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

2027 Evidence of Coverage

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of BlueCare Plus Choice (HMO D-SNP)℠

For questions about this document, please contact Member Service at 1-800-332-5762. (TTY users should call 711.) From 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.

January 1 – December 31, 2027

Your Health and Drug Coverage under BlueCare Plus Choice HMO

Evidence of Coverage Introduction

This Evidence of Coverage tells you about your coverage under our plan through December 31, 2027. It explains health care services, behavioral health (mental health and substance use disorder) services, drug coverage and long-term services and supports (LTSS). Key terms and their definitions appear in alphabetical order in **Chapter 12** of this *Evidence of Coverage*.

This is an important legal document. Keep it in a safe place.

When this *Evidence of Coverage* says “we”, “us”, “our”, or “our plan”, 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 for free in Spanish and Arabic.

You can get this document for free in other formats, such as large print, braille, and/or audio by calling Member Service at the number at the bottom of this page. The call is free.

- Members can call Member Service at the toll-free number at the bottom of this page to request needed materials in their preferred language and/or alternate format. If you would like to receive these materials annually, please let us know when you make your request. We will document your preferences and send you these materials annually. If you would like to stop receiving these materials annually, please call us at the toll-free number at the bottom of this page.

Do you need free help with this letter?

If you speak a language other than English, help in your language is available for free. This page tells you how to get help in a language other than English. It also tells you about other help that's available.

Spanish: Español

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-332-5762 (TRS/TTY: 711: 1-866-503-0264).

Kurdish: كوردى

ئاگاداری: ئەگەر بە زمانی کوردی قەسە دەکەیت، خزمەتگوزاریەکانی یارمەتی زمان، بەخۆڕایی، بۆ تۆ بەردەستە. پەیوەندی بە (1-866-503-0264 TRS/TTY:711) 1-800-332-5762 . بکە.

Arabic: العربية

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم
(1-866-503-0264 أو TRS/TTY: 711) 1-800-332-5762

Chinese: 繁體中文

注意：如果您使用繁體中文， 您可以免費獲得語言援助服務。請致電 1-800-332-5762 (TRS/TTY: 711: 1-866-503-0264)

Vietnamese: Tiếng Việt

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-332-5762(TRS/TTY: 711: 1-866-503-0264)

Korean: 한국어

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-332-5762(TRS/TTY: 711: 1-866-503-0264) 번으로 전화해 주십시오.

French: Français

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-332-5762(ATS: 711: 1-866-503-0264).

Amharic: አማርኛ

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-332-5762(TRS/TTY: 711: 1-866-503-0264).

Gujarati: ગુજરાતી સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-332-5762(TRS/TTY: 711: 1-866-503-0264).
Laotian: ພາສາລາວ ໂປດ ຊາບ: ຖ້າ ວ່າ ທ່ານ ເວົ້າ ພາ ສາ ລາວ, ການ ບໍ ລິ ການ ຊ່ວຍ ເຫຼືອ ດ້ານ ພາ ສາ, ໂດຍບໍ່ ເສັຽ ຄ່າ, ແມ່ນມີ ພ້ອມໃຫ້ ທ່ານ. ໂທ ຣ 1-800-332-5762(TRS/TTY: 711: 1-866-503-0264).
German: Deutsch ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-332-5762 (TRS/TTY: 711: 1-866-503-0264).
Tagalog: Tagalog PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-332-5762(TRS/TTY: 711: 1-866-503-0264).
Hindi: हिंदी ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-332-5762 (TRS/TTY: 711: 1-866-503-0264)पर कॉल करें।
Serbo-Croatian: Srpsko-hrvatski OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-332-5762 (TRS- Telefon za osobe sa oštećenim govorom ili sluhom: 711).
Russian: Русский ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-332-5762 (телетайп: (TRS/TTY: 711: 1-866-503-0264)).
Nepali: नेपाली ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-332-5762 (टिटिवाइ: TRS:711).
Persian: فارسی توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-332-5762 تماس بگیرید (TRS/TTY:711: 1-866-503-0264).

- Do you need help talking with us or reading what we send you?
- Do you have a disability and need help getting care or taking part in one of our programs or services?
- Or do you have more questions about your health care?

Call us for free at 1-800-332-5762. (TTY users should call 711) We can connect you with the free help or service you need. (For TRS call 711.)

We obey federal and state civil rights laws. We don't treat people in a different way because of their race, color, birthplace, language, age, disability, religion, or sex. Do you think we didn't help you or you were treated differently because of your race, color, birthplace, language, age, disability, religion, or sex? You can file a complaint by mail, by email, or by phone. Here are two places where you can file a complaint:

TennCare Office of Civil Rights Compliance 310 Great Circle Road, 3W, Nashville, Tennessee 37243 Email: HCFA.Fairtreatment@tn.gov Phone: 1-855-857-1673 (TRS 711) You can get a complaint form online at: www.tn.gov/content/dam/tn/tenncare/documents/complaintform.pdf
U.S. Department of Health & Human Services, Office for Civil Rights 200 Independence Ave SW, Rm 509F, HHH Bldg., Washington, DC 20201 Phone: 1-800-368-1019 (TDD): 1-800-537-7697 You can file a complaint online at: www.ocrportal.hhs.gov/ocr/smartscreen/main.jsf

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Disclaimers

- 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.

- The BlueCare Plus Choice plan has a network of doctors, hospitals, pharmacies and other providers. If you use providers who aren't in our network, the plan won't pay for these services, unless authorized in advance or in emergency situations. Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call us at the toll-free number at the bottom of this page for more information, including information on the cost-sharing that applies to out-of-network services. This plan doesn't require referrals to see specialists in the BlueCare Plus Tennessee network.

- The healthy food benefit listed is a special supplemental benefit for members with certain chronic conditions. Qualifying chronic conditions include, but aren't limited to, cardiovascular disorders, diabetes mellitus, obesity, chronic lung disorders and chronic gastrointestinal disorders. Additional qualifying conditions exist. See plan materials for a complete list. Not all members (even those with a qualifying condition) qualify. Eligibility is based on meeting the CMS definition of "chronically ill enrollee" and all applicable plan coverage criteria.

- 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

- Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2028.

- Our covered drugs, pharmacy network, and/or provider network may change at any time. You'll get a notice about any changes that may affect you at least 30 days in advance.

Chapter 1: Getting started as a member

Introduction

This chapter includes information about BlueCare Plus Choice, a health plan that coordinates all of your Medicare and TennCare services, and your membership in it. It also tells you what to expect and what other information you'll get from us. Key terms and their definitions appear in alphabetical order in the last chapter of this *Evidence of Coverage*.

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A. Welcome to our plan

Our plan provides Medicare and TennCare services to individuals who are eligible for both programs. Our plan includes doctors, hospitals, pharmacies, providers of long-term services and supports, behavioral health providers, and other providers. We also have coordinators and care teams to help you manage your providers and services. They all work together to provide the care you need.

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; Long Term Services and Supports (LTSS) CHOICES or Employment and Community First (ECF) CHOICES.

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 for more information.

B. Information about Medicare and TennCare

B1. Medicare

Medicare is the federal health insurance program for:

- people 65 years of age or over,
- some people under age 65 with certain disabilities, **and**
- people with end-stage renal disease (kidney failure).

B2. TennCare

TennCare is the name of Tennessee's Medicaid program. TennCare is run by the state and is paid for by the state and the federal government. TennCare helps people with limited incomes and resources to pay for Long-Term Services and Supports (LTSS) and medical costs. It covers extra services and drugs not covered by Medicare.

Each state decides:

- what counts as income and resources,
- who is eligible,
- what services are covered, **and**
- the cost for services.

States can decide how to run their programs, as long as they follow the federal rules.

Medicare and the state of Tennessee approved our plan. You can get Medicare and TennCare services through our plan as long as:

- we choose to offer the plan, **and**
- Medicare and the state of Tennessee allow us to continue to offer this plan.

Even if our plan stops operating in the future, your eligibility for Medicare and TennCare services isn't affected.

C. Advantages of our plan

You'll now get all your covered Medicare and TennCare services from our plan, including drugs. **You don't pay extra to join this health plan.**

We help make your Medicare and Medicaid benefits work better together and work better for you. Some of the advantages include:

- You can work with us for **most** of your health care needs.
- You have a care team that you help put together. Your care team may include yourself, your caregiver, doctors, nurses, counselors, or other health professionals.
- You have access to a coordinator. This is a person who works with you, with our plan, and with your care team to help make a care plan.
- You're able to direct your own care with help from your care team and coordinator.

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- Your care team and coordinator work with you to make a care plan designed to meet **your** health needs. The care team helps coordinate the services you need. For example, this means that your care team makes sure:
    - Your doctors know about all the medicines you take so they can make sure you're taking the right medicines and can reduce any side effects that you may have from the medicines.
    - Your test results are shared with all of your doctors and other providers, as appropriate.
- New members to BlueCare Plus Choice: In most instances you'll be enrolled in BlueCare Plus Choice for your Medicare benefits the 1st day of the month after you request to be enrolled in BlueCare Plus Choice. You may still receive your TennCare from your previous TennCare health plan for one additional month. After that, you'll receive your TennCare services through BlueCare Plus Choice. There will be no gap in your TennCare coverage. Please call us at the number at the bottom of the page if you have any questions.

D. Our plan's service area

Our service area includes all counties in Tennessee.

Only people who live in our service area can join our plan.

You can't stay in our plan if you move outside of our service area. Refer to **Chapter 8** of this *Evidence of Coverage* for more information about the effects of moving out of our service area.

E. What makes you eligible to be a plan member

You're eligible for our plan as long as you:

- live in our service area (incarcerated individuals aren't considered living in the service area even if they're physically located in it), **and**
- have both Medicare Part A and Medicare Part B, **and**
- are a United States citizen or national, or an eligible non-citizen, **and**
- are currently eligible for TennCare **and** assigned to BlueCare as your Medicaid provider **and**

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- are eligible for Long Term Care in CHOICES or Employment and Community First CHOICES.

If you lose eligibility, we may be required to disenroll you from our plan. Call member service at 1-800-332-5762, TTY 711, for more information and to see if you're eligible for a different plan.

F. What to expect when you first join our health plan

When you first join our plan, you get a health risk assessment (HRA) within 90 days before or after your enrollment effective date.

We must complete an HRA for you. This HRA is the basis for developing your care plan. The HRA includes questions to identify your medical, behavioral health, and functional needs. Every member is case managed by their Care Team. The team consists of clinical and nonclinical staff. The Care Team is responsible for conducting a Health Risk Assessment (HRA) with you or your caregiver. These assessment tools assist the Care Team, you or your caregiver, and the providers involved in your care and in developing a plan of care for you based on your individual care needs.

We reach out to you to complete the HRA. We can complete the HRA by an in-person visit. We will review your needs and LTSS services annually or sooner as appropriate.

We'll send you more information about this HRA.

You may continue to see your previous provider or receive previous services for at least 30 days to ensure continuity of care pending the provider enrolling under the health plan or finding a new provider under the health plan to facilitate a seamless transition of those services.

G. Your care team and care plan

G1. Care team

A care team can help you keep getting the care you need. A care team may include your doctor, a care/support coordinator, your specialists, or other health professionals that you choose.

A coordinator is a person trained to help you manage the care you need. You get a coordinator when you enroll in our plan. This person also refers you to other community resources that our plan may not provide and will work with your care team to help coordinate your care. Call us at the numbers at the bottom of the page for more information about your coordinator and care team.

G2. Care plan

Your care team works with you to make a care plan. A care plan tells you and your doctors what services you need and how to get them. It includes your medical, behavioral health, and LTSS services using a person-centered approach to your needs assessment and care planning.

A member's Individual Care Plan (ICP) is the mechanism for evaluating the member's current health status. It is the ongoing action plan of the Interdisciplinary Care Team (ICT) to address the member's health needs. Each member's ICP is developed by utilizing information provided in the Health Risk Assessment (HRA), claims, and pharmacy data, and additional tools to identify social risk factors, health related social needs, and health equity. An ICP process starts with conversations with the member, review of health records, and considering recommendations from the ICT. These are used in the creation of the ICP for all SNP members.

Your care plan includes:

- your health care goals **and**
- an on-going action plan to address your health needs **and**
- a timeline for getting the services you need **and**
- a Health Risk Assessment used in developing your care plan

Your care team meets with you after your HRA. They ask you about services you need. They also tell you about services you may want to think about getting. Your care plan is created based on your needs and goals. Your care team works with you to update your care plan at least every year.

H. Summary of Important Costs

Your costs may include the following:

- Plan premium (**Section H1**)
- Monthly Medicare Part B Premium (**Section H2**)
- Medicare Prescription Payment Plan Amount (**Section H3**)

In some situations, your plan premium could be less.

The "Extra Help" program helps people with limited resources pay for their drugs. Learn more about this program in **Chapter 2, Section H2**. If you qualify, enrolling in the program might lower your monthly plan premium.

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If you already get help from this program, **the information about premiums in this *Evidence of Coverage* doesn't 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 at the number at the bottom of this page and ask for the "LIS Rider".

H1. 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.

H2. 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 E** above, 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 Medicare Part A premium (if you don't qualify for it automatically) and Part B premium.

If Medicaid isn't paying your Medicare premiums for you, you must continue to pay your Medicare premiums to stay a member of our plan. This includes your premium for Medicare Part B. You may also pay a premium for Medicare Part A if you aren't eligible for premium-free Medicare Part **A. In addition, please contact Member Service or your coordinator and inform them of this change.**

H3. Medicare Prescription Payment Amount

If you're participating in the Medicare Prescription Payment Plan, you'll get a bill from our plan for your drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Chapter 2, Section H3 tells more about the Medicare Prescription Payment Plan. If you disagree with the amount billed as part of this payment option, you can follow the steps in **Chapter 9, Section E** to make a complaint or appeal.

I. This *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you. This means that we must follow all rules in this document. If you think we've done something that goes against these rules, you may be able to

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appeal our decision. For information about appeals, refer to **Chapter 9** of this *Evidence of Coverage* or call 1-800-MEDICARE (1-800-633-4227).

You can ask for an *Evidence of Coverage* by calling Member Service at the numbers at the bottom of the page. You can also refer to the *Evidence of Coverage* found on our website at the web address at the bottom of the page.

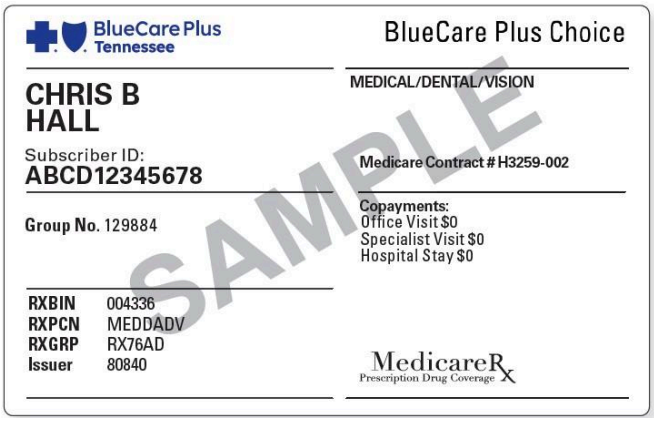
The contract is in effect for the months you're enrolled in our plan between January 1 – December 31, 2027.

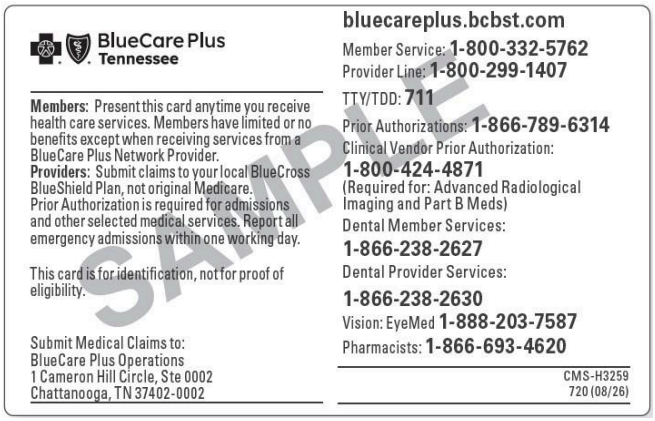
J. Other important information you get from us

Other important information we provide to you includes your Member ID Card, information about how to access a *Provider and Pharmacy Directory* and information about how to access a *List of Covered Drugs*, also known as a *Drug List* or *Formulary*.

J1. Your Member ID Card

Under our plan, you have one card for your Medicare and TennCare services, including LTSS, certain behavioral health services, and prescriptions. You show this card when you get any services or prescriptions. Here is a sample Member ID Card:





If your Member ID Card is damaged, lost, or stolen, call Member Service at the number at the bottom of the page right away. We'll send you a new card.

As long as you're a member of our plan, you don't need to use your red, white, and blue Medicare card or your TennCare card to get most services. Keep those cards in a safe place, in case you need them later. If you show your Medicare card instead of your Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. You may be asked to show your Medicare card if you need hospital services, hospice services, or participate in Medicare-approved clinical research studies (also

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called clinical trials). Refer to **Chapter 7** of this *Evidence of Coverage* to find out what to do if you get a bill from a provider.

J2. *Provider and Pharmacy Directory*

The *Provider and Pharmacy Directory* lists the providers and pharmacies in our plan's network. While you're a member of our plan, you must use network providers to get covered services.

You can ask for a *Provider and Pharmacy Directory* (electronically or in hard copy form) by calling Member Service at the numbers at the bottom of the page. Requests for hard copy Provider and Pharmacy Directories will be mailed to you within three business days. You can also refer to the *Provider and Pharmacy Directory* at the web address at the bottom of the page.

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.

When first enrolled or when there's a change to your provider, you can continue to receive your service or Medicaid for at least 30 days.

Definition of network providers

- Our network providers include:
  - doctors, nurses, and other health care professionals that you can use as a member of our plan;
  - clinics, hospitals, nursing facilities, and other places that provide health services in our plan; **and**
  - LTSS, behavioral health services, home health agencies, durable medical equipment (DME) suppliers, and others who provide goods and services that you get through Medicare or Medicaid.

Network providers agree to accept payment from our plan for covered services as payment in full.

Definition of network pharmacies

- Network pharmacies are pharmacies that agree to fill prescriptions for our plan members. Use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use.
- Except during an emergency, you must fill your prescriptions at one of our network pharmacies if you want our plan to help you pay for them.

Call Member Service at the numbers at the bottom of the page for more information. Both Member Service and our website can give you the most up-to-date information about changes in our network pharmacies and providers.

J3. *List of Covered Drugs*

Our plan has a *List of Covered Drugs*. We call it the *Drug List* for short. It tells you which drugs our plan covers. The drugs on this list are selected by our plan with the help of doctors and pharmacists. The *Drug List* must meet Medicare's requirements. Drugs with negotiated prices under the Medicare Drug Price Negotiation Program will be included on your *Drug List* unless they've been removed and replaced as described in **Chapter 5, Section B.** Medicare approved the BlueCare Plus Choice *Drug List*.

The *Drug List* also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. Refer to **Chapter 5** of this *Evidence of Coverage* for more information.

Each year, we send you information about how to access the *Drug List*, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, call Member Service or visit our website at the address at the bottom of the page.

J4. The *Explanation of Benefits*

When you use your Medicare Part D drug benefits, we send you a summary to help you understand and keep track of payments for your Medicare Part D drugs. This summary is called the *Explanation of Benefits* (EOB).

The EOB tells you the total amount you, or others on your behalf, spent on your Medicare Part D drugs and the total amount we paid for each of your Medicare Part D drugs during the month. This EOB isn't a bill. The EOB has more information about the drugs you take such as increases in price and other drugs with lower cost-sharing that may be available. You can talk to your prescriber about these lower cost options. **Chapter 6** of this *Evidence of Coverage* gives more information about the EOB and how it helps you track your drug coverage.

You can also ask for an EOB. To get a copy, contact Member Service at the numbers at the bottom of the page.

K. Keeping your membership record up to date

You can keep your membership record up to date by telling us when your information changes.

We need this information to make sure that we have your correct information in our records. The doctors, hospitals, pharmacists, and other providers in our plan's network use your membership record to know what services and drugs are covered and your cost-sharing amounts. Because of this, it's very important to help us keep your information up to date.

Tell us right away about the following:

- changes to your name, address, or phone number;
- changes to any other health insurance coverage, such as from your employer, your spouse's employer, or your domestic partner's employer, or workers' compensation;
- any liability claims, such as claims from an automobile accident;
- admission to a nursing facility or hospital;
- care from a hospital or emergency room;
- changes in your caregiver (or anyone responsible for you); **and**
- you participate in a clinical research study. (**Note:** You're not required to tell us about a clinical research study you intend to participate in, but we encourage you to do so.)

If any information changes, call Member Service at the numbers at the bottom of the page.

TennCare Connect is an online tool for Tennesseans to apply and manage their TennCare benefits. You can access the website: tenncareconnect.tn.gov or call TennCare customer service at 1-855-259-0701.

K1. Privacy of personal health information (PHI)

Information in your membership record may include personal health information (PHI). Federal and state laws require that we keep your PHI private. We protect your PHI. For more details about how we protect your PHI, refer to **Chapter 8** of this *Evidence of Coverage*.

Chapter 2: Important phone numbers and resources

Introduction

This chapter gives you contact information for important resources that can help you answer your questions about our plan and your health care benefits. You can also use this chapter to get information about how to contact your coordinator and others to advocate on your behalf. Key terms and their definitions appear in alphabetical order in the last chapter of this *Evidence of Coverage*.

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A. Member Service

CALL	**1-800-332-5762**. This call is free. Calls to this number are free. From **Oct. 1 to Mar. 31**, you can call us 7 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. You can get this Evidence of Coverage for free in other formats, such as large print, accessible electronic document, or audio. Members can Chat-on-line with a specialist from 8:00 a.m. to 6:00 p.m. ET, by logging into the Member Portal on bluecareplus.bcbst.com We have free interpreter services for people who don't speak English.
TTY	**711.** This call is free. From **Oct. 1 to Mar. 31**, you can call us 7 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.
FAX	1-888-725-6849
WRITE	BlueCare Plus Tennessee 1 Cameron Hill Circle, Suite 0002 Chattanooga, TN 37402-0002
WEBSITE	bluecareplus.bcbst.com

Contact Member Service to get help with:

- questions about the plan
- questions about claims or billing
- coverage decisions about your health care

This section is continued on next page

- A coverage decision about your health care is a decision about:
  - your benefits and covered services **or**
  - the amount we pay for your health services.
- Call us at the numbers below if you have questions about a coverage decision about your health care.
- To learn more about coverage decisions, refer to **Chapter 9** of this *Evidence of Coverage*.

Method	Coverage Decisions for Medical Care - Contact Information
CALL	**1-800-332-5762** Calls to this number are free. From **Oct. 1 to Mar. 31**, you can call us 7 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.
TTY	**711** Calls to this number are free. From **Oct. 1 to Mar. 31**, you can call us 7 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.
FAX	1-866-325-6698
WRITE	BlueCare Plus Tennessee 1 Cameron Hill Circle, Suite 0002 Chattanooga, TN 37402-0002
WEBSITE	bluecareplus.bcbst.com

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- Appeals about your health care
  - An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake or disagree with the decision.
  - To learn more about making an appeal, refer to **Chapter 9** of this *Evidence of Coverage* or contact Member Service.

Method	Appeals for Medical Care – Contact Information
CALL	**1-800-332-5762** Calls to this number are free. From **Oct. 1 to Mar. 31**, you can call us 7 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.
TTY	**711** Calls to this number are free. From **Oct. 1 to Mar. 31**, you can call us 7 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.
FAX	1-888-416-3026
WRITE	BlueCare Plus Tennessee Member Appeals 1 Cameron Hill Circle, Suite 0042 Chattanooga, TN 37402-0042
WEBSITE	bluecareplus.bcbst.com

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- Complaints about your health care
  - You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with our plan. You can also make a complaint to us or to the Quality Improvement Organization (QIO) about the quality of the care you received (refer to Section D, **Chapter 2** of your *Evidence of Coverage* or contact Member Service).
  - You can call us and explain your complaint at 1-800-332-5762.
  - If your complaint is about a coverage decision about your health care, you can make an appeal (refer to the section above or to **Chapter 9, Section E2** of your *Evidence of Coverage).*
  - You can send a complaint about our plan to Medicare. You can use an online form at www.medicare.gov/my/medicare-complaint. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - You can file a Medical Appeal with TennCare at 1-800-878-3192 or 1-866-771-7043 TTY. Or you can visit online at www.tn.gov/tenncare/members-applicants/how-to-file-a-medical-appeal to get additional information on how to file a Medical Appeal.
  - To learn more about making a complaint about your health care, refer to **Chapter 9** of this *Evidence of Coverage*.

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Method	Complaints about Medical Care – Contact Information
CALL	**1-800-332-5762** Calls to this number are free. From **Oct. 1 to Mar. 31**, you can call us 7 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.
TTY	**711** Calls to this number are free. From **Oct. 1 to Mar. 31**, you can call us 7 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.
FAX	1-888-416-3026
WRITE	BlueCare Plus Tennessee BlueCare Plus Operations 1 Cameron Hill Circle, Suite 0042 Chattanooga, TN 37402-0042
MEDICARE WEBSITE	You can submit a complaint about BlueCare Plus Choice directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx.

This section is continued on next page

- Coverage decisions about your drugs
  - A coverage decision about your drugs is a decision about:
    - your benefits and covered drugs or
    - the amount we pay for your drugs.
  - This applies to your Medicare Part D drugs and your TennCare CoverRX benefits.
  - For more on coverage decisions about your drugs, refer to **Chapter 9** of this *Evidence of Coverage*.

Method	Coverage Decisions for Part D Prescription Drugs – Contact Information
CALL	**1-800-332-5762** Calls to this number are free. From **Oct. 1. to Mar. 31**, you can call us 7 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.
TTY	**711** Calls to this number are free. From **Oct. 1. to Mar. 31**, you can call us 7 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.
FAX	1-423-591-9514
WRITE	BlueCare Plus Tennessee Medicare Part D Coverage Determinations and Appeals 1 Cameron Hill Circle, Suite 0051 Chattanooga, TN 37402-0051
WEBSITE	bluecareplus.bcbst.com

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- Appeals about your drugs
  - An appeal is a way to ask us to change a coverage decision.
  - For more on making an appeal about your drugs, refer to **Chapter 9** of this *Evidence of Coverage*.

Method	Appeals for Part D Prescription Drugs – Contact Information
CALL	**1-800-332-5762** Calls to this number are free. From **Oct. 1. to Mar. 31**, you can call us 7 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.
TTY	**711** Calls to this number are free. From **Oct. 1. to Mar. 31**, you can call us 7 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.
FAX	1-423-591-9514
WRITE	BlueCare Plus Tennessee Medicare Part D Coverage Determinations and Appeals 1 Cameron Hill Circle, Suite 0051 Chattanooga, TN 37402-0051
WEBSITE	bluecareplus.bcbst.com

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- Complaints about your drugs
  - You can make a complaint about us or any pharmacy. This includes a complaint about your drugs.
  - If your complaint is about a coverage decision about your drugs, you can make an appeal. (Refer to the section above: **Section A**, Appeals About Your Drugs.)
  - You can send a complaint about our plan to Medicare. You can use an online form at www.medicare.gov/my/medicare-complaint. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - For more on making a complaint about your drugs, refer to **Chapter 9** of this *Evidence of Coverage*.

