services not covered by Medicare</b>	<b>Not covered under any condition</b>	<b>Covered only under specific conditions</b>
generally accepted by the medical community.		(See Chapter 3, Section 5 for more information on clinical research studies.)
Fees charged for care by your immediate relatives or members of your household.		✓
Full-time nursing care in your home.		✓
Home-delivered meals		We provide 56 meals following discharge from an acute patient hospital or skilled nursing facility and through Choices up to 1 meal per day
Homemaker services including basic household assistance, such as light housekeeping or light meal preparation.		✓
Naturopath services (uses natural or alternative treatments)	<b>Not covered under any condition</b>	
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	<b>Not covered under any condition</b>	
Private room in a hospital.		<ul style="list-style-type: none"> <li>• Covered only when medically necessary</li> </ul>
Radial keratotomy, LASIK surgery, and other low vision aids	<b>Not covered under any condition</b>	
Reversal of sterilization procedures and/or non-	<b>Not covered under any condition</b>	



**Chapter 4. Medical Benefits Chart (what is covered)**

---

<b>Services not covered by Medicare</b>	<b>Not covered under any condition</b>	<b>Covered only under specific conditions</b>
prescription contraceptive supplies		
Services considered not reasonable and necessary, according to Original Medicare standards	<b>Not covered under any condition</b>	

# CHAPTER 5:

*Using the plan's coverage for  
Part D prescription drugs*



## How can you get information about your drug costs?

Because you are eligible for TennCare (Medicaid), you qualify for and are getting "Extra Help" from Medicare to pay for your prescription drug plan costs. Because you are in the "Extra Help" program, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the Low-Income Subsidy Rider or the LIS Rider), which tells you about your drug coverage. If you don't have this insert, please call Member Service and ask for the LIS Rider. (Phone numbers for Member Service are printed on the back cover of this document.)

---

## SECTION 1 Introduction

---

This chapter **explains rules for using your coverage for Part D drugs.** Please see Chapter 4 for Medicare Part B drug benefits and hospice drug benefits.

In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your TennCare (Medicaid) benefits. However, if you are an adult age 21 or older and have Medicare, you get your prescription medicine from Medicare Part D through BlueCare Plus Choice, not from TennCare's Pharmacy Program.

<b>Section 1.1 Basic rules for the plan's Part D drug coverage</b>
--

The plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription which must be valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy or through the plan's mail-order service*).
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See Section 3, *Your drugs need to be on the plan's "Drug List"*).
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain references. (See Section 3 for more information about a medically accepted indication.)

---

## SECTION 2 Fill your prescription at a network pharmacy or through the plan's mail-order service

---

### Section 2.1 Use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term covered drugs means all of the Part D prescription drugs that are on the plan's "Drug List."

### Section 2.2 Network pharmacies

#### How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Pharmacy Directory*, visit our website ([bluecareplus.bcbst.com](http://bluecareplus.bcbst.com)), and/or call Member Service.

You may go to any of our network pharmacies.

#### What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another pharmacy in your area, you can get help from Member Service or use the *Pharmacy Directory*. You can also find information on our website at [bluecareplus.bcbst.com](http://bluecareplus.bcbst.com).

#### What if you need a specialized pharmacy?

Some prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Member Service.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (**Note:** This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Pharmacy Directory* or call Member Service.

**Section 2.3 Using the plan's mail-order service**

Our plan's mail-order service allows you to order **up to a 90-day supply**.

To get order forms and information about filling your prescriptions by mail, contact mail order Member Service at 1-844-740-0602 (TTY: 711).

Usually a mail-order pharmacy order will be delivered to you in no more than 14 days. If you request expedited shipping, additional charges may apply. If your mail-order is delayed, you will have to get your prescriptions filled at another pharmacy. Your doctor may need to provide a new prescription to the network pharmacy in your area while your mail-order prescription is being delivered. Please contact mail-order Member Service at 1-844-740-0602 (TTY: 711) for assistance in coordinating the coverage of your prescriptions from both a delayed mail-order shipment and from another network pharmacy in your area.

**New prescriptions the pharmacy receives directly from your doctor's office.** After the pharmacy receives a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time. It is important that you respond each time you are contacted by the pharmacy, to let them know whether to ship, delay, or stop the new prescription.

**Refills on mail-order prescriptions.** For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you prior to shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed.

If you choose not to use our auto-refill program but still want the mail-order pharmacy to send you your prescription, please contact your pharmacy 21 days before your current prescription will run out. This will ensure your order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, please contact your mail-order pharmacy at **1-844-740-0602**, TTY **711**.

**Refills on mail-order prescriptions.** For refills, please contact your pharmacy 21 days before your current prescription will run out to make sure your next order is shipped to you in time.

If you receive a refill automatically by mail that you do not want, you may be eligible for a refund.

**Section 2.4 How can you get a long-term supply of drugs?**

The plan offers two ways to get a long-term supply (also called an extended supply) of maintenance drugs on our plan's "Drug List." (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

**Chapter 5. Using the plan's coverage for Part D prescription drugs**

---

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. Your *Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Member Service for more information.
2. You may also receive maintenance drugs through our mail-order program. Please see Section 2.3 for more information.

**Section 2.5 When can you use a pharmacy that is not in the plan's network?****Your prescription may be covered in certain situations**

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. To help you, we have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. **Please check first with Member Service** to see if there is a network pharmacy nearby. You will most likely be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- You become ill and need a Part D covered drug while traveling outside your plan's service area, and you cannot access a network pharmacy.
- You are not able to obtain a Part D covered drug in a timely manner within your plan's service area. For example, there is no network pharmacy within a reasonable driving distance that provides 24-hour service, 7 days a week.
- You are filling a prescription for a Part D covered drug that is not regularly stocked at an accessible network retail or mail-order pharmacy.
- Part D covered drugs are dispensed by an out-of-network institution-based pharmacy while you are a patient in an emergency department, provider-based clinic, outpatient surgery, or other outpatient setting.
- In case of any other emergency when a Part D covered drug is required and a network pharmacy is not available.
- You are a member getting a Medicare Part D vaccine that is medically necessary.

For all the above situations, the maximum limit for out-of-network claims filled is a 14-day supply.

In these situations, **please check first with Member Service** to see if there is a network pharmacy nearby. (Phone numbers for Member Service are printed on the back cover of this booklet.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

## How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost at the time you fill your prescription. You can ask us to reimburse you. (Chapter 7, Section 2.1 explains how to ask the plan to pay you back.)

---

## **SECTION 3 Your drugs need to be on the plan's "Drug List"**

---

<b>Section 3.1 The "Drug List" tells which Part D drugs are covered</b>
---

The plan has a *List of Covered Drugs (Formulary)*. In this *Evidence of Coverage*, we call it the **"Drug List" for short.**

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare.

The "Drug List" includes the drugs covered under Medicare Part D. In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your TennCare (Medicaid) benefits. You can contact your state TennCare (Medicaid) agency to find out about drugs covered under your TennCare (Medicaid) coverage (see contact information listed in Chapter 2). TennCare (Medicaid) may also be able to provide a TennCare (Medicaid) "Drug List" that tells you how to find out which drugs are covered under TennCare (Medicaid). However, if you are an adult age 21 or older and have Medicare, you get your prescription medicine from Medicare Part D through BlueCare Plus Choice, not from TennCare's (Medicaid) Pharmacy Program.

The "Drug List" includes the drugs covered under Medicare Part D.

We will generally cover a drug on the plan's "Drug List" as long as you follow the other coverage rules explained in this chapter and the use of the drug is a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- Approved by the Food and Drug Administration for the diagnosis or condition for which it is being prescribed.
- *or* -- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

The "Drug List" includes brand name drugs, generic drugs, and biosimilars.

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand name drugs that are more complex than typical drugs (for example, drugs that are based on a protein) are called biological products. On the "Drug List", when we refer to "drugs," this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, generics and biosimilars work just

**Chapter 5. Using the plan's coverage for Part D prescription drugs**

---

as well as the brand name drug or biological product and usually cost less. There are generic drug substitutes available for many brand name drugs. There are biosimilar alternatives for some biological products.

**What is *not* on the “Drug List”?**

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on the “Drug List.” In some cases, you may be able to obtain a drug that is not on the “Drug List.” For more information, please see Chapter 9.

**Section 3.2 There is 1 “cost sharing tier” for drugs on the Drug List**

Every drug on the plan's "Drug List" is in one cost sharing tier. In general, the higher the cost-sharing tier, the higher your cost for the drug:

- Tier 1 - Generic and Brand Drugs (This is the only tier and includes all covered drugs.)

The amount you pay for drugs in this cost sharing tier is shown in Chapter 6 (*What you pay for your Part D prescription drugs*).

**Section 3.3 How can you find out if a specific drug is on the Drug List?**

You have 3 ways to find out:

1. Check the most recent "Drug List" we provided electronically.
2. Visit the plan's website ([bluecareplus.bcbst.com](http://bluecareplus.bcbst.com)). The "Drug List" on the website is always the most current.
3. Call Member Service to find out if a particular drug is on the plan's "Drug List" or to ask for a copy of the list.
4. Use the plan's “Real-Time Benefit Tool” ([bluecareplus.bcbst.com](http://bluecareplus.bcbst.com) or by calling Member Service). With this tool you can search for drugs on the “Drug List” to see an estimate of what you will pay and if there are alternative drugs on the “Drug List” that could treat the same condition.

---

**SECTION 4 There are restrictions on coverage for some drugs**

---

**Section 4.1 Why do some drugs have restrictions?**

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective way. To find out if any of these restrictions apply to a drug you take



**Chapter 5. Using the plan's coverage for Part D prescription drugs**

---

or want to take, check the “Drug List.” If a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan’s rules are designed to encourage you and your provider to use that lower-cost option.

Please note that sometimes a drug may appear more than once in our “Drug List.” This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your health care provider, and different restrictions or cost sharing may apply to the different versions of the drug (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

**Section 4.2 What kinds of restrictions?**

The sections below tell you more about the types of restrictions we use for certain drugs.

**If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug.** Contact Member Service to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9)

**Restricting brand name drugs or original biological products when a generic or interchangeable biosimilar version is available**

Generally, a **generic** drug or interchangeable biosimilar works the same as a brand name drug or original biological product and usually costs less. **In most cases, when a generic or interchangeable biosimilar version of a brand name drug or original biological product is available, our network pharmacies will provide you the generic or interchangeable biosimilar version instead of the brand name drug or original biological product.** However, if your provider has told us the medical reason that the generic drug or interchangeable biosimilar will not work for you *OR* has written “No substitutions” on your prescription for a brand name drug or original biological product *OR* has told us the medical reason that neither the generic drug, interchangeable biosimilar, nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug or original biological product. (Your share of the cost may be greater for the brand name drug or original biological product than for the generic drug or interchangeable biosimilar.)

**Getting plan approval in advance**

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called **prior authorization**. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

**Trying a different drug first**

This requirement encourages you to try less costly but usually just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition

**Chapter 5. Using the plan's coverage for Part D prescription drugs**

---

and Drug A is less costly, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called **step therapy**

**Quantity limits**

For certain drugs, we limit how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

---

**SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered?**

---

**Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered**

There are situations where there is a prescription drug you are taking, or one that you and your provider think you should be taking, that is not on our formulary or is on our formulary with restrictions. For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug, as explained in Section 4.
- There are things you can do if your drug is not covered in the way that you'd like it to be covered.
- If your drug is not on the "Drug List" or if your drug is restricted, go to Section 5.2 to learn what you can do.

**Section 5.2 What can you do if your drug is not on the Drug List or if the drug is restricted in some way?**

If your drug is not on the "Drug List" or is restricted, here are options:

- You may be able to get a temporary supply of the drug.
- You can change to another drug.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

## You may be able to get a temporary supply

Under certain circumstances, the plan must provide a temporary supply of a drug that you are already taking. This temporary supply gives you time to talk with your provider about the change in coverage and decide what to do.

To be eligible for a temporary supply, the drug you have been taking **must no longer be on the plan's "Drug List" OR is now restricted in some way.**

- **If you are a new member**, we will cover a temporary supply of your drug during the first **90 days** of your membership in the plan.
- **If you were in the plan last year**, we will cover a temporary supply of your drug during the first **90 days** of the calendar year.
- This temporary supply will be for a maximum of a 30-day supply (or 31-day supply for long-term care (LTC)). If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 30-day supply (or 31-day supply for long-term care (LTC)) of medication. The prescription must be filled at a network pharmacy. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For those members who have been in the plan for more than 90 days and reside in a long-term care facility and need a supply right away:** We will cover one 31-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.
- **For those members who have been in the plan for more than 90 days and experience a level of care change and need a supply right away:** We will cover one 30-day supply (or 31-day supply for long-term care (LTC)) or less if your prescription is written for fewer days, when you experience a level of care change. This includes transferring from one treatment setting to another. This is in addition to all other temporary supplies. One example of a level of care change would be if you were discharged home from the hospital.

For questions about a temporary supply, call Member Service.

During the time when you are using a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You have two options:

### 1) You can change to another drug

Talk with your provider about whether there is a different drug covered by the plan that may work just as well for you. You can call Member Service to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

## 2) You can ask for an exception

You and your provider can ask the plan to make an exception and cover the drug in the way you would like it covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception. For example, you can ask the plan to cover a drug even though it is not on the plan's "Drug List." Or you can ask the plan to make an exception and cover the drug without restrictions.

If you and your provider want to ask for an exception, Chapter 9, Section 7.4 tells you what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

---

## **SECTION 6 What if your coverage changes for one of your drugs?**

---

<b>Section 6.1 The "Drug List" can change during the year</b>
---

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan can make some changes to the "Drug List." For example, the plan might:

- **Add or remove drugs from the "Drug List."**
- **Add or remove a restriction on coverage for a drug.**
- **Replace a brand name drug with a generic version of the drug.**
- **Replace an original biological product with an interchangeable biosimilar version of the biological product.**

We must follow Medicare requirements before we change the plan's "Drug List."

<b>Section 6.2 What happens if coverage changes for a drug you are taking?</b>
--

### **Information on changes to drug coverage**

When changes to the "Drug List" occur, we post information on our website about those changes. We also update our online "Drug List" on a regularly scheduled basis. Below we point out the times that you would get direct notice if changes were made to a drug that you are taking.

### **Changes to your drug coverage that affect you during the current plan year**

- **A generic drug or interchangeable biosimilar replaces a brand name drug on the "Drug List" (or we change the cost sharing tier or add new restrictions to the brand name drug or both)**
  - We may remove a brand name drug or original biological product from our "Drug List" if we are replacing it with a generic version of the same drug or an interchangeable biosimilar version of the same biological product. We may decide to keep the brand name drug or original biological product on our "Drug List," but

**Chapter 5. Using the plan's coverage for Part D prescription drugs**

---

move it to a higher cost-sharing tier or add new restrictions or both when the generic or interchangeable biosimilar is added.

- If a brand name drug or original biological product you are taking is replaced by a generic or interchangeable biosimilar or moved to a higher cost-sharing tier, we must give you at least 30 days' advance notice of the change or give you notice of the change and a 30-day (or 31-day for long-term care (LTC)) refill of your brand name drug or original biological product.
  - After you receive notice of the change, you should work with your provider to switch to the generic or interchangeable biosimilar or to a different drug that we cover.
  - You or your prescriber can ask us to make an exception and continue to cover the brand name drug or interchangeable biosimilar for you. For information on how to ask for an exception, see Chapter 9
- **Unsafe drugs and other drugs on the “Drug List” that are withdrawn from the market**
    - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the “Drug List.” If you are taking that drug, we will tell you right away.
    - Your prescriber will also know about this change, and can work with you to find another drug for your condition.
- **Other changes to drugs on the “Drug List”**
    - We may make other changes once the year has started that affect drugs you are taking. For example, we might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
    - For these changes we must give you at least 30 days' advance notice of the change or give you notice of the change and a 30-day (or 31-day long-term care (LTC)) refill of the drug you are taking at a network pharmacy.
    - After you receive notice of the change, you should work with your prescriber to switch to a different drug that we cover or to satisfy any new restrictions on the drug you are taking.
    - You or your prescriber can ask us to make an exception and continue to cover the drug for you. For information on how to ask for an exception, see Chapter 9.

**Changes to the “Drug List” that do not affect you during this plan year**

We may make certain changes to the “Drug List” that are not described above. In these cases, the change will not apply to you if you are taking the drug when the change is made; however, these changes will likely affect you starting January 1 of the next plan year if you stay in the same plan.

In general, changes that will not affect you during the current plan year are:

**Chapter 5. Using the plan's coverage for Part D prescription drugs**

---

- We put a new restriction on the use of your drug.
- We remove your drug from the “Drug List.”

If any of these changes happen for a drug you are taking (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restrictions to your use of the drug.

We will not tell you about these types of changes directly during the current plan year. You will need to check the “Drug List” for the next plan year (when the list is available during the open enrollment period) to see if there are any changes to the drugs you are taking that will impact you during the next plan year.

---

**SECTION 7 What types of drugs are *not* covered by the plan?**

---

**Section 7.1 Types of drugs we do not cover**

This section tells you what kinds of prescription drugs are **excluded**. This means Medicare does not pay for these drugs.

If you appeal and the requested drug is found not to be excluded under Part D, we will pay for or cover it. (For information about appealing a decision, go to Chapter 9.) If the drug is excluded, you must pay for it yourself.

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States or its territories.
- Our plan usually cannot cover off-label use. Off-label use is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
- Coverage for off-label use is allowed only when the use is supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

In addition, by law, the following categories of drugs listed below are not covered by Medicare. However, some of these drugs may be covered for you under your TennCare (Medicaid) drug coverage. You can contact the TennCare (Medicaid) agency to find out about drugs covered under your TennCare (Medicaid) coverage. (See contact information listed in Chapter 2.)

TennCare (Medicaid) may also be able to provide a TennCare (Medicaid) Drug List that tells you how to find out which drugs are covered under TennCare (Medicaid). However, if you are an adult age 21 or older and have Medicare, you get your prescription medicine from Medicare Part D through BlueCare Plus Choice, not from TennCare's Pharmacy Program.

**Chapter 5. Using the plan's coverage for Part D prescription drugs**

---

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction
- Drugs used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

**If you are receiving “Extra Help” from Medicare** to pay for your prescriptions, the “Extra Help” program will not pay for the drugs not normally covered. However, if you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

---

**SECTION 8 Filling a prescription**

---

**Section 8.1 Provide your membership information**

To fill your prescription, provide your plan membership information, which can be found on your membership card, at the network pharmacy you choose. The network pharmacy will automatically bill the plan for our share of the costs of your drug. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

**Section 8.2 What if you don't have your membership information with you?**

If you don't have your plan membership information with you when you fill your prescription, you or the pharmacy can call the plan to get the necessary information, or you can ask the pharmacy to look up your plan enrollment information.

Our plan is not allowed to reimburse you for TennCare (Medicaid)-covered benefits. If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up.** (You can then **ask us to reimburse you.** See Chapter 7, Section 2 for information about how to ask the plan for reimbursement.)

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up.** (You can then **ask us to reimburse you** for our share. See Chapter 7, Section 2.1 for information about how to ask the plan for reimbursement.)

---

**SECTION 9 Part D drug coverage in special situations**

---

**Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?**

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the plan will cover your prescription drugs as long as the drugs meet all of our rules for coverage described in this Chapter.

**Section 9.2 What if you're a resident in a long-term care (LTC) facility?**

Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy, or uses a pharmacy that supplies drugs for all of its residents. If you are a resident of an LTC facility, you may get your prescription drugs through the facility's pharmacy or the one it uses, as long as it is part of our network.

Check your *Pharmacy Directory* to find out if your LTC facility's pharmacy or the one that it uses is part of our network. If it isn't, or if you need more information or assistance, please contact Member Service. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies.

**What if you're a resident in a long-term care (LTC) facility and need a drug that is not on our "Drug List" or is restricted in some way?**

Please refer to Section 5.2 about a temporary or emergency supply.

**Section 9.3 What if you're in Medicare-certified hospice?**

Hospice and our plan do not cover the same drug at the same time. If you are enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea, drugs, laxative, pain medication or anti-anxiety drugs) that are not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover your drugs as explained in this document. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, bring documentation to the pharmacy to verify your revocation or discharge.



---

**SECTION 10 Programs on drug safety and managing medications**

---

**Section 10.1 Programs to help members use drugs safely**

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Possible medication errors
- Drugs that may not be necessary because you are taking another drug to treat the same condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking
- Unsafe amounts of opioid pain medications

If we see a possible problem in your use of medications, we will work with your provider to correct the problem.

**Section 10.2 Drug Management Program (DMP) to help members safely use their opioid medications**

We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several doctors or pharmacies, or if you had a recent opioid overdose, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid or benzodiazepine medications may not be safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain doctor(s)
- Limiting the amount of opioid or benzodiazepine medications we will cover for you

If we plan on limiting how you may get these medications or how much you can get, we will send you a letter in advance. The letter will tell you if we will limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific doctor or pharmacy. You will have an opportunity to tell us which doctors or pharmacies you prefer to use,

**Chapter 5. Using the plan's coverage for Part D prescription drugs**

---

and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we will send you another letter confirming the limitation. If you think we made a mistake or you disagree with our decision or with the limitation, you and your prescriber have the right to appeal. If you appeal, we will review your case and give you a new decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan. See Chapter 9 for information about how to ask for an appeal.

You will not be placed in our DMP if you have certain medical conditions, such as active cancer-related pain or sickle cell disease, you are receiving hospice, palliative, or end-of-life care, or live in a long-term care facility.

**Section 10.3 Medication Therapy Management (MTM) program to help members manage their medications**

We have a program that can help our members with complex health needs. Our program is called a Medication Therapy Management (MTM) program. This program is voluntary and free. A team of pharmacists and doctors developed the program for us to help make sure that our members get the most benefit from the drugs they take.

Some members who take medications for different medical conditions and have high drug costs, or are in a DMP to help members use their opioids safely, may be able to get services through an MTM program. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will receive information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list up to date and with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you. If you have any questions about this program, please contact Member Service.

# CHAPTER 6:

*What you pay for your  
Part D prescription drugs*



## How can you get information about your drug costs?

Because you are eligible for TennCare (Medicaid), you qualify for and are getting "Extra Help" from Medicare to pay for your prescription drug plan costs. Because you are in the "Extra Help" program, **some information in this *Evidence of Coverage about the costs for Part D prescription drugs may not apply to you.*** We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the Low Income Subsidy Rider or the LIS Rider), which tells you about your drug coverage. If you don't have this insert, please call Member Service and ask for the LIS Rider.

You won't pay more than \$11.20 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.

Please see Section 9 of this chapter for more information on Part D vaccines cost sharing for Part D vaccines.

---

## SECTION 1 Introduction

---

<b>Section 1.1</b>	<b>Use this chapter together with other materials that explain your drug coverage</b>
--------------------	---

This chapter focuses on what you pay for Part D prescription drugs. To keep things simple, we use **drug** in this chapter to mean a Part D prescription drug. As explained in Chapter 5, not all drugs are Part D drugs – some drugs are excluded from Part D coverage by law. Some of the drugs excluded from Part D coverage are covered under Medicare Part A or Part B.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5, Sections 1 through 4 explain these rules. When you use the plan's "Real-Time Benefit Tool" to look up drug coverage (see Chapter 3, Section 3.3), the cost shown is provided in "real time" meaning the cost you see in the tool reflects a moment in time to provide an estimate of the out-of-pocket costs you are expected to pay. You can also obtain information provided by the Real "Time Benefit Tool" by calling Member Service.

<b>Section 1.2</b>	<b>Types of out-of-pocket costs you may pay for covered drugs</b>
--------------------	---

There are different types of out-of-pocket costs for Part D drugs. The amount that you pay for a drug is called **cost sharing**, and there are three ways you may be asked to pay.

- **Deductible** is the amount you pay for drugs before our plan begins to pay its share.
- **Copayment** is a fixed amount you pay each time you fill a prescription.
- **Coinsurance** is a percentage of the total cost you pay each time you fill a prescription.

---

### Section 1.3 How Medicare calculates your out-of-pocket costs

---

Medicare has rules about what counts and what does not count toward your out-of-pocket costs. Here are the rules we must follow to keep track of your out-of-pocket costs.

---

#### **These payments are included in your out-of-pocket costs**

**Your out-of-pocket costs include** the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 5):

- The amount you pay for drugs when you are in any of the following drug payment stages:
  - The Initial Coverage Stage
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

#### **It matters who pays:**

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are *also included* in your out-of-pocket costs if they are made on your behalf by **certain other individuals or organizations**. This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Some payments made by the Medicare Coverage Gap Discount Program are included in your out-of-pocket costs. The amount the manufacturer pays for your brand name drugs is included. But the amount the plan pays for your generic drugs is not included.

#### **Moving on to the Catastrophic Coverage Stage:**

When you (or those paying on your behalf) have spent a total of \$8,000 in out-of-pocket costs within the calendar year, you will move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

---

#### **These payments are not included in your out-of-pocket costs**

Your out-of-pocket costs do not include any of these types of payments:

- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.

**Chapter 6. What you pay for your Part D prescription drugs**

---

- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments made by the plan for your brand or generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Affairs.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation).

*Reminder:* If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan by calling Member Service.