Method	Complaints about Part D Prescription Drugs – Contact Information
CALL	**1-800-332-5762** Calls to this number are free. From **Oct. 1 to Mar. 31**, you can call us 7 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.
TTY	**711** Calls to this number are free. From **Oct. 1 to Mar. 31**, you can call us 7 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.
FAX	1-888-416-3026
WRITE	BlueCare Plus Tennessee 1 Cameron Hill Circle, Suite 0042 Chattanooga, TN 37402-0042
MEDICARE WEBSITE	You can submit a complaint about BlueCare Plus Choice directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx.

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- Payment for health care or drugs you already paid for
  - For more on how to ask us to pay you back, or to pay a bill you got, refer to **Chapter 7** of this *Evidence of Coverage*.
  - If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. Refer to **Chapter 9** of this *Evidence of Coverage.*
  - 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 at the bottom of this page).

Method	Payment Requests – Contact Information
CALL	**1-800-332-5762** Calls to this number are free. From **Oct. 1 to Mar. 31**, you can call us 7 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.
TTY	**711** Calls to this number are free. From **Oct. 1 to Mar. 31**, you can call us 7 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.
FAX	**Medical (Part C) Payment Requests:** 1-888-725-6849 **Prescription (Part D) Payment Requests:** 1-423-591-9495
WRITE	**Medical (Part C) Payment Requests:** BlueCare Plus Tennessee 1 Cameron Hill Circle, Suite 0002 Chattanooga, TN 37402-0002 **Prescription (Part D) Payments Requests:** BlueCare Plus Tennessee Medicare Part D Prescription Drug Claim Request 1 Cameron Hill Circle, Suite 48 Chattanooga, TN 37402-0048
WEBSITE	bluecareplus.bcbst.com

B. Your coordinator

BlueCare Plus Choice has coordinators and care teams to help you manage your providers and services. Your care team works with you to make an Individualized Care Plan. An Individualized Care Plan tells you and your doctors what services you need and how to get them. It includes your medical, behavioral health, and long-term services and support needs using a person-centered approach to your needs assessment and care planning.

We will assign you a coordinator when you enroll in CHOICES or ECF CHOICES. Your coordinator will play a very important role. Your coordinator is your primary contact person and is the first person that you should go to if you have any questions about your services.

If you're unhappy with your coordinator and would like a different one, you can ask us if you can have a new coordinator if one is available. That doesn't mean you can pick whoever you want to be your coordinator. We must be able to meet the needs of all CHOICES and ECF CHOICES members and assign staff in a way that allows us to do that. To ask for a different coordinator, call us at **1-877-715-9503, TTY 711.** Tell us why you want to change coordinators. If we can't give you a new coordinator, we'll tell you why. And, we'll help to address any problems or concerns you have with your coordinator.

If you're in CHOICES or ECF CHOICES, you can contact your 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 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 can't wait until the next day, you can call us at **1-877-715-9503,** TTY **711**

CALL	1-877-715-9503. This call is free. Monday through Friday, 8 a.m. to 6 p.m. ET We have free interpreter services for people who don't speak English.
TTY	TTY 711. This call is free. You can call us Monday through Friday from 8 a.m. to 6 p.m. ET.
FAX	1-866-325-6694
WRITE	BlueCare Plus Tennessee 1 Cameron Hill Circle, Suite 0002 Chattanooga, TN 37402-0002

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WEBSITE	bluecareplus.bcbst.com

Contact your coordinator to get help with:

- questions about your health care
- questions about getting behavioral health, mental health and substance use disorder services
- questions about transportation
- questions about TennCare Long-Term Services and Supports programs, including the following:
  - 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 facility if it's needed.
  - Employment Community First CHOICES (ECF CHOICES) is for people of all ages who have an intellectual or developmental disability (I/DD). This includes people who have significant disabilities. Services help people with I/DD gain as much independence as possible. People are supported to live with their family or in the community, not in an institution. Residential services are available for adults with I/DD who don't live with family but need supports where they live.
  - ECF CHOICES can help the person with I/DD explore the possibility of working. Services can also help people learn skills for work, find a job, and keep a job. This could be a part-time job, a full-time job or self-employment. Other services help people learn and do things at home and in the community that help people achieve their goals. If a person lives at home with their family, the services help the family support the person to become as independent as possible. Services also help people get actively involved in their communities and include peer supports for the person and for their family.

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- **Your coordinator team will also:**
  - Make sure your plan of care is carried out and working the way that it needs to.
  - Monitor to make sure you're getting what you need and that gaps in care are addressed right away.
  - ECF CHOICES members will be contacted by telephone quarterly for Group 4 members and monthly for Groups 5 and 6. Visits will be in the home semi-annually for Group 4 members, quarterly for Group 5 members, and Group 6 individuals will have home visits based on their level of need. All ECF members residing in Community Living Supports (CLS) will have monthly home visits. ECF members in Group 7 and 8 will have home visits based on how long they have been enrolled.

C. TN SHIP (TN State Health Insurance Assistance Program)

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

TN SHIP is an independent state program (not connected with any insurance company or health plan) that gets money from the federal government to give free local health insurance counseling to people with Medicare.

CALL	1-877-801-0044 8 a.m. – 4:30 p.m. CST
TTY	1-800-848-0299 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Davy Crockett Tower, 2nd Floor, 500 James Robertson Pkwy, Nashville, TN 37243
EMAIL	dda.ship@tn.gov
WEBSITE	www.tn.gov/disability-and-aging/disability-aging-programs/tn-ship.html

Contact TN SHIP for help with:

- questions about Medicare
- TN SHIP counselors can answer your questions about changing to a new plan and help you:
  - understand your rights,
  - understand your plan choices,
  - answer questions about switching plans,
  - make complaints about your health care or treatment, **and**
  - straighten out problems with your bills.

D. Quality Improvement Organization (QIO)

Our state has an organization called Acentra Health. This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. Acentra Health is an independent organization. It's not connected with our plan.

CALL	Members: 1-888-317-0751 TTY: 711 Fax: 1-844-877-7921 Calls to this number are free. Monday through Friday, 9 a.m. to 5 p.m.; Weekends and Holidays – 10:00 a.m. to 4:00 p.m.; in Eastern, Central, Mountain, Pacific, Alaska, and Hawaii-Aleutian time zones
WRITE	Acentra Health 1650 Summit Lake Dr, Suite 102 Tallahassee, FL 32317
EMAIL	QIOCommunications@acentra.com

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WEBSITE	https://www.acentraqio.com

Contact Acentra Health for help with:

- questions about your health care rights
- making a complaint about the care you got if you:
  - have a problem with the quality of care such as getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis,
  - think your hospital stay is ending too soon, **or**
  - think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

E. Medicare

Medicare is the federal health insurance program for people 65 years of age or over, 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 Service, or CMS. This agency contracts with Medicare Advantage organizations including our plan.

CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1-877-486-2048. This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
CHAT LIVE	Chat live at www.Medicare.gov/talk-to-someone
WRITE	Write to Medicare at PO Box 1270, Lawrence, KS 66044

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WEBSITE	www.medicare.gov • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventive services (like screenings, shots, or vaccines, and yearly "wellness" visits). • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers. To submit a complaint to Medicare, go to www.medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

F. TennCare

TennCare is Tennessee's managed care Medicaid program which provides health insurance coverage to certain groups of low-income individuals such as pregnant women, children, parents or caretaker relatives of minor children, older adults, and adults with disabilities.

CALL	TennCare Connect at 1-855-259-0701 8 a.m. – 4:30 p.m. CST
TTY	1-800-848-0299
WRITE	Division of TennCare 310 Great Circle Rd. Nashville, TN 37243
EMAIL	tenn.care@tn.gov
WEBSITE	www.tenncareconnect.tn.gov/

G. Tennessee State Long-Term Care (LTC) Ombudsman

The Tennessee State LTC Ombudsman helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

Tennessee State LTC 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 **doesn't** work for the facility, the state, or BlueCare Plus Tennessee. 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 Department of Disability and Aging.

CALL	Tel: 615-253-5412 Fax: 615-741-3309 Toll Free: 877-236-0013 Monday through Friday, 8 a.m. to 4:30 p.m. CST
TTY	Toll Free: 1-800-848-0299 615-532-3893 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking

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WRITE	Davy Crockett Tower, 2nd Floor, 500 James Robertson Pkwy, Nashville, TN 37243
EMAIL	ombudsman.notification@tn.gov
WEBSITE	www.tn.gov/disability-and-aging/disability-aging-programs/long-term-care-ombudsman.html

H. Programs to Help People Pay for Drugs

The Medicare website (www.medicare.gov/basics/costs/help/drug-costs) provides information on how to lower your drug costs. For people with limited incomes, there are also other programs to assist, as described below.

H1. Extra Help from Medicare

Because you're eligible for Medicaid, you qualify for and are getting "Extra Help" from Medicare to pay for your drug plan costs. You don't need to do anything to get this "Extra Help."

CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WEBSITE	www.medicare.gov

If you think you're paying an incorrect amount for your prescription at a pharmacy, our plan has a process to help get evidence of your correct copayment amount. If you already have evidence of the right amount, we can help you share this evidence with us.

This section is continued on next page

- 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.
- When we get the evidence showing the right copayment level, we'll update our system so you can pay the right copayment amount when you get your next prescription. If you overpay your copayment, we'll pay you back either by check or a future copayment credit. If the pharmacy didn't collect your copayment and you owe them a debt, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Call Member Service at the number at the bottom of the page if you have questions.

H2. AIDS Drug Assistance Program (ADAP)

ADAP helps ADAP-eligible people living with HIV/AIDS have access to life-saving HIV drugs. Medicare Part D drugs that are also on the ADAP formulary qualify for prescription cost-sharing help through the Tennessee Ryan White Part B Program.

Note: To be eligible for the ADAP in your state, people must meet certain criteria, including proof of the state residence and HIV status, low income as defined by the state, and uninsured/under-insured status. If you change plans, 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 615-532-6509.

H3. The Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across the calendar year (January- December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. If you're participating in the Medicare Prescription Payment Plan and stay in the same plan, you don't need to do anything to continue this option.** "Extra Help" from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in this payment option, no matter your income level, and plans with drug coverage must offer this payment option. To learn more about this payment option, call Member Service at the phone number at the bottom of the page or visit www.Medicare.gov.

I. Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment.

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

CALL	1-800-772-1213 Calls to this number are free. Available 8 a.m. to 7 p.m., Monday through Friday. You can use their automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WEBSITE	www.ssa.gov

J. Railroad Retirement Board (RRB)

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

CALL	1-877-772-5772 Calls to this number are free. Press "0" to speak with a RRB representative from 9 a.m. to 3:30 p.m., Monday, Tuesday, Thursday and Friday, and from 9 a.m. to 12 p.m. on Wednesday. Press "1" to access the automated RRB Help Line and get recorded information 24 hours a day, including weekends and holidays.

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TTY	1-312-751-4701 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. Calls to this number *aren't* free.
WEBSITE	www.rrb.gov

K. Group insurance or other insurance from an employer

If you (or your spouse or domestic partner) get benefits from your (or your spouse's or domestic partner's) employer or retiree group as part of this plan, call the employer/union benefits administrator or Member Service at the phone number at the bottom of the page with any questions. You can ask about your (or your spouse's or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. You can also call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2048.

If you have other drug coverage through your (or your spouse's or domestic partner's) employer or retiree group, contact **that group's benefits administrator.** The benefits administrator can help you understand how your current drug coverage will work with our plan.

Chapter 3: Using our plan's coverage for your health care and other covered services

Introduction

This chapter has specific terms and rules you need to know to get health care and other covered services with BlueCare Plus Choice. It also tells you about your coordinator, how to get care from different kinds of providers and under certain special circumstances (including from out-of-network providers or pharmacies), what to do if you're billed directly for services we cover, and the rules for owning Durable Medical Equipment (DME). Key terms and their definitions appear in alphabetical order in the last chapter of this *Evidence of Coverage*.

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A. Information about services and providers

Services are health care, long-term services and supports (LTSS), supplies, behavioral health services, prescription drugs, equipment and other services. **Covered services** are any of these services that our plan pays for. Covered health care, behavioral health, and LTSS are in **Chapter 4** of this *Evidence of Coverage*. Your covered services for prescription drugs are in **Chapter 5** of this *Evidence of Coverage*.

Providers are doctors, nurses, and other people who give you services and care and are licensed by the state. Providers also include hospitals, home health agencies, clinics, and other places that give you health care services, behavioral health services medical equipment, and certain LTSS.

Network providers are providers who work with our plan. These providers agree to accept our payment which includes cost-sharing as full payment. We arranged for these providers to deliver covered services to you. Network providers bill us directly for care they give you. When you use a network provider, you usually pay nothing for covered services.

B. Rules for getting services our plan covers

Our plan covers all services covered by Medicare and TennCare. This includes behavioral health and LTSS.

Our plan will generally pay for health care services, behavioral health services and LTSS you get when you follow our rules. To be covered by our plan:

- The care you get must be included in our Medical Benefits Chart in **Chapter 4** of this *Evidence of Coverage*.
- The care must be **medically necessary**. By medically necessary, we mean you need services to prevent, diagnose, or treat your condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.
- For medical services, you must have a network **primary care provider (PCP)** providing and overseeing your care. As a plan member, you must choose a network provider to be your PCP (go to **Section D1** for more information).
    - You don't need referrals from your PCP for emergency care or urgently needed care or to use a woman's health provider. You can get other kinds of care without having a referral from your PCP (go to **Section D1** for more information).
- **You must get your care from network providers.** Usually, we won't cover care from a provider who doesn't work with our health plan. This means that you'll have to pay the provider in full for services you get. Here are some cases when this rule doesn't apply:

This section is continued on next page

- If you need emergency or urgently needed care from an out-of-network provider (for more information, go to **Section I**).
- If you need care from a Specialist that our plan covers and our network providers can't give it to you, you can get care from an out-of-network provider. You MUST get prior approval for these services. In this situation, we cover the care as if you got it from a network provider at no additional cost to you. For information about getting approval to use an out-of-network provider, go to **Section D4**.
- If you need kidney dialysis services when you're outside our plan's service area for a short time or when your provider is temporarily unavailable or not accessible. The cost-sharing you pay for dialysis can never be higher than the cost-sharing in Original Medicare. If you're outside our plan's service area and get dialysis from a provider outside the plan's network, your cost-sharing can't be higher than the cost-sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to get services inside our service area from an out-of-network provider your cost-sharing for the dialysis may be higher. If possible, call Member Service at the number at the bottom of the page before you leave the service area so we can help arrange for you to have maintenance dialysis while you're away.
- If you were already getting care or treatment when your TennCare started, you may be able to keep getting the care without an approval or referral.

C. Your coordinator

We're 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. We'll assign you a coordinator when you enroll in our plan.

C1. What's a coordinator

Your coordinator will play a very important role. Your coordinator is your primary contact person and is the first person that you should go to if you have any questions about your services. Your coordinator will:

- Provide information about your coverage 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.

This section is continued on next page

- 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.

C2. How you can contact your coordinator

To find out who your coordinator is or how to contact them please call us at 1-877-715-9503. (TTY users should call 711.)

C3. How you can change your coordinator

If you're unhappy with your coordinator and would like a different one, you can ask us. You can have a new coordinator if one is available. That doesn't mean you can pick whoever you want to be your coordinator. We must be able to meet the needs of all LTSS members and assign staff in a way that allows us to do that. To ask for a different coordinator, call us at 1-800-332-5762, TTY 711. Tell us why you want to change coordinators. If we can't give you a new coordinator, we'll tell you why. And, we'll help to address any problems or concerns you have with your coordinator.

D. Care from providers

D1. Care from a primary care provider (PCP)

You must choose a PCP to provide and manage your care.

Definition of a PCP and what a PCP does do for you

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

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The role of a PCP:

- 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.
- 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.

Your choice of 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.

Option to change your PCP

You can change your PCP for any reason, at any time. It's also possible that your PCP may leave our plan's network. If your PCP leaves our network, we can help you find a new PCP in our network.

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.

Find a new PCP by using our Find a Doctor tool at 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.

Services you can get without approval from your PCP

You can get services like the ones listed below without getting approval from your PCP first:

- Emergency services from network providers or out-of-network providers.
- Urgently needed covered services that require immediate medical attention (but not an emergency) if you're either temporarily outside our plan's service area, or if it's unreasonable

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given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our network is temporarily unavailable.

- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're outside our plan's service area. Call Member Service before you leave the service area. We can help you get dialysis while you're away.
- Flu shots and COVID-19 vaccines as well as hepatitis B vaccines and pneumonia vaccines as long as you get them from a network provider.
- Routine women's health care and family planning services. This 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.
- Additionally, if eligible to get services from Indian health providers, you may use these providers without a referral.
- Bone mineral density testing every 24 months or more frequently, if medically necessary, as long as you get testing from a network provider.
- Preventive Screening Colonoscopy (or screening barium enema as an alternative) for people at high risk of colorectal cancer every 24 months, as long as you get testing from a network provider. 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, as long as you get screening from a network provider.

D2. Care from specialists and other network providers

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

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart problems.
- Orthopedists care for patients with bone, joint, or muscle problems.

Which services will require authorization from us?
See **Chapter 4, Section C** for information about which services require prior authorization.

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

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A Prior Authorization (PA) means you will get plan approval before getting a specific service or drug or before using an out-of-network provider. While participating network providers, including physicians or other providers, are responsible for obtaining prior authorizations and/or other coverage or advance terminations 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.

D3. When a provider leaves our plan

A network provider you use may leave our plan. If one of your providers leaves our plan, you have these rights and protections that are summarized below:

- Even if our network of providers change during the year, we must give you uninterrupted access to qualified providers.
- We'll 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'll notify you if you visited that provider within the past three years.
    - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past three months.

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- We help you select a new qualified in-network provider to continue managing your health care needs.
- If you're currently undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies you're getting continues. We'll work with you so you can continue to get care.
- We'll give you information about the available periods and options you may have for changing plans.
- If we can't find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. Prior authorization is required.
- If you find out one of your providers is leaving our plan, contact us. We can help you choose a new provider and to manage your care.
- If you think we haven't replaced your previous provider with a qualified provider or that we aren't managing your care well, you have the right to file a quality of care complaint to the Quality Improvement Organization (QIO), a quality of care grievance, or both. (Refer to **Chapter 9** of the *Evidence of Coverage* for more information.)

D4. Out-of-network providers

Care that you receive from out-of-network (OON) providers will not be covered unless the care meets one of the exceptions described in **Section D** 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 I** in this chapter.

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

- Your network PCP who is providing and overseeing your care refers you to an OON provider.
- 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 isn't 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 D2 above. You can also refer to **Chapter 9 Section, F2** *Asking for coverage decisions and making an appeal* in this document.

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If you use an out-of-network provider, the provider must be eligible to participate in Medicare and/or TennCare.

- We can't pay a provider who isn't eligible to participate in Medicare and/or TennCare.
- If you use a provider who isn't eligible to participate in Medicare, you must pay the full cost of the services you get.
- Providers must tell you if they aren't eligible to participate in Medicare.

E. Long-term services and supports (LTSS) CHOICES and Employment and Community First CHOICES (ECF)

TennCare CHOICES is Long-Term Services and Supports program (or CHOICES for short) 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's needed.

TennCare Employment Community First CHOICES is a Long-Term Services and Supports program (or ECF CHOICES for short) for people of all ages who have an intellectual or developmental disability (I/DD). This includes people who have significant disabilities. Services help people with I/DD gain as much independence as possible. People are supported to live with their family or in the community, not in an institution. Residential services are available for adults with I/DD who don't live with family but need supports where they live.

ECF CHOICES can help the person with I/DD explore the possibility of working. Services can also help people learn skills for work, find a job, and keep a job. This could be a part-time job, a full-time job or self-employment. Other services help people learn and do things at home and in the community that help people achieve their goals. If a person lives at home with their family, the services help the family support the person to become as independent as possible. Services also help people get actively involved in their communities and include peer supports for the person and for their family.

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E1. How do I apply for CHOICES or ECF CHOICES?

Apply for CHOICES:

If you think you need CHOICES, call us at 1-800-332-5762, TTY 711**.** We may use a short screening that will be done over the phone to help decide if you may qualify for CHOICES. If the screening shows that you don't appear to qualify for CHOICES, you'll get a letter that says how you can finish applying for CHOICES.

If the screening shows that you might qualify for CHOICES, or if we don't conduct a screening over the phone, we'll send a care coordinator to your home to do an assessment.

The purpose of the in-home assessment is to help you apply for CHOICES. It's also to find out:

- The kinds of help you need;
- the kinds of care being provided by family members and other caregivers to help meet your needs; **and**
- the gaps in care for which paid long-term services and supports may be needed.

If you want to receive care at home or in the community (instead of going to a nursing home), the assessment will help decide if your needs can be safely met in the home or community setting. For CHOICES Group 2 (you can read about all of the CHOICES Groups below), it will help decide if the cost of your care would exceed the cost of nursing home care.

This **doesn't** mean that you'll receive services up to the cost of nursing home care. CHOICES won't pay for more services than you must have to safely meet your needs at home. And CHOICES only pays for services to meet long-term services and supports needs that can't be met in other ways.

CHOICES services provided to you in your home or in the community won't take the place of care you get from family and friends or services you already receive.

If you're getting help from community programs, receive services paid for by Medicare or other insurance, or have a family member that takes care of you, these services won't be replaced by paid care through CHOICES. Instead, the home care you receive through CHOICES will work together with the assistance you already receive to help you stay in your home and community longer. Care in CHOICES will be provided as cost-effectively as possible so that more people who need care will be able to get help.

However, if you've been getting services through the State-funded Options program, you won't qualify to get those services anymore. They're for people who don't get Medicaid. And if you've been getting services from programs funded by the Older Americans Act (like Meals on Wheels, homemaker, or the

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National Caregiver Family Support Programs) that you can now get through CHOICES, you'll get the care you need through CHOICES.

If you want home care, the care coordinator will also assess risk. This will help to identify any additional risks you may face as a result of choosing to receive care at home. It will also help to identify ways to help reduce those risks and to help keep you safe and healthy.

To see if you qualify to enroll in CHOICES, call us at 1-800-332-5762, TTY 711.

Does someone you know that isn't on TennCare want to apply for CHOICES? They should contact their local Area Agency on Aging and Disability (AAAD) for free at 866-836-6678. Their local AAAD will help them find out if they qualify for TennCare and CHOICES.

Apply for ECF CHOICES:

There's a limited amount of funding to serve people each year. This means that not everyone who wants to apply can enroll or get services right away.

There's a referral list for ECF CHOICES. To get on the referral list, a self-referral must be completed. Filling out the self–referral for ECF CHOICES doesn't mean you'll be enrolled in the program. You must qualify to enroll in the program. There must be room in the program to enroll you AND you must be in one of the groups that may qualify to get services now.

To complete a self-referral, visit https://perlss.tenncare.tn.gov/externalreferral. If you need help with a self-referral for ECF CHOICES, call us at 1-800-332-5762, TTY 711.

ECF CHOICES services provided to you in your home or in the community won't take the place of care you get from family and friends or services you already receive.

If you're getting help from community programs, receive services paid for by Medicare or other insurance, or have a family member that takes care of you, these services won't be replaced by paid care through ECF CHOICES. Instead, the home care you receive through ECF CHOICES will work together with the assistance you already receive to help you stay in your home and community longer. Care in ECF CHOICES will be provided as cost-effectively as possible so that more people who need care will be able to get help.

However, if you've been getting services through the State-funded Family Support program, you won't qualify to get those services anymore. They are for people who don't get Medicaid. And if you've been getting services from programs funded by the other state or federal programs (like Meals on Wheels, homemaker, or the National Caregiver Family Support Programs) that you can now get through ECF CHOICES, you'll get the care you need through ECF CHOICES.

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To see if you qualify to enroll in ECF CHOICES, call us at 1-800-332-5762, TTY 711.

Does someone you know that isn't on TennCare want to apply for ECF CHOICES? They can complete a self-referral by visiting https://perlss.tenncare.tn.gov/externalreferral. If they need help with the self-referral, they should contact the Department of Disability and Aging (DDA) Regional Intake office in their area of the state.

- West Tennessee (866) 372-5709
- Middle Tennessee (800) 654-4839
- East Tennessee (888) 531-9876

This office will help them find out if they qualify for TennCare and ECF CHOICES.

E2. Who can qualify to enroll in CHOICES or ECF CHOICES?

There are three (3) groups of people who can qualify to enroll in CHOICES.

CHOICES Group 1 is for people of all ages who receive nursing home care.

To be in CHOICES Group 1, you must:

- Need the level of care provided in a nursing home, **and**
- qualify for Medicaid long-term services and supports, **and**
- receive nursing home services that TennCare pays for.

TennCare Long-Term Services and Supports will decide if you need the level of care provided in a nursing home. TennCare Member Service will decide if you qualify for Medicaid long-term services and supports. We'll help you fill out the papers TennCare needs to decide. What if TennCare says yes? If you're receiving nursing home services that TennCare will pay for, TennCare will enroll you into CHOICES Group 1. If TennCare says you don't qualify, you'll get a letter that says why. It will say how to appeal if you think it's a mistake.

CHOICES Group 2 is for certain people who qualify for nursing home care but choose to receive home care instead. To be in CHOICES Group 2, you must:

- Need the level of care provided in a nursing home, **and**
- qualify for Medicaid long-term services and supports because you receive SSI payments OR because you'll need and will receive home care services instead of nursing home care, **and**

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- be an adult 65 years of age or older, **or**
- be an adult 21 years of age or older with a physical disability.

If you need home care services but don't qualify in one of these groups, you can't be in CHOICES Group 2, but you may qualify for other kinds of long-term services and supports.

TennCare Long-Term Services and Supports will decide if you need the level of care provided in a nursing home. TennCare Member Service will decide if you qualify for Medicaid long-term services and supports for one of the reasons listed above. We'll help you fill out the papers they need to decide. If TennCare says yes, to enroll in CHOICES Group 2 and begin receiving home care services:

- We must be able to safely meet your needs at home.
- And the cost of your home care can't be more than the cost of nursing home care. The cost of your home care includes any home health or private duty nursing care you may need.

If we can't safely meet your needs at home, **or** if your care would cost more than nursing home care, you can't be in CHOICES Group 2. But you may qualify for other kinds of long-term services and supports.

If TennCare says you don't qualify, you'll get a letter that says why. It will say how to appeal if you think it's a mistake.

CHOICES Group 3 is for certain people who **don't qualify for nursing home care** but **need home care** to help them stay at home safely.

To be in CHOICES Group 3, you must:

- Be "at risk" of going into a nursing home unless you receive home care, **and**
- qualify for Medicaid long-term services and supports because you receive SSI payments OR because you don't receive SSI payments but you'll receive home care services instead of nursing home care and there's an available slot, **and**
- be an adult 65 years of age or older, **or**
- be an adult 21 years of age or older with a physical disability.

TennCare Long-Term Services and Supports will decide if you're "at risk" of going into a nursing home. TennCare Member Services will decide if you qualify for Medicaid long-term services and supports for one of the reasons listed above. We'll help you fill out the papers they need to decide.

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If TennCare says yes, to enroll in CHOICES Group 3 and begin receiving home care services:

- We must be able to safely meet your needs at home with the care you'd get in CHOICES Group 3.
- If we can't safely meet your needs with the care that you'd get in CHOICES Group 3, you can't be in CHOICES Group 3. But TennCare may decide that you qualify for other kinds of long-term services and supports, including nursing home care

There are five groups of people who can qualify to enroll in ECF CHOICES.

Essential Family Supports (This is sometimes called "Group 4.") - Family Support services are for families caring for a child under the age of 21 who has an intellectual or developmental disability (I/DD). The child must live at home with their family (not a foster family).

Adults age 21 with I/DD living at home with their family can also choose to enroll in this group if they qualify.

Essential Supports for Employment and Independent Living (This is sometimes called "Group 5.") - Essential Support services are for adults age 21 and older who have an I/DD but don't qualify for the level of care in a nursing home.

- A person age 18-21 with I/DD may be enrolled in this group if they can't live with their family anymore.
- A person who would qualify to receive care in a nursing home can choose to enroll in this group if ECF CHOICES Group 6 is full and their needs can be met with these services.

Comprehensive Supports for Employment and Community Living (This is sometimes called "Group 6.") - These services are only for adults age 21 and older who would qualify to get care in a nursing home. (This doesn't mean the person has to receive care in a nursing home. This program provides services at home and in the community. They just need to qualify for nursing home care.)

- A person age 18-21 with I/DD may be enrolled in this group if they can't live with their family anymore.
- Comprehensive Support services are for people who need more services to help them live in the community and achieve their employment and community living goals.

Intensive Behavioral Family Supports (This is sometimes called "Group 7.") - This group is for a small number of children under age 21 who live with their family and have I/DD and severe behavior

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support needs that place the child or others at risk of serious harm. The behaviors are so challenging that the child is at risk of being placed outside the home. This group provides mental health treatment and other services in the home with the family. (The family must be willing to be part of the child's treatment.) The services will train and support the family to support the child so they can keep living safely together. People are usually in this group short-term. Once the person is stable in the community, they'll move to a different benefit group that can safely meet their needs.

Comprehensive Behavioral Supports for Employment and Community Living (This is sometimes called "Group 8.") - This group is for a small number of adults who have I/DD and severe behavior support needs and are moving into the community from a place with lots of structure and supervision. This could be coming from a mental health hospital, the foster care system, jail, or a nursing home. These services are mostly for adults age 21 or older. But sometimes, a person age 18-20 can get them too. They combine 24/7 residential services with mental health treatment and support. People are usually in this group short-term. Once the person is stable in the community, they'll move to a different benefit group that can safely meet their needs.

TennCare Long-Term Services and Supports will decide if you meet the level of care rules to enroll in ECF CHOICES. TennCare Member Services will decide if you meet the income and resource rules to qualify for Medicaid long-term services and supports through ECF CHOICES. We'll help you fill out the papers they need to decide. If TennCare says yes, to enroll in ECF CHOICES and begin receiving home care services:

- We must be able to safely meet your needs at home.
- And, the cost of your home care can't be more than the expenditure cap for your ECF CHOICES Group. The cost of your home care includes any home health or private duty nursing care you may need.

If we can't safely meet your needs at home, or if your care would cost more than the expenditure cap for your ECF CHOICES Group, you can't be in ECF CHOICES. But you may qualify for other kinds of long-term services and supports.

If TennCare says you don't qualify, you'll get a letter that says why. It will say how to appeal if you think it's a mistake.

E3. Limits on Enrollment into CHOICES Group 2 and 3 and ECF CHOICES

Not everyone who qualifies to enroll in CHOICES Group 2 or Group 3 may be able to enroll. There's an enrollment target for CHOICES Group 2 and Group 3. It's like a limit on the number of people who can be in the group at one time. (The number of people who can enroll is sometimes called "slots".) This

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helps to ensure that the program doesn't grow faster than the State's money to pay for home care. It also helps to ensure that there are enough home care providers to deliver needed services.

The enrollment target for the number of slots that can be filled in CHOICES Group 2 and Group 3 will be set by the state in TennCare Rules.

For CHOICES Group 2 it doesn't apply to people moving out of a nursing home. And, it **may** not apply to some people who are on TennCare that would have to go into a nursing home right away if less costly home care isn't available. We must decide if you would go into a nursing home right away and provide proof to TennCare. And we must show TennCare that there are home care providers ready to start giving you care at home.

Some slots will be held back (or reserved) for emergencies. This includes things like when a person is leaving the hospital and will be admitted to a nursing home if home care isn't available. Reserved slots won't be used until all the other slots have been filled. The number of reserved slots and the guidelines to qualify in one of those slots is in TennCare Rules. If the only slots left are reserved, you'll have to meet the guidelines for reserved slots to enroll in CHOICES Group 2 or Group 3.

If you don't meet the guidelines for reserved slots or there are no slots available and you qualify to enroll in CHOICES Group 2 or Group 3, your name will be placed on a waiting list. Or, if you meet the guidelines for CHOICES Group 2, you can choose to enroll in CHOICES Group 1 and receive nursing home care. There's no limit on the number of people that can be enrolled in Group 1 and go into a nursing home. (But you don't have to receive nursing home care unless you want to. You can wait for home care instead.)

People enrolled in CHOICES Group 2 above the enrollment target must get the first slots that open up. (These are people who have moved out of nursing homes or people already on TennCare and would have gone into a nursing home right away if less costly home care wasn't available.)

When everyone in CHOICES Group 2 is under the enrollment target and there are still slots available, TennCare can enroll from the waiting list based on need.

Not everyone who qualifies to enroll in ECF CHOICES may be able to enroll. There is an enrollment target for ECF CHOICES Groups. It's like a limit on the number of people who can be in the group at one time. (The number of people who can enroll is sometimes called "slots".) This helps to ensure that the program doesn't grow faster than the State's money to pay for care. It also helps to ensure that there are enough home care providers to deliver needed services.

Some slots will be held back (or reserved) for emergencies. This includes things like when a person with an intellectual disability has a primary caregiver who is at least 75 years old, when a person with a developmental disability has a primary caregiver who is at least 80 years old, or the primary caregiver is

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permanently incapacitated or deceased. The number of reserved slots and the guidelines to qualify in one of those slots is in TennCare Rules. If the only slots left are reserved, you'll have to meet the guidelines for reserved slots to enroll in ECF CHOICES.

If you don't meet the guidelines for reserved slots or there are no slots available and you qualify to enroll in ECF CHOICES, your name will be placed on a referral list.

When there are slots available, TennCare can enroll from the referral list based on priority. These priority rules are in TennCare Rules.

E4. Receiving Services in the CHOICES Program or ECF CHOICES Program

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 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 expenditure cap with a yearly limit on services in CHOICES Group 3.

The kinds of home care covered in CHOICES Group 2 and Group 3 are included below. 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.

These services include:

Personal care visits (up to 2,580 hours per calendar year) - This means someone will help you with personal care needs and support in your home, on the job, or in the community. This can be things like helping with household chores such as fixing meals, cleaning, or laundry. Or they can run errands for you, like grocery shopping or picking up your medicine.

This Personal Care service is only for you. Personal Care will do these services if no one else in the household can do them for you. This isn't for other family members who aren't enrolled in CHOICES.

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Community Transportation (Up to $225 per month if you get this service through consumer direction) - Helps you get to work or to other places in the community when public transportation isn't available, and you don't have any other way to get there.

Home-delivered meals (one meal per day).

Personal Emergency Response System - A call button so you can get help in an emergency when your caregiver isn't around.

Adult day care (up to 2,080 hours per calendar year) - A place that provides supervised care and activities during the day.

In-home respite care (up to 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 (up to nine 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 (up to $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 (up to $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 (up to nine 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 four 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.)

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Community Living Supports (CLS) – A shared home or apartment where you and no more than three 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 three 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.

Enabling Technology is a new service (up to $5,000 per calendar year) – Enabling technology 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.

Employment Supports – There are many different kinds of services to help you get and keep a job. They'll help you:

- Decide if you want to work and the kinds of jobs you might like and be really good at.
- Try out certain jobs to see what they're like and what you need to do to get ready for those jobs.
- Write a plan to get a job (or start your own business) and carry out that plan.
- Have a job coach to support you when you start your job until you can do the job by yourself or with help from co-workers.
- Get a better job, earning more money.
- Understand how the money you earn from working will impact other benefits you get, including Social Security and TennCare.

Employment services are available to all individuals in CHOICES Groups 2 and 3.

The goal in this program is "individual, integrated, competitive employment." Here's what that means.

"**Individual**" means that you're employed by yourself and not as part of a small group of people with disabilities. This doesn't mean you can't work with other people or be part of a team on your job. You could also be "self-employed." This means you have a business and work for yourself.

"**Integrated**" means your work (or your business if you're self-employed) is in the community. You work with (or provide services to) people who don't have disabilities.

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"**Competitive**" means the wage you earn for your work (or from your business, after expenses) is at least the minimum wage. And it should be the same wage that's paid to people who don't have disabilities that do the same work.

For some people, a job may be "customized." This means that your employment provider helps find or develop a job that's just for you. They match the kinds of things you like and are good at with the needs of an employer.

There will be a special agreement between you and your employer to make sure both of your needs are met. The employer may agree to change things about the job to make it work for you. You may only do parts of a job, share parts of the job with someone else, or do things that no one else does. The agreement may also cover things like:

- Where you work.
- The hours you work.
- The supports you need.
- How much you're paid.

If you have greater support needs, "customized employment" may help find a job that's right for you.

What if you don't think you want to work? Before you make up your mind, we want to help you explore the kinds of jobs you might like and be good at. We want to help you understand the benefits of work and answer any questions you have. This is called **Employment Informed Choice**. It means you have the facts you need to make a good decision about working.

You can get Exploration to help you make an informed choice about employment.

Exploration – Helps you decide if you want to work and the kinds of jobs you might like and be really good at by visiting job sites that match your skills and interests. Also helps you (and your family) understand the benefits of working and helps answer your questions about work.

Receiving Services in the ECF CHOICES Program

The services you can receive in ECF CHOICES depend on which benefit group you're in. **There are five benefit groups:**

Essential Family Supports

Or "Family Support services" for short. (This is sometimes called "**Group 4**.") Family Support services are only for people who live at home with their family. They'll help you plan for and get a job, and live as independently as possible in the community. They'll help you do things in the community that you want

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to do—to help you build relationships and reach your goals. They'll also help your family support you in planning for and reaching your goals.

The total cost of Family Support services you get can't exceed the cost cap each year. The cost cap is set by TennCare every year. It starts on January 1 each year and ends on December 31 each year. Only in Essential Family Supports, your cost cap doesn't include the cost of any Minor Home Modifications. We also won't count the cost of Family-to-Family Support.

Essential Supports for Employment and Independent Living
Or "Essential Support services" for short. (This is sometimes called "**Group 5**.")
These services are **only** for adults age 21 and older. They'll help you get or keep a job and live as independently as possible in the community. They'll help you do things in the community that you want to do—to help you build relationships and reach your goals.

The total cost of Essential Support services you get can't exceed the cost cap each year. The cost cap is set by TennCare every year. It starts on January 1 each year and ends on December 31 each year. What if you have an emergency and need more services to stay in the community? You may be able to get more Essential Support services for that year. But they can't cost more than $6,000.

You may also be able to go over your cap to get employment services OR if you need more help for a short time to transition safely to living in the community.

Comprehensive Supports for Employment and Community Living
Or "Comprehensive Support services" for short. (This is sometimes called "**Group 6**.")
These services are **only** for adults age 21 and older who would qualify to get care in a nursing home. (But these services are provided in the community.)

They'll help you get or keep a job and live as independently as possible **in the community**. They'll help you do things in the community that you want to do—to help you build relationships and reach your goals.

You'll have a limit (or "cost cap") on the total cost of Comprehensive Support services you can get each year. Your yearly cost cap is based on an assessment of your "level of need". Your "level of need" tells us how much support you need. Everyone in the Comprehensive Support Services group (ECF CHOICES Group 6) will have an assessed "level of need." The assessment isn't done by TennCare or your health plan.

The total cost of Comprehensive Support services you get can't be more than your cost cap each year. It starts on January 1 each year and ends on December 31 each year. What if you have an emergency and need more services to stay in the community? ONLY if you have a low, moderate, or high level of

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need (but not exceptional medical or behavioral needs), you may be able to get more Comprehensive Support services for that year. But they can't cost more than $7,500.

ONLY if you have a low, moderate, or high level of need (but not exceptional medical or behavioral needs), you may also be able to go over your cap to get employment services. Except for these, no one can get Comprehensive Support services that cost more than their cost cap each year.

Only if you're assessed to have exceptional medical and/or behavioral needs: you'll have a higher cost cap. The amount is based on the average yearly cost of care in an institution you would qualify to receive.

- If you have an **intellectual disability**: Your cost cap is based on the average yearly cost of services in a private ICF/IID (Intermediate Care Facility for Individuals with Intellectual Disabilities).
- If you have a **developmental disability**: Your cost cap is based on the average yearly cost of nursing home care **plus** the average cost of special services a person with a developmental disability would need in a nursing home.
- These average yearly costs change every year.
- This **doesn't** mean you will get services in an ICF/IID or nursing home. Employment and Community First CHOICES provides services **in the community**. These amounts are used to set the yearly limit on the total cost of support services you can receive in the community—your cost cap (but **only** when you have exceptional medical or behavioral needs).
- If your cost cap is based on the cost of care in an ICF/IID or nursing home, any home health or private duty nursing TennCare pays for **will** also **count** against your cap. This is the only time other TennCare services count against your cost cap. **Except** for home health and private duty nursing for people with exceptional medical or behavioral needs, other TennCare services don't count against your cost cap.
- TennCare will get your assessment and tell you how much your cost cap will be. If you have questions, ask your support coordinator.

Intensive Behavioral Family Supports (This is sometimes called "**Group 7**.")
This group is for a small number of children under age 21 who live with their family and have I/DD and severe behavior support needs that place the child or others at risk of serious harm. The behaviors are so challenging that the child is at risk of being placed outside the home. This group provides mental health treatment and other services in the home with the family. (The family must be willing to be part of

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the child's treatment.) The services will train and support the family to support the child so they can keep living safely together.

Your cost cap is based on the average yearly cost of services in a private ICF/IID (Intermediate Care Facility for Individuals with Intellectual Disabilities). These average yearly costs change every year.

This **doesn't** mean you will get services in an ICF/IID. Employment and Community First CHOICES provides services **in the community**. These amounts are used to set the yearly limit on the total cost of support services you can receive in the community—your cost cap (but **only** when you have exceptional medical or behavioral needs).

Any home health or private duty nursing TennCare pays for **will** also **count** against your cap. This is the only time other TennCare services count against your cost cap. **Except** for home health and private duty nursing for people with exceptional medical or behavioral needs, other TennCare services don't count against your cost cap.

TennCare will tell you how much your cost cap will be. If you have questions, ask your support coordinator.

Comprehensive Behavioral Supports for Employment and Community Living
(This is sometimes called "**Group 8**.")
This group is for a small number of adults who have I/DD and severe behavior support needs and are moving into the community from a place with lots of structure and supervision. This could be coming from a mental health hospital, the foster care system, jail, or a nursing home. These services are mostly for adults age 21 or older. But sometimes, a person age 18-20 can get them too. They combine 24/7 residential services with mental health treatment and support. People are usually in this group short-term. Once the person is stable in the community, they'll move to a different benefit group that can safely meet their needs.

- For the first year, your cost cap is based on the average yearly cost of services in a public ICF/IID (Intermediate Care Facility for Individuals with Intellectual Disabilities).
- For the second year and every year after, your cost cap is based on the average yearly cost of services in a private ICF/IID.
- These average yearly costs change every year.
- This **doesn't** mean you will get services in an ICF/IID. Employment and Community First CHOICES provides services **in the community**. These amounts are used to set the yearly limit on the total cost of support services you can receive in the community—your cost cap (but **only** when you have exceptional medical or behavioral needs).

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- **If** your cost cap is based on the cost of care in an ICF/IID or nursing home, any home health or private duty nursing TennCare pays for **will** also **count** against your cap. This is the only time other TennCare services count against your cost cap. **Except** for home health and private duty nursing for people with exceptional medical or behavioral needs, other TennCare services don't count against your cost cap.
- TennCare will get your assessment and tell you how much your cost cap will be. If you have questions, ask your support coordinator.
- For the first year that you're in Employment and Community First CHOICES, your cost cap will be "pro-rated." This means your yearly cost cap will be divided by the 365 days in a year and then multiplied by the number of days you'll actually be in the program that year.
- No matter how much your cost cap is, it **doesn't** mean that you'll get services up to the cost cap amount. Employment and Community First CHOICES will only pay for services you must have to meet your needs at home or in your community.
- This includes services you need to work, live as independently as possible, be part of your community, and reach your goals.
- We'll help you use or develop "natural supports" when you can. These are people who can help provide the support you need without being paid—like family, friends and co-workers. Using natural supports can help you build relationships and be part of your community.

The **kinds** of support services covered in Employment and Community First CHOICES are listed in Benefits Chart in **Chapter 4**. Some of these services have limits. This means that TennCare will only pay for a certain amount of these services. The chart tells you how each service can help you, what benefit groups cover it, and the limits of that service. If you have questions about a service, ask your support coordinator.

Employment Supports

There are many different kinds of services to help you get and keep a job. They'll help you:

- Decide if you want to work and the kinds of jobs you might like and be really good at.
- Try out certain jobs to see what they're like and what you need to do to get ready for those jobs.
- Write a plan to get a job (or start your own business) and carry out that plan.

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- Have a job coach to support you when you start your job until you can do the job by yourself or with help from co-workers.
- Get a better job, earning more money.
- Understand how the money you earn from working will impact other benefits you get, including Social Security and TennCare.

Employment services are available to individuals of working age in all five benefit groups. In Tennessee, the working age starts at 16.

The goal in this program is "individual, integrated, competitive employment." Here's what that means.

"**Individual**" means that you're employed by yourself and not as part of a small group of people with disabilities. This doesn't mean you can't work with other people or be part of a team on your job. You could also be "self-employed." This means you have a business and work for yourself.

"**Integrated**" means your work (or your business if you're self-employed) is in the community. You work with (or provide services to) people who don't have disabilities.

"**Competitive**" means the wage you earn for your work (or from your business, after expenses) is at least the minimum wage and it should be the same wage that's paid to people who don't have disabilities that do the same work.

For some people, a job may be "customized." This means that your employment provider helps find or develop a job that's just for you. They match the kinds of things you like and are good at with the needs of an employer.

There will be a special agreement between you and your employer to make sure both of your needs are met. The employer may agree to change things about the job to make it work for you. You may only do parts of a job, share parts of the job with someone else, or do things that no one else does. The agreement may also cover things like:

- Where you work.
- The hours you work.
- The supports you need.
- How much you're paid.

If you have greater support needs, "customized employment" may help find a job that's right for you.

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What if you don't think you want to work? Before you make up your mind, we want to help you explore the kinds of jobs you might like and be good at. We want to help you understand the benefits of work and answer any questions you have. This is called **Employment Informed Choice**. It means you have the facts you need to make a good decision about working.

There are 2 services you can get to help you make an informed choice about employment:

- **Exploration** – Helps you decide if you want to work and the kinds of jobs you might like and be really good at by visiting job sites that match your skills and interests. Also helps you (and your family) understand the benefits of working and helps answer your questions about work.
- **Peer-to-Peer Self-Direction, Employment and Community Support and Navigation** – Guidance and support from another person with disabilities who has experience and training to help you and answer your questions. Includes support to help you:
  - Direct your support plan.
  - Direct your services (hire and supervise your own staff in Consumer Direction).
  - Think about and try employment or community living options.

Are you between the ages of 16 and 62? You must agree to complete the Employment Informed Choice process **before** you can get certain kinds of Independent Community Living Supports. Then, you can get other kinds of services **at the same time**. These include:

- **Community Integration Support Services** – Helps you do things in the community that you want to do. Take a class, join a club, volunteer, get or stay healthy, do something fun, build relationships, and reach your goals.
- **Independent Living Skills Training** – Helps you learn new things so you can live more independently. These skills can help you take care of yourself, your home, or your money.

To complete the Employment Informed Choice process, you must receive at least the Exploration service. You can also choose to receive the Peer-to-Peer Support service.

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What if you get at least the Exploration service and still don't want to work right now?
Then you must sign a page that says you've received all of the facts and still don't want to work. Then, if you need Community Integration Support Services or Independent Living Skills Training, you can get them. But they'll be limited to no more than 20 hours a week **combined**. You can only get these services if you **don'**t get residential services like Community Living Supports (including Family Model). If you get Community Living Supports, help to do these things are part of the residential service you receive.

Enabling technology

Enabling technology is a service (up to $5,000 per calendar year in combination with Assistive Technology)– Enabling technology 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.

Coverage decisions for Long-Term Services and Supports

Sometimes you may have to ask us if we cover your medical care 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 a coverage decision. Please review **Chapter 9** for more information on what to do, if this occurs.

Using Long-Term Services and Supports Providers Who Work with BlueCare Plus Choice

Just like health care 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 bluecareplus.bcbst.com. Or call us at 1-800-332-5762, TTY 711 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 1-800-332-5762, TTY 711 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 doesn't usually work with us. But, we must first say that it's OK to use a long-term services and supports provider who doesn't usually work with BlueCare Plus Choice.

F. Behavioral health (mental health and substance use disorder) services

You **don't** need to see your PCP before getting behavioral health services. But you'll need to get your care from someone who is in our network.

A Community Mental Health Agency (CMHA) is one place you can go for mental health or substance use disorder services. Most CMHAs take TennCare.

G. How to get consumer directed care

G1. What consumer directed care is

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
- in-home respite
- companion care (only if you qualify for and are enrolled in CHOICES Group 2)
- community transportation

In ECF CHOICES, the services available through Consumer Direction are:

- personal assistance
- supportive home care
- respite
- community transportation

G2. Who can provide consumer directed care

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

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- 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 Electronic Visit Verification (EVV) system **every** time they work.
   - Make sure your workers provide *only* as much care as you're approved to receive.
   - Make sure that no hourly worker gives you more than 40 hours of care in a week (CHOICES only).
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.

G3. Representative for Consumer Direction (if applicable)

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 can't 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 two kinds of help you'll receive:

1. The FEA will help you and your workers fill out all of the paperwork that you must complete. They'll pay your workers for the care they give. And, they'll 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**

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- 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 can't:

- Pay your spouse to provide care;
- Pay someone who lives with you to provide personal care, personal assistance, in-home respite services, respite, supportive home care, or transportation;
- 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 five years to provide Companion Care;
- Pay a Representative for Consumer Direction, legal guardian, Conservator, or Power of Attorney (if they're your Employer of Record)

And, you can't pay family members or others to provide care they would have given for free. CHOICES and ECF 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 or ECF CHOICES and need services that can be consumer directed your coordinator will talk with you about Consumer Direction. If you want to be in Consumer Direction, your coordinator will work with you to decide which of the services you'll direct and start the process to enroll you in Consumer Direction. Until Consumer Direction is set up, you'll get the services that are in your support plan from a provider who works with BlueCare Plus Choice, unless **you choose** to wait for your

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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're directing one or more services and decide **not** to be in Consumer Direction anymore, you won't stop getting long-term services and supports. You'll still be in CHOICES or ECF CHOICES. You'll get the services you need from a provider who works with BlueCare Plus Choice instead.

H. Transportation services

If you don't have a way to get to your health care visits, you may be able to get a ride from TennCare.

You can get help with a ride:

- **Only** for services covered by TennCare, **and**
- **Only** if you don't have any other way to get there.

You can have someone ride with you to your appointment if:

- You're a child under the age of 21 **or**
- You have a disability or need help to get the service (like someone to open doors for you, push your wheelchair, help you with reading or decision making).

Try to call **at least two business days before** your health care appointment to make sure that you can get a ride. If you change times or cancel your health care appointment, you must change or cancel your ride too.

TennCare (Medicaid) provides transportation for plan-approved covered TennCare services. If you need a ride to your appointment, call Verida at 855-735-4660 or go to member.verida.com. If you're a minor riding alone or you're traveling out of state, or if you have questions about having someone ride with you, call us at 800-468-9698.

If you need a ride to your appointment or have questions about having someone ride with you, call us at 1-800-332-5762, TTY 711.

I. Covered services in a medical emergency, when urgently needed, or during a disaster

I1. Care in a medical emergency

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A medical emergency is a medical condition with symptoms such as illness, severe pain, serious injury, or a medical condition that's quickly getting worse. The condition is so serious that, if it doesn't get immediate medical attention, you or anyone with an average knowledge of health and medicine could expect it to result in:

- serious risk to your life and, if you're pregnant, loss of an unborn child; **or**
- loss of or serious harm to bodily functions; **or**
- loss of a limb or function of a limb; **or**
- In the case of a pregnant woman in active labor, when:
  - There isn't enough time to safely transfer you to another hospital before delivery.
  - A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or use the nearest emergency room or hospital. Call for an ambulance if you need it. You **don't** need approval or a referral from your PCP. You don't need to use a network provider. You can get covered emergency medical care whenever you need it, anywhere in the U.S. or its territories from any provider with an appropriate state license even if they're not part of our network.
- **As soon as possible, tell BlueCare Plus Choice about your emergency.** We follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. However, you won't pay for emergency services if you delay telling us. The Member Service number is located at the bottom of this page. The Member Service number can also be found on the back of your member ID Card.

Covered services in a medical emergency

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency. To learn more, refer to the Benefits Chart in **Chapter 4** of this *Evidence of Coverage.*

The providers who give you emergency care decide when your condition is stable and the medical emergency is over. They'll continue to treat you and will contact us to make plans if you need follow-up care to get better.

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Our plan covers your follow-up care. If you get your emergency care from out-of-network providers, we'll try to get network providers to take over your care as soon as possible.

Getting emergency care if it wasn't an emergency

Sometimes it can be hard to know if you have a medical or behavioral health emergency. You may go in for emergency care and the doctor says it wasn't really an emergency. As long as you reasonably thought your health was in serious danger, we cover your care.

However, after the doctor says it wasn't an emergency, we cover your additional care only if:

- You use a network provider **or**
- The additional care you get is considered "urgently needed care" and you follow the rules for getting it. Refer to the next section.

I2. Urgently needed care

Urgently needed care is care you get for a situation that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition or an unforeseen illness or injury.

Urgently needed care in our plan's service area

In most cases, we cover urgently needed care only if:

- You get this care from a network provider **and**
- You follow the rules described in this chapter.

If it's not possible or reasonable to get to a network provider, given your time, place or circumstances we cover urgently needed care 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, TTY 711. BlueCare Plus Choice has urgent care centers in our provider network that can provide urgently needed services.

Urgently needed care outside our plan's service area

When you're outside our plan's service area, you may not be able to get care from a network provider. In that case, our plan covers urgently needed care you get from any provider. However, medically necessary routine provider visits, such as annual checkups, aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

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Show your BlueCare Plus Choice member ID card when you get the urgently needed care. Ask the provider to send the bill to BlueCare Plus Choice. If the provider says no, ask if they'll send the bill to you at home. Or if you have to pay for the care, get a receipt.

When you get home, call us and tell us you had to pay for your health care or that you have a bill for it. We'll work with you and the provider to put in a claim for your care.