---

**How can you keep track of your out-of-pocket total?**

- **We will help you.** The Part D Explanation of Benefits (EOB) report you receive includes the current amount of your out-of-pocket costs. When this amount reaches \$8,000, this report will tell you that you have left the Initial Coverage Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

---

**SECTION 2 What you pay for a drug depends on which drug payment stage you are in when you get the drug**

---

<b>Section 2.1</b>	<b>What are the drug payment stages for BlueCare Plus Choice members?</b>
--------------------	---

There are four **drug payment stages** for your Medicare Part D prescription drug coverage under BlueCare Plus Choice. How much you pay depends on what stage you are in when you get a prescription filled or refilled. Details of each stage are in Sections 4 through 7 of this chapter. The stages are:

**Stage 1: Yearly Deductible Stage** (does not apply; see Section 4 in this chapter)

Stage 2: Initial Coverage Stage

Stage 3: Coverage Gap Stage

Stage 4: Catastrophic Coverage Stage

---

## SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in

---

<b>Section 3.1 We send you a monthly summary called the <i>Part D Explanation of Benefits</i> (the Part D EOB)</b>
--

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your **Out-of-Pocket Costs**.
- We keep track of your **Total Drug Costs**. This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

If you have had one or more prescriptions filled through the plan during the previous month we will send you a Part D EOB. The Part D EOB includes:

- **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called year-to-date information. It shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This information will display the total drug price, and information about increases in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This will include information about other available drugs with lower cost sharing for each prescription claim.

<b>Section 3.2 Help us keep our information about your drug payments up to date</b>
---

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card every time you get a prescription filled.** This helps us make sure we know about the prescriptions you are filling and what you are paying.

**Chapter 6. What you pay for your Part D prescription drugs**

---

- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. Here are examples of when you should give us copies of your drug receipts:
  - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit
  - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program
  - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances

If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.

- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive the Part D EOB, look it over to be sure the information is complete and correct. If you think something is missing or you have any questions, please call us at Member Service. Be sure to keep these reports.

---

**SECTION 4 There is no deductible for BlueCare Plus Choice**

---

There is no deductible for BlueCare Plus Choice. You begin in the Initial Coverage Stage when you fill your first prescription for the year. See Section 5 for information about your coverage in the Initial Coverage Stage.

---

**SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share**

---

<b>Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription</b>
---

During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share (your copayment amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

**The plan has 1 cost sharing tier**

Every drug on the plan's Drug List is in one cost sharing tier.



**Chapter 6. What you pay for your Part D prescription drugs**

- Tier 1 - Generic and Brand Drugs (This is the only tier and includes all covered drugs.)

**Your pharmacy choices**

How much you pay for a drug depends on whether you get the drug from:

- A network retail pharmacy
- A pharmacy that is not in the plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5 to find out when we will cover a prescription filled at an out-of-network pharmacy.
- The plan's mail-order pharmacy.

For more information about these pharmacy choices and filling your prescriptions, see Chapter 5 and the plan's *Pharmacy Directory*.

**Section 5.2 A table that shows your costs for a one-month supply of a drug**

During the Initial Coverage Stage, your share of the cost of a covered drug will be a copayment.

**Your share of the cost when you get a one-month supply of a covered Part D prescription drug:**

<b>Tier</b>	<b>Standard retail cost sharing (in-network)</b> (up to a 30-day supply)	<b>Mail-order cost sharing</b> (up to a 30-day supply)	<b>Long-term care (LTC) cost sharing</b> (up to a 31-day supply)	<b>Out-of-network cost sharing</b> (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 14-day supply)
<b>Tier 1</b> (Generic and Brand Drugs)	<b>Generic:</b> <b>\$0.00 to \$4.50</b> copay	<b>Generic:</b> <b>\$0.00 to \$4.50</b> copay	<b>Generic:</b> <b>\$0.00 to \$4.50</b> copay	<b>Generic:</b> <b>\$0.00 to \$4.50</b> copay
The amount you pay is determined by the covered Part D prescription and your low-income subsidy coverage. Please refer to your <i>LIS Rider</i> for the specific amount you pay.	<b>Brand:</b> <b>\$0.00 to \$11.20</b> copay	<b>Brand:</b> <b>\$0.00 to \$11.20</b> copay	<b>Brand:</b> <b>\$0.00 to \$11.20</b> copay	<b>Brand:</b> <b>\$0.00 to \$11.20</b> copay

**Chapter 6. What you pay for your Part D prescription drugs**

You won't pay more than \$11.20 for a one-month supply of each covered insulin product regardless of the cost-sharing tier.

Please see Section 9 of this chapter for more information on Part D vaccines cost sharing for Part D vaccines.

**Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply**

Typically, the amount you pay for a prescription drug covers a full month's supply. There may be times when you or your doctor would like you to have less than a month's supply of a drug (for example, when you are trying a medication for the first time). You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply of your drugs, if this will help you better plan refill dates for different prescriptions.

If you receive less than a full month's supply of certain drugs, you will not have to pay for the full month's supply.

- If you are responsible for coinsurance, you pay a *percentage* of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower.
- If you are responsible for a copayment for the drug, you will only pay for the number of days of the drug that you receive instead of a whole month. We will calculate the amount you pay per day for your drug (the daily cost-sharing rate) and multiply it by the number of days of the drug you receive.

**Section 5.4 A table that shows your costs for a *long-term* (up to a 90-day) supply of a drug**

For some drugs, you can get a long-term supply (also called an extended supply). A long-term supply is up to a 90-day supply.

The table below shows what you pay when you get a long-term supply of a drug.

**Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug:**

<b>Tier</b>	<b>Standard retail cost sharing (in-network) (up to a 90-day supply)</b>	<b>Mail-order cost sharing (up to a 90-day supply)</b>
<b>Tier 1</b> (Generic and Brand Drugs)	<b>Generic:</b> \$0.00 to \$4.50 copay	<b>Generic:</b> \$0.00 to \$4.50 copay
The amount you pay is	<b>Brand:</b>	<b>Brand:</b>

**Chapter 6. What you pay for your Part D prescription drugs**

<b>Tier</b>	<b>Standard retail cost sharing (in-network)</b> (up to a 90-day supply)	<b>Mail-order cost sharing</b> (up to a 90-day supply)
determined by the covered Part D prescription and your low-income subsidy coverage. Please refer to your LIS Rider for the specific amount you pay.	<b>\$0.00 to \$11.20</b> copay	<b>\$0.00 to \$11.20</b> copay

**Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach \$8,000**

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach \$8,000. You then move on to the Catastrophic Coverage Stage.

The Part D EOB that you receive will help you keep track of how much you, the plan, and any third parties have spent on your behalf during the year. Many people do not reach the \$8,000 limit in a year.

We will let you know if you reach this amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage. See Section 1.3 on how Medicare calculates your out-of-pocket costs.

**SECTION 6 There is no coverage gap for BlueCare Plus Choice**

There is no coverage gap for BlueCare Plus Choice. Once you leave the Initial Coverage Stage, you move on to the Catastrophic Coverage Stage (see Section 7).

**SECTION 7 During the Catastrophic Coverage Stage, the plan pays the full cost for your covered Part D drugs**

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the \$8,000 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this payment stage, the plan pays the full cost for your Part D covered drugs. You pay nothing.

---

**SECTION 8 Additional benefits information**

---

1. We cover up to an annual 90-day supply override for maintenance medication(s) for vacation. Stolen medication requires a police report before overriding.
2. Specialty Drugs will be covered up to a 30-day supply only, unless the smallest package available will last more than 30 days.
3. Diabetic testing supplies covered under Medicare Part B: Ascensia's Contour and Johnson & Johnson's Lifescan OneTouch products are both preferred brands. All other brands are not covered without prior authorization.

---

**SECTION 9 Part D Vaccines. What you pay for depends on how and where you get them**

---

**Important Message About What You Pay for Vaccines** – Some vaccines are considered medical benefits. Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's "Drug List." Our plan covers most adult Part D vaccines at no cost to you. Refer to your plan's "Drug List" or contact Member Service for coverage and cost sharing details about specific vaccines.

There are two parts to our coverage of Part D vaccinations:

- The first part of coverage is the cost of **the vaccine itself**.
- The second part of coverage is for the cost of **giving you the vaccine**. (This is sometimes called the administration of the vaccine.)

Your costs for a Part D vaccination depend on three things:

- 1. Whether the vaccine is recommended for adults by an organization called the Advisory Committee on Immunization Practices (ACIP).**
  - Most adult Part D vaccinations are recommended by ACIP and cost you nothing.
- 2. Where you get the vaccine.**
  - The vaccine itself may be dispensed by a pharmacy or provided by the doctor's office.
- 3. Who gives you the vaccine.**
  - A pharmacist or another provider may give the vaccine in the pharmacy. Alternatively, a provider may give it in the doctor's office.

What you pay at the time you get the Part D vaccination can vary depending on the circumstances and what **drug payment stage** you are in.

- Sometimes when you get a vaccination, you have to pay for the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask our plan to

**Chapter 6. What you pay for your Part D prescription drugs**

---

pay you back for our share of the cost. For most adult Part D vaccines, this means you will be reimbursed the entire cost you paid.

- Other times, when you get a vaccination, you will pay only your share of the cost under your Part D benefit. For most adult Part D vaccines, you will pay nothing.

Below are three examples of ways you might get a Part D vaccine.

*Situation 1:* You get the Part D vaccination at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to give certain vaccines.)

- For most adult Part D vaccines, you will pay nothing.
- For other Part D vaccines, you will pay the pharmacy your copayment for the vaccine itself which includes the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

*Situation 2:* You get the Part D vaccination at your doctor's office.

- When you get the vaccine, you may have to pay for the entire cost of the vaccine itself and the cost for the provider to give it to you.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 7.
- For most adult Part D vaccines, you will be reimbursed the full amount you paid. For other Part D vaccines, you will be reimbursed the amount you paid less any copayment for the vaccine (including administration) and less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help," we will reimburse you for this difference.)

*Situation 3:* You buy the Part D vaccine itself at the network pharmacy, and then take it to your doctor's office where they give you the vaccine.

- For most adult Part D vaccines, you will pay nothing for the vaccine itself.
- For other Part D vaccines, you will pay the pharmacy your copayment for the vaccine itself
- When your doctor gives you the vaccine, you may have to pay the entire cost for this service.
- You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.
- For most adult Part D vaccines, you will be reimbursed the full amount you paid. For other Part D vaccines, you will be reimbursed the amount you paid less any coinsurance for the vaccine administration.

**Chapter 6. What you pay for your Part D prescription drugs**

---

Below are a few examples of vaccines covered under Part D of this plan:

- Tdap (Tetanus, Diphtheria and Pertussis (Whooping Cough))
- Shingles

## CHAPTER 7:

*Asking us to pay our share of a bill  
you have received for covered  
medical services or drugs*

---

## **SECTION 1 Situations in which you should ask us to pay for your covered services or drugs**

---

Our network providers bill the plan directly for your covered services and drugs. If you get a bill for the full cost of medical care or drugs you have received, you should send this bill to us so that we can pay it. When you send us the bill, we will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

**If you have already paid for a Medicare service or item covered by the plan**, you can ask our plan to pay you back (paying you back is often called **reimbursing** you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs that are covered by our plan. There may be deadlines that you must meet to get paid back. Please see Section 2 of this chapter. When you send us a bill you have already paid, we will look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we will pay you back for the services or drugs.

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

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received:

### **1. When you've received emergency or urgently needed medical care from a provider who is not in our plan's network**

You can receive emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases, ask the provider to bill the plan.

- If you pay the entire amount yourself at the time you receive the care, ask us to pay you back. Send us the bill, along with documentation of any payments you have made.
- You may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
  - If the provider is owed anything, we will pay the provider directly.
  - If you have already paid for the service, we will pay you back.



**Chapter 7. Asking us to pay our share of a bill you have received for covered medical services or drugs**

---

**2. When a network provider sends you a bill you think you should not pay**

Network providers should always bill the plan directly. But sometimes they make mistakes, and ask you to pay for your services.

- Whenever you get a bill from a network provider, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, send us the bill along with documentation of any payment you have made. You should ask us to pay you back for your covered services.

**3. If you are retroactively enrolled in our plan**

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

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

**4. When you use an out-of-network pharmacy to get a prescription filled**

If you go to an out-of-network pharmacy, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out-of-network pharmacies in limited circumstances. See Chapter 5, Section 2.5 for a discussion of these circumstances.

**5. When you pay the full cost for a prescription because you don't have your plan membership card with you**

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself. Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

**6. When you pay the full cost for a prescription in other situations**

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on the plan's "Drug List" or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost of the drug.

**Chapter 7. Asking us to pay our share of a bill you have received for covered medical services or drugs**

---

We will accept paper claims for prescriptions that are filled at an out-of-network pharmacy (see Chapter 5, Section 2.5).