IMPORTANT: TennCare and BlueCare Plus Choice will only pay for emergencies away from home that are inside the United States and its territories. We can't pay for care you get out of the country.

I3. Care during a disaster

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

Visit our website for information on how to get care you need during a declared disaster: bluecareplus.bcbst.com.

During a declared disaster, if you can't use a network provider, you can get care from out-of-network providers at the in-network cost-sharing rate. If you can't use a network pharmacy during a declared disaster, you can fill your drugs at an out-of-network pharmacy. Refer to **Chapter 5** of this *Evidence of Coverage* for more information.

J. What if you're billed directly for covered services

BlueCare Plus Choice is not allowed to reimburse members for TennCare (Medicaid) covered benefits. 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 may be able to get a refund from that health care provider if you followed the rules for getting the service or item. BlueCare Plus Choice members should check if the service is covered by TennCare (Medicaid) before paying for the cost of the service.

If you paid for your covered services or if you got a bill for the full cost of covered medical services, refer to **Chapter 7** of this *Evidence of Coverage* to find out what to do.

You shouldn't pay the bill yourself. If you do, we may not be able to pay you back.

J1. What to do if our plan doesn't cover services

You won't have to pay for services that are covered by Medicaid. If you choose to pay out of pocket for a covered service, you WON'T be reimbursed. Our plan covers all services:

- that are determined medically necessary, **and**
- that are listed in our plan's Benefits Chart (refer to **Chapter 4** of this *Evidence of Coverage*), **and**
- that you get by following plan rules.

If you get services that our plan doesn't cover, **you pay the full cost yourself.**

If you want to know if we pay for any medical service or care, you have the right to ask us. You also have the right to ask for this in writing. If we say we won't pay for your services, you have the right to appeal our decision.

Chapter 9 of this *Evidence of Coverage* explains what to do if you want us to cover a medical service or item. It also tells you how to appeal our coverage decision. Call Member Service to learn more about your appeal rights.

We pay for some services up to a certain limit. If you go over the limit, you pay the full cost to get more of that type of service. Refer to **Chapter 4** for specific benefit limits. Call Member Service to find out what the benefit limits are and how much of your benefits you've used.

K. Coverage of health care services in a clinical research study

K1. Definition of a clinical research study

A clinical research study (also called a clinical trial) is a way doctors test new types of health care or drugs. A clinical research study approved by Medicare typically asks for volunteers to be in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that's not related to the study) through our plan.

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

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We encourage you to tell us before you take part in a clinical research study.

If you plan to be in a clinical research study, covered for enrollees by Original Medicare, we encourage you or your coordinator to contact Member Service to let us know you'll take part in a clinical trial.

K2. Payment for services when you're in a clinical research study

If you volunteer for a clinical research study that Medicare approves, you pay nothing for the services covered under the study. Medicare pays for services covered under the study as well as routine costs associated with your care. Once you join a Medicare-approved clinical research study, you're covered for most services and items you get as part of the study. This includes:

- 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 that's part of the research study
- treatment of any side effects and complications of the new care

If you're part of a study that Medicare **hasn't** approved, you pay any costs for being in the study.

K3. More about clinical research studies

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website (www.medicare.gov/coverage/clinical-research-studies). You can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

L. How your health care services are covered in a religious non-medical health care institution

Sometimes your provider can't give you the care or treatment you need because of their conscience/ethical/moral or religious reasons. Call us at Member Service 1-800-332-5762, TTY 711. We can help you find a provider who can give you the care or treatment you need.

L1. Definition of a religious non-medical health care institution

A religious non-medical health care institution is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we cover care in a religious non-medical health care institution.

This benefit is only for Medicare Part A inpatient services (non-medical health care services).

L2. Care from a religious non-medical health care institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you're against getting medical treatment that's "non-excepted."

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

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

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

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

M. Durable medical equipment (DME)

M1. DME as a member of our plan

DME includes certain medically necessary items ordered by a provider, such as wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, intravenous (IV) infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

You always own some DME items, such as prosthetics.

Other types of DME you must rent. As a member of our plan, you usually **won't** own the rented DME items, no matter how long you rent it.

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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 of continuous rental. 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 at the phone number at the bottom of the page to find out about the requirements you must meet and the documentation you need to provide.

Even if you had DME for up to 12 months in a row under Medicare before you joined our plan, you won't own the equipment.

M2. DME ownership if you switch to Original Medicare

In the Original Medicare program, people who rent certain types of DME own it after 13 months. In a Medicare Advantage (MA) plan, the plan can set the number of months people must rent certain types of DME before they own it.

You'll have to make 13 payments in a row under Original Medicare, or you'll have to make the number of payments in a row set by the MA plan, to own the DME item if:

- you didn't become the owner of the DME item while you were in our plan, **and**
- you leave our plan and get your Medicare benefits outside of any health plan in the Original Medicare program or an MA plan.

If you made payments for the DME item under Original Medicare or an MA plan before you joined our plan, **those Original Medicare or MA plan payments don't count toward the payments you need to make after leaving our plan**.

- You'll have to make 13 new payments in a row under Original Medicare or a number of new payments in a row set by the MA plan to own the DME item.
- There are no exceptions to this when you return to Original Medicare or an MA plan.

M3. Oxygen equipment benefits as a member of our plan

If you qualify for oxygen equipment covered by Medicare we cover:

- rental of oxygen equipment

This section is continued on next page

- delivery of oxygen and oxygen contents
- tubing and related accessories for the delivery of oxygen and oxygen contents
- maintenance and repairs of oxygen equipment

Oxygen equipment must be returned when it's no longer medically necessary for you or if you leave our plan (if not covered by your next plan).

M4. Oxygen equipment when you switch to Original Medicare or another Medicare Advantage (MA) plan

When oxygen equipment is medically necessary and **you leave our plan and switch to Original Medicare**, you rent it from a supplier for 36 months. Your monthly rental payments cover the oxygen equipment and the supplies and services listed above.

If oxygen equipment is medically necessary **after you rent it for 36 months**, your supplier must provide:

- oxygen equipment, supplies, and services for another 24 months
- oxygen equipment and supplies for up to five years if medically necessary

If oxygen equipment is still medically necessary **at the end of the five-year period**:

- Your supplier no longer has to provide it, and you may choose to get replacement equipment from any supplier.
- A new five-year period begins.
- You rent from a supplier for 36 months.
- Your supplier then provides the oxygen equipment, supplies, and services for another 24 months.
- A new cycle begins every five years as long as oxygen equipment is medically necessary.

When oxygen equipment is medically necessary and **you leave our plan and switch to another MA plan**, the plan will cover at least what Original Medicare covers. You can ask your new MA plan what oxygen equipment and supplies it covers and what your costs will be.

Chapter 4: Benefits chart

Introduction

This chapter tells you about the services our plan covers and any restrictions or limits on those services and how much you pay for each service. It also tells you about benefits not covered under our plan. Key terms and their definitions appear in alphabetical order in the last chapter of this *Evidence of Coverage*.

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A. Your covered services and your out-of-pocket costs

This chapter tells you about services our plan covers and how much you pay for each service. You can also learn about services that aren't covered. Information about drug benefits is in **Chapter 5** of this *Evidence of Coverage*. This chapter also explains limits on some services.

For some services, you're charged an out-of-pocket cost called a copay. This is a fixed amount (for example, $5) you pay each time you get that service. You pay the copay at the time you get the medical service. Because you get help from TennCare (Medicaid), you pay nothing for your covered services as long as you follow our plan's rules. Refer to **Chapter 3** of this *Evidence of Coverage* for details about our plan's rules.

Medicaid offers programs to help people pay their Medicare costs, depending on your eligibility. 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)**: Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full TennCare (Medicaid) benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB+):** Eligible for full Medicaid benefits. Helps pay Part B premiums.

If you need help understanding what services are covered, call Member Service at 1-800-332-5762, TTY 711.

B. Rules against providers charging you for services

We don't allow our providers to bill you for in-network covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.

You should never get a bill from a provider for covered services. If you do, refer to **Chapter 7** of this *Evidence of Coverage* or call Member Service.

C. About our plan's Benefits Chart

The Benefits Chart tells you the services our plan pays for and what you pay out of pocket for each service. (Drug coverage is in **Chapter 5.**) It lists covered services in alphabetical order and explains them.

We cover the services listed in the Benefits Chart when the following rules are met. You **don't** pay anything for the services listed in the Benefits Chart, as long as you meet the requirements described below.

- We provide covered Medicare and TennCare (Medicaid) covered services according to the rules set by Medicare and TennCare (Medicaid).
- The services *(including medical care, behavioral health and substance use services, long-term services and supports, supplies, equipment, and drugs)* must be "medically necessary." Medically necessary describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.
- For new enrollees, for the first 90 days we may not require you to get approval in advance for any active course of treatment, even if the course of treatment was for a service that began with an out-of-network provider.
- You get your care from a network provider. A network provider is a provider who works with us. In most cases, care you get from an out-of-network provider won't be covered unless it's an emergency or urgently needed care or unless our plan or a network provider gave you a referral. This means that you pay the provider in full for out-of-network services you get. **Chapter 3** of this *Evidence of Coverage* has more information about using network and out-of-network providers.
- You have a primary care provider (PCP) or a care team providing and managing your care.

This section is continued on next page

- We cover some services listed in the Benefits Chart only if your doctor or other network provider gets our approval first. This is called prior authorization (PA). We mark covered services in the Benefits Chart that need PA with an asterisk (*).
- If our plan provides approval of a PA request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care based on coverage criteria, your medical history, and the treating provider's recommendations.
- Like all Medicare health plans, we cover everything that Original Medicare covers. (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You* 2027 handbook. View it online at www.Medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.)
- If Medicare adds coverage for any new services during 2027, either Medicare or our plan will cover those services.
- If you lose your TennCare eligibility but can be expected to regain it within six months, we'll continue to provide all Medicare benefits covered by BlueCare Plus Choice. When your TennCare coverage ends, we won't pay for your TennCare benefits. You will be responsible for any cost share that TennCare coverage would have normally paid.

  If your TennCare eligibility is restored while you're still enrolled with us for your Medicare coverage, we'll resume paying for your TennCare benefits and your enrollment with us will continue. If you can't regain TennCare within six months, we'll disenroll you from BlueCare Plus Choice. If you regain TennCare eligibility after being disenrolled, you'll need to contact us to reenroll in the plan.

Important Benefit Information for Members with Certain Chronic Conditions.

- If you have any of the chronic condition(s) listed below and meet certain criteria, you may be eligible for special supplemental benefits for the chronically ill:
  - Autoimmune disorders
  - Cancer
  - Cardiovascular disorders
  - Chronic alcohol use disorder and other substance use disorders (SUDs)
  - Chronic and disabling mental health conditions

This section is continued on next page

- Chronic gastrointestinal disease
- Chronic heart failure
- Chronic kidney disease (CKD)
- Chronic lung disorders
- Conditions associated with cognitive impairment
- Conditions that require continued therapy services in order for individuals to maintain or retain functioning
- Conditions with functional challenges and require similar services including the following: spinal cord injuries, paralysis, limb loss and arthritis
- Chronic conditions that impair vision, hearing (deafness), taste, touch and smell
- Dementia
- Diabetes mellitus
- HIV/AIDS
- Immunodeficiency and Immunosuppressive disorders
- Neurological disorders
- Overweight, obesity, or metabolic syndrome
- Post-organ transplantation care
- Severe hematologic disorder
- Stroke

Eligibility is based on qualifying clinical criteria of a chronic condition as determined and provided by your physician.

These qualifications are defined below:

- one or more comorbid and medically complex chronic conditions that is life-threatening or significantly limits the overall health or function of the enrollee;
- a high risk of hospitalization or other adverse health outcomes; and

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- requires intensive care coordination.

For more detail, go to the **Help with certain chronic conditions** row in the Benefits Chart below.

Contact us to find out exactly which benefits you may be eligible for.

All preventive services are free. This apple shows the preventive services in the Benefits Chart.

D. Our plan's Benefits Chart

Covered Service		What you pay
	Abdominal aortic aneurysm screening We cover a one-time ultrasound screening for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS).	**In-Network:** **Medicare-covered** Eligible members pay nothing for this preventive screening.
	Acupuncture* We cover up to 12 acupuncture visits in 90 days if you have chronic low back pain, defined as: • lasting 12 weeks or longer; • not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease); • not associated with surgery; • not associated with pregnancy. In addition, we cover an additional eight sessions of acupuncture for chronic low back pain if you show improvement. You may not get more than 20 acupuncture treatments for chronic low back pain each year. Acupuncture treatments must be stopped if you don't get better or if you get worse. Provider Requirements: Physicians may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture **This benefit is continued on the next page**	**Prior authorization is required.** **In-Network:** **Medicare-covered** You pay nothing for covered acupuncture services.

Covered Service		What you pay
	Acupuncture* (continued) and Oriental Medicine (ACAOM); and, • 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. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations.	
	Alcohol misuse screening and counseling We cover one alcohol-misuse screening for adults who misuse alcohol but aren't alcohol dependent. This includes pregnant women. If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you're able and alert during counseling) with a qualified primary care provider (PCP) or practitioner in a primary care setting.	**In-Network:** **Medicare-covered** You pay nothing for the covered screening and counseling to reduce alcohol misuse preventive benefit.
	Ambulance services* Covered ambulance services, whether for an emergency or non-emergency situation, include ground and air (airplane and helicopter), and ambulance services. The ambulance will take you to the nearest place that can give you care. Your condition must be serious enough that other ways of getting to a place of care could risk your health or life. Ambulance services for other cases (non-emergent) must be approved by us. In cases that aren't emergencies, we may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health.	**Prior authorization may be required for non-emergent transportation.** **Medicare-Covered** You pay nothing for covered ambulance services.
	Annual wellness visit You can get an annual checkup. This is to make or update a prevention plan based on your current risk **This benefit is continued on the next page**	**In-Network:** **Medicare-covered** You pay nothing for the

Covered Service		What you pay
	Annual wellness visit (continued) factors. We cover this once every 12 months. **Note:** Your first annual wellness visit can't take place within 12 months of your **Welcome to Medicare** visit. However, you don't need to have a **Welcome to Medicare** visit to get annual wellness visits after you've had Part B for 12 months.	covered annual wellness visit.
	Bone mass measurement We cover certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. We cover the services once every 24 months, or more often if medically necessary. We also cover for a doctor to look at and comment on the results.	**In-Network:** **Medicare-covered** You pay nothing for covered bone mass measurement.
	Breast cancer screening (mammograms) We cover the following services: • one baseline mammogram between the ages of 35 and 39 • one screening mammogram every 12 months for women aged 40 and over • clinical breast exams once every 24 months	**In-Network:** **Medicare-covered** You pay nothing for covered breast cancer screenings (mammograms).
	Cardiac (heart) rehabilitation services We cover cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions and have a doctor's order. We cover these comprehensive programs if you've had at least one of these conditions: • heart attack in the last 12 months • coronary artery bypass surgery **This benefit is continued on the next page**	**In-Network:** **Medicare-covered** You pay nothing for covered cardiac rehabilitation services.

Covered Service		What you pay
	Cardiac (heart) rehabilitation services (continued) • stable angina pectoris (chest pain) • heart valve repair or replacement • coronary angioplasty (a medical procedure used to open a blocked artery) or coronary stenting (a procedure used to keep an artery open) • heart or heart and lung transplant • stable chronic heart failure Coverage limitations: You can get up to 36 cardiac rehabilitation sessions. You can have two sessions per day (each lasting one hour), and the program can last up to 36 weeks. If you qualify, you may be able to get 36 more sessions that can be spread out over a longer time period.	
	Cardiovascular (heart) disease risk reduction visit (therapy for heart disease) We cover one visit a year, or more if medically necessary, with your primary care provider (PCP) to help lower your risk for heart disease. During the visit, your doctor may: • discuss aspirin use, • check your blood pressure, **and/or** • give you tips to make sure you're eating well.	**In-Network:** **Medicare-covered** You pay nothing for the covered cardiovascular disease preventive benefit.
	Cardiovascular (heart) disease screening tests We cover blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease.	**In-Network:** **Medicare-covered** You pay nothing for covered cardiovascular disease testing.

Covered Service		What you pay
	Cervical and vaginal cancer screening We cover the following services: • for all women: Pap tests and pelvic exams once every 24 months • for women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months • for women who have had an abnormal Pap test within the last three years and are of childbearing age: one Pap test every 12 months	**In-Network:** **Medicare-covered** You pay nothing for covered preventive Pap and pelvic exams.
	Chiropractic services* We cover the following services: • adjustments of the spine to correct alignment • Additionally, a limit of 20 supplemental routine visits per year for the relief of pain and neuromusculoskeletal disorders.	**Prior authorization rules may apply.** **In-Network:** **Medicare-covered** You pay nothing for covered chiropractic services.
	Colorectal cancer screening We cover the following services: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (ten years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 years and older who aren't at high risk of colorectal cancer is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed, or when 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at **This benefit is continued on the next page**	**In-Network:** **Medicare-covered** You pay nothing for a covered colorectal cancer screening exam. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam.

Covered Service		What you pay
	Colorectal cancer screening (continued) high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every three years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every three years. • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test. • Colorectal cancer screening tests include a follow-up screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.	
	Dental services* In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. However, Medicare currently pays for dental services in a limited number of circumstances, **This benefit is continued on the next page**	**Prior authorization may be required.** **In-Network:** **Plan-Covered** There is no coinsurance, copayment or deductible for

Covered Service		What you pay
	Dental services* (continued) specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. In addition, we cover: ***Preventive dental services*** • Routine oral exams, up to 2 per year (1 standard exam per 6-month period) • Cleanings, up to 2 per year (1 cleaning per 6-month period) • Dental x-ray (1-set of four bitewings per 12-month period) (1 panoramic or full mouth x-ray per 36-month period) ***Comprehensive dental services (list is not all-inclusive)*** • Fillings • Extractions • Dentures (1 per 5 years) • Endodontics • Prosthodontics • Oral/maxillofacial surgery Refer to the *Dental Quick Reference Guide* for information regarding limitations and exclusions for dental services. You may also contact Member Service for details.	covered **Preventive** and **Comprehensive dental services.** **$3000** maximum annual allowance for covered **Comprehensive Dental Services**; ex: Fillings, Dentures, Extractions. Advance determinations are recommended. **TennCare (Medicaid)-covered** TennCare will consider benefits for any service not covered by Medicare. Supplemental dental under BlueCare Plus Choice is primary and must be used first.
	Depression screening We cover one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and/or referrals.	**In-Network:** **Medicare-covered** You pay nothing for the covered annual depression screening.

Covered Service		What you pay
	Diabetes screening 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 • history of high blood sugar (glucose) Tests may be covered in some other cases, such as if you're overweight and have a family history of diabetes. You may qualify for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.	**In-Network:** **Medicare-covered** You pay nothing for covered diabetes screening tests.

	Diabetic self-management training, services, and supplies
	We cover the following services for all people who have diabetes (whether they use insulin or not):
	• Supplies to monitor your blood glucose, including the following:
	  ○ a blood glucose monitor
	  ○ blood glucose test strips
	  ○ lancet devices and lancets
	  ○ glucose-control solutions for checking the accuracy of test strips and monitors
	• For people with diabetes who have severe diabetic foot disease, we cover the following:
	  ○ one pair of therapeutic custom-molded shoes (including inserts), including the fitting, and two extra pairs of inserts each calendar year, **or**
	  ○ one pair of depth shoes, including the fitting, and three pairs of inserts each year
	This benefit is continued on the next page
		In-Network:
		Medicare-covered
		You pay nothing for covered diabetic self-management training, services, and supplies.
		(**Note**: This does not include continuous glucose monitor coverage which is described under Durable medical equipment (DME) and related supplies.)
		Diabetic testing supplies covered under Part B: Ascencia's Contour and Roche Accu-Check products are both preferred brands. All other products are covered only with a prior authorization. Approved exceptions will be treated as in-network benefits.

Covered Service		What you pay

	Diabetic self-management training, services, and supplies (continued)
	(not including the non-customized removable inserts provided with such shoes)
	• In some cases, we cover training to help you manage your diabetes. To find out more, contact Member Service.
	• The following diabetic testing supplies are limited to:
	  • Calibration Solution: 1 per 365 days
	  • Glucometer: 1 per 365 days
	  • Lancets: 600 per 90 days
	  • Lancet Device: 1 per 365 days
	  • Test Strips: 300 per 90 days (100 per month)
	• Talking monitors are covered for members with severe visual impairment with prior authorization.
	Diabetic supplies are only available through the pharmacy (rather than a DME supplier). Insulin pumps and adjunctive glucometers can be furnished through a DME supplier.	

	Durable medical equipment (DME) and related supplies* Refer to **Chapter 12** of this *Evidence of Coverage* for a definition of "Durable medical equipment (DME)." We cover the following items: • wheelchairs • crutches • powered mattress systems • diabetic supplies • hospital beds ordered by a provider for use in the **This benefit is continued on the next page**	**Prior Authorization may be required.** **In-Network:** **Medicare-covered** You pay nothing for covered Durable Medical Equipment (DME) and related supplies. **TennCare (Medicaid)-covered** TennCare will consider benefits for any service not covered by Medicare or after

Covered Service		What you pay
	Durable medical equipment (DME) and related supplies* (continued) home • intravenous (IV) infusion pumps and pole • speech generating devices • oxygen equipment and supplies • nebulizers • walkers • standard curved handle or quad cane and replacement supplies • cervical traction (over the door) • bone stimulator • dialysis care equipment Other items may be covered. 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 products. DME such as insulin pumps with integrated adjunctive CGMs require authorization. We cover all medically necessary DME covered by Original Medicare and Medicaid. If our supplier in your area doesn't carry a particular brand, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at bluecareplus.bcbst.com. Generally, our plan covers any DME covered by Medicare and Medicaid from the brands and makers on this list. We don't cover other brands and makers unless your doctor or other provider tells us that you need the brand. If you're new to our plan and using a brand of DME not on our list, we'll continue to pay for this brand for you for up to 90 days. During this time, talk with your doctor to decide what brand is medically right for you after the 90-day period. (If you disagree with your doctor, you can ask them to refer you for a second **This benefit is continued on the next page**	Medicare coverage has been exhausted.

Covered Service		What you pay
	Durable medical equipment (DME) and related supplies* (continued) opinion.) If you (or your doctor) don't agree with our plan's coverage decision, you or your doctor can file an appeal. You can also file an appeal if you don't agree with your doctor's decision about what product or brand is appropriate for your medical condition. For more information about appeals, refer to **Chapter 9** of this *Evidence of Coverage*. Incontinence Supplies are covered by TennCare (Medicaid).	

	Emergency care
	Emergency care means services that are:
	• given by a provider trained to give emergency services,
	• needed to evaluate or treat a medical emergency.
	A medical emergency is an illness, injury, severe pain, or medical condition that's quickly getting worse. The condition is so serious that, if it doesn't get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in:
	• serious risk to your life *or to that of your unborn child*; **or**
	• serious harm to bodily functions; **or**
	• loss of a limb, or loss of function of a limb.
	• In the case of *a pregnant woman in active labor, when:*
	  ○ There isn't enough time to safely transfer you to another hospital before delivery.
	  ○ A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.
	This benefit is continued on the next page
		In-Network:
		Medicare-covered
		You pay nothing for covered emergency care.
		If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, you must move to a network hospital 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.

Covered Service		What you pay
	Emergency care (continued) Our plan does not cover emergency services outside of the United States and its territories.	
	Family planning services The law lets you choose any provider – whether a network provider or out-of-network provider – for certain family planning services. This means any doctor, clinic, hospital, pharmacy or family planning office. We cover the following services: • family planning exam and medical treatment • family planning lab and diagnostic tests • family planning methods (IUC/IUD, implants, injections, birth control pills, patch, or ring) • family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap) • counseling and diagnosis of infertility and related services • counseling, testing, and treatment for sexually transmitted infections (STIs) • counseling and testing for HIV and AIDS, and other HIV-related conditions • permanent contraception (You must be age 21 or over to choose this method of family planning. You must sign a federal sterilization consent form at least 30 days, but not more than 180 days before the date of surgery.) • genetic counseling We also cover some other family planning services. However, you must use a provider in our provider network for the following services: • treatment for medical conditions of infertility (This service doesn't include artificial ways to become **This benefit is continued on the next page**	**In-Network:** **Medicare-covered** You pay nothing for approved family planning services. **TennCare (Medicaid)-covered** TennCare will consider benefits for any service not covered by Medicare or after Medicare coverage has been Exhausted.

Covered Service		What you pay
	Family planning services (continued) pregnant.) • treatment for AIDS and other HIV-related conditions • genetic testing	
	Flex Card Allowance 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 Over-The-Counter (OTC) items and Healthy Food[1]. The Flex Card is only for your personal use, cannot be sold or transferred, and has no cash value. You will receive an easy-to-use pre-loaded debit card. Your allowances will be reloaded at the start of each benefit period. The benefit period will be at the start of each month. **Remember:** Unused funds don't roll over. They expire at the end of each benefit period. Use one card for the following supplemental benefits: • **Over-The-Counter (OTC) items** • **Healthy Food[1]** If you need help activating your card, need help placing an order, need to 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. **OTC and Healthy Food[1]** Our plan provides a monthly allowance for OTC items and Healthy Food[1] 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 **This benefit is continued on the next page**	**Plan Covered** There is no coinsurance, copayment or deductible for covered OTC and Healthy Food[1]. The maximum combined coverage for covered OTC and Healthy Food[1] is **$352** every month. Any unused amount will expire at the end of each month.

Covered Service		What you pay
	Flex Card Allowance (continued) 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[1]** ○ 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. 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. Purchases may be restricted to certain types of items and services. **[1]The Healthy Food benefit is a special supplemental benefit for people living with chronic health conditions (SSBCI) and is available only to members who qualify. Not all members are eligible.** **Refer to Section C in this chapter for more information about qualifying Chronic health conditions.**	
	Health and wellness education programs Our health and wellness programs are available to all members at no additional cost. They are designed to assist members with improving healthy behaviors. **Health Education:** *Wellness Services:* **This benefit is continued on the next page**	**In-Network:** **Medicare-covered** You pay nothing for covered health and wellness education programs.

Covered Service	What you pay

Health and wellness education programs (continued)
 	
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.
 	
Fitness Program:
 	
The Silver&Fit® Healthy Aging and Exercise Program
 	
As a member, you have the following choices available at no cost to you:
 	
• Fitness center membership: To enroll you can:
  ○ Visit a standard Silver&Fit participating fitness center near you.
  ○ Visit SilverandFit.com.
  ○ Or, you can call 1-888-797-8091, TTY 711 (Monday to Friday 8 a.m. to 9 p.m. ET).
 	
• A customized program for your exercise of choice, including instructions on how to get started and suggested online workout videos
• On-demand videos through the website digital library
• Healthy Aging resources tailored to your interests and healthy habit goals
 	
Enhanced Disease Management
 	
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 with their doctor's plan of care and educated in ways to control and manage their chronic diseases. Members are monitored relative to prescription
 	
This benefit is continued on the next page	

Covered Service		What you pay
	Health and wellness education programs (continued) 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. **Remote Access Technology:** *Nurse Hotline:* 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. *Tele-Monitoring:* Home-based tele-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 Medicare. See **Diabetic self-management training, services, and supplies** above for additional information.	
	Hearing services - Medicare Covered We cover hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They're covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. **Hearing Services - Supplemental** One routine hearing exam per year (exam must be obtained from a TruHearing® provider). **This benefit is continued on the next page**	**In-Network:** **Medicare-covered** There is no coinsurance, copayment or deductible for each Medicare-covered hearing exam. **Plan-covered** There is no coinsurance, copayment or deductible for supplemental plan covered

Covered Service		What you pay
	Hearing services - Medicare Covered (continued) Up to two TruHearing branded hearing aids (one per ear) every three years. You must see a TruHearing® provider to use this benefit. Call 1-833-414-8998, TTY 711 (Monday to Friday 8 am to 8 pm ET) to schedule an appointment. Hearing aid purchase includes: • First year of follow-up provider visits • 60-day trial period • 3-year extended warranty • 80 batteries per aid for non-rechargeable models **Benefit does not include or cover any of the following:** • Additional fee for optional hearing aid rechargeability • Ear molds • Hearing aid accessories • Additional provider visits • Additional batteries; batteries when a rechargeable hearing aid is purchased • Hearing aids that are not TruHearing-branded hearing aids • Costs associated with loss and damage warranty claims Costs associated with excluded items are the responsibility of the member and are not covered by the plan.	hearing exams, fittings or devices.
	Help with certain chronic conditions Important Benefit Information for Enrollees with Chronic Conditions: **This benefit is continued on the next page**	

Covered Service		What you pay
	Help with certain chronic conditions (continued) Members who qualify for the Special Supplemental benefit for the Chronically Ill (SSBCI) can use the combined monthly Flex Card allowance of **$352** for Healthy Food Items like fruits and vegetables. If you have any of the chronic condition(s) listed below and meet certain medical criteria, you may be eligible for the **Healthy Food** SSBCI Benefit. • Autoimmune disorders • Cancer • Cardiovascular disorders • Chronic alcohol use disorder and other substance use disorders (SUDs) • Chronic and disabling mental health conditions • Chronic gastrointestinal disease • Chronic heart failure • Chronic kidney disease (CKD) • Chronic lung disorders • Conditions associated with cognitive impairment • Conditions that require continued therapy services in order for individuals to maintain or retain functioning • Conditions with functional challenges and require similar services including the following: spinal cord injuries, paralysis, limb loss and arthritis • Chronic conditions that impair vision, hearing (deafness), taste, touch and smell • Dementia • Diabetes mellitus • HIV/AIDS • Immunodeficiency and Immunosuppressive disorders **This benefit is continued on the next page**	

Covered Service		What you pay
	Help with certain chronic conditions (continued) • Neurological disorders • Overweight, obesity, or metabolic syndrome • Post-organ transplantation care • Severe hematologic disorder • Stroke Eligibility is based on qualifying clinical criteria of a chronic condition as determined and provided by your physician.	
	HIV screening We cover one HIV screening exam every 12 months for people who: • ask for an HIV screening test, **or** • are at increased risk for HIV infection. If you're pregnant, we cover up to three HIV screening tests during a pregnancy.	**In-Network:** **Medicare-covered** You pay nothing for covered HIV screening.
	Home health agency care* Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency and medically necessary. You must be homebound, which means leaving home is a major effort. We cover the following additional home health services, and maybe other services not listed here: **Medicare-covered** • 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 eight hours per day and 35 hours per week.) • physical therapy, occupational therapy, and speech therapy • medical and social services **This benefit is continued on the next page**	**Prior authorization is required.** **In-Network:** **Medicare-covered** You pay nothing for covered home health agency care. **TennCare (Medicaid)-covered** TennCare will consider benefits for any service not covered by Medicare or after Medicare coverage has been exhausted. You may have to pay part of the cost of your Community Living Supports (CLS) care. It's

Covered Service		What you pay
	Home health agency care* (continued) • medical equipment and supplies **TennCare – Medicaid Services** 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. 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 tracheostomy along with the need of certain nursing care and must be medically necessary. **Community Living Supports (CLS)** A CLS is 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.	called "patient liability." The amount you pay depends on your income and countable expenses.
	Home infusion therapy* Our plan covers home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion: • the drug or biological substance, such as an antiviral or immune globulin; • equipment, such as a pump; **and** • supplies, such as tubing or a catheter. Our plan covers home infusion services that include but aren't limited to: • professional services, including nursing services, provided in accordance with your care plan; • member training and education not already included in the DME benefit; • remote monitoring; **and** **This benefit is continued on the next page**	**Prior authorization may be required.** **In-Network:** **Medicare-covered** You pay nothing for covered home infusion therapy.

Covered Service		What you pay
	Home infusion therapy* (continued) • monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.	
	Hospice care You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. Our plan must help you find Medicare-certified hospice programs in the plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • drugs to treat symptoms and pain • short-term respite care • home care When you're admitted to a hospice, you have the right to stay in our plan. **For hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis are billed to Medicare:** • Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A or B services related to your terminal illness. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. **For services that are covered by Medicare Part A or B and are not related to your terminal prognosis:** • 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 whether **This benefit is continued on the next page**	**Medicare-covered** 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. You must get care from a Medicare-certified hospice provider. The Plan will cover a consultation visit before you select hospice. You pay nothing for this consultation visit.

Covered Service		What you pay
	Hospice care (continued) you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization). • 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 **For services covered by our plan but not covered by Medicare Part A or Medicare Part B:** • Our plan covers services not covered under Medicare Part A or Medicare Part B. We cover the services whether or not they relate to your terminal prognosis. You pay nothing for these services if obtained by an in-network provider. **For drugs that may be covered by our plan's Medicare Part D benefit:** • Drugs are never covered by both hospice and our plan at the same time. For more information, refer to **Chapter 5** of this *Evidence of Coverage.* **Note:** If you need non-hospice care, call your coordinator and/or member service to arrange the services. Non-hospice care is care that **isn't** related to your terminal prognosis. Our plan covers hospice consultation services (one time only) for a terminally ill member who hasn't chosen the hospice benefit.	
	Immunizations We cover the following services: • pneumonia vaccines • flu/influenza shots, once each flu/influenza season in the fall and winter, with additional flu/influenza shots if medically necessary • hepatitis B vaccines if you've never received a complete series, you don't know your vaccination **This benefit is continued on the next page**	**In-Network:** **Medicare-covered** You pay nothing for covered immunizations. Please see Chapter 6, Section G for more information on Part D covered vaccines.

Covered Service		What you pay
	Immunizations (continued) history, or you have any other condition that puts you at high or intermediate risk of getting hepatitis B • COVID-19 vaccines • other vaccines if you're at risk and they meet Medicare Part B coverage rules We cover other vaccines that meet the Medicare Part D coverage rules. Refer to **Chapter 6** of this *Evidence of Coverage* to learn more. Vaccines also covered: • Tdap (Tetanus, Diphtheria and Pertussis (Whooping Cough) • Shingles	
	Inpatient hospital care* Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. We cover the following services and other medically necessary services not listed here: • semi-private room (or a private room if medically necessary) • meals, including special diets • regular nursing services • costs of special care units, such as intensive care or coronary care units • drugs and medications • lab tests • X-rays and other radiology services **This benefit is continued on the next page**	**Prior Authorization is required.** You must get approval from our plan to get inpatient care at an out-of-network hospital after your emergency is stabilized. **In-Network:** **Medicare-covered** You pay nothing for covered inpatient hospital care. 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

Covered Service		What you pay
	Inpatient hospital care* (continued) • needed surgical and medical supplies • appliances, such as wheelchairs • operating and recovery room services • physical, occupational, and speech therapy • inpatient substance abuse services • in some cases, the following types of transplants: corneal, kidney, kidney/pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivesicular. If you need a transplant, a Medicare-approved transplant center will review your case and decide if you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If our plan provides transplant services outside the pattern of care for our community and you choose to get your transplant there, we arrange or cover lodging and travel costs for you and one other person. BlueCare Plus Choice Transplant benefits are **limited to:** • **$150/day for member and one companion lodging and meals** with a $10,000 maximum benefit per transplant. Gas and Mileage is not included in the $150/day limit. Mileage or air travel, if necessary, is included in the $10,000 maximum benefit limit. • Travel must be more than 30 miles one way from the member's home to the facility and/or provider for meals and lodging to be covered. • Limited to 3 meals per day for the member and/or caregiver • Blood, including storage and administration. Coverage of whole blood and packed red cells **This benefit is continued on the next page**	have. **TennCare (Medicaid)-covered** TennCare (Medicaid) will consider benefits for any service not covered by Medicare or after Medicare coverage has been exhausted.

Covered Service		What you pay
	Inpatient hospital care* (continued) starts only with the fourth pint of blood you need. You must either pay the costs for the first three pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered starting with the first pint. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you're not sure if you're an inpatient or an outpatient, ask the hospital staff. Get more information from the Medicare fact sheet *Medicare Hospital Benefits* available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	
	Inpatient services in a psychiatric hospital* We cover mental health care services that require a hospital stay. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. • The 190-day limit doesn't apply to inpatient mental health services provided in a psychiatric unit of a general hospital.	**Prior Authorization is required.** **In-Network:** **Medicare-covered** You pay nothing for covered inpatient services in a psychiatric hospital. **TennCare (Medicaid)-covered** TennCare will consider benefits for any service not covered by Medicare or after Medicare coverage has been exhausted.

Covered Service	What you pay

Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay
 	
We don't cover your inpatient stay if you've used all of your inpatient benefit or if the stay isn't reasonable and medically necessary. However, TennCare (Medicaid) will consider benefits for any service not covered by Medicare or after Medicare coverage has been exhausted.
 	
In certain situations where inpatient care isn't covered, we may cover services you get while you're in a hospital or nursing facility. To find out more, contact Member Service.
 	
We cover the following services, and maybe other services not listed here:
• doctor services
• diagnostic tests, like lab tests
• X-ray, radium, and isotope therapy, including technician materials and services
• surgical dressings
• splints, casts, and other devices used for fractures and dislocations
• prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that replace all or part of:
  ○ an internal body organ (including contiguous tissue), **or**
  ○ the function of an inoperative or malfunctioning internal body organ.
• leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed
 	
This benefit is continued on the next page
	In-Network:
	
	Medicare-covered
	
	You pay nothing for each covered service received in a hospital or SNF during a non-covered inpatient stay.
	
	TennCare (Medicaid)-covered
	
	TennCare will consider benefits for any service not covered by Medicare or after Medicare coverage has been exhausted.

Covered Service		What you pay
	Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay (continued) because of breakage, wear, loss, or a change in your condition • physical therapy, speech therapy, and occupational therapy **Note:** A 3-day acute hospital inpatient stay is not required to be eligible for a covered SNF inpatient stay.	
	Kidney disease services and supplies We cover the following services: • Kidney disease education services to teach kidney care and help you make good decisions about your care. You must have stage IV chronic kidney disease, and your doctor must refer you. We cover up to six sessions of kidney disease education services. • Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in **Chapter 3** of this *Evidence of Coverage*, or when your provider for this service is temporarily unavailable or inaccessible. • Inpatient dialysis treatments if you're admitted as an inpatient to a hospital for special care • Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments • Home dialysis equipment and supplies • Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply. Medicare Part B covers some drugs for dialysis. For **This benefit is continued on the next page**	**In-Network:** **Medicare-covered** You pay nothing for covered kidney disease services and supplies. **TennCare (Medicaid)-covered** TennCare (Medicaid) will consider benefits for any service not covered by Medicare or after Medicare coverage has been exhausted.

Covered Service		What you pay
	Kidney disease services and supplies (continued) information, refer to “Medicare Part B drugs” in this chart.	
	Lung cancer screening with low dose computed tomography (LDCT) Our plan covers lung cancer screening every 12 months if you: • are aged 50-77, **and** • have a counseling and shared decision-making visit with your doctor or other qualified provider, **and** • have smoked at least one pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years After the first screening, our plan covers another LDCT lung cancer screening each year with a written order from your doctor or other qualified provider. If a provider elects to provide a lung cancer screening counseling and shared decision-making visit for lung cancer screenings, the visit must meet the Medicare criteria for such visits.	**In-Network:** **Medicare-covered** You pay nothing for covered lung cancer screening.
	Meals Our plan covers **28** meals following discharge from an acute inpatient hospital or skilled nursing facility stay. **TennCare-Covered** Choices Groups 2 & 3 - Home-delivered meals (1 meal per day).	**Notification is required.** **In-Network:** **Plan-covered** You pay nothing for covered meals. **TennCare-Covered** Offered for Choices Groups 2 & 3
	Medical nutrition therapy This benefit is for people with diabetes or kidney disease without dialysis. It’s also for after a kidney **This benefit is continued on the next page**	**In-Network:** **Medicare-covered** You pay nothing for covered

Covered Service		What you pay
	Medical nutrition therapy (continued) transplant when ordered by your doctor. We cover three hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare. We may approve additional services if medically necessary. We cover two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's order. A doctor must prescribe these services and renew the order each year if you need treatment in the next calendar year. We may approve additional services if medically necessary.	medical nutrition therapy.
	Medicare Diabetes Prevention Program (MDPP) Our plan covers MDPP services for eligible people. MDPP is designed to help you increase healthy behavior. It provides practical training in: • long-term dietary change, **and** • increased physical activity, **and** • ways to maintain weight loss and a healthy lifestyle.	**In-Network:** **Medicare-covered** You pay nothing for the covered Medicare Diabetes Prevention Program.
	Medicare Part B drug* These drugs are covered under Part B of Medicare. Our plan covers the following drugs: • drugs you don't usually give yourself and are injected or infused while you get doctor, hospital outpatient, or ambulatory surgery center services • insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • other drugs you take using durable medical equipment (such as nebulizers) that our plan authorized • the Alzheimer's drug, Leqembi® (generic **This benefit is continued on the next page**	**Prior authorization or step therapy through Part B or Part D medications may be required.** **In-Network:** **Medicare-covered** You pay nothing for Medicare Part B-covered drugs (including insulin and chemotherapy drugs).

Covered Service		What you pay
	Medicare Part B drug* (continued) lecanemab) which is given intravenously (IV). In addition to medication costs, you may need additional scans and tests before and/or during treatment. Talk to your doctor about what scans and tests you may need as part of your treatment. • clotting factors you give yourself by injection if you have hemophilia • transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D covers immunosuppressive drugs if Part B doesn't cover them • osteoporosis drugs that are injected. We cover these drugs if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't inject the drug yourself • some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug). As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does • oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are **This benefit is continued on the next page**	

Covered Service		What you pay
	Medicare Part B drug* (continued) used as a full therapeutic replacement for an intravenous anti-nausea drug • certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B • calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv®, and the oral medication Sensipar • certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary) and topical anesthetics • erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have ESRD or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit® Epoetin Alfa, Aranesp®, Darbepoetin Alfa®, Mircera®, or Methoxy polyethylene glycol-epotin beta) • IV immune globulin for the home treatment of primary immune deficiency diseases • parenteral and enteral nutrition (IV and tube feeding) • gene therapy, such as chimeric antigen receptor (CAR) T-cell therapy The following link takes you to a list of Medicare Part B drugs that may be subject to step therapy: bluecareplus.bcbst.com/pharmacy. We also cover some vaccines under our Medicare Part B and most adult vaccines under our Medicare Part D drug benefit. **Chapter 5** of this *Evidence of Coverage* explains our drug benefit. It explains rules you must follow to have prescriptions covered. **Chapter 6** of this *Evidence of Coverage* explains what you pay for your drugs through our plan.	

Covered Service		What you pay
	Nursing facility care Note: This benefit applies to CHOICES Group 1 only. A nursing facility (NF) is a place that provides care for people who can't get care at home but who don't need to be in a hospital. CHOICES benefits (Nursing Facility care and certain Home and Community Based Services, HCBS) are included in these services. Services that TennCare covers include, but aren't limited to, the following: • semiprivate room (or a private room if medically necessary) • meals, including special diets • nursing services • physical therapy, occupational therapy, and speech therapy • respiratory therapy • drugs given to you as part of your plan of care. (This includes substances that are naturally present in the body, such as blood-clotting factors.) • blood, including storage and administration • medical and surgical supplies usually given by nursing facilities • lab tests usually given by nursing facilities • X-rays and other radiology services usually given by nursing facilities • use of appliances, such as wheelchairs usually given by nursing facilities **This benefit is continued on the next page**	**TennCare (Medicaid)-covered** TennCare will consider benefits for any service not covered by Medicare or after Medicare coverage has been exhausted. You may have to pay part of the cost of your nursing facility care. It's called "patient liability." The amount you pay depends on your income and countable expenses.

Covered Service		What you pay
	Nursing facility care (continued) • physician/practitioner services • durable medical equipment • dental services, including dentures • vision benefits • hearing exams • chiropractic care • podiatry services You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • a nursing facility or continuing care retirement community where you were living right before you went to the hospital (as long as it provides nursing facility care). • a nursing facility where your spouse or domestic partner is living at the time you leave the hospital.	
	Obesity screening and therapy to keep weight down If you have a body mass index of 30 or more, we cover counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more.	**In-Network:** **Medicare-covered** You pay nothing for covered obesity screening and therapy to keep weight down.
	Occupational therapy* In-home assessments and recommendations by a Licensed Occupational Therapist pertaining to the use of **This benefit is continued on the next page**	**Prior Authorization may be required.** **In-Network:**

Covered Service		What you pay
	Occupational therapy* (continued) technology to restore, improve, or stabilize impaired functions.	**Medicare-covered** You pay nothing for covered Occupational therapy.
	Opioid treatment program (OTP) services* Our plan covers the following services to treat opioid use disorder (OUD) through an OTP which includes the following services: • intake activities • periodic assessments • medications approved by the FDA and, if applicable, managing and giving you these medications • substance use counseling • individual and group therapy • testing for drugs or chemicals in your body (toxicology testing)	**Prior Authorization may be required.** **In-Network:** **Medicare-covered** You pay nothing for covered Opioid treatment program (OTP) services. **TennCare (Medicaid)-covered** TennCare (Medicaid) will consider benefits for any service not covered by Medicare or after Medicare coverage has been exhausted.
	Organ and tissue transplants and donor organ services* **This benefit is continued on the next page**	**Prior authorization may be required.** **In-Network:** **Medicare-covered** You pay nothing for covered Organ and tissue transplants and donor organ services. **TennCare (Medicaid)-covered** TennCare (Medicaid) will consider benefits for any service not covered by Medicare or after Medicare

Covered Service		What you pay
	Organ and tissue transplants and donor organ services* (continued)	coverage has been exhausted.
	Outpatient diagnostic tests and therapeutic services and supplies* We cover the following services and other medically necessary services not listed here: • X-rays • radiation (radium and isotope) therapy, including technician materials and supplies • surgical supplies, such as dressings • splints, casts, and other devices used for fractures and dislocations • lab tests • blood, including storage and administration • diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical condition • other outpatient diagnostic tests	**Prior authorization may be required.** **In-Network:** **Medicare-covered** You pay nothing for covered outpatient diagnostic tests or therapeutic services and supplies. **TennCare (Medicaid)-covered** TennCare (Medicaid) will consider benefits for any service not covered by Medicare or after Medicare coverage has been exhausted.
	Outpatient hospital observation We pay for outpatient hospital observation services to determine if you need to be admitted as an inpatient or can be discharged. The services must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient. Even if you stay in the hospital overnight, you might still **This benefit is continued on the next page**	**In-Network:** **Medicare-covered** You pay nothing for covered outpatient hospital observation.

Covered Service		What you pay
	Outpatient hospital observation (continued) be considered an outpatient. If you aren't sure if you're an outpatient, ask hospital staff. Get more information from the Medicare fact sheet *Medicare Hospital Benefits* available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf.	
	Outpatient hospital services* We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury, such as: • Services in an emergency department or outpatient clinic, such as outpatient surgery or observation services • Labs and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it • X-rays and other radiology services billed by the hospital • Medical supplies, such as splints and casts • Some drugs and biologicals that you can't give yourself • Self-administered drugs. **Note:** You are considered outpatient unless a provider has issued a written order to admit you as inpatient. If you're unsure of your status, ask the hospital staff to confirm whether you are admitted as an inpatient or being treated as an outpatient. You can also find more information in a Medicare fact sheet called Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask! This fact sheet is available on the Web at **This benefit is continued on the next page**	**Prior authorization may be required.** **In-Network:** **Medicare-covered** You pay nothing for covered outpatient hospital services.

Covered Service		What you pay
	Outpatient hospital services* (continued) https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf 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.	
	Outpatient mental health care* We cover mental health services provided by: • a state-licensed psychiatrist or doctor • a clinical psychologist • a clinical social worker (CSW) • a clinical nurse specialist (CNS) • a licensed professional counselor (LPC) • a licensed marriage and family therapist (LMFT) • a nurse practitioner (NP) • a physician assistant (PA) • any other Medicare-qualified mental health care professional as allowed under applicable state laws Outpatient Behavioral health services include: • all laboratory services in an inpatient, outpatient, or professional setting • uncategorized professional services (such as evaluation and management, health screenings, and specialists' visits) • mental health and substance use disorder services • crisis services • outpatient radiology • outpatient professional services • therapy **This benefit is continued on the next page**	**Prior authorization may be required.** **In-Network:** **Medicare-covered** You pay nothing for covered outpatient mental health care. **TennCare (Medicaid)-covered** TennCare (Medicaid) will consider benefits for any service not covered by Medicare or after Medicare coverage has been exhausted.

Covered Service		What you pay
	Outpatient mental health care* (continued) • assessment & testing • substance use treatment • medication management • counseling/Intervention • detox • rehab • other behavioral health treatment	
	Outpatient rehabilitation services* We cover physical therapy, occupational therapy, and speech therapy. You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.	**Prior authorization may be required.** **In-Network:** **Medicare-covered** You pay nothing for covered outpatient rehabilitation services. **TennCare (Medicaid)-covered** TennCare (Medicaid) will consider benefits for any service not covered by Medicare or after Medicare coverage has been exhausted.
	Outpatient substance use disorder services* We cover the following services, and maybe other services not listed here: • alcohol misuse screening and counseling • treatment of drug abuse • group or individual counseling by a qualified clinician **This benefit is continued on the next page**	**Prior authorization may be required.** **In-Network:** **Medicare-covered** You pay nothing for covered outpatient substance use disorder services. **TennCare (Medicaid)-**

Covered Service		What you pay
	Outpatient substance use disorder services* (continued) • subacute detoxification in a residential addiction program • alcohol and/or drug services in an intensive outpatient treatment center • extended-release Naltrexone (vivitrol) treatment 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.	**covered** TennCare (Medicaid) will consider benefits for any service not covered by Medicare or after Medicare coverage has been exhausted.
	Outpatient surgery* We cover outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers. **Note:** If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient. Even if you stay in the hospital overnight, you might still be considered an outpatient.	**Prior authorization may be required.** **In-Network:** **Medicare-covered** There is no coinsurance, copayment or deductible for Medicare-covered outpatient surgeries. **TennCare (Medicaid)-covered** TennCare (Medicaid) will consider benefits for any service not covered by Medicare or after Medicare coverage has been exhausted.
	Partial hospitalization services and intensive outpatient services* **Partial hospitalization** is a structured program of active psychiatric treatment. It's offered as a hospital outpatient service or by a community mental health center that's **This benefit is continued on the next page**	**Prior Authorization may be required.** **In-Network:**

Covered Service		What you pay
	Partial hospitalization services and intensive outpatient services* (continued) more intense than the care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office. It can help keep you from having to stay in the hospital. **Intensive outpatient** service is a structured program of active behavioral (mental) health therapy treatment provided as a hospital outpatient service, a community mental health center, a federally qualified health center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, LMFT, or licensed professional counselor's office but less intense than partial hospitalization.	**Medicare-covered** You pay nothing for covered partial hospitalization or intensive outpatient services. **TennCare (Medicaid)-covered** TennCare (Medicaid) will consider benefits for any service not covered by Medicare or after Medicare coverage has been exhausted.

	Physician/provider services, including doctor's office visits*
	
	Covered services include:
	• medically necessary health care or surgery services given in places such as:
	  ○ physician's office
	  ○ certified ambulatory surgical center (Authorization may be required for some surgery services.)
	  ○ hospital outpatient department
	  ○ any other location
	• consultation, diagnosis, and treatment by a specialist
	• basic hearing and balance exams given by your primary care provider or specialist, if your doctor orders them to find out whether you need treatment
	• Certain telehealth services, including: specific urgently needed medical services and individual sessions for specific mental health specialty
	
	This benefit is continued on the next page
		Prior authorization may be required.
		
		In-Network:
		
		Medicare-covered
		
		You pay nothing for covered primary care, specialist or other health care professional services.
		
		TennCare (Medicaid)-covered
		
		TennCare (Medicaid) will consider benefits for any service not covered by Medicare or after Medicare coverage has been exhausted.

Covered Service		What you pay
	Physician/provider services, including doctor's office visits* (continued) services. ○ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. ○ This plan utilizes a vendor that offers telephonic and web-based access to a licensed provider for the medical consultation, diagnosis and/or treatment of urgent conditions when the member's treating provider isn't 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. • telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or at home • telehealth services to diagnose, evaluate, or treat symptoms of a stroke • telehealth services for members with a substance use disorder or co-occurring mental health disorder regardless of your location • telehealth services for diagnosis, evaluation, and treatment of mental health disorders • telehealth services for mental health visits provided by rural health clinics and federally qualified health centers. • virtual check-ins (for example, by phone or video chat) with your doctor for five-ten minutes **if** **This benefit is continued on the next page**	

Covered Service		What you pay
	Physician/provider services, including doctor's office visits* (continued) ○ you're not a new patient **and** ○ the check-in isn't related to an office visit in the past seven days **and** ○ the check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours **if**: ○ you're not a new patient and ○ the evaluation isn't related to an office visit in the past seven days **and** ○ the evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient • Second opinion by another network provider before surgery	
	Podiatry services We cover the following services: • diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) • routine foot care for members with conditions affecting the legs, such as diabetes • 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.	**In-Network:** **Medicare-covered** You pay nothing for covered podiatry services.

Covered Service		What you pay
	Pre-exposure prophylaxis (PrEP) for HIV prevention* If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication including the fee for injecting the drug, if applicable. • Up to eight individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to eight HIV screenings every 12 months. • A one-time hepatitis B virus screening.	**Prior authorization may be required.** **In-Network:** **Medicare-covered** You pay nothing for covered Pre-exposure prophylaxis (PrEP) medication and related services.
	Prostate cancer screening exams For men aged 50 and over, we cover the following services once every 12 months: • a digital rectal exam • a prostate specific antigen (PSA) test	**In-Network:** **Medicare-covered** You pay nothing for a covered annual digital rectal exam or PSA test.
	Prosthetic and orthotic devices and related supplies* Prosthetic devices replace all or part of a body part or function. These include but aren't limited to: • testing, fitting, or training in the use of prosthetic and orthotic devices • colostomy bags and supplies related to colostomy care • pacemakers • braces • prosthetic shoes • artificial arms and legs **This benefit is continued on the next page**	**Prior authorization may be required.** **In-Network:** **Medicare-covered** You pay nothing for covered prosthetic devices and related supplies.