When you send us a request for payment, we will 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 will pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 9 of this document has information about how to make an appeal.

---

**SECTION 2 How to ask us to pay you back or to pay a bill you have received**

---

You may request us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records. **You must submit your medical claim to us within twelve months** of the date you received the service or item. **Pharmacy requests must be submitted within thirty-six months** from the received date of the drug.

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

- You don't have to use the form, but it will help us process the information faster. 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.
- Either download a copy of the form from our website ([bluecareplus.bcbst.com](http://bluecareplus.bcbst.com)) or call Member Service and ask for the form.

Mail your request for payment together with any bills or paid receipts to us at one of the following addresses:

**Medical Requests:**

BlueCare Plus Tennessee  
ATTN: BlueCare Plus Operations  
1 Cameron Hill Circle, Suite 0002  
Chattanooga, TN 37402-0002

**Pharmacy Requests:**

BlueCross BlueShield of Tennessee  
ATTN: Medicare Part D Prescription Drug Claim Request  
1 Cameron Hill Circle, Suite 48  
Chattanooga, TN 37402-0048

**Chapter 7. Asking us to pay our share of a bill you have received for covered medical services or drugs**

---

---

**SECTION 3 We will consider your request for payment and say yes or no**

---

**Section 3.1 We check to see whether we should cover the service or drug and how much we owe**

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

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

**Section 3.2 If we tell you that we will not pay for all or part of the medical care or drug, you can make an appeal**

If you think we have made a mistake in turning down your request for payment or the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 9 of this document.

# CHAPTER 8:

*Your rights and responsibilities*

---

## **SECTION 1 Our plan must honor your rights and cultural sensitivities as a member of the plan**

---

<b>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 or alternate formats)</b>
---

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

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Service.

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

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

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Member Service at 1-800-332-5762 (TTY: 711). You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

<b>Section 1.2 We must ensure that you get timely access to your covered services and drugs</b>
---

You have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral. We do not require you to get referrals to go to network providers.

You have the right to get appointments and covered services from the plan's network of providers *within a reasonable amount of time*. This includes the right to get timely services from

specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time. Chapter 9 tells what you can do.

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

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

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

#### **How do we protect the privacy of your health information?**

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

#### **You can see the information in your records and know how it has been shared with others**

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

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

If you have questions or concerns about the privacy of your personal health information, please call Member Service.

<b>Section 1.4 We must give you information about the plan, its network of providers, and your covered services</b>
---

As a member of BlueCare Plus Choice, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call Member Service:

- **Information about our plan.** This includes, for example, information about the plan's financial condition.
- **Information about our network providers and pharmacies.** You have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services. Chapters 5 and 6 provide information about Part D prescription drug coverage.
- **Information about why something is not covered and what you can do about it.** Chapter 9 provides information on asking for a written explanation on why a medical service or Part D drug is not covered or if your coverage is restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.

<b>Section 1.5 We must support your right to make decisions about your care</b>
---

**You have the right to know your treatment options and participate in decisions about your health care**

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

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

- **To know about all of your choices.** You have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.

- **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. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

### **You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself**

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

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

The legal documents that you can use to give your directions in advance in these situations are called **advance directives**. There are different types of advance directives and different names for them. Documents called **living will** and **power of attorney for health care** are examples of advance directives.

If you want to use an advance directive to give your instructions, here is what to do:

- **Get the form.** You can get an advance directive form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Member Service to ask for the forms.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

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



**Remember, it is your choice whether you want to fill out an advance directive** (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

### **What if your instructions are not followed?**

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the Tennessee Department of Health.

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

If you have any problems, concerns, or complaints and need to request coverage, or make an appeal, Chapter 9 of this document tells what you can do. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

### **Section 1.7 What can you do if you believe you are being treated unfairly or your rights are not being respected?**

#### **If it is about discrimination, call the Office for Civil Rights**

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

#### **Is it about something else?**

If you believe you have been treated unfairly or your rights have not been respected, *and it's not* about discrimination, you can get help dealing with the problem you are having:

- You can **call Member Service.**
- You can **call the SHIP.** For details, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

#### **Long-Term Care Ombudsman**

The State's Long-Term Care Ombudsman program offers assistance to persons living in nursing homes or other community-based residential settings, like an assisted living or critical adult care home. A Long-Term Care Ombudsman does **not** work for the facility, the State, or BlueCare Plus Choice. This helps them to be fair and objective in resolving problems and concerns.

The Long-Term Care Ombudsman in each area of the State can:

- Provide information about admission to and discharge from long-term services and supports facilities.

- Provide education about resident rights and responsibilities.
- Help residents and their families resolve questions or problems they have been unable to address on their own with the facility. Concerns can include things like:
  - Quality of care;
  - Resident rights; or
  - Admissions, transfers, and discharges

To find out more about the Long-Term Care Ombudsman program, or to contact the Ombudsman in your area, call the Tennessee Commission on Aging and Disability for free at **1-877-236-0013**.

### **Section 1.8 How to get more information about your rights**

There are several places where you can get more information about your rights:

- You can **call Member Service**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- You can contact **Medicare**.
  - You can visit the Medicare website to read or download the publication *Medicare Rights & Protections*. (The publication is available at: [www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf](http://www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf).)
  - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

## **SECTION 2 You have some responsibilities as a member of the plan**

Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Service.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this Evidence of Coverage to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapters 3 and 4 give the details about your medical services.
  - Chapters 5 and 6 give the details about your Part D prescription drug coverage.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription drugs.

- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - You must continue to pay your Medicare premiums to remain a member of the plan.
  - For most of your drugs covered by the plan, you must pay your share of the cost when you get the drug.
  - If you are required to pay the extra amount for Part D because of your higher income (as reported on your last tax return), you must continue to pay the extra amount directly to the government to remain a member of the plan.
- **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 cannot remain a member of our plan.**
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).
- **Paying TennCare (Medicaid) back for the services you get in Long Term Services and Supports: Estate Recovery**

## Estate Recovery

### What is Estate Recovery?

Estate Recovery is the way TennCare collects money from the estates of people who passed away and received TennCare long-term services and supports. The kinds of care that must be paid back are listed below. TennCare is required by federal law to recoup (get back) these payments after the death of the recipient. This is referred to as “estate recovery.”

Estate recovery is using the value of property you leave behind when you die to pay TennCare back for care you received while you were living. Your “estate” is the property, belongings, money, and other assets that you own at the time of your death. Keep reading to find out who has to pay TennCare back and how much your estate will have to pay back.

TennCare can’t ask for the money back until **after** your death. TennCare can’t ask for more money back than we paid for your care. TennCare can’t ask your family to pay for your care out of their own pockets.

If the value of all of your assets at the time of your death is less than TennCare’s bill, TennCare is only entitled to the value of your assets and no more. For example, if the only thing that you own at the time of your death is a home valued at \$50,000 but TennCare has a bill of \$75,000, then TennCare is only entitled to collect \$50,000. TennCare cannot seek repayment of the remaining amount from your family.

### Who has to pay TennCare back for their care?

TennCare **must** ask to be repaid for money it spent on your care if you are:

- Age 55 and older and got care in a nursing home or ICF/IID, home care—called home and community-based services or HCBS, home health or private duty nursing

### What kinds of care must be paid back to TennCare?

TennCare **must** ask to be repaid for:

- Care in a nursing home or ICF/IID.
- Home care, known as home and community-based services or HCBS.
- Home Health or private duty nursing.
- Hospital care and prescription drugs related to your long-term care services.

### How much your estate will have to pay TennCare back for your care

To provide long-term care, TennCare contracts with a health insurance company (also called a “managed care organization” or “MCO”). When someone receives TennCare, TennCare pays a monthly premium to the insurance company. The monthly premium is called a “capitation rate.” In return, the insurance company pays the health care provider (such as a nursing facility or other entity providing long-term care in the home/community) for the person’s care. Under federal law, TennCare is required to seek repayment of the premium payment it made to the insurance company on your behalf.



The premium payment made to the insurance company is the same each month, no matter what services you actually receive that month. The premium payment can also vary depending on what type of long-term care you have and the part of the state you live in.

**TennCare may not have to get the money back from your estate if:**

- You do not have money, property, or other assets when you die or
- The things you left can't be used to pay people you owe through probate court. An example is life insurance money.

**What if I sell or give away my home while I am receiving TennCare?**

Then you must disclose to TennCare that you sold or gave away your home, which may affect your TennCare eligibility. You must also disclose any transfer made five years before you received TennCare. If you do not disclose the transfer, TennCare may have the transfer set aside and will seek repayment from your estate, family member(s), or any other person that participated in the transfer.

**What are the reasons that TennCare may delay estate recovery?**

In some situations, estate recovery is delayed or "deferred," which means that it is not pursued until a later date. TennCare defers estate recovery for an individual's estate when:

- You have a surviving husband or wife. TennCare may not recover against your estate until the death of your husband or wife.
- You have a child that is under the age of 21. TennCare may not recover against your estate until your child is over the age of 21.
- You have a blind or permanently disabled child. TennCare may not recover until the death of the disabled child.
- You have a son or daughter whose care kept you out of the nursing home for at least two years. The son or daughter must reside at the property during this time and continue residing there after you pass away in order for the deferral to continue to exist. If the son or daughter sells or no longer resides at the home, then TennCare may collect its claim.
- Your brother or sister whose care kept you out of the nursing home lived in your home for a year **before** you got nursing home or home care. If the brother or sister passes away or no longer resides at the property, then the deferral no longer exists.
- If the property is the family's only income, such as a family farm.

### **How will your family find out if your estate owes money to TennCare?**

To find out if the estate owes money to TennCare, your family or representative must submit a Request for Release Form to TennCare in one of three ways:

1. Get the Request for Release online at:  
<https://www.tn.gov/content/dam/tn/tenncare/documents/releaseform.pdf>
2. Get the Request for Release from the Probate Court Clerk's office by asking for a "Request for Release from Estate Recovery".
3. Get the Request for Release from TennCare by sending a letter or fax to:



**Mail to:**

Division of TennCare  
Estate Recovery Unit  
310 Great Circle Rd.  
4<sup>th</sup> Floor  
Nashville, TN 37243






**Fax to:**

**615-413-1941**

### **What if you do have to pay TennCare money from your estate?**

Your family or representative has several options if there is a TennCare claim:

1. They can pay the TennCare claim from your remaining belongings
2. Your estate can be admitted to "Probate." When this happens, a Court will appoint someone known as an administrator (or if you have a will this person is known as an executor) to sell your property, to pay any debts that you might have had while alive, and then give your heirs the remaining property/money if there is anything left. Your family or TennCare may request that an administrator be appointed for your estate.
3. They may apply for a deferral of Estate Recovery.

<b>Do you have questions or need help with estate recovery?</b>	
	<b>MAIL:</b> Division of TennCare Estate Recovery Unit 310 Great Circle Road, 3W Nashville, TN 37243
	<b>FAX:</b> 615-413-1941.
	<b>CALL:</b> 844-629-0941.

## CHAPTER 9:

*What to do if you have a problem  
or complaint (coverage decisions,  
appeals, complaints)*



**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

---

---

---

**SECTION 1 Introduction**

---

**Section 1.1 What to do if you have a problem or concern**

This chapter explains the processes for handling problems and concerns. The process you use to handle your problem depends on the type of problem you are having:

- 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.

Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

**Section 3** will help you identify the right process to use and what you should do.

**Section 1.2 What about the legal terms?**

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand. To make things easier, this chapter:

- Uses simpler words in place of certain legal terms. For example, this chapter generally says making a complaint rather than filing a grievance, coverage decision rather than integrated organization determination or coverage determination or at-risk determination, and independent review organization instead of Independent Review Entity.
- It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms. Knowing which terms to use will help you communicate more accurately to get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

---

**SECTION 2 Where to get more information and personalized assistance**

---

We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. Therefore, you should always reach out to customer service for help. But in some situations, you may also want help or guidance from someone who is not connected with us. Below are two entities that can assist you.

## Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

---

### State Health Insurance Assistance Program (SHIP)

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

The services of SHIP counselors are free. You will find phone numbers and website URLs in Chapter 2, Section 3 of this document.

### Medicare

You can also contact Medicare to get help. To contact Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You also can visit the Medicare website ([www.medicare.gov](http://www.medicare.gov)).

### You can get help and information from TennCare (Medicaid)

TennCare (Medicaid) (TennCare Solutions)	
<b>CALL</b>	1-800-878-3192
<b>TTY</b>	1-877-779-3103  This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
<b>WRITE</b>	TennCare Solutions PO Box 593 Nashville, TN 37202-0593
<b>WEBSITE</b>	<a href="http://www.tn.gov/tenncare">www.tn.gov/tenncare</a>

---

## SECTION 3 Understanding Medicare and TennCare (Medicaid) complaints and appeals in our plan

---

You have Medicare and get assistance from TennCare (Medicaid). Information in this chapter applies to all of your Medicare and TennCare (Medicaid) benefits. This is sometimes called an

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

---

integrated process because it combines, or integrates, Medicare and TennCare (Medicaid) processes.