Covered Service		What you pay
	Prosthetic and orthotic devices and related supplies* (continued) • breast prostheses (including a surgical brassiere after a mastectomy) We cover some supplies related to prosthetic and orthotic devices. We also pay to repair or replace prosthetic and orthotic devices. We offer some coverage after cataract removal or cataract surgery. Refer to “Vision care” later in this chart for details.	
	Pulmonary rehabilitation services We cover pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). You must have an order for pulmonary rehabilitation from the doctor or provider treating the COPD. These services are limited to two one-hour sessions per day with a limit of 36 sessions per year.	**In-Network:** **Medicare-covered** You pay nothing for covered pulmonary rehabilitation services. **TennCare (Medicaid)-covered** TennCare (Medicaid) will consider benefits for any service not covered by Medicare or after Medicare coverage has been exhausted.
	Reconstructive breast surgery Surgery to restore a breast to near normal shape, appearance, and size after having a mastectomy due to cancer. This includes: • reconstructive surgery for a cancerous breast; and • reconstructive surgery for a breast without cancer so that the breasts are the same size and shape This surgery is covered as long as it’s done within five years of the reconstructive surgery on the diseased breast.	**In-Network:** **Medicare-covered** You pay nothing for covered reconstructive breast services.

Covered Service		What you pay
	Screening for Hepatitis C Virus infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. If you were born between 1945-1965 and aren't considered high risk, we cover a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	**In-Network:** **Medicare-covered** You pay nothing for each covered Hepatitis C screening.
	Sexually transmitted infections (STIs) screening and counseling We cover screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. We cover these counseling sessions as a preventive service only if given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.	**In-Network:** **Medicare-covered** You pay nothing for covered sexually transmitted infections screening and counseling.
	Skilled nursing facility (SNF) care* For a definition of skilled nursing facility care, go to **Chapter 12.** You are covered for 100 days of medically necessary care per benefit period when authorized by BlueCare **This benefit is continued on the next page**	**Prior authorization is required.** **In-Network:** **Medicare-covered** You pay nothing for covered skilled nursing facility care for

Covered Service		What you pay
	Skilled nursing facility (SNF) care* (continued) Plus Choice. We cover the following services, and maybe other services not listed here: • a semi-private room, or a private room if it's medically necessary • meals, including special diets • skilled nursing services • physical therapy, occupational therapy, and speech therapy • drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors • blood, including storage and administration • medical and surgical supplies given by SNFs • lab tests given by SNFs • X-rays and other radiology services given by nursing facilities • appliances, such as wheelchairs, usually given by nursing facilities • physician/provider services You usually get SNF care from network facilities. Under certain conditions you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • a nursing facility or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) • a nursing facility where your spouse or domestic partner lives at the time you leave the hospital	day 1 – 100 of each benefit period. 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. **TennCare (Medicaid)-covered** TennCare (Medicaid) will consider benefits for any service not covered by Medicare or after Medicare coverage has been exhausted.

Covered Service		What you pay
	Smoking and tobacco use cessation Counseling to quit smoking and tobacco use is covered on an outpatient and hospitalized basis for people who meet these criteria: • use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • are competent and alert during counseling • a qualified physician or other Medicare-recognized practitioner providers counseling We cover two quit attempts per year (each attempt may include a maximum of four intermediate or intensive sessions, with up to eight sessions per year).	**In-Network:** **Medicare-covered** You pay nothing for covered smoking and tobacco use cessation services.
	Supervised exercise therapy (SET) We cover SET for members with symptomatic peripheral artery disease (PAD) who have a referral for SET from the physician responsible for PAD treatment. Our plan pays for: • up to 36 sessions during a 12-week period if all SET requirements are met • an additional 36 sessions over time if deemed medically necessary by a health care provider The SET program must be: • 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication) • in a hospital outpatient setting or in a physician's office • delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD • under the direct supervision of a physician, physician assistant (PA), or nurse practitioner **This benefit is continued on the next page**	**In-Network:** **Medicare-covered** You pay nothing for covered supervised exercise therapy.

Covered Service		What you pay
	Supervised exercise therapy (SET) (continued) (NP)/clinical nurse specialist (CNS) trained in both basic and advanced life support techniques	
	Tennessee Health Link 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. Members who are eligible for Health Link services are identified based on: • your diagnosis • certain health care services you use or • functional need. Health Link professionals will use care coordination and other services to help members with your behavioral and physical health. This includes: • Comprehensive care management (e.g., creating care coordination and treatment plans) • Care coordination (e.g., proactive outreach and follow up with primary care and behavioral health providers) • Health promotion (e.g., educating the patient and his/her family on independent living skills) • Transitional care (e.g., participating in the development of discharge plans) • Patient and family support (e.g., supporting adherence to behavioral and physical health treatment) • Referral to social supports (e.g., helping to find **This benefit is continued on the next page**	**TennCare (Medicaid) Covered** You pay nothing for TennCare (Medicaid) covered services.

Covered Service		What you pay
	Tennessee Health Link (continued) access to community supports including scheduling and follow through)	
	Transportation Services* **Plan-covered** This benefit is for transportation access to Medicare covered benefit locations not covered by member's TennCare (Medicaid) benefit. Plan covers **100** one-way trips to plan-approved locations every year. Examples of approved locations would be medical, vision, dental, and hearing appointments, fitness center visits and non-emergency ambulance rides that are not covered by the member's Medicaid plan. **TennCare (Medicaid)-covered** TennCare provides transportation for plan-approved non-emergent medical appointments. 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.	**Prior authorization may be required.** **Plan-covered** There is no coinsurance, copayment or deductible for plan-approved transportation services. **TennCare (Medicaid)-covered** Provides transportation for plan-approved non-emergent medical appointments.
	Urgently needed care Urgently needed care is care given to treat: • a non-emergency that requires immediate medical care, **or** • an unforeseen illness, **or** • an injury, **or** • a condition that needs care right away. If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you can't get to a **This benefit is continued on the next page**	**In-Network:** **Medicare-covered** You pay nothing for covered urgently needed services.

Covered Service		What you pay
	Urgently needed care (continued) network provider because given your time, place, or circumstances, it's not possible, or it's unreasonable, to get this service from network providers (for example, when you're outside the plan's service area and you require medically needed immediate services for an unseen condition but it's not a medical emergency). Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. Coverage is limited to within the United States.	
	Vision care We cover outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example, treatment for age-related macular degeneration. For people at high risk of glaucoma, we cover one glaucoma screening each year. People at high risk of glaucoma include: • people with a family history of glaucoma • people with diabetes • African-Americans who are 50 and over • Hispanic Americans who are 65 and over For people with diabetes, we cover screening for diabetic retinopathy once per year. We cover one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You can't get two pairs of glasses after the second surgery, even if you didn't get a pair of glasses after the first surgery. **This benefit is continued on the next page**	**In-Network:** **Medicare-covered** You pay nothing for covered exams to diagnose and treat diseases/conditions of the eye, glaucoma screening, eyeglasses/contact lenses after cataract surgery. **Plan-covered** There is no coinsurance, copayment or deductible for supplemental vision exams or eyewear. **$400** annual allowance for supplemental vision care services.

Covered Service		What you pay
	Vision care (continued) **Vision care - Supplemental** Covered services include: • One routine eye exam each year • Limit of one pair of eyeglasses (lenses and/or frames) or contact lenses each year.	
	"Welcome to Medicare" preventive visit We cover the one-time "Welcome to Medicare" preventive visit. The visit includes: • a review of your health, • education and counseling about preventive services you need (including screenings and shots (or vaccines)), **and** • referrals for other care if you need it. **Note**: We cover the "Welcome to Medicare" preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor's office you want to schedule your "Welcome to Medicare" preventive visit.	**In-Network:** **Medicare-covered** You pay nothing for covered preventive visits.

E. Benefits covered outside of our plan

We don't cover the following services, but they're available through Medicare or TennCare (Medicaid).

E1. Hospice care

You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. The plan must help you find Medicare-certified hospice programs. Your hospice doctor can be a network provider or an out-of-network provider.

This section is continued on next page

Refer to the Benefits Chart in **Section D** for more information about what we cover while you are getting hospice care services.

For hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis

- The hospice provider bills Medicare for your services. Medicare pays for hospice services related to your terminal prognosis. You pay nothing for these services.

For services covered by Medicare Part A or Medicare Part B that are not related to your terminal prognosis

- The provider will bill Medicare for your services. Medicare will pay for the services covered by Medicare Part A or Medicare Part B. You pay nothing for these services.

For drugs that may be covered by our plan's Medicare Part D benefit

- Drugs are never covered by both hospice and our plan at the same time. For more information, refer to **Chapter 5** of your *Evidence of Coverage*.

Note: If you need non-hospice care, call your coordinator to arrange the services. Non-hospice care is care not related to your terminal prognosis.

E2. Population Health

Population Health services provide you with information on how to stay healthy. If you have an ongoing illness or unmet health needs, Population Health services can help you do things like:

- understand your illness and how to feel better
- help you or your child find a primary care doctor and get to your appointments
- develop a plan of care based on your doctor's or your child's doctor's advice for medical and behavioral health needs
- be a partner to you or your child to coordinate care with all of your health care providers
- have a healthy pregnancy and healthy delivery
- help with getting your prescription medications
- help keep you or your child out of the hospital by getting care in the community
- identify community organizations that can provide non-medical supports and resources to improve the health and well-being of you or your child

This section is continued on next page

- help you with lifestyle changes that you want to make like quitting smoking or managing your weight
- help explain important health information to you or to your doctors

Population Health services are provided whether you're well, have an ongoing health problem or have a terrible health episode. Population Health services are available to you depending on your health risks and need for the service.

Population Health can provide you with a care manager. A care manager can help you get all the care you need. You may be able to have a care manager if you:

- go to the ER a lot, or if you have to go into the hospital a lot, or
- need health care before or after you have a transplant, or
- have a lot of different doctors for different health problems, or
- have an ongoing illness that you don't know how to deal with

To see if you can have a care manager, or if you want to participate in the Population Health services, you (or someone on your behalf) can call your plan.

E3. Sterilization

Sterilization is the medical treatment or surgery that makes unable to have children. To have this treatment, you must:

- be an adult age 21 or older
- be mentally stable and able to make decisions about your health
- not be in a mental institution or in prison
- fill out a paper that gives your OK. This is called a Sterilization Consent Form. You must fill this out with your provider.

You have to fill the paper out at least 30 days before you have the treatment. But in an emergency like premature delivery or abdominal surgery, you can fill the paper out at least 72 hours before you have the treatment.

E4. Abortion

Abortions may only be covered by TennCare in limited cases, like if you have a physical illness that you could die from without an abortion.

Your doctor must fill out a paper called Certification of Medical Necessity for Abortion.

E5. Hysterectomy

A hysterectomy is a medical surgery that removes reproductive organs. A hysterectomy can be covered when you must have it to fix other medical problems. After a hysterectomy, you won't be able to have children. But, TennCare won't cover this treatment if you have it just so you won't have children. TennCare pays for this treatment only if it's for a covered reason and medically necessary.

You have to be told in words and in writing that having a hysterectomy means you aren't able to have children. You have to sign a paper called Hysterectomy Acknowledgement Form.

E6. CHOICES

Tennessee's CHOICES program provides older adults (age 65 and older) & adults with physical disabilities (age 21 and older) who are eligible for needed long-term services and supports in the home/community setting or in a nursing facility.

CHOICES offers services to help a person live in their own home or in the community; these services are considered Home and Community Based Services (HCBS). These services assist individuals with daily living activities and allow people to work and be actively involved in their local community. If needed, CHOICES also provides care in a nursing facility as an alternative to HCBS.

All members in CHOICES are assigned to a group. There are three groups (1, 2 and 3) which provide specific services based on the individual's needs.

- Group 1: For people of all ages who receive nursing home care.
- Group 2: For adults (age 21 and older) with a physical disability and seniors (age 65 and older) who qualify to receive nursing home care but choose to receive home care services instead.
- Group 3: For adults (age 21 and older) with a disability and seniors (age 65 and older) who don't qualify for nursing home care but still need care to delay or prevent the need for nursing home care.

For a complete list of services, please download the CHOICES Benefit Table at https://www.tn.gov/content/dam/tn/tenncare/documents/CHOICESMemberBenefitTable.pdf.

E7. Employment and Community First CHOICES

Employment and Community First CHOICES is for people of all ages who have an intellectual or developmental disability (I/DD). This includes people who have significant disabilities.

Services help people with I/DD gain as much independence as possible. People are supported to live with their family or in the community, not in an institution. Residential services are available for adults with I/DD who don't live with family but need supports where they live.

Employment and Community First CHOICES can help the person with I/DD explore the possibility of working. Services can also help people learn skills for work, find a job, and keep a job. This could be a part-time job, a full-time job or self-employment. Working helps people earn money, learn new skills, meet new people, and play an important role in their communities. Work can also help people stay healthy and build self-confidence.

Other services help people learn and do things at home and in the community that help people achieve their goals. If a person lives at home with their family, the services help the family support the person to become as independent as possible. Services also help people get actively involved in their communities and include peer supports for the person and for their family.

All members in Employment and Community First CHOICES are assigned a group. There are five groups (4,5,6,7, or 8), which **provide specific services based on an individual's needs.**

- Group 4: Essential Family Supports
- Group 5: Essential Supports for Employment and Independent Living
- Group 6: Comprehensive Supports for Employment and Community Living
- Group 7: Intensive Behavioral Family-Centered Treatment, Stabilization and Supports
- Group 8: Intensive Behavioral Community Transition and Stabilization Services

Please view the Member Benefit Table at https://www.tn.gov/content/dam/tn/tenncare/documents/MemberBenefitTable.pdf for a complete list of services covered in each benefit group, how they can help, and any limits.

F. Benefits not covered by our plan, Medicare, or TennCare

This section tells you about benefits excluded by our plan. “Excluded” means that we don’t cover these benefits. Medicare and Medicaid don’t cover them either.

The list below describes some services and items not covered by us under any conditions and some excluded by us only in some cases.

We don’t cover excluded medical benefits listed in this section (or anywhere else in this *Evidence of Coverage*) except under specific conditions listed. Even if you get the services at an emergency facility, the plan won’t cover the services. If you think that our plan should cover a service that isn’t covered, you can request an appeal. For information about appeals, refer to **Chapter 9** of this *Evidence of Coverage*.

In addition to any exclusions or limitations described in the Benefits Chart, our plan doesn’t cover the following items and services:

- services considered not “reasonable and medically necessary”, according to Medicare and TennCare (Medicaid) standards, unless we list these as covered services
- experimental medical and surgical treatments, items, and drugs, unless Medicare, a Medicare-approved clinical research study, or our plan covers them. Refer to **Chapter 3** of this *Evidence of Coverage* for more information on clinical research studies. Experimental treatment and items are those that aren’t generally accepted by the medical community.
- surgical treatment for morbid obesity, except when medically necessary and Medicare pays for it
- a private room in a hospital, except when medically necessary
- personal items in your room at a hospital or a nursing facility, such as a telephone or television
- full-time nursing care in your home
- fees charged by your immediate relatives or members of your household
- elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary

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- cosmetic surgery or other cosmetic work, unless it's needed because of an accidental injury or to improve a part of the body that isn't shaped right. However, we pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it
- routine foot care, except as described in Podiatry services in the Benefits Chart in **Section D**
- orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease
- supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease
- radial keratotomy, LASIK surgery, and other low-vision aids
- reversal of sterilization procedures and non-prescription contraceptive supplies
- naturopath services (the use of natural or alternative treatments)
- services provided to veterans in Veterans Affairs (VA) facilities. However, when a veteran gets emergency services at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we'll reimburse the veteran for the difference. You're still responsible for your cost-sharing amounts.

Chapter 5: Getting your outpatient drugs

Introduction

This chapter explains rules for getting your outpatient drugs. These are drugs that your provider orders for you that you get from a pharmacy or by mail-order. They include drugs covered under Medicare Part D and TennCare (Medicaid). **Chapter 6** of this *Evidence of Coverage* tells you what you pay for these drugs. Key terms and their definitions appear in alphabetical order in the last chapter of this *Evidence of Coverage*.

We also cover the following drugs, although they're not discussed in this chapter:

- **Drugs covered by Medicare Part A.** These generally include drugs given to you while you're in a hospital or nursing facility.
- **Drugs covered by Medicare Part B.** These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, and drugs you're given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, refer to the Benefits Chart in **Chapter 4** of this *Evidence of Coverage*.
- In addition to the plan's Medicare Part D and medical benefits coverage, your drugs may be covered by Original Medicare if you're in Medicare hospice. For more information, please refer to **Chapter 5, Section F3** "In a Medicare-certified hospice program."

Rules for our plan's outpatient drug coverage

We usually cover your drugs as long as you follow the rules in this section.

You must have a provider (doctor, dentist, or other prescriber) write your prescription, which must be valid under applicable state law. This person often is your primary care provider (PCP). It could also be another provider if your PCP has referred you for care.

Your prescriber must **not** be on Medicare's Exclusion or Preclusion Lists or TennCare's Terminated Provider List.

You generally must use a network pharmacy to fill your prescription. (Refer to **Section A1** for more information). Or you can fill your prescription through the plan's mail-order service.

Your prescribed drug must be on our plan's *List of Covered Drugs*. We call it the *"Drug List"* for short. (Refer to **Section B** of this chapter.)

- If it's not on the *Drug List*, we may be able to cover it by giving you an exception.

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- Refer to **Chapter 9, Section G4** to learn about asking for an exception.

Your drug must be used for a medically accepted indication. This means that use of the drug is either approved by the Food and Drug Administration (FDA) or supported by certain medical references. Your prescriber may be able to help identify medical references to support the requested use of the prescribed drug.

Your drug may require approval from our plan based on certain criteria before we'll cover it. Refer to **Section C** in this chapter.

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A. Getting your prescriptions filled

A1. Filling your prescription at a network pharmacy

In most cases, we pay for prescriptions only when filled at any of our network pharmacies. A network pharmacy is a drug store that agrees to fill prescriptions for our plan members. You may use any of our network pharmacies. (Refer to **Section A8** for information about when we cover prescriptions filled at out-of-network pharmacies.)

To find a network pharmacy, refer to the Provider and Pharmacy Directory, visit our website or contact Member Service.

A2. Using your Member ID Card when you fill a prescription

To fill your prescription, **show your Member ID Card** at your network pharmacy. The network pharmacy bills us for our share of the cost of your covered drug. You may need to pay the pharmacy a copay when you pick up your prescription.

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

If the pharmacy can't get the necessary information, you may have to pay the full cost of the prescription when you pick it up. Then you can ask us to pay you back for our share. **If you can't pay for the drug, contact Member Service right away.** We'll do everything we can to help.

- To ask us to pay you back, refer to **Chapter 7** of this *Evidence of Coverage*.
- If you need help getting a prescription filled, contact Member Service or your coordinator.

A3. What to do if you change your network pharmacy

If you change pharmacies and need a prescription refill, you can either ask to have a new prescription written by a provider or ask your pharmacy to transfer the prescription to the new pharmacy if there are any refills left.

If you need help changing your network pharmacy, contact Member Service.

A4. What to do if your pharmacy leaves the network

If the pharmacy you use leaves our plan's network, you need to find a new network pharmacy.

To find a new network pharmacy, refer to the Provider and Pharmacy Directory, visit our website, or contact Member Service.

A5. Using a specialized pharmacy

Sometimes 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 facility, such as a nursing facility.
  - Usually, long-term care facilities have their own pharmacies. If you're a resident of a long-term care facility, we make sure you can get the drugs you need at the facility's pharmacy.
  - If your long-term care facility's pharmacy isn't in our network or you have difficulty getting your drugs in a long-term care facility, contact Member Service.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives may use these pharmacies.
- Pharmacies that dispense drugs 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 find a specialized pharmacy, refer to the *Provider and Pharmacy Directory*, visit our website, or contact Member Service.

A6. Using mail-order services to get your drugs

Our plan's mail-order service allows you to order up to a 90 or 100-day supply of the drug. A 90-day supply has the same copay as a one-month supply.

Filling prescriptions by mail

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 prescription arrives within 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.

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Mail-order processes

Mail-order service has different procedures for new prescriptions it gets from you, new prescriptions it gets directly from your provider's office, and refills on your mail-order prescriptions.

1. New prescriptions the pharmacy gets from you

The pharmacy automatically fills and delivers new prescriptions it gets from you.

2. New prescriptions the pharmacy gets from your provider's office

After the pharmacy gets a prescription from a health care provider, it contacts you to find out if you want the medication filled immediately or at a later time.

- This gives you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if needed, allows you to stop or delay the order before you're billed and it's shipped.
- Respond each time the pharmacy contacts you, to let them know what to do with the new prescription and to prevent any delays in shipping.

3. 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 start to process your next refill automatically when our records show you should be close to running out of your drug.

- The pharmacy contacts you before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough medication or your medication has changed.
- If you choose not to use our auto refill program, contact your pharmacy **21** days before your current prescription will run out to make sure your next order is shipped to you in time.

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

Let the pharmacy know the best ways to contact you so they can reach you to confirm your order before shipping by contacting your mail-order pharmacy at 1-844-740-0602, TTY 711.

A7. Getting a long-term supply of drugs

You can get a long-term supply of maintenance drugs on our plan's Drug List. Maintenance drugs are drugs you take on a regular basis, for a chronic or long-term medical condition. When you get a long-term supply of drugs, your copay may be lower.

Some network pharmacies allow you to get a long-term supply of maintenance drugs. A 90-day supply has the same copay as a one-month supply. The *Provider and Pharmacy Directory* tells you which pharmacies can give you a long-term supply of maintenance drugs.

You can also call Member Service for more information.

You can use our plan's network mail-order services to get a long-term supply of maintenance drugs. Refer to **Section A6** in this chapter to learn about mail-order services.

A8. Using a pharmacy not in our plan's network

Generally, we pay for drugs filled at an out-of-network pharmacy only when you aren't able to use a network pharmacy. We have network pharmacies outside of our service area where you can get prescriptions filled as a member of our plan. In these cases, check with Member Service first to find out if there's a network pharmacy nearby.

We pay for prescriptions filled at an out-of-network pharmacy in the following cases:

- 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.)

A9. Paying you back for a prescription

If you must use an out-of-network pharmacy, you must generally pay the full cost when you get your prescription. You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost we would cover at an in-network pharmacy.

To learn more about this, refer to **Chapter 7** of this *Evidence of Coverage*.

B. Our plan's *Drug List*

We have a *List of Covered Drugs*. We call it the "*Drug List*" for short.

We select the drugs on the *Drug List* with the help of a team of doctors and pharmacists. The *Drug List* also tells you the rules you need to follow to get your drugs.

We generally cover a drug on our plan's *Drug List* when you follow the rules we explain in this chapter.

B1. Drugs on our *Drug List*

Our *Drug List* includes 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.

Our *Drug List* includes brand name drugs, generic drugs, and biological products (which may include biosimilars).

A brand name drug is a drug sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. On our *Drug List*, when we refer to "drugs" this could mean a drug or a biological product.

Generic drugs have the same active ingredients as brand name drugs. Biological products have alternatives called biosimilars. Generally, generic drugs and biosimilars work just as well as brand name or original biological products and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

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Refer to **Chapter 12** of the *Evidence of Coverage* for definitions of the types of drugs that may be on the *Drug List*.

Our plan also covers certain OTC drugs and products. Some OTC drugs cost less than drugs and work just as well. For more information, call Member Service.

B2. How to find a drug on our *Drug List*

To find out if a drug you take is on our *Drug List*, you can:

- Visit our plan's website at bluecareplus.bcbst.com/pharmacy. The *Drug List* on our website is always the most current one.
- Call Member Service to find out if a drug is on our *Drug List* or to ask for a copy of the list.
- Use our "Real Time Benefit Tool" at www.bcbst.com/rxplan to search for drugs on the *Drug List* to get an estimate of what you'll pay and if there are alternative drugs on the *Drug List* that could treat the same condition. You can also call Member Service.

B3. Drugs not on our *Drug List*

We don't cover all drugs.

- Some drugs aren't on our *Drug List* because the law doesn't allow us to cover those drugs.
- In other cases, we decided not to include a drug on our *Drug List*.
- In some cases, you may be able to get a drug that isn't on our *Drug List*. For more information refer to **Chapter 9.**

Our plan doesn't pay for the kinds of drugs described in this section. These are called **excluded drugs**. If you get a prescription for an excluded drug, you may need to pay for it yourself. If you think we should pay for an excluded drug because of your case, you can make an appeal. Refer to **Chapter 9** of this *Evidence of Coverage* for more information about appeals.

Here are three general rules for excluded drugs:

1. Our plan's outpatient drug coverage (which includes Medicare Part D and TennCare drugs) can't pay for a drug that Medicare Part A or Medicare Part B already covers. Our plan covers drugs covered under Medicare Part A or Medicare Part B for free, but these drugs aren't considered part of your outpatient drug benefits
2. Our plan can't cover a drug purchased outside the United States and its territories.

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3. Use of the drug must be approved by the FDA or supported by certain medical references as a treatment for your condition. Your doctor or other provider may prescribe a certain drug to treat your condition, even though it wasn't approved to treat the condition. This is called "off-label use." Our plan usually doesn't cover drugs prescribed for off-label use.

Also, by law, Medicare or TennCare can't cover the types of drugs listed below.

- 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 the treatment of anorexia, weight loss or weight gain
- Outpatient drugs made by a company that says you must have tests or services done only by them

B4. *Drug List* cost-sharing tiers

Every drug on our *Drug List* is in one of 6 tiers. A tier is a group of drugs of generally the same type (for example, brand name, generic, or OTC drugs).

Tier 1: **Preferred Generic** Drugs

Tier 2: **Generic** Drugs

Tier 3: **Preferred Brand** Drugs

Tier 4: **Non-Preferred** Drugs

Tier 5: **Specialty** Drugs

Tier 6: **Select Care** Drugs (Lowest cost-sharing tier)

To find out which cost-sharing tier your drug is in, look for the drug on our *Drug List*.

Chapter 6 of this *Evidence of Coverage* tells the amount you pay for drugs in each tier.

C. Limits on some drugs

For certain drugs, special rules limit how and when our plan covers them. Generally, our rules encourage you to get a drug that works for your medical condition and is safe and effective. When a

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safe, lower-cost drug works just as well as a higher-cost drug, we expect your provider to prescribe the lower-cost drug.

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 provider, and different restrictions may apply to the different versions of the drugs (for example, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid.)

If there's a special rule for your drug, it usually means that you or your provider must take extra steps for us to cover the drug. For example, your provider may have to tell us your diagnosis or provide results of blood tests first. If you or your provider thinks our rule shouldn't apply to your situation, ask us to use the coverage decision process to make an exception. We may or may not agree to let you use the drug without taking extra steps.

To learn more about asking for exceptions, refer to **Chapter 9** of this *Evidence of Coverage*.

1. **Limiting use of a brand name drug 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. If there's a generic or interchangeable biosimilar version of a brand name drug or original biological product available, our network pharmacies give you the generic or interchangeable biosimilar version.

   - We usually don't pay for the brand name drug or original biological product when there's an available generic version.
   - However, if your provider told us the medical reason that the generic drug or interchangeable biosimilar won't work for you **or** wrote "No substitutions" on your prescription for a brand name drug or original biological product **or** told us the medical reason that the generic drug, interchangeable biosimilar, or other covered drugs that treat the same condition won't work for you, then we cover the brand name drug.
   - Your copay may be greater for the brand name drug or original biological product than for the generic drug or interchangeable biosimilar.

2. **Getting plan approval in advance**

   For some drugs, you or your prescriber must get approval from our plan before you fill your prescription. This is called prior authorization. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you don't get approval, we may not cover the drug. Call Member Service at the number at the bottom of the page or on our

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website at bluecareplus.bcbst.com/use-insurance/documents-forms/bluecare-plus for more information about prior authorization.

3. **Trying a different drug first**

   In general, we want you to try lower-cost drugs that are as effective before we cover drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than Drug B, we may require you to try Drug A first.

   If Drug A **doesn't** work for you, then we cover Drug B. This is called step therapy. Call Member Service at the number at the bottom of the page or on our website at bluecareplus.bcbst.com/use-insurance/documents-forms/bluecare-plus for more information about step therapy.

4. **Quantity limits**

   For some drugs, we limit the amount of the drug you can have. This is called a quantity limit. For example, if it's normally considered safe to take only one pill per day for a certain drug, we might limit how much of a drug you can get each time you fill your prescription.

To find out if any of the rules above apply to a drug you take or want to take, check our *Drug List*. For the most up-to-date information, call Member Service or check our website at bluecareplus.bcbst.com/pharmacy. If you disagree with our coverage decision based on any of the above reasons you may request an appeal. Please refer to **Chapter 9** of this *Evidence of Coverage*.

D. Reasons your drug might not be covered

We try to make your drug coverage work well for you, but sometimes a drug may not be covered in the way that you like. For example:

- Our plan doesn't cover the drug you want to take. The drug may not be on our *Drug List*. We may cover a generic version of the drug but not the brand name version you want to take. A drug may be new, and we haven't reviewed it for safety and effectiveness yet.
- Our plan covers the drug, but there are special rules or limits on coverage. As explained in **Section C** above, some drugs our plan covers have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception.
- The drug is covered, but in a cost-sharing tier that makes your cost more expensive than you think it should be.

There are things you can do if we don't cover a drug the way you want us to cover it.

D1. Getting a temporary supply

In some cases, we can give you a temporary supply of a drug when the drug isn't on our *Drug List* or is limited in some way. This gives you time to talk with your provider about getting a different drug or to ask us to cover the drug.

To get a temporary supply of a drug, you must meet the two rules below:

1. The drug you've been taking:
   - is no longer on our *Drug List* **or**
   - was never on our *Drug List* **or**
   - is now limited in some way.
2. You must be in one of these situations:
   - You were in our plan last year.
     - We cover a temporary supply of your drug **during the first 90 days of the calendar year**.
     - This temporary supply is for up to 30 days.
     - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 30 days of medication (or 31 days for long-term care (LTC)). You must fill the prescription at a network pharmacy.
     - Long-term care pharmacies may provide your drug in small amounts at a time to prevent waste.
   - You're new to our plan.
     - We cover a temporary supply of your drug **during the first 90 days of your membership in our plan**.
     - This temporary supply is for up to 30 days.
     - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 30 days of medication (or 31 days for long-term care (LTC)). You must fill the prescription at a network pharmacy.
     - Long-term care pharmacies may provide your drug in small amounts at a time to prevent waste.

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- You've been in our plan for more than 90 days, live in a long-term care facility, and need a supply right away.
  - We cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the temporary supply above.
- 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.

D2. Asking for a temporary supply

To ask for a temporary supply of a drug, call Member Service.

When you get a temporary supply of a drug, talk with your provider as soon as possible to decide what to do when your supply runs out. Here are your choices:

- Change to another drug.

  Our plan may cover a different drug that works for you. Call Member Service to ask for a list of drugs we cover that treat the same medical condition. The list can help your provider find a covered drug that may work for you.

  OR

- Ask for an exception.

You and your provider can ask us to make an exception. For example, you can ask us to cover a drug that isn't on our *Drug List* or ask us to cover the drug without limits. If your provider says you have a good medical reason for an exception, they can help you ask for one.

E. Coverage changes for your drugs

Most changes in drug coverage happen on January 1, but we may add or remove drugs on our *Drug List* during the year. We may also change our rules about drugs. For example, we may:

- Decide to require or not require prior authorization (PA) for a drug (permission from us before you can get a drug).
- Add or change the amount of a drug you can get (quantity limits).
- Add or change step therapy restrictions on a drug (you must try one drug before we cover another drug).
- Replace an original biological product with an interchangeable biosimilar version of the biological product.

We must follow Medicare requirements before we change our plan's Drug List. For more information on these drug rules, refer to **Section C.**

If you take a drug that we covered at the **beginning** of the year, we generally won't remove or change coverage of that drug **during the rest of the year** unless:

- a new, cheaper drug comes on the market that works as well as a drug on our *Drug List* now, **or**
- we learn that a drug isn't safe, **or**
- a drug is removed from the market.

What happens if coverage changes for a drug you're taking?

To get more information on what happens when our *Drug List* changes, you can always:

- Check our current *Drug List* online at bluecareplus.bcbst.com/pharmacy **or**
- Call Member Service at the number at the bottom of the page to check our current *Drug List*.

Changes we may make to the *Drug List* that affect you during the current plan year

Some changes to the *Drug List* will happen immediately. For example:

- A new generic drug becomes available. Sometimes, a new generic drug or biosimilar comes on the market that works as well as a brand name drug or original biological product on the *Drug List* now. When that happens, we may remove the brand name drug

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and add the new generic drug, but your cost for the new drug will stay the same or will be lower.

When we add the new generic drug, we may also decide to keep the brand name drug on the list but change its coverage rules or limits.

- We may not tell you before we make this change, but we'll send you information about the specific change we made once it happens.
- You or your provider can ask for an "exception" from these changes. We'll send you a notice with the steps you can take to ask for an exception. Please refer to **Chapter 9** of this *Evidence of Coverage* [*Section G1, Medicare Part D coverage decisions and appeals*] for more information on exceptions.

Removing unsafe drugs and other drugs that are taken off the market. Sometimes a drug may be found unsafe or taken off the market for another reason. If this happens, we may immediately take it off our *Drug List*. If you're taking the drug, we'll send you a notice after we make the change. Your prescriber will also know about this change and can work with you to find another drug for your condition.

We may make other changes that affect the drugs you take. We tell you in advance about these other changes to our Drug List. These changes might happen if:

- The FDA provides new guidance or there are new clinical guidelines about a drug.

When these changes happen, we:

- Tell you at least 30 days before we make the change to our *Drug List* **or**
- Let you know and give you a 30-day supply (or 31-day long-term care (LTC)) of the drug after you ask for a refill.

This gives you time to talk to your doctor or other prescriber. They can help you decide:

- If there's a similar drug on our *Drug List* you can take instead **or**
- If you should ask for an exception from these changes to continue covering the drug or the version of the drug you've been taking. To learn more about asking for exceptions, refer to **Chapter 9** of this *Evidence of Coverage*.

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Changes to the *Drug List* that don't affect you during this plan year

We may make changes to drugs you take that aren't described above and don't affect you now. For such changes, if you're taking a drug we covered at the **beginning** of the year, we generally don't remove or change coverage of that drug **during the rest of the year**.

For example, if we remove a drug you're taking or limit its use, then the change doesn't affect your use of the drug or what you pay for the drug for the rest of the year.

If any of these changes happen for a drug you're taking (except for the changes noted in the section above), the change won't affect your use until January 1 of the next year.

We won't tell you about these types of changes directly during the current year. You'll 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 that will impact you during the next plan year.

F. Drug coverage in special cases

F1. In a hospital or a skilled nursing facility for a stay that our plan covers

If you're admitted to a hospital or skilled nursing facility for a stay our plan covers, we generally cover the cost of your drugs during your stay. You won't pay a copay. Once you leave the hospital or skilled nursing facility, we cover your drugs as long as the drugs meet all of our coverage rules.

To learn more about drug coverage and what you pay, refer to **Chapter 6 of this** *Evidence of Coverage*.

F2. In a long-term care facility

Usually, a long-term care facility, such as a nursing facility, has its own pharmacy or a pharmacy that supplies drugs for all of their residents. If you live in a long-term care facility, you may get your drugs through the facility's pharmacy if it's part of our network.

Check your *Provider and Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it isn't or if you need more information, contact Member Service.

F3. In a Medicare-certified hospice program

Drugs are never covered by both hospice and our plan at the same time.

- You may be enrolled in a Medicare hospice and require certain drugs (e.g., pain, anti-nausea drugs, laxative, or anti-anxiety drugs) that your hospice doesn't cover because it isn't related to your terminal prognosis and conditions. In that case, our plan must get

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notification from the prescriber or your hospice provider that the drug is unrelated before we can cover the drug.

- To prevent delays in getting any unrelated drugs that our plan should cover, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

If you leave hospice, our plan covers all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, take documentation to the pharmacy to verify that you left hospice.

Refer to earlier parts of this chapter that tell about drugs our plan covers. Refer to **Chapter 4** of this *Evidence of Coverage* for more information about the hospice benefit.

G. Programs on drug safety and managing drugs

G1. Programs to help you use drugs safely

Each time you fill a prescription, we look for possible problems, such as drug errors or drugs that:

- may not be needed because you take another similar drug that does the same thing
- may not be safe for your age or gender
- could harm you if you take them at the same time
- have ingredients that you are or may be allergic to
- may be an error in the amount (dosage)
- have unsafe amounts of opioid pain medications

If we find a possible problem in your use of drugs, we work with your provider to correct the problem.

G2. Programs to help you manage your drugs

Our plan has a program to help members with complex health needs. In such cases, you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. This program is voluntary and free. This program helps you and your provider make sure that your medications are working to improve your health. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all of your medications and talk with you about:

- how to get the most benefit from the drugs you take
- any concerns you have, like medication costs and drug reactions

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- how best to take your medications
- any questions or problems you have about your prescription and over-the-counter medication

Then, they'll give you:

- A written summary of this discussion. The summary has a medication action plan that recommends what you can do for the best use of your medications.
- A personal medication list that includes all medications you take, how much you take, and when and why you take them.
- Information about safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your prescriber about your action plan and medication list.

- Take your action plan and medication list to your visit or anytime you talk with your doctors, pharmacists, and other health care providers.
- Take your medication list with you if you go to the hospital or emergency room.

MTM programs are voluntary and free to members who qualify. If we have a program that fits your needs, we enroll you in the program and send you information. If you don't want to be in the program, let us know, and we'll take you out of it.

If you have questions about these programs, contact Member Service.

G3. Drug management program (DMP) to help members safely use 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 prescribers or pharmacies or if you had a recent opioid overdose, we may talk to your prescriber to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescriber, 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 include:

- Requiring you to get all prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)

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- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain prescriber(s)
- Limiting the amount of opioid or benzodiazepine medications we'll cover for you

If we plan on limiting how you get these medications or how much you can get, we'll send you a letter in advance. The letter will tell you if we'll limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific provider or pharmacy.

You'll have a chance to tell us which prescribers or pharmacies you prefer to use and any 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'll send you another letter that confirms the limitations.

If you think we made a mistake, or you disagree with our decision or the limitation, you and your prescriber can make an appeal. If you appeal, we'll review your case and give you a new decision. If we continue to deny any part of your appeal related to limitations that apply to your access to medications, we'll automatically send your case to an Independent Review Organization (IRO). (To learn more about appeals and the IRO, refer to **Chapter 9** of this *Evidence of Coverage*.)

The DMP may not apply to you if you:

- have certain medical conditions, such as cancer or sickle cell disease,
- are getting hospice, palliative, or end-of-life care, **or**
- live in a long-term care facility.

Chapter 6: What you pay for your Medicare and TennCare drugs

Introduction

This chapter tells what you pay for your outpatient drugs. By "drugs," we mean:

- Medicare Part D drugs, **and**
- Drugs and items covered under Medicaid

Because you're eligible for TennCare (Medicaid) you get Extra Help from Medicare to help pay for your Medicare Part D drugs. 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."

> **Extra Help** is a Medicare program that helps people with limited incomes and resources reduce Medicare Part D drug costs, such as premiums, deductibles, and copays. Extra Help is also called the "Low-Income Subsidy," or "LIS."

Other key terms and their definitions appear in alphabetical order in the last chapter of this *Evidence of Coverage*.

To learn more about drugs, you can look in these places:

- Our *List of Covered Drugs*.
  - We call this the *Drug List*. It tells you:
    - which drugs we pay for
    - which of the 6 tiers each drug is in
    - if there are any limits on the drugs
  - If you need a copy of our *Drug List*, call Member Service. You can also find the most current copy of our *Drug List* on our website at bluecareplus.bcbst.com/pharmacy.
- **Chapter 5** of this *Evidence of Coverage*.
  - It tells how to get your outpatient drugs through our plan.

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- It includes rules you need to follow. It also tells which types of drugs our plan doesn't cover.
- When you use the plan's "Real Time Benefit Tool" to look up drug coverage (refer to **Chapter 5**, **Section B2**), the cost shown is an estimate of the out-of-pocket costs you're expected to pay. You can call Member Service for more information.

- Our *Provider and Pharmacy Directory*.
  - In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that agree to work with us.
  - The *Provider and Pharmacy Directory* lists our network pharmacies. Refer to **Chapter 5** of this *Evidence of Coverage* for more information about network pharmacies.

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A. The *Explanation of Benefits* (EOB)

Our plan keeps track of your drug costs and the payments you make when you get prescriptions at the pharmacy. We track two types of costs:

- Your **out-of-pocket costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions. This includes what you paid when you got a covered Part D drug, any payments for your drugs made by family or friends, any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs and charities.
- Your **total drug costs**. This is the total of all payments made for your covered Part D drugs. It includes what our plan paid, and what other programs or organizations paid for your covered Part D drugs.

When you get drugs through our plan, we send you a summary called the *Explanation of Benefits*. We call it the EOB for short. The EOB isn't a bill. The EOB has more information about the drugs you take such as increases in price and other drugs with lower cost-sharing that may be available. You can talk to your prescriber about these lower cost options. The EOB includes:

- **Information for the month**. The summary tells what drugs you got for the previous month. It shows the total drug costs, what we paid, and what you and others paid for you.
- **Totals for the year since January 1**. This shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information**. This is the total price of the drug and changes in the drug price since the first fill for each prescription claim of the same quantity.
- **Lower cost alternatives**. When applicable, information about other available drugs with lower cost-sharing for each prescription.

We offer coverage of drugs not covered under Medicare.

- Payments made for these drugs don't count towards your total out-of-pocket costs.
- To find out which drugs our plan covers, refer to our *Drug List*.

B. How to keep track of your drug costs

To keep track of your drug costs and the payments you make, we use records we get from you and from your pharmacy. Here is how you can help us:

1. **Use your Member ID Card.**

   Show your Member ID Card every time you get a prescription filled. This helps us know what prescriptions you fill and what you pay.

2. **Make sure we have the information we need.**

   Give us copies of receipts for covered drugs that you paid for. You can ask us to pay you back for our share of the cost of the drug.

   Here are examples of when you should give us copies of your receipts:

   - When you buy a covered drug at a network pharmacy at a special price or use a discount card that isn't part of our plan's benefit.
   - When you pay a copay for drugs that you get under a drug maker's patient assistance program.
   - When you buy covered drugs at an out-of-network pharmacy.
   - When you pay the full price for a covered drug under special circumstances.

   For more information about asking us to pay you back for our share of the cost of a drug, refer to **Chapter 7** of this *Evidence of Coverage*.

3. **Send us information about payments others make for you.**

   Payments made by certain other people 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. This can help you qualify for catastrophic coverage. When you reach the Catastrophic Coverage Stage, our plan pays all of the costs of your Medicare Part D drugs for the rest of the year.

4. **Check the EOBs we send you.**

When you get an EOB in the mail, make sure it's complete and correct.

- **Do you recognize the name of each pharmacy?** Check the dates. Did you get drugs that day?

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- **Did you get the drugs listed?** Do they match those listed on your receipts? Do the drugs match what your doctor prescribed?

B1. What if you find mistakes on this summary?

If something is confusing or doesn't seem right on this EOB, please call us at BlueCare Plus Choice Member Service. You can also find answers to many questions on our website: bluecareplus.bcbst.com.

B2. What about possible fraud?

If this summary shows drugs you're not taking or anything else that seems suspicious to you, please contact us.

- Call us at BlueCare Plus Choice Member Service.
- Or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call these numbers for free.
- TennCare Office of Inspector General (OIG) at 1-800-433-3982 or

  P.O. Box 282368
  Nashville, TN 37228
- Tennessee Bureau of Investigation (TBI) Medicaid Fraud unit at 1-800-433-5454 or

  901 R.S. Glass Blvd
  Nashville, TN 37216
- **Member Fraud:** https://www.tn.gov/finance/fa-oig.html
- **Provider Fraud:** www.tn.gov/tenncare/fraud-and-abuse/program-integrity.html

If you think something is wrong or missing, or if you have any questions, call Member Service. Keep these EOBs. They're an important record of your drug expenses.

C. Drug Payment Stages for Medicare Part D drugs

There are two payment stages for your Medicare Part D drug coverage under our plan. How much you pay for each prescription depends on your level of Extra Help and which stage you're in when you get a prescription filled or refilled. These are the two stages:

Stage 1: Initial Coverage Stage	Stage 2: Catastrophic Coverage Stage
During this stage, we pay part of the costs of your drugs, and you pay your share. Your share is called the copay. You begin in this stage when you fill your first prescription of the year.	During this stage, we pay all of the costs of your drugs through the end of the calendar year. You begin this stage when you've paid a certain amount of out-of-pocket costs.

C1. Our plan has 6 cost-sharing tiers

Cost-sharing tiers include groups of drugs with the same copay. Every drug on our *Drug List* is in one of 6 cost-sharing tiers. To find the cost-sharing tiers for your drugs, refer to our *Drug List*.

- Tier 1 - **Preferred Generic** Drugs – 25% coinsurance of the total cost of the drug
- Tier 2 - **Generic** Drugs – 25% coinsurance of the total cost of the drug
- Tier 3 – **Preferred Brand** name Drugs – 25% coinsurance of the total cost of the drug
- Tier 4 – **Non-Preferred** Drugs – 25% coinsurance of the total cost of the drug
- Tier 5 – **Specialty** Drugs – 25% coinsurance of the total cost of the drug
- Tier 6 – **Select Care** Drugs – $0 copay (Lowest cost-sharing tier)

C2. Your pharmacy choices

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

- a network pharmacy, **or**
- an out-of-network pharmacy. In limited cases, we cover prescriptions filled at out-of-network pharmacies. Refer to **Chapter 5** of this *Evidence of Coverage* to find out when we do that.
- Our plan's mail-order pharmacy.

Refer to **Chapter 9** of this *Evidence of Coverage* to learn about how to file an appeal if you're told a drug won't be covered. To learn more about these pharmacy choices, refer to **Chapter 5** of this *Evidence of Coverage* and our *Provider and Pharmacy Directory*.

C3. Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an “extended supply”) when you fill your prescription. A long-term supply is up to a 90 or 100-day supply. It costs you the same as a one-month supply.

For details on where and how to get a long-term supply of a drug, refer to **Chapter 5** of this *Evidence of Coverage* or our *Provider and Pharmacy Directory*.

C4. What you pay

You may pay a copay when you fill a prescription. If your covered drug costs less than the copay, you pay the lower price.

Contact Member Service to find out how much your copay is for any covered drug.

Your share of the cost when you get a one-month or long-term supply of a covered drug from:

This section is continued on next page

	A network pharmacy A 30-day supply or up to a 100-day supply for **Tiers 1-3 and Tier 6**; A 30-day supply or up to a 90-day supply for **Tier 4**; A 30-day supply only for **Tier 5**	**Our plan's mail-order service** A 30-day supply or up to a 100-day supply for **Tiers 1-3 and Tier 6**; A 30-day supply or up to a 90-day supply for **Tier 4**; A 30-day supply only for **Tier 5**	**A network long-term care pharmacy** A 31-day supply **only** for long-term care for **Tiers 1-6** Coverage is limited to certain cases. Refer to **Chapter 5** of this *Evidence of Coverage* for details.
Cost-sharing Tier 1 (Preferred Generic Drugs)	**25%** coinsurance	**25%** coinsurance	**25%** coinsurance
Cost-sharing Tier 2 (Generic Drugs)	**25%** coinsurance	**25%** coinsurance	**25%** coinsurance
Cost-sharing Tier 3 (Preferred Brand Drugs) (Insulin)	**25%** coinsurance 30-100-day supply of each covered insulin product is **25%** coinsurance of the total cost, but no more than **$35 monthly.**	**25%** coinsurance 30-100-day supply of each covered insulin product is **25%** coinsurance of the total cost, but no more than **$35 monthly.**	**25%** coinsurance 31-day supply of each covered insulin product is **25%** coinsurance of the total cost, but no more than **$35 monthly.**
Cost-sharing Tier 4 (Non-Preferred Drugs)	**25%** coinsurance	**25%** coinsurance	**25%** coinsurance

	A network pharmacy A 30-day supply or up to a 100-day supply for **Tiers 1-3 and Tier 6**; A 30-day supply or up to a 90-day supply for **Tier 4**; A 30-day supply only for **Tier 5**	**Our plan's mail-order service** A 30-day supply or up to a 100-day supply for **Tiers 1-3 and Tier 6**; A 30-day supply or up to a 90-day supply for **Tier 4**; A 30-day supply only for **Tier 5**	**A network long-term care pharmacy** A 31-day supply **only** for long-term care for **Tiers 1-6** Coverage is limited to certain cases. Refer to **Chapter 5** of this *Evidence of Coverage* for details.
Cost-sharing Tier 5 (Specialty Drugs) 30-day supply **only** for **Tier 5**	**25%** coinsurance	**25%** coinsurance	**25%** coinsurance
Cost-sharing Tier 6 (Select Care Drugs)	**$0** copay	**$0** copay	**$0** copay

For information about which pharmacies can give you long-term supplies, refer to our plan's *Provider and Pharmacy Directory*.

D. Stage 1: The Initial Coverage Stage

During the Initial Coverage Stage, we pay a share of the cost of your covered drugs, and you pay your share. Your share is called the copay. The copay depends on the cost-sharing tier the drug is in and where you get it.

Cost-sharing tiers include groups of drugs with the same copay. Every drug on our plan's *Drug List* is in one of 6 cost-sharing tiers. To find the cost-sharing tiers for your drugs, refer to our *Drug List.*

- Tier 1 **Preferred Generic** Drugs - 25% coinsurance of the total cost of the drug

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- Tier 2 **Generic** Drugs - 25% coinsurance of the total cost of the drug
- Tier 3 **Preferred Brand** name Drugs - 25% coinsurance of the total cost of the drug
- Tier 4 **Non-Preferred** Drugs - 25% coinsurance of the total cost of the drug
- Tier 5 **Specialty** Drugs - 25% coinsurance of the total cost of the drug
- Tier 6 **Select** Care Drugs - $0 copay (Lowest cost-sharing tier)

D1. Your pharmacy choices

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

- A network retail pharmacy **or**
- An out-of-network pharmacy. In limited cases, we cover prescriptions filled at out-of-network pharmacies. Refer to **Chapter 5** of this *Evidence of Coverage* to find out when we do that.
- Our plan's mail-order pharmacy.

To learn more about these choices, refer to **Chapter 5** of this *Evidence of Coverage* and to our *Provider and Pharmacy Directory*.

D2. Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 90 or 100-day supply. It costs you the same as a one-month supply.

For details on where and how to get a long-term supply of a drug, refer to **Chapter 5** of this *Evidence of Coverage* or our plan's *Provider and Pharmacy Directory.*

D3. What you pay

During the Initial Coverage Stage, you may pay a copay each time you fill a prescription. If your covered drug costs less than the copay, you pay the lower price.

Contact Member Service to find out how much your copay is for any covered drug.

Your share of the cost when you get a one-month or long-term supply of a covered drug from:

This section is continued on next page

	A network pharmacy A 30-day supply or up to a 100-day supply for **Tiers 1-3 and Tier 6**; A 30-day supply or up to a 90-day supply for **Tier 4**; A 30-day supply only for **Tier 5**	**Our plan's mail-order service** A 30-day supply or up to a 100-day supply for **Tiers 1-3 and Tier 6**; A 30-day supply or up to a 90-day supply for **Tier 4**; A 30-day supply only for **Tier 5**	**A network long-term care pharmacy** A 31-day supply **only** for long-term care for **Tiers 1-6** Coverage is limited to certain cases. Refer to **Chapter 5** of this *Evidence of Coverage* for details.
Cost-sharing Tier 1 (Preferred Generic Drugs)	**25%** coinsurance	**25%** coinsurance	**25%** coinsurance
Cost-sharing Tier 2 (Generic Drugs)	**25%** coinsurance	**25%** coinsurance	**25%** coinsurance
Cost-sharing Tier 3 (Preferred Brand Drugs) (Insulin)	**25%** coinsurance 30-100-day supply of each covered insulin product is **25%** coinsurance of the total cost, but no more than **$35 monthly.**	**25%** coinsurance 30-100-day supply of each covered insulin product is **25%** coinsurance of the total cost, but no more than **$35 monthly.**	**25%** coinsurance 31-day supply of each covered insulin product is **25%** coinsurance of the total cost, but no more than **$35 monthly.**
Cost-sharing Tier 4 (Non-Preferred Drugs)	**25%** coinsurance	**25%** coinsurance	**25%** coinsurance

	A network pharmacy A 30-day supply or up to a 100-day supply for **Tiers 1-3 and Tier 6**; A 30-day supply or up to a 90-day supply for **Tier 4**; A 30-day supply only for **Tier 5**	**Our plan's mail-order service** A 30-day supply or up to a 100-day supply for **Tiers 1-3 and Tier 6**; A 30-day supply or up to a 90-day supply for **Tier 4**; A 30-day supply only for **Tier 5**	**A network long-term care pharmacy** A 31-day supply **only** for long-term care for **Tiers 1-6** Coverage is limited to certain cases. Refer to **Chapter 5** of this *Evidence of Coverage* for details.
Cost-sharing Tier 5 (Specialty Drugs) 30-day supply **only** for **Tier 5**	**25%** coinsurance	**25%** coinsurance	**25%** coinsurance
Cost-sharing Tier 6 (Select Care Drugs)	**$0** copay	**$0** copay	**$0** copay

For information about which pharmacies can give you long-term supplies, refer to our *Provider and Pharmacy Directory*.

D4. End of the Initial Coverage Stage

The Initial Coverage Stage ends when your total out-of-pocket costs reach **$2,400**. At that point, the Catastrophic Coverage Stage begins. We cover all your drug costs from then until the end of the year.

Your EOB helps you keep track of how much you've paid for your drugs during the year. We let you know if you reach the **$2,400** limit. Many people don't reach it in a year.

E. Stage 2: The Catastrophic Coverage Stage

When you reach the out-of-pocket limit of **$2,400** for your drugs, the Catastrophic Coverage Stage begins. You stay in the Catastrophic Coverage Stage until the end of the calendar year. During this stage, you pay nothing for your Part D covered drugs.

F. Your drug costs if your doctor prescribes less than a full month's supply

Usually, you pay a copay to cover a full month's supply of a covered drug. However, your doctor can prescribe less than a month's supply of drugs.

- There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you're trying a drug for the first time).
- If your doctor agrees, you don't pay for the full month's supply for certain drugs.