Sometimes the Medicare and Medicaid processes are not combined. In those situations, you use a Medicare process for a benefit covered by Medicare and a TennCare (Medicaid) process for a benefit covered by TennCare (Medicaid). These situations are explained in **Section 6.4** of this chapter, *Step-by-step: How a Level 2 appeal is done*.

---

**PROBLEMS ABOUT YOUR BENEFITS**

---

---

**SECTION 4 Coverage decisions and appeals**

---

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The information below will help you find the right section of this chapter for problems or complaints about **benefits covered by Medicare or TennCare (Medicaid)**.

**Is your problem or concern about your benefits or coverage?**

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

**Yes.**

Go on to the next section of this chapter, **Section 5, “A guide to the basics of coverage decisions and appeals.”**

**No.**

Skip ahead to **Section 11** at the end of this chapter, **“How to make a complaint about quality of care, waiting times, customer service, or other concerns.”**

---

---

**SECTION 5 A guide to the basics of coverage decisions and appeals**

---

<b>Section 5.1</b>	<b>Asking for coverage decisions and making appeals: the big picture</b>
--------------------	--

Coverage decisions and appeals deal with problems related to your benefits and coverage for your medical care (services, items, and Part B prescription drugs, including payment). To keep things simple, we generally refer to medical items, services and Medicare Part B prescription 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.

## Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

---

### Asking for coverage decisions prior to receiving benefits

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical care. For example, if your plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either your network doctor can show that you received 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 will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical care before you receive it, you can ask us to make a coverage decision for you. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide medical care is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

### Making an appeal

If we make a coverage decision, whether before or after a benefit is received, and you are not satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

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

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

If we 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 that is not connected to us.

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

- You do not 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 do not fully agree with your Level 1 appeal.
- See **Section 6.4** of this chapter for more information about Level 2 appeals.
- For Part D drug appeals, if we say no to all or part of your appeal, you will need to ask for a Level 2 appeal. Part D appeals are discussed further in Section 7 of this chapter.

If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 10 in this chapter explains the Level 3, 4, and 5 appeals processes).

**Section 5.2 How to get help when you are asking for a coverage decision or making an appeal**

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

- **You can call us at Member Service.**
- **You can get free help** from your State Health Insurance Assistance Program.
- **Your doctor or other health care provider can make a request for you.** If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call Member Service and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at [www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf](http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf) or on our website at [bluecareplus.bcbst.com](http://bluecareplus.bcbst.com).)
  - For medical care, your doctor or other health care provider can request a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
  - If your doctor or other health provider asks that a service or item that you are already getting be continued during your appeal, you **may** need to name your doctor or other prescriber as your representative to act on your behalf.
  - For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied your doctor or prescriber can request a Level 2 appeal.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your representative to ask for a coverage decision or make an appeal.
  - If you want a friend, relative, or other person to be your representative, call Member Service and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at [www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf](http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf) or on our website at [bluecareplus.bcbst.com](http://bluecareplus.bcbst.com).) The form gives that person permission to act on your behalf. It must be signed by you and by the person you would like to act on your behalf. You must give us a copy of the signed form.

## Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You may contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

### Section 5.3 Which section of this chapter gives the details for your situation?

There are four different situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 6** of this chapter, “Your medical care: How to ask for a coverage decision or make an appeal”
- **Section 7** of this chapter, “Your Part D prescription drugs: How to ask for a coverage decision or make an appeal”
- **Section 8** of this chapter, “How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon”
- **Section 9** of this chapter, “How to ask us to keep covering certain medical services if you think your coverage is ending too soon” (This section only applies to these services: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you’re not sure which section you should be using, call Member Service. You can also get help or information from government organizations such as your SHIP.

## SECTION 6 Your medical care: How to ask for a coverage decision or make an appeal of a coverage decision

### Section 6.1 This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for your care

This section is about your benefits for medical care. These benefits are described in Chapter 4 of this document: *Medical Benefits Chart (what is covered)*. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

This section tells what you can do if you are in any of the five following situations:

## Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

1. You are not getting certain medical care you want, and you believe that our plan covers this care. **Ask for a coverage decision. Section 6.2.**
2. Our plan will not approve the medical care your doctor or other health care provider wants to give you, and you believe that our plan covers this care. **Ask for a coverage decision. Section 6.2.**
3. You have received medical care that you believe our plan should cover, but we have said we will not pay for this care. **Make an appeal. Section 6.3.**
4. You have received and paid for medical care that you believe our plan should cover, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 6.5.**
5. You are being told that coverage for certain medical care you have been getting (that we previously approved) will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 6.3.**

**Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read Sections 8 and 9 of this chapter. Special rules apply to these types of care.**

### Section 6.2 Step-by-step: How to ask for a coverage decision

#### Legal Terms

When a coverage decision involves your medical care, it is called an **organization determination**.

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

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

**A standard coverage decision is usually made within 14 days or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. In order to get a fast coverage decision, you must meet two requirements:**

- You may *only ask* for coverage for medical items and/or services (not requests for payment for items and/or services already received).
- You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor tells us that your health requires a fast coverage decision, we will automatically agree to give you a fast coverage decision.**

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

---

- **If you ask for a fast coverage decision on your own, without your doctor’s support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:

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

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

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

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

*For standard coverage decisions we use the standard deadlines.*

**This means we will give you an answer within 14 calendar days** after we receive your request **for a medical item or service**. If your request is for a **Medicare Part B prescription drug**, we will give you an answer **within 72 hours** after we receive your request.

- **However**, if you ask for more time, or if we need more information that may benefit you **we can take up to 14 more days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a fast complaint. We will give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. See Section 11 of this chapter for information on complaints.)

*For Fast Coverage decisions we use an expedited timeframe*

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

- **However**, if you ask for more time, or if we need more that may benefit you **we can take up to 14 more days**. If we take extra days, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a fast complaint. (See Section 11 of this chapter for information on complaints.) We will call you as soon as we make the decision.



## Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

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

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

### **Section 6.3 Step-by-step: How to make a Level 1 appeal**

#### **Legal Terms**

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

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

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

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

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we will give you a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 6.2 of this chapter.

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

- **If you are asking for a standard appeal, submit your standard appeal in writing.** You may also ask for an appeal by calling us. Chapter 2 has contact information.
- **If you are asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a free copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.**

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

---

*If we told you we were going to stop or reduce services or items that you were already getting, you may be able to keep those services or items during your appeal.*

- If we decided to change or stop coverage for a service or item that you currently get, we will send you a notice before taking the proposed action.
- If you disagree with the action, you can file a Level 1 appeal. We will continue covering the service or item if you ask for a Level 1 appeal within 10 calendar days of the postmark date on our letter or by the intended effective date of the action, whichever is later.
- If you meet this deadline, you can keep getting the service or item with no changes while your Level 1 appeal is pending. You will also keep getting all other services or items (that are not the subject of your appeal) with no changes.

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

- When we are reviewing your appeal, we take a careful look at all of the information. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if needed, possibly contacting you or your doctor.

***Deadlines for a fast appeal***

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to.
  - However, if you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time if your request is for a Medicare Part B prescription drug.
  - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it receives your appeal.

***Deadlines for a standard appeal***

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
  - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item

## Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

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

- If you believe we should **not** take extra days, you can file a fast complaint. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see **Section 11** of this chapter.)
- If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal where an independent review organization will review the appeal. Section 6.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage within **30 calendar days**, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug, after we receive your appeal.
- **If our plan says no to part or all of your appeal, you have additional appeal rights.**
- If we say no to part or all of what you asked for, we will send you a letter.
  - If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the independent review organization for a Level 2 appeal.
  - If your problem is about coverage of a Medicaid service or item, the letter will tell you how to file a Level 2 appeal yourself.

### Section 6.4 Step-by-step: How a Level 2 appeal is done

#### Legal Term

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

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

- If your problem is about a service or item that is usually **covered by Medicare**, we will automatically send your case to Level 2 of the appeals process as soon as the Level 1 appeal is complete.
- If your problem is about a service or item that is usually **covered by TennCare (Medicaid)**, you can file a Level 2 appeal yourself. The letter will tell you how to do this. Information is also below.
- If your problem is about a service or item that could be **covered by both Medicare and TennCare (Medicaid)**, you will automatically get a Level 2 appeal with the independent review organization. You can also ask for a Fair Hearing with the state.

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

---

If you qualified for continuation of benefits when you filed your Level 1 appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Go to page 186 for information about continuing your benefits during Level 1 appeals.

- If your problem is about a service that is usually covered by Medicare only, your benefits for that service will not continue during the Level 2 appeals process with the independent review organization.
- If your problem is about a service that is usually covered by TennCare (Medicaid), your benefits for that service will continue if you submit a Level 2 appeal within 10 calendar days after receiving the plan's decision letter.

**If your problem is about a service or item Medicare usually covers:**

**Step 1: The independent review organization reviews your appeal.**

- We will send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a free copy of your case file.**
- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

***If you had a fast appeal at Level 1, you will also have a fast appeal at Level 2***

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

***If you had a standard appeal at Level 1, you will also have a standard appeal at Level 2***

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

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

---

**Step 2: The independent review organization gives you their answer.**

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

- **If the 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 receive the independent review organization's decision for **standard requests** or provide the service **within 72 hours** from the date we receive the independent review organization's decision for **expedited requests**.
- **If the independent review organization says yes to part or all of a request for a Medicare Part B prescription drug**, we must authorize or provide the Medicare Part B prescription drug **within 72 hours** after we receive the independent review organization's decision for **standard requests** or **within 24 hours** from the date we receive the independent review organization's decision for **expedited requests**.
- **If this organization says no to part or all of your appeal**, it means they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called **upholding the decision** or **turning down your appeal**.) In this case, the independent review organization will send you a letter:
  - Explaining its decision.
  - Notifying you of the right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
  - Telling you how to file a Level 3 appeal.
- If your Level 2 appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third 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 10** in this chapter explains the process for Level 3, 4, and 5 appeals.

**If your problem is about a service or item TennCare (Medicaid) usually covers:****Step 1: You can ask for a Fair Hearing with the state.**

- Level 2 of the appeals process for services that are usually covered by TennCare (Medicaid) is a Fair Hearing with the state. You must ask for a Fair Hearing in writing or over the phone **within 120 calendar days** of the date that we sent the decision letter on your Level 1 appeal. The letter you get from us will tell you where to submit your hearing request.

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)****Step 2: The Fair Hearing office gives you their answer.**

The Fair Hearing office will tell you their decision in writing and explain the reasons for it.

- **If the Fair Hearing office says yes to part or all of a request for a medical item or service**, we must authorize or provide the service or item within 72 hours after we receive the decision from the Fair Hearing office.
- **If the Fair Hearing office says no to part or all of your appeal**, they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called **upholding the decision** or **turning down your appeal**.)

**If the decision is no for all or part of what I asked for, can I make another appeal?**

If the independent review organization or Fair Hearing office decision is no for all or part of what you asked for, you have **additional appeal rights**.

The letter you get from the Fair Hearing office will describe this next appeal option.

See **Section 10** of this chapter for more information on your appeal rights after Level 2.

**Section 6.5      What if you are asking us to pay you back for a bill you have received for medical care?**

**We can't reimburse you directly for a Medicaid service or item.** If you get a bill for Medicaid-covered services and items, send the bill to us. **You should not pay the bill yourself.** We will contact the provider directly and take care of the problem. But if you do pay the bill, you can get a refund from that health care provider if you followed the rules for getting the service or item.

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

**Asking to be paid back for something you have already paid for:**

If you send us the paperwork asking for reimbursement, you are asking for a coverage decision. We can't reimburse you directly for a **Medicaid** service or item. If you get a bill for Medicaid covered services and items, send the bill to us. **You should not pay the bill yourself.** We will contact the health care provider directly and take care of the problem. But if you do pay the bill, you can get a refund from that health care provider if you followed the rules for getting services or items.

If you want us to reimburse you for a **Medicare** service or item or you are asking us to pay a health care provider for a Medicaid service or item you paid for, you will ask us to make this coverage decision. We will check to see if the medical care you paid for is a covered service. We will also check to see if you followed all the rules for using your coverage for medical care.

## Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

---

- **If we say yes to your request:**
- If the Medicare medical care is covered, we will send you the payment for the cost within 60 calendar days after we receive your request.
  - If the Medicaid care that you paid a health care provider for is covered and you think we should pay the health care provider instead, we will send your health care provider the payment for the cost within 60 calendar days after we receive your request.
  - Then you will need to contact your health care provider to get them to pay you back. If you haven't paid for the medical care, we will send the payment directly to the health care provider.
- **If we say no to your request:** If the medical care is not covered, or you did not follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the medical care and the reasons why.

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

**To make this appeal, follow the process for appeals that we describe in Section 5.3.** For appeals concerning reimbursement, please note:

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

---

## SECTION 7 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

---

<b>Section 7.1</b> <b>This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug</b>
---

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (See Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs please see Chapters 5 and 6. **This section is about your Part D drugs only.** To keep things simple, we generally say *drug* in the rest of this section, instead of repeating *covered outpatient prescription drug* or *Part D drug* every time. We also use the term “Drug List” instead of *List of Covered Drugs* or *Formulary*.

## Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- If you do not know if a drug is covered or if you meet the rules, you can ask us. Some drugs require that you get approval from us before we will cover it.
- If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

### Part D coverage decisions and appeals

Legal Term
------------

An initial coverage decision about your Part D drugs is called a <b>coverage determination</b> .
--

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs. This section tells what you can do if you are in any of the following situations:

- Asking to cover a Part D drug that is not on the plan's *List of Covered Drugs*. **Ask for an exception. Section 7.2.**
- Asking to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get). **Ask for an exception. Section 7.2.**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 7.4.**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 7.4.**

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal.

Section 7.2 What is an exception?
-----------------------------------

Legal Terms
-------------

Asking for coverage of a drug that is not on the "Drug List" is sometimes called asking for a <b>formulary exception</b> .
--

Asking for removal of a restriction on coverage for a drug is sometimes called asking for a <b>formulary exception</b> .
--

Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a <b>tiering exception</b> .
--

If a drug is not covered in the way you would like it to be covered, you can ask us to make an **exception**. An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are two examples of exceptions that you or your doctor or other prescriber can ask us to make:



## Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

1. **Covering a Part D drug for you that is not on our “Drug List.”** If we agree to cover a drug not on the “Drug List,” you will need to pay the cost-sharing amount that applies to all of our drugs. You cannot ask for an exception to the cost-sharing amount we require you to pay for the drug.
2. **Removing a restriction for a covered drug.** Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our “Drug List.”

### Section 7.3 Important things to know about asking for exceptions

#### Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our “Drug List” includes more than one drug for treating a particular condition. These different possibilities are called **alternative** drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally **not** approve your request for an exception.

#### We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request, you can ask for another review by making an appeal.

### Section 7.4 Step-by-step: How to ask for a coverage decision, including an exception

#### Legal Term

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

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

**Standard coverage decisions** are made within **72 hours** after we receive your doctor’s statement. **Fast coverage decisions** are made within **24 hours** after we receive your doctor’s statement.

***If your health requires it, ask us to give you a fast coverage decision. To get a fast coverage decision, you must meet two requirements:***

- You must be asking for a *drug you have not yet received*. (You cannot ask for fast coverage decision to be paid back for a drug you have already bought.)

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

---

- Using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we will automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
  - Explains that we will use the standard deadlines.
  - Explains if your doctor or other prescriber asks for the fast coverage decision, we will automatically give you a fast coverage decision.
  - Tells you how you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. We will answer your complaint within 24 hours of receipt.

**Step 2: Request a standard coverage decision or a 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 can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the *CMS Model Coverage Determination Request Form* which is available on our website. Chapter 2 has contact information. You may submit a pharmacy request through our secure portal via our website [members.bcbst.com/wps/myportal/member/home/pharmacy](https://members.bcbst.com/wps/myportal/member/home/pharmacy). To initiate the request, you must have registered an online account, sign in, and provide specific information and details related to the type of drug, quantity, and prescriber. To assist us in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.

You, your doctor, (or other prescriber) or your representative can do this. You can also have a lawyer act on your behalf. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.

- **If you are requesting an exception, provide the supporting statement**, which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

**Step 3: We consider your request and give you our answer.*****Deadlines for a fast coverage decision***

- We must generally give you our answer **within 24 hours** after we receive your request.
  - For exceptions, we will give you our answer within 24 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

---

- If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

***Deadlines for a standard coverage decision about a drug you have not yet received***

- We must give you our answer **within 72 hours** after we receive your request.
  - For exceptions, we will give you our answer within 72 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested**, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

***Deadlines for a standard coverage decision about payment for a drug you have already bought***

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization
- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

**Step 4: If we say no to your coverage request, you can make an 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 drug coverage you want. If you make an appeal, it means you are going on to Level 1 of the appeals process.

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)****Legal Term**

An appeal to the plan about a Part D drug coverage decision is called a plan **redetermination**.

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

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

*A standard appeal is usually made within 7 days. A fast appeal is generally made within 72 hours. If your health requires it, ask for a fast appeal.*

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 6.4 of this chapter.

**Step 2: You, your representative, doctor or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a fast appeal.**

- **For standard appeals, submit a written request.** Chapter 2 has contact information.
- **For fast appeals either submit your appeal in writing or call us at 1-800-332-5762.** Chapter 2 has contact information.
- **We must accept any written request**, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website. Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.
- You may submit a request through our secure portal via our website at [members.bcbst.com/wps/myportal/member/home/pharmacy](https://members.bcbst.com/wps/myportal/member/home/pharmacy). To initiate the request, you must sign in and provide specific information and details related to the type of drug, quantity, and prescriber.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** 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 we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

---

said no to your request. We may contact you or your doctor or other prescriber to get more information.

***Deadlines for a fast appeal***

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to.
  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. **Section 7.6** explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how you can appeal our decision.

***Deadlines for a standard appeal for a drug you have not yet received***

- For standard appeals, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.
  - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. **Section 7.6** explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how you can appeal our decision.

***Deadlines for a standard appeal about payment for a drug you have already bought***

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 30 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

**Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal.**

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)****Section 7.6 Step-by-step: How to make a Level 2 appeal****Legal Term**

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

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

**Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.**

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the review organization. If, however, we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding **at-risk** determination under our drug management program, we will automatically forward your claim to the IRE.
- We will send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file.**
- You have a right to give the independent review organization additional information to support your appeal.

**Step 2: The independent review organization reviews your appeal.**

Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

***Deadlines for fast appeal***

- If your health requires it, ask the independent review organization for a fast appeal.
- If the organization agrees to give you a fast appeal, the organization must give you an answer to your Level 2 appeal **within 72 hours** after it receives your appeal request.

***Deadlines for standard appeal***

- For standard appeals, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it receives your appeal if it is for a drug you have not yet received. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it receives your request.

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

---

**Step 3: The independent review organization gives you their answer.***For fast appeals:*

- **If the independent review organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

*For standard appeals:*

- **If the independent review organization says yes to part or all of your request for coverage,** we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
- **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

**What if the review organization says no to your appeal?**

**If this organization says no to part or all of your appeal,** it means they agree with our decision not to approve your request (or part of your request). (This is called **upholding the decision** or **turning down your appeal**.) In this case, the independent review organization will send you a letter:

- Explaining its decision.
- Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you are requesting meets a certain minimum. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final.
- Telling you the dollar value that must be in dispute to continue with the appeals process.

**Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.**

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. **Section 10** of this chapter tells more about the process for Level 3, 4, and 5 appeals.

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

---

**SECTION 8 How to ask us to cover a longer inpatient hospital stay if  
you think you are being discharged too soon**

---

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

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will 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 are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered.

<b>Section 8.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights</b>
--

Within two days of being admitted to the hospital, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice.

If you do not get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Member Service or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

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

- Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be involved in any decisions about your hospital stay.
- Where to report any concerns you have about the quality of your hospital care.
- Your right to **request an immediate review** of the decision to discharge you if you think you are being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time.

**2. You will be asked to sign the written notice to show that you received it and understand your rights.**

- You or someone who is acting on your behalf will be asked to sign the notice.



**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

- Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does not mean** you are agreeing on a discharge date.

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

- If you sign the notice more than two days before your discharge date, you will get another copy before you are scheduled to be discharged.
- To look at a copy of this notice in advance, you can call Member Service or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see the notice online at [www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeappealNotices](http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeappealNotices).

**Section 8.2 Step-by-step: How to make a Level 1 appeal to change your hospital discharge date**

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, call Member Service. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

**During a Level 1 appeal, the Quality Improvement Organization reviews your appeal.** It checks to see if your planned discharge date is medically appropriate for you.

The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts are not part of our plan.

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

*How can you contact this organization?*

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

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

---

***Act quickly:***

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge**.
  - **If you meet this deadline**, you may stay in the hospital *after* your discharge date **without paying for it** while you wait to get the decision from the Quality Improvement Organization.
  - **If you do *not* meet this deadline**, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see Section 8.4 of this chapter.

Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted we will give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

You can get a sample of the **Detailed Notice of Discharge** by calling Member Service or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at [www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeappealNotices](http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeappealNotices).

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

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

**Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.*****What happens if the answer is yes?***

- If the review organization says yes, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**

## Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

---

- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services.

### *What happens if the answer is no?*

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

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

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

<h3><b>Section 8.3 Step-by-step: How to make a Level 2 appeal to change your hospital discharge date</b></h3>
---

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

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

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

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

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

### **Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you their decision.**

#### *If the review organization says yes:*

- **We must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.**

## Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- You must continue to pay your share of the costs and coverage limitations may apply.

### *If the review organization says no:*

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

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. **Section 10** of this chapter tells more about Levels 3, 4, and 5 of the appeals process.

<b>Section 8.4      What if you miss the deadline for making your Level 1 appeal to change your hospital discharge date?</b>
--

<b>Legal Term</b>
-------------------

A fast review (or fast appeal) is also called an <b>expedited appeal</b> .
--

### **You can appeal to us instead**

As explained above, you must act quickly to start your Level 1 appeal of your hospital discharge date. If you miss the deadline for contacting the Quality Improvement Organization, there is another way to make your appeal.

If you use this other way of making your appeal, **the first two levels of appeal are different.**

### **Step-by-Step: How to make a Level 1 Alternate appeal**

#### **Step 1: Contact us and ask for a “fast review.”**

- **Ask for a fast review.** This means you are asking us to give you an answer using the fast deadlines rather than the standard deadlines. Chapter 2 has contact information.

#### **Step 2: We do a fast review of your planned discharge date, checking to see if it was medically appropriate.**

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We see if the decision about when you should leave the hospital was fair and followed all the rules.

## Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

### **Step 3: We give you our decision within 72 hours after you ask for a fast review.**

- **If we say yes to your appeal**, it means we have agreed with you that you still need to be in the hospital after the discharge date. We will keep providing your covered inpatient hospital services for as long as they are medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your appeal**, we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
  - If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

### **Step 4: If we say *no* to your appeal, your case will automatically be sent on to the next level of the appeals process.**

#### **Step-by-Step: Level 2 *Alternate* appeal Process**

<b>Legal Term</b>
The formal name for the independent review organization is the <b>Independent Review Entity</b> . It is sometimes called the <b>IRE</b> .

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

### **Step 1: We will automatically forward your case to the independent review organization.**

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 11 of this chapter tells how to make a complaint.)

### **Step 2: The independent review organization does a fast review of your appeal. The reviewers give you an answer within 72 hours.**

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says yes to your appeal**, then we must pay you back for our share of the costs of hospital care you received since the date of your planned discharge. We must also continue the plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are

## Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.

- **If this organization says no to your appeal**, it means they agree that your planned hospital discharge date was medically appropriate.
  - The written notice you get from the independent review organization will tell you how to start a Level 3 appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

### **Step 3: If the independent review organization turns down your appeal, you choose whether you want to take your appeal further.**

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 appeal, you decide whether to accept their decision or go on to Level 3 appeal.
- Section 10 of this chapter tells more about the process for Level 3, 4, and 5 appeals.

## **SECTION 9 How to ask us to keep covering certain medical services if you think your coverage is ending too soon**

### **Section 9.1 This section is only about three services: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services**

When you are 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 is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, **we will stop paying** *for your care*.

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

### **Section 9.2 We will tell you in advance when your coverage will be ending**

#### **Legal Term**

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

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

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

**Section 9.3 Step-by-step: How to make a Level 1 appeal to have our plan cover your care for a longer time**

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

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, call Member Service. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

**During a Level 1 appeal, the Quality Improvement Organization reviews your appeal.** It decides if the end date for your care is medically appropriate.

The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts are not part of our plan.

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

*How can you contact this organization?*

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

*Act quickly:*

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the Notice of Medicare Non-Coverage.

## Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see Section 9.5 of this chapter.

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

Legal Term
<b>Detailed Explanation of Non-Coverage.</b> Notice that provides details on reasons for ending coverage.

#### *What happens during this review?*

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

### **Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.**

#### *What happens if the reviewers say yes?*

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

#### *What happens if the reviewers say no?*

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

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

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



**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)****Section 9.4 Step-by-step: How to make a Level 2 appeal to have our plan cover your care for a longer time**

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

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

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

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

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

**Step 3: Within 14 days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.*****What happens if the review organization says yes?***

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

***What happens if the review organization says no?***

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

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

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.

## Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 10 of this chapter tells more about the process for Level 3, 4, and 5 appeals.

### Section 9.5 What if you miss the deadline for making your Level 1 appeal?

#### You can appeal to us instead

As explained above, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, **the first two levels of appeal are different.**

#### Step-by-Step: How to make a Level 1 Alternate appeal

Legal Term
A fast review (or fast appeal) is also called an <b>expedited appeal.</b>

#### Step 1: Contact us and ask for a fast review.

- **Ask for a fast review.** This means you are asking us to give you an answer using the fast deadlines rather than the standard deadlines. Chapter 2 has contact information.

#### Step 2: We do a fast review of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan's coverage for services you were receiving.

#### Step 3: We give you our decision within 72 hours after you ask for a fast review.

- **If we say yes to your appeal,** it means we have agreed with you that you need services longer, and we will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs, and there may be coverage limitations that apply.)
- **If we say no to your appeal,** then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end, then **you will have to pay the full cost** of this care.

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

**Step 4: If we say no to your fast appeal, your case will automatically go on to the next level of the appeals process.**

Legal Term
The formal name for the independent review organization is the <b>Independent Review Entity</b> . It is sometimes called the <b>IRE</b> .

**Step-by-Step: Level 2 Alternate appeal Process**

During the Level 2 appeal, the **independent review organization** reviews the decision we made to your fast appeal. This organization decides whether the decision should be changed. **The independent review organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the independent review organization. Medicare oversees its work.

**Step 1: We automatically forward your case to the independent review organization.**

- We are required to send the information for your Level 2 appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 11 of this chapter tells how to make a complaint.)

**Step 2: The independent review organization does a fast review of your appeal. The reviewers give you an answer within 72 hours.**

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.
- **If this organization says yes to your appeal**, then we must pay you back for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover services.
- **If this organization says no to your appeal**, it means they agree with the decision our plan made to your first appeal and will not change it.
  - The notice you get from the independent review organization will tell you in writing what you can do if you wish to go on to a Level 3 appeal.

**Step 3: If the independent review organization says no to your appeal, you choose whether you want to take your appeal further.**

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.

## Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- A Level 3 appeal is reviewed by an Administrative Law Judge or attorney adjudicator. Section 10 of this chapter tells more about the process for Level 3, 4, and 5 appeals.

### SECTION 10 Taking your appeal to Level 3 and beyond

#### Section 10.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

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

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

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

**Level 3 appeal** An Administrative Law Judge or an attorney adjudicator who works for the Federal government will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process may or may not be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that is favorable to you. If we decide to appeal it will go to a Level 4 appeal.
  - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.
  - If we decide to appeal the decision, we will send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the 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.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal..

**Level 4 appeal** The Medicare Appeals Council (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 Appeal decision, the appeals process may or may not be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We will decide whether to appeal this decision to Level 5.

## Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after receiving the Council’s decision.
- If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 appeal and how to continue with a Level 5 appeal.

**Level 5 appeal** A judge at the **Federal District Court** will review your appeal.

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

### Section 10.2 Additional TennCare (Medicaid) appeals

You also have other appeal rights if your appeal is about services or items that TennCare (Medicaid) usually covers. The letter you get from the Fair Hearing office will tell you what to do if you wish to continue the appeals process.

### Section 10.3 Appeal Levels 3, 4 and 5 for Part D Drug Requests

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

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

**Level 3 appeal** An **Administrative Law Judge or attorney adjudicator who works for the Federal** government will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process may or may not be over.**

## Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

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

**Level 4 appeal** The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

**Level 5 appeal** A judge at the **Federal District Court** will review your appeal.

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

## SECTION 11 How to make a complaint about quality of care, waiting times, customer service, or other concerns

### Section 11.1 What kinds of problems are handled by the complaint process?

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

Complaint	Example
Quality of your medical care	<ul style="list-style-type: none"> <li>• Are you unhappy with the quality of the care you have received (including care in the hospital)?</li> </ul>
Respecting your privacy	<ul style="list-style-type: none"> <li>• Did someone not respect your right to privacy or share confidential information?</li> </ul>

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

Complaint	Example
<b>Disrespect, poor customer service, or other negative behaviors</b>	<ul style="list-style-type: none"> <li>• Has someone been rude or disrespectful to you?</li> <li>• Are you unhappy with our Member Service?</li> <li>• Do you feel you are being encouraged to leave the plan?</li> </ul>
<b>Waiting times</b>	<ul style="list-style-type: none"> <li>• Are you having trouble getting an appointment, or waiting too long to get it?</li> <li>• Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Service or other staff at the plan? <ul style="list-style-type: none"> <li>○ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.</li> </ul> </li> </ul>
<b>Cleanliness</b>	<ul style="list-style-type: none"> <li>• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?</li> </ul>
<b>Information you get from us</b>	<ul style="list-style-type: none"> <li>• Did we fail to give you a required notice?</li> <li>• Is our written information hard to understand?</li> </ul>
<b>Timeliness</b> (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)	<p>If you have asked for a coverage decision or made an appeal and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples:</p> <ul style="list-style-type: none"> <li>• You asked us for a "fast coverage decision" or a "fast appeal", and we have said no; you can make a complaint.</li> <li>• You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint.</li> <li>• You believe we are not meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint.</li> <li>• You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.</li> </ul>

**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)****Section 11.2 How to make a complaint****Legal Terms**

- A **Complaint** is also called a **grievance**.
- **Making a complaint** is also called **filing a grievance**.
- **Using the process for complaints** is also called **using the process for filing a grievance**.
- A **fast complaint** is also called an **expedited grievance**.

**Section 11.3 Step-by-step: Making a complaint****Step 1: Contact us promptly – either by phone or in writing.**

- **Usually, calling Member Service is the first step.** If there is anything else you need to do, Member Service will let you know.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- You may file a grievance by calling our Member Service department. We will try to resolve your grievance over the phone but, if you don't feel comfortable calling Member Service, you may send us a formal grievance by letter or fax. We will respond to you or your representative as soon as possible but no later than 30 days from the date your grievance was received. You may also file a grievance if we take an extension on the coverage decision or appeal timeframe or we decide to apply the standard timeframe to a requested fast coverage decision or appeal. In this case, you may file an expedited grievance. We will respond to your expedited grievance within 24 hours. In both cases, if we need additional time to respond, we will contact you to explain why additional time is needed. If you have a complaint about quality of care or ask for a written response, we will respond to you in writing.
- **Whether you call or write, you should contact Member Service right away.** You can make the complaint at any time after you had the problem you want to complain about.

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

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.



**Chapter 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, complaints)**

- **If you are making a complaint because we denied your request for a fast coverage decision or a fast appeal, we will automatically give you a fast complaint.** If you have a fast complaint, it means we will give you **an answer within 24 hours.**
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

**Section 11.4 You can also make complaints about quality of care to the Quality Improvement Organization**

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

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

*Or*

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

**Section 11.5 You can also tell Medicare about your complaint**

You can submit a complaint about BlueCare Plus Choice directly to Medicare. To submit a complaint to Medicare, go to [www.medicare.gov/MedicareComplaintForm/home.aspx](http://www.medicare.gov/MedicareComplaintForm/home.aspx). You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

# CHAPTER 10:

*Ending your membership in the plan*

---

## SECTION 1 Introduction to ending your membership in our plan

---

Ending your membership in BlueCare Plus Choice may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, our plan must continue to provide your medical care and prescription drugs and you will continue to pay your cost share until your membership ends.

---

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

---

<b>Section 2.1</b> <b>You may be able to end your membership because you have Medicare and TennCare (Medicaid)</b>
--

Most people with Medicare can end their membership only during certain times of the year. Because you have TennCare (Medicaid), you may be able to end your membership in our plan or switch to a different plan one time during each of the following Special Enrollment Periods:

- January to March
- April to June
- July to September

If you joined our plan during one of these periods, you'll have to wait for the next period to end your membership or switch to a different plan. You can't use this Special Enrollment Period to end your membership in our plan between October and December. However, all people with Medicare can make changes from October 15 – December 7 during the Annual Enrollment Period. Section 2.2 tells you more about the Annual Enrollment Period.

- Choose any of the following types of Medicare plans:
  - Another Medicare health plan, with or without prescription drug coverage
  - Original Medicare *with* a separate Medicare prescription drug plan
  - Original Medicare without a separate Medicare prescription drug plan
    - If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

**Note:** If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for a continuous period of 63 days or more, you

may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

Contact your State Medicaid Office to learn about your TennCare (Medicaid) plan options (telephone numbers are in Chapter 2, Section 6 of this document).

- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plans. Your enrollment in your new plan will also begin on this day.

### **Section 2.2 You can end your membership during the Annual Enrollment Period**

You can end your membership during the Annual Enrollment Period (also known as the **Annual Open Enrollment Period**). During this time, review your health and drug coverage and decide about coverage for the upcoming year.

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

**If you receive “Extra Help” from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

**Note:** If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

### **Section 2.3 You can end your membership during the Medicare Advantage Open Enrollment Period**

You have the opportunity to make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period**.

- **The annual Medicare Advantage Open Enrollment Period** is from January 1 to March 31.
- **During the annual Medicare Advantage Open Enrollment Period** you can:
  - Switch to another Medicare Advantage Plan with or without prescription drug coverage.
  - Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

<b>Section 2.4</b>	<b>In certain situations, you can end your membership during a Special Enrollment Period</b>
--------------------	--

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

**You may be eligible to end your membership during a Special Enrollment Period** if any of the following situations apply to you. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website ([www.medicare.gov](http://www.medicare.gov)):

- Usually, when you have moved
- If you have TennCare (Medicaid)
- If you are eligible for “Extra Help” with paying for your Medicare prescriptions
- If we violate our contract with you.
- If you are 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).

**Note:** If you’re in a drug management program, you may not be able to change plans. Chapter 5, Section 10 tells you more about drug management programs.

**Note:** Section 2.1 tells you more about the special enrollment period for people with TennCare (Medicaid).

- **The enrollment time periods vary** depending on your situation.
- **To find out if you are eligible for a Special Enrollment Period**, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation,

you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:

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

– *or* – Original Medicare *without* a separate Medicare prescription drug plan.

**Note:** If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

**If you receive “Extra Help” from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

**Your membership will usually end** on the first day of the month after your request to change your plan is received.

**Note:** Sections 2.1 and 2.2 tell you more about the special enrollment period for people with TennCare (Medicaid) and Extra Help.

<b>Section 2.5</b> <b>Where can you get more information about when you can end your membership?</b>
--

If you have any questions about ending your membership you can:

- **Call Member Service.**
- Find the information in the *Medicare & You 2024* handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

---

## **SECTION 3    How do you end your membership in our plan?**

---

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

<b>If you would like to switch from our plan to:</b>	<b>This is what you should do:</b>
<ul style="list-style-type: none"><li>• Another Medicare health plan</li></ul>	<ul style="list-style-type: none"><li>• Enroll in the new Medicare health plan. Your new coverage will begin on the first day of the following month.</li><li>• You will automatically be disenrolled from BlueCare Plus Choice when your new plan’s coverage begins.</li></ul>

<b>If you would like to switch from our plan to:</b>	<b>This is what you should do:</b>
<ul style="list-style-type: none"><li>• Original Medicare <i>with</i> a separate Medicare prescription drug plan</li></ul>	<ul style="list-style-type: none"><li>• Enroll in the new Medicare prescription drug plan. Your new coverage will begin on the first day of the following month.</li><li>• You will automatically be disenrolled from BlueCare Plus Choice when your new plan's coverage begins.</li></ul>
<ul style="list-style-type: none"><li>• Original Medicare <i>without</i> a separate Medicare prescription drug plan<ul style="list-style-type: none"><li>○ If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.</li><li>○ If you disenroll from Medicare prescription drug coverage and go 63 days or more in a row without creditable prescription drug coverage, you may have to pay a late enrollment penalty if you join a Medicare drug plan later.</li></ul></li></ul>	<ul style="list-style-type: none"><li>• <b>Send us a written request to disenroll.</b> Contact Member Service if you need more information on how to do this.</li><li>• You can also contact <b>Medicare</b>, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.</li><li>• You will be disenrolled from BlueCare Plus Choice when your coverage in Original Medicare begins.</li></ul>

**Note:** If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

For questions about your TennCare (Medicaid) benefits, contact TennCare (Medicaid) at 1-800-342-3145, Monday through Friday, 8 a.m. to 5 p.m. in all time zones. TennCare (Medicaid) is closed on state holidays. TTY users should call 1-877-779-3103. Ask how joining another plan or returning to Original Medicare affects how you get your TennCare (Medicaid) coverage.

---

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

---

Until your membership BlueCare Plus Choice ends, and your new Medicare and TennCare (Medicaid) coverage begins, you must continue to get your medical items, services and prescription drugs through our plan.

- **Continue to use our network providers to receive medical care.**
- **Continue to use our network pharmacies or mail order to get your prescriptions filled.**
- **If you are hospitalized on the day that your membership ends, your hospital stay will be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

---

## **SECTION 5 BlueCare Plus Choice must end your membership in the plan in certain situations**

---

<b>Section 5.1 When must we end your membership in the plan?</b>
--

**BlueCare Plus Choice must end your membership in the plan if any of the following happen:**

- If you no longer have Medicare Part A and Part B
- If you are no longer eligible for TennCare (Medicaid). As stated in Chapter 1, Section 2.1, our plan is for people who are eligible for both Medicare and TennCare (Medicaid). If you have been without TennCare (Medicaid) coverage for more than 6 months or you are no longer enrolled in the minimum required level of TennCare (Medicaid) coverage, we are required to disenroll you from our plan
- If you move out of our service area
- If you are away from our service area for more than six months
  - If you move or take a long trip, call Member Service to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison)
- If you are no longer a United States citizen or lawfully present in the United States
- If you lie or withhold information about other insurance you have that provides prescription drug coverage
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)



- If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan.

### **Where can you get more information?**

If you have questions or would like more information on when we can end your membership call Member Service.

<b>Section 5.2      We <u>cannot</u> ask you to leave our plan for any health-related reason</b>
--

BlueCare Plus Choice is not allowed to ask you to leave our plan for any health-related reason.

### **What should you do if this happens?**

If you feel that you are being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week (TTY 1-877-486-2048).

<b>Section 5.3      You have the right to make a complaint if we end your membership in our plan</b>
--

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 11:

*Legal notices*

---

## SECTION 1 Notice about governing law

---

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

---

## SECTION 2 Notice about nondiscrimination

---

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

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

If you have a disability and need help with access to care, please call us at Member Service. If you have a complaint, such as a problem with wheelchair access, Member Service can help.

---

## SECTION 3 Notice about Medicare Secondary Payer subrogation rights

---

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, BlueCare Plus Choice, 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

**Chapter 11. Legal notices**

---

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 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](http://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 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.

**Chapter 11. Legal notices**

---

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 Notice and Multi-Language Insert

---



### 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 **1-800-332-5762**, 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 **1-800-332-5762**, 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](mailto: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 [ocrportal.hhs.gov/ocr/portal/lobby.jsf](http://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 [hhs.gov/ocr/office/file/index.html](http://hhs.gov/ocr/office/file/index.html).

## Multi-language Interpreter Services

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-332-5762, TTY 711. Someone who speaks English/Language can help you. This is a free service.

**Spanish:** Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-332-5762, TTY 711. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

**Chinese Mandarin:** 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-800-332-5762, TTY 711。我们的中文工作人员很乐意帮助您。这是一项免费服务。

**Chinese Cantonese:** 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-800-332-5762, TTY 711。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

**Tagalog:** Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-332-5762, TTY 711. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

**French:** Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-332-5762, TTY 711. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

**Vietnamese:** Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-800-332-5762, TTY 711 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

**German:** Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-332-5762, TTY 711. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-332-5762, TTY 711 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

**Russian:** Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-332-5762, TTY 711. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic:** إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-332-5762, TTY 711. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

**Hindi:** हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-332-5762, TTY 711 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

**Italian:** È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-332-5762, TTY 711. Un nostro incaricato che parla Italianovi fomirà l'assistenza necessaria. È un servizio gratuito.

**Portugués:** Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-332-5762, TTY 711. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

**French Creole:** Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-332-5762, TTY 711. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

**Polish:** Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-332-5762, TTY 711. Ta usługa jest bezpłatna.

**Japanese:** 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-800-332-5762, TTY 711 にお電話ください。日本語を話す人 者が支えたいします。これは無料のサービスです。



# CHAPTER 12:

*Definitions of important words*

**Ambulatory Surgical Center** – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

**Appeal** – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving.

**Benefit Period** – The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you have not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

**Biological Product** – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. Biosimilars generally work just as well, and are as safe, as the original biological products.

**Biosimilar** – A prescription drug that is considered to be very similar, but not identical, to the original biological product. Biosimilars generally work just as well, and are as safe, as the original biological product; however, biosimilars generally require a new prescription to substitute for the original biological product. Interchangeable biosimilars have met additional requirements that allow them to be substituted for the original biological product at the pharmacy without a new prescription, subject to state laws.

**Brand Name Drug** – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

**Catastrophic Coverage Stage** – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent \$8,000 for Part D covered drugs during the covered year. During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

**Centers for Medicare & Medicaid Services (CMS)** – The Federal agency that administers Medicare.

**Chronic-Care Special Needs Plan** – C-SNPs are SNPs that restrict enrollment to MA eligible individuals who have one or more severe or disabling chronic conditions, as defined under 42 CFR 422.2, including restricting enrollment based on the multiple commonly co-morbid and clinically-linked condition groupings specified in 42 CFR 422.4(a)(1)(iv).

**Coinsurance** – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services or prescription drugs.

**Complaint** — The formal name for making a complaint is **filing a grievance**. The complaint process is used *only* for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

**Comprehensive Outpatient Rehabilitation Facility (CORF)** – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

**Copayment (or copay)** – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor’s visit, hospital outpatient visit, or a prescription drug. 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 or drugs are received. Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed copayment amount that a plan requires when a specific service or drug is received; or (3) any coinsurance amount, a percentage of the total amount paid for a service or drug that a plan requires when a specific service or drug is received.

**Coverage Determination** – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn’t covered under your plan, that isn’t a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called coverage decisions in this document.

**Covered Drugs** – The term we use to mean all of the prescription drugs covered by our plan.

**Covered Services** – The term we use to mean all of the health care services and supplies that are covered by our plan.

**Creditable Prescription Drug Coverage** – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

**Custodial Care** – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care provided by people who do not have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn’t pay for custodial care.

**Daily cost sharing rate** – A daily cost-sharing rate may apply when your doctor prescribes less than a full month’s supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month’s supply. Here is an example: If your copayment for a one-month supply of a drug is \$30, and a one-month’s supply in your plan is 30 days, then your “daily cost-sharing rate” is \$1 per day.

**Deductible** – The amount you must pay for health care or prescriptions before our plan pays.

**Disenroll or Disenrollment** – The process of ending your membership in our plan.

**Dispensing Fee** – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist’s time to prepare and package the prescription.

**Dual Eligible Special Needs Plans (D-SNP)**– D-SNPs enroll individuals who are entitled to both Medicare (title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (title XIX). States cover some Medicare costs, depending on the state and the individual’s eligibility.

**Dual Eligible Individual** – A person who qualifies for Medicare and TennCare (Medicaid) coverage.

**Durable Medical Equipment (DME)** – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

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

**Emergency Care** – Covered services that are: (1) provided by a provider qualified to furnish emergency services; and (2) needed to treat, evaluate, or stabilize an emergency medical condition.

**Evidence of Coverage (EOC) and Disclosure Information** – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

**Exception** – A type of coverage decision that, if approved, allows you to get a drug that is not on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if our plan requires you to try another drug before receiving the drug you are requesting, or if our plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

**Extra Help** – A Medicare or a State program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

**Generic Drug** – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a generic drug works the same as a brand name drug and usually costs less.

**Home Health Aide** – A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

**Hospice** – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer.

**Hospital Inpatient Stay** – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an outpatient.

**Initial Coverage Limit**- The maximum limit of coverage under the Initial Coverage Stage.

**Initial Coverage Stage** – This is the stage before your out-of-pocket costs for the year have reached \$8,000.

**Initial Enrollment Period** – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

**Integrated Grievance** – A type of complaint you make about us or pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

**Integrated Organization Determination** – The Medicare Advantage plan has made an organization determination when it makes a decision 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 booklet. Chapter 9 explains how to ask us for a coverage decision.

**List of Covered Drugs (Formulary or “Drug List”)** – A list of prescription drugs covered by the plan.

**Low Income Subsidy (LIS)** – See “Extra Help.”

**Maximum Out-of-Pocket Amount** – The most that you pay out-of-pocket during the calendar year for covered Part A and Part B services. Amounts you pay for your Medicare Part A and Part

B premiums and prescription drugs do not count toward the maximum out-of-pocket amount. (Note: Because our members also get assistance from TennCare (Medicaid), very few members ever reach this out-of-pocket maximum.)

**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 Accepted Indication** – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books.

**Medically Necessary** – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

**Medicare** – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

**Medicare Advantage Open Enrollment Period** – The time period from January 1 until March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan, or obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after an individual is first eligible for Medicare.

**Medicare Advantage (MA) Plan** – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an i) HMO, ii) PPO, a iii) Private Fee-for-Service (PFFS) plan, or a iv) Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

**Medicare Coverage Gap Discount Program** – A program that provides discounts on most covered Part D brand name drugs to Part D members who have reached the Coverage Gap Stage and who are not already receiving “Extra Help.” Discounts are based on agreements between the Federal government and certain drug manufacturers.

**Medicare-Covered Services** – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and B. The term Medicare-Covered Services does not include the extra benefits, such as vision, dental, or hearing, that a Medicare Advantage plan may offer.

**Medicare Health Plan** – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs

Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

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

**Medigap (Medicare Supplement Insurance) Policy** – Medicare supplement insurance sold by private insurance companies to fill gaps in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

**Member (Member of our Plan, or Plan Member)** – A person with Medicare who is eligible to get covered services, who has enrolled in our plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

**Member Service** – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

**Network Pharmacy** – A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

**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.”

**Original Medicare** (Traditional Medicare or Fee-for-service Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

**Out-of-Network Pharmacy** – A pharmacy that does not have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

**Out-of-Network Provider or Out-of-Network Facility** – A provider or facility that does not have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan.

**Out-of-Pocket Costs** – See the definition for cost sharing above. A member’s cost sharing requirement to pay for a portion of services or drugs received is also referred to as the member’s out-of-pocket cost requirement.

**PACE plan** – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans receive both their Medicare and TennCare (Medicaid) benefits through the plan.

**Part C** – see Medicare Advantage (MA) Plan.

**Part D** – The voluntary Medicare Prescription Drug Benefit Program.

**Part D Drugs** – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded from Part D coverage by Congress. Certain categories of Part D drugs must be covered by every plan.

**Part D Late Enrollment Penalty** – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you are first eligible to join a Part D plan. If you lose Extra Help, you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.

**Preferred Provider Organization (PPO) Plan** – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (non-preferred) providers.

**Premium** – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

**Primary Care Provider (PCP)** – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

**Prior Authorization** – Approval in advance to get services or certain drugs. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary.

**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.



**Quantity Limits** – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

**Real Time Benefit Tool** – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

**Rehabilitation Services** – These services include physical therapy, speech and language therapy, and occupational therapy.

**Service Area** – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan must disenroll you if you permanently move out of the plan's service area.

**Skilled Nursing Facility (SNF) Care** – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

**Special Needs Plan** – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

**Step Therapy** – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

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

**Urgently Needed Services** – Covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.

## BlueCare Plus Choice Member Service

Method	Member Service – Contact Information
<b>CALL</b>	1-800-332-5762 Calls to this number are free. From <b>Oct. 1</b> to <b>March 31</b> , you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From <b>April 1</b> to <b>Sept. 30</b> , you can call us Monday through Friday from 8 a.m. to 9 p.m. ET. Member Service also has free language interpreter services available for non-English speakers.
<b>TTY</b>	711 Calls to this number are free. From <b>Oct. 1</b> to <b>March 31</b> , you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From <b>April 1</b> to <b>Sept. 30</b> , you can call us Monday through Friday from 8 a.m. to 9 p.m. ET.
<b>FAX</b>	1-888-725-6849
<b>WRITE</b>	BlueCross BlueShield of Tennessee BlueCare Plus Operations 1 Cameron Hill Circle, Suite 0002 Chattanooga, TN 37402-0002
<b>WEBSITE</b>	<a href="http://bluecareplus.bcbst.com">bluecareplus.bcbst.com</a>

## Tennessee State Health Insurance Assistance Program

Tennessee State Health Insurance Assistance Program is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	Contact Information
<b>CALL</b>	Toll Free: 1-877-801-0044
<b>TTY</b>	1-800-848-0299 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
<b>WRITE</b>	Tennessee State Health Insurance Assistance Program 500 Deaderick Street Nashville, TN 37243-0860
<b>WEBSITE</b>	You will find the website for the Tennessee State Health Insurance Assistance Program at <a href="http://www.medicare.gov">www.medicare.gov</a> under Search Tools by selecting Helpful Phone Numbers and Web Sites. <a href="http://www.tn.gov/aging/our-programs/state-health-insurance-assistance-program--ship-.html">www.tn.gov/aging/our-programs/state-health-insurance-assistance-program--ship-.html</a>

**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, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.