When you get less than a month's supply of a drug, the amount you pay is based on the number of days of the drug that you get. We 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 get.

- **Here's an example:** Let's say the copay for your drug for a full month's supply (a 30-day supply) is $1.35. This means that the amount you pay for your drug is less than $0.05 per day. If you get a seven days' supply of the drug, your payment is less than $.05 per day multiplied by seven days, for a total payment less than $0.35.
- Daily cost-sharing allows you to make sure a drug works for you before you pay for an entire month's supply.
- You can also ask your provider to prescribe less than a full month's supply of a drug to help you:
    - Better plan when to refill your drugs
    - Coordinate refills with other drugs so you can take fewer trips to the pharmacy

G. What you pay for Part D vaccines

Important message about what you pay for vaccines: Some vaccines are considered medical benefits and are covered under Medicare Part B. Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in our *Drug List*. Our plan covers most adult Medicare Part D vaccines at no cost to you. Refer to our 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 Medicare Part D vaccines:

1. The first part is for the cost of the vaccine itself.
2. The second part is for the cost of giving you the vaccine. For example, sometimes you may get the vaccine as a shot given to you by your doctor.

G1. What you need to know before you get a vaccine

We recommend that you call Member Service if you plan to get a vaccine.

- We can tell you about how our plan covers your vaccine and explain your share of the cost.
- We can tell you how to keep your costs down by using network pharmacies and providers. Network pharmacies and providers agree to work with our plan.

G2. What you pay for a vaccine covered by Medicare Part D

What you pay for a vaccine depends on the type of vaccine (what you're being vaccinated for).

- Some vaccines are considered health benefits rather than drugs. These vaccines are covered at no cost to you. To learn about coverage of these vaccines, refer to the Benefits Chart in **Chapter 4** of this *Evidence of Coverage*.
- Other vaccines are considered Medicare Part D drugs. You can find these vaccines on our plan's *Drug List*. You may have to pay a copay for Medicare Part D vaccines. If the vaccine is recommended for adults by an organization called the **Advisory Committee on Immunization Practices (ACIP)** then the vaccine will cost you nothing.

Here are three common ways you might get a Medicare Part D vaccine.

1. You get the Medicare Part D vaccine and your shot at a network pharmacy.
   - For most adult Part D vaccines, you'll pay nothing.
   - For other Part D vaccines, you pay a copay for the vaccine.
2. You get the Medicare Part D vaccine at your doctor's office, and your doctor gives you the shot.
   - You pay a copay to the doctor for the vaccine.
   - Our plan pays for the cost of giving you the shot.
   - The doctor's office should call our plan in this situation so we can make sure they know you have to pay for the vaccine.
3. You get the Medicare Part D vaccine medication at a pharmacy, and you take it to your doctor's office to get the shot.
   - For most adult Part D vaccines, you'll pay nothing for the vaccine itself.

This section is continued on next page

- For other Part D vaccines, you pay a copay for the vaccine.
- Our plan pays for the cost of giving you the shot.

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 got for covered services or drugs

Introduction

This chapter tells you how and when to send us a bill to ask for payment. It also tells you how to make an appeal if you don't agree with a coverage decision. Key terms and their definitions appear in alphabetical order in the last chapter of this *Evidence of Coverage*.

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A. Asking us to pay for your services or drugs

Our network providers must bill the plan for your covered services and drugs after you get them. A network provider is a provider who works with the health plan.

We don't allow BlueCare Plus Choice providers to bill you for these services or drugs. We pay our providers directly, and we protect you from any charges.

If you get a bill for the full cost of health care or drugs, don't pay the bill and send the bill to us. To send us a bill, refer to **Chapter 7, Section B** of this *Evidence of Coverage*.

- If we cover the services or drugs, we'll pay the provider directly.
- If we cover the services or drugs and you already paid more than your share of the cost, it's your right to be paid back.
    - If you paid for services covered by Medicare, we'll pay you back.
    - If you paid for services covered by TennCare we can't pay you back, but the provider will. Member Service can help you contact the provider's office. Refer to the bottom of the page for the Member Service phone number.
- If we don't cover the services or drugs, we'll tell you.

Contact Member Service if you have any questions. If you don't know what you should've paid, or if you get a bill and you don't know what to do about it, we can help. You can also call if you want to tell us information about a request for payment you already sent to us.

Examples of times when you may need to ask us to pay you back or to pay a bill you got include:

1. **When you get emergency or urgently needed health care from an out-of-network provider**

   Ask the provider to bill us.

   - If you pay the full amount when you get the care, ask us to pay you back for our share of the cost. Send us the bill and proof of any payment you made.
   - You may get a bill from the provider asking for payment that you think you don't owe. Send us the bill and proof of any payment you made.
       - If the provider should be paid, we'll pay the provider directly.

This section is continued on next page

- If you already paid more than your share of the cost for the Medicare service, we'll figure out how much you owed and pay you back for our share of the cost.

2. When a network provider sends you a bill

Network providers must always bill us. It's important to show your Member ID Card when you get any services or prescriptions. But sometimes they make mistakes and ask you to pay for your services or more than your share of the costs. **Call Member Service** at the number at the bottom of this page **if you get any bills.**

- As a plan member, you only pay the copay when you get services we cover. We don't allow providers to bill you more than this amount. This is true even if we pay the provider less than the provider charged for a service. Even if we decide not to pay for some charges, you still don't pay them.
- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We'll contact the provider directly and take care of the problem.
- If you already paid a bill from a network provider for Medicare-covered services but feel you paid too much, send us the bill and proof of any payment you made. We'll pay you back for your covered services.

3. If you're retroactively enrolled in our plan

Sometimes your enrollment in the plan can be retroactive. (This means that the first day of your enrollment has passed. It may have even been last year.)

- If you were enrolled retroactively and you paid a bill after the enrollment date, you can ask us to pay you back.
- Send us the bill and proof of any payment you made.

4. When you use an out-of-network pharmacy to fill a prescription

If you use an out-of-network pharmacy, you pay the full cost of your prescription.

- In only a few cases, we'll cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back for our share of the cost.
- Refer to **Chapter 5** of this *Evidence of Coverage* to learn more about out-of-network pharmacies.

This section is continued on next page

- We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount that we'd pay at an in-network pharmacy.

5. When you pay the full prescription cost because you don't have your Member ID Card with you

If you don't have your Member ID Card with you, you can ask the pharmacy to call us or look up your plan enrollment information.

- If the pharmacy can't get the information right away, you may have to pay the full prescription cost yourself or return to the pharmacy with your Member ID Card.
- Send us a copy of your receipt when you ask us to pay you back for our share of the cost.
- We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

6. When you pay the full prescription cost for a drug that's not covered

You may pay the full prescription cost because the drug isn't covered.

- The drug may not be on our *List of Covered Drugs* (*Drug List*) on our website, or it may have a requirement or restriction that you don't know about or don't think applies to you. If you decide to get the drug, you may need to pay the full cost.
    - If you don't pay for the drug but think we should cover it, you can ask for a coverage decision (refer to **Chapter 9** of this *Evidence of Coverage*).
    - If you and your doctor or other prescriber think you need the drug right away, (within 24 hours), you can ask for a fast coverage decision (refer to **Chapter 9** of this *Evidence of Coverage*).
- Send us a copy of your receipt when you ask us to pay you back. In some cases, we may need to get more information from your doctor or other prescriber to pay you back for our share of the cost of the drug. We may not pay you back the full cost you paid if the price you paid is higher than our negotiated price for the prescription.

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

If we deny your request for payment, you can appeal our decision. To learn how to make an appeal, refer to **Chapter 9** of this *Evidence of Coverage*.

B. Sending us a request for payment

Send us your bill and proof of any payment you made for Medicare services. Proof of payment can be a copy of the check you wrote or a receipt from the provider. **It's a good idea to make a copy of your bill and receipts for your records.** You must send your medical information to us within twelve months of the date you received the service, item, or drug. Pharmacy requests must be submitted within thirty-six months from the received date of the drug.

To make sure you give us all the information we need to decide, you can fill out our claim form to ask for payment.

- You aren't required to use the form, but it helps us process the information faster. The following information is required for a decision: Member ID number, Member Name, National Provider Identifier (NPI) number, Provider Name, Date(s) of Service, Procedure Code, itemization of the charge for each service, and proof of payment.
- You can get the form on our website (bluecareplus.bcbst.com), or you can call Member Service and ask for the form.

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

- **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

C. Coverage decisions

When we get your request for payment, we make a coverage decision. This means that we decide if our plan covers your service, item, or drug. We also decide the amount of money, if any, you must pay.

- We'll let you know if we need more information from you.
- If we decide that our plan covers the service, item, or drug and you followed all the rules for getting it, we'll pay our share of the cost for it. If you already paid for the service or drug, we'll mail you a check for our share of the cost. If you paid the full cost of a drug, you might not be reimbursed the full amount you paid (for example, if you got a drug at an out-of-network pharmacy or if the cash price you paid is higher than our negotiated price). If you haven't paid, we'll pay the provider directly.

Chapter 3 of this Evidence of Coverage explains the rules for getting your services covered. **Chapter 5** of this Evidence of Coverage explains the rules for getting your Medicare Part D drugs covered.

- If we decide not to pay for our share of the cost of the service or drug, we'll send you a letter with the reasons. The letter also explains your rights to make an appeal.
- To learn more about coverage decisions, refer to **Chapter 9, Section E1** of the *Evidence of Coverage.*

D. Appeals

If you think we made a mistake in turning down your request for payment, you can ask us to change our decision. This is called "making an appeal." You can also make an appeal if you don't agree with the amount we pay.

The formal appeals process has detailed procedures and deadlines. To learn more about appeals, refer to **Chapter 9** of this *Evidence of Coverage:*

- To make an appeal about getting paid back for a health care service, refer to **Section F**.
- To make an appeal about getting paid back for a drug, refer to **Section G**.

Chapter 8: Your rights and responsibilities

Introduction

This chapter includes your rights and responsibilities as a member of our plan. We must honor your rights. Key terms and their definitions appear in alphabetical order in the last chapter of this *Evidence of Coverage*.

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A. Your right to get services and information in a way that meets your needs

We must ensure **all** services, both clinical and non-clinical, are provided to you in a culturally competent and accessible manner including for those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. We must also tell you about our plan's benefits and your rights in a way that you can understand. We must tell you about your rights each year that you're in our plan.

- To get information in a way that you can understand, call Member Service. Our plan has free interpreter services available to answer questions in different languages.
- Our plan can also give you materials in languages other than English including Spanish and Arabic and in formats such as large print, braille, or audio. To get materials in one of these alternative formats, please call Member Service or write to BlueCare Plus Tennessee, 1 Cameron Hill Circle, Suite 0039, Chattanooga, TN 37402
- Members can call Member Service at the toll-free number at the bottom of this page to request needed materials in their preferred language or format. If you would like to receive these materials in your preferred language or format annually, please let us know when you make your request. We will document your preferences and send you these materials annually. If you would like to stop receiving these materials annually, please call us at the toll-free number at the bottom of this page.
- If English isn't your first language, you can ask for an interpreter when you get your care. This is a free service for you. **Before your appointment, call us or your provider** so you can get help with language services.
- You can also check in our Provider Directory to find doctors who speak other languages. You can access our online Provider Directory for the most up to date information at bluecareplus.bcbst.com. Our plan has free interpreter services available to answer questions from non-English speaking members.
- You can also get free help to communicate with your doctor like a sign language interpreter, writing notes, or a story board. **Before your appointment, call us or your provider** to get this help.
- Si el inglés no es su primer idioma, puede pedir un intérprete para sus consultas. Éste es un servicio gratuito para usted. **Antes de su cita, llámenos o llame a su proveedor** para que pueda recibir ayuda con servicios lingüísticos.

This section is continued on next page

- También puede consultar nuestro Directorio de Proveedores para buscar médicos que hablan otros idiomas
- También puede recibir ayuda gratuita para comunicarse con su doctor, como un intérprete de lenguaje de señas, escribir notas o un guión gráfico. **Antes de su cita, llámenos o lláme a su proveedor** para recibir esta ayuda.

If you have trouble getting information from our plan because of language problems or a disability and you want to file a complaint, call:

- Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- TennCare, Office of Civil Rights Compliance at 1-855-857-1673 (TRS 711) To file a complaint or learn more about your rights visit www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html.
- U.S. Department of Health & Human Services Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697. To file a complaint or learn more about your rights visit: www.hhs.gov/ocr/complaints/index.html.

B. Our responsibility for your timely access to covered services and drugs

You have rights as a member of our plan.

- You have the right to choose a primary care provider (PCP) in our network. A network provider is a provider who works with us. You can find more information about what types of providers may act as a PCP and how to choose a PCP in **Chapter 3** of this *Evidence of Coverage*.
    - Call Member Service or go to the *Provider and Pharmacy Directory* to learn more about network providers and which doctors are accepting new patients.
- We **don't** require you to get referrals.
- You have the right to get covered services from network providers within a reasonable amount of time.
    - This includes the right to get timely services from specialists.
    - If you can't get services within a reasonable amount of time, we must pay for out-of-network care.

This section is continued on next page

- You have the right to get emergency services or care that's urgently needed without prior authorization (PA).
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can use an out-of-network provider. To learn about out-of-network providers, refer to **Chapter 3** of this *Evidence of Coverage*.

Chapter 9 of this Evidence of Coverage tells what you can do if you think you aren't getting your services or drugs within a reasonable amount of time. It also tells what you can do if we denied coverage for your services or drugs and you don't agree with our decision.

C. Our responsibility to protect your personal health information (PHI)

We protect your PHI as required by federal and state laws.

Your PHI includes the personal information you gave us when you enrolled in our plan. It also includes your medical records and other medical and health information.

You have rights when it comes to your information and controlling how your PHI is used. We can give you a written notice that tells about these rights and explains how we protect the privacy of your PHI. The notice is called the "Notice of Privacy Practice." You can also view the Notice of Privacy Practice on our website at bluecareplus.bcbst.com/docs/privacy_policy.pdf. For more information, please call Member Service at 1-800-332-5762, TTY 711.

C1. How we protect your PHI

We make sure that no unauthorized people look at or change your records.

Except for the cases noted below, we don't give your PHI to anyone not providing your care or paying for your care. If we do, we must get written permission from you first. You, or someone legally authorized to make decisions for you, can give written permission.

Sometimes we don't need to get your written permission first. These exceptions are allowed or required by law:

- We must release PHI to government agencies checking on our plan's quality of care.
- We must release PHI by court order.
- We must give Medicare your PHI including information about your Medicare Part D drugs. If Medicare releases your PHI for research or other uses, they do it according to federal laws. TennCare exchanges PHI under restricted and limited use to process and pay claims, in accordance with federal regulations.

C2. Your right to look at your medical records

- You have the right to look at your medical records and to get a copy of your records. We may charge you a fee for making a copy of your medical records.
- You have the right to ask us to update or correct your medical records. If you ask us to do this, we work with your health care provider to decide if changes should be made.
- You have the right to know if and how we share your PHI with others for any purposes that aren't routine.

If you have questions or concerns about the privacy of your PHI, call Member Service.

D. Our responsibility to give you information

As a member of our plan, you have the right to get information from us about our plan, our network providers, and your covered services.

If you don't speak English, we have interpreter services to answer questions you have about our plan. To get an interpreter, call Member Service. This is a free service to you. Some plan materials are available for free in Spanish and Arabic upon request. We can also give you information in large print, braille, or audio. If you want information about any of the following, call Member Service:

- How to choose or change plans
- Our plan, including:
    - financial information
    - how plan members have rated us
    - the number of appeals made by members
    - how to leave our plan
- Our network providers and our network pharmacies, including:
    - how to choose or change primary care providers
    - qualifications of our network providers and pharmacies
    - how we pay providers in our network
- Covered services and drugs, including:

This section is continued on next page

  - services (refer to **Chapters 3 and 4** of this *Evidence of Coverage*) and drugs (refer to **Chapters 5 and 6** of this *Evidence of Coverage*) covered by our plan
  - limits to your coverage and drugs
  - rules you must follow to get covered services and drugs
- Why something isn't covered and what you can do about it (refer to **Chapter 9** of this *Evidence of Coverage*), including asking us to:
  - put in writing why something isn't covered
  - change a decision we made
  - pay for a bill you got

E. Inability of network providers to bill you directly

Doctors, hospitals, and other providers in our network can't make you pay for covered services. They also can't balance bill or charge you if we pay less than the amount the provider charged. To learn what to do if a network provider tries to charge you for covered services, refer to **Chapter 7** of this Evidence of Coverage.

F. Your right to leave our plan

No one can make you stay in our plan if you don't want to.

- You have the right to get most of your health care services through Original Medicare or another Medicare Advantage (MA) plan.
- You can get your Medicare Part D drug benefits from a drug plan or from another MA plan.
- Refer to **Chapter 10** of this *Evidence of Coverage*:
  - For more information about when you can join a new MA or drug benefit plan.
  - For information about how you'll get your TennCare (Medicaid) benefits if you leave our plan.

G. Your right to make decisions about your health care

You have the right to full information from your doctors and other health care providers to help you make decisions about your health care.

G1. Your right to know your treatment choices and make decisions

Your providers must explain your condition and your treatment choices in a way that you can understand. You have the right to:

- **Know your choices.** You have the right to be told about all treatment options.
- **Know the risks.** You have the right to be told about any risks involved. We must tell you in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **Get a second opinion.** You have the right to use another doctor before deciding on treatment.
- **Say no.** You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You have the right to stop taking a prescribed drug. If you refuse treatment or stop taking a prescribed drug, we won't drop you from our plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **Ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider denied care that you think you should get.
- **Ask us to cover a service or drug that we denied or usually don't cover.** This is called a coverage decision. **Chapter 9** of this *Evidence of Coverage* tells how to ask us for a coverage decision.

G2. Your right to say what you want to happen if you can't make health care decisions for yourself

Sometimes people can't make health care decisions for themselves. Before that happens to you, you can:

- Fill out a written form **giving someone the right to make health care decisions for you** if you ever can't make decisions for yourself.
- **Give your doctors written instructions** about how to handle your health care if you can't make decisions for yourself, including care you **don't** want.

The legal document you use to give your directions is called an "advance directive." There are different types of advance directives and different names for them. Examples are a living will and a power of attorney for health care.

This section is continued on next page

You aren't required to have an advance directive, but you can. Here's what to do if you want to use an advance directive:

- **Get the form.** You can get the form from your doctor, a lawyer, a social worker or some office supply stores. Pharmacies and provider offices often have the forms. You can find a free form online and download it. You can also contact Member Service to ask for the form.
- **Fill out the form and sign it.** The form is a legal document. Consider having a lawyer or someone else you trust, such as a family member or your PCP, help you complete it.
- **Give copies of the form to people who need to know.** Give a copy of the form to your doctor. You should also give a copy to the person you name to 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're being hospitalized and you have a signed advance directive, **take a copy of it to the hospital**.
    - The hospital will ask if you have a signed advance directive form and if you have it with you.
    - If you don't have a signed advance directive form, the hospital has forms and will ask if you want to sign one.

You have the right to:

- Have your advance directive placed in your medical records.
- Change or cancel your advance directive at any time.

By law, no one can deny you care or discriminate against you based on whether you signed an advance directive. Call Member Service for more information.

G3. What to do if your instructions aren't followed

If you signed an advance directive and you think a doctor or hospital didn't follow the instructions in it, you can make a complaint with the Tennessee Department of Health.

H. Your right to make complaints and ask us to reconsider our decisions

Chapter 9 of this *Evidence of Coverage* tells you what you can do if you have any problems or concerns about your covered services or care. For example, you can ask us to make a coverage decision, make an appeal to change a coverage decision, or make a complaint.

You have the right to get information about appeals and complaints that other plan members have filed against us. Call Member Service to get this information.

H1. What to do about unfair treatment or to get more information about your rights

If you think we treated you unfairly – and it **isn't** about discrimination for reasons listed in **Chapter 11** of this *Evidence of Coverage* – or you want more information about your rights, you can call:

- Member Service.
- TennCare Connect at 1-855-259-0701.
- The Ombudsman Program 1-877-236-0013 or 615-532-3893 (TDD). For more details about this program, refer to **Chapter 2** of this *Evidence of Coverage.*
- Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. (You can also read or download "Medicare Rights & Protections," found on the Medicare website at www.medicare.gov/publications/11534-medicare-rights-and-protections.pdf.)

I. Your responsibilities as a plan member

As a plan member, you have a responsibility to do the things that are listed below. If you have any questions, call Member Service.

- **Read this *Evidence of Coverage*** to learn what our plan covers and the rules to follow to get covered services and drugs. For details about your:
    - Covered services, refer to **Chapters 3 and 4** of this *Evidence of Coverage*. Those chapters tell you what's covered, what isn't covered, what rules you need to follow, and what you pay.

This section is continued on next page

  - Covered drugs, refer to **Chapters 5 and 6** of this *Evidence of Coverage*.

- **Tell us about any other health or drug coverage** you have. We must make sure you use all of your coverage options when you get health care. Call Member Service if you have other coverage.

- **Tell your doctor and other health care providers** that you're a member of our plan. Show your Member ID Card when you get services or drugs.

- **Help your doctors** and other health care providers give you the best care.

  - Give them information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.

  - Make sure your doctors and other providers know about all the drugs you take. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.

  - Ask any questions you have. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you don't understand the answer, ask again.

- **Be considerate.** We expect all plan members to respect the rights of others. We also expect you to act with respect in your doctor's office, hospitals, and other provider offices.

- **Pay what you owe.** As a plan member, you're responsible for these payments:

  - Medicare Part A and Medicare Part B premiums. For most BlueCare Plus Choice members, Medicaid pays for your Medicare Part A premium and for your Medicare Part B premium.

  - For some of your long-term services and supports *or drugs* covered by our plan, you must pay your share of the cost when you get the service *or drug*. This will be a *copayment/copay.* **Chapter 4** tells what you must pay for your long-term services and supports. **Chapter 6** tells what you must pay for your drugs.

  - **If you get any services or drugs that aren't covered by our plan, you must pay the full cost.** (**Note:** If you disagree with our decision to not cover a service or drug, you can make an appeal. Please refer to **Chapter 9, Section E2** to learn how to make an appeal.

This section is continued on next page

- **Tell us if you move.** If you plan to move, tell us right away. Call Member Service.
    - **If you move outside of our service area, you can't stay in our plan.** Only people who live in our service area can be members of this plan. **Chapter 1** of this *Evidence of Coverage* tells about our service area.
    - We can help you find out if you're moving outside our service area. We can tell you if we have a plan in your new area.
    - Tell Medicare and TennCare your new address when you move. Refer to **Chapter 2** of this *Evidence of Coverage* for phone numbers for Medicare and TennCare.
    - **If you move and stay in our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.
    - **If you move, tell Social Security (or the Railroad Retirement Board).**
- **Call Member Service for help if you have questions or concerns.**

I1. Estate Recovery

Estate Recovery is the way TennCare collects money from the estates of people who received TennCare long-term services and supports and passed away. TennCare is required by federal law to recoup (get back) these payments after the death of the member. This is referred to as "estate recovery." The kinds of care that must be paid back are listed below.

Your "estate" is the property, belongings, money, and other assets that you own at the time of your death. Estate recovery is using the value of your property after you die to pay TennCare back for care you got. 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 what was paid for. 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 allowed to get 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 allowed to collect $50,000. TennCare can't ask your family to pay for the remaining amount.

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I2. Who has to pay TennCare back for their care?

TennCare **must** ask to be paid back for money it spent on your care if you're age 55 and older and got care in a nursing home or intermediate care facility for individuals with intellectual disabilities (ICF/IID), home care—called home and community-based services or HCBS, home health or private duty nursing, and there are no waivers or undue hardships that apply.

I3. 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 drugs related to your long-term care services.

I4. How much will your estate 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 (like a nursing facility or other entity providing long-term care in the home/community) for the person's care. Under federal law, TennCare must ask to be paid back the premium payment it made to the insurance company for you.

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 be different depending on what type of long-term care you have and the part of the state you live in.

I5. TennCare may not have to get the money back from your estate if:

- You don't 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.

I6. What if I sell or give away my home while I'm receiving TennCare?

Then you must tell TennCare that you sold or gave away your home, which can affect your TennCare eligibility. You must also tell TennCare about any transfer made five years before you received TennCare. If you don't tell them about the transfer, they can have the transfer set aside and ask to be paid back from your estate, family member(s), or any other person that participated in the transfer.

I7. What are the reasons that TennCare can delay estate recovery?

In some situations, estate recovery is delayed or "deferred," which means that TennCare won't go after your estate until a later date. TennCare defers estate recovery for an individual's estate when:

- You have a surviving husband or wife. TennCare can't collect money from your estate until the death of your husband or wife.
- You have a child that's under the age of 21. TennCare can't collect money from your estate until your child is over the age of 21.
- You have a blind or permanently disabled child. TennCare can't 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. TennCare can't collect money from your estate until your son or daughter no longer lives at the property.
- 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, like a family farm.

I8. 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:

- Get the Request for Release online at: www.tn.gov/content/dam/tn/tenncare/documents/releaseform.pdf
- Get the Request for Release from the Probate Court Clerk's office by asking for a "Request for Release from Estate Recovery".
- **Get the Request for Release from TennCare by sending an email, letter, or fax to:**

Email: RFR.Tenncare@tn.gov**.**

This section is continued on next page

Mail to:

Division of TennCare

Estate Recovery Unit

310 Great Circle Rd.

4th Floor

Nashville, TN 37243

Fax: 615-413-1941

I9. What if you do have to pay TennCare money from your estate?

Your family or representative has many options if there's a TennCare claim:

- They can pay the TennCare claim from your remaining belongings.
- 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's anything left. Your family or TennCare can request that an administrator be appointed for your estate.
- They may apply for a deferral of Estate Recovery.

Do you have questions or need help with estate recovery?

EMAIL: Estate.recovery@tn.gov

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	MAIL: Division of TennCare Estate Recovery Unit 310 Great Circle Road, 3W Nashville, TN 37243
	FAX: 615-413-1941
	CALL: 844-629-0941

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Introduction

This chapter has information about your rights. Read this chapter to find out what to do if:

- You have a problem with or complaint about our plan.
- You need a service, item, or medication that our plan said it won't pay for.
- You disagree with a decision our plan made about your care.
- You think your covered services are ending too soon.

This chapter is in different sections to help you easily find what you're looking for. **If you have a problem or concern, read the parts of this chapter that apply to your situation.**

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A. What to do if you have a problem or concern

This chapter explains how to handle problems and concerns. The process you use depends on the type of problem you have. Use one process for **coverage decisions and appeals** and another for **making complaints** (also called grievances).

To ensure fairness and promptness, each process has a set of rules, procedures, and deadlines that we and you must follow.

A1. About the legal terms

There are legal terms in this chapter for some rules and deadlines. Many of these terms can be hard to understand, so we use simpler words in place of certain legal terms when we can. We use abbreviations as little as possible.

For example, we say:

- “Making a complaint” instead of “filing a grievance”
- “Coverage decision” instead of “organization determination”, “benefit determination”, “at-risk determination”, or “coverage determination”
- “Fast coverage decision” instead of “expedited determination”
- “Independent Review Organization” (IRO) instead of “Independent Review Entity” (IRE)

Knowing the proper legal terms may help you communicate more clearly, so we provide those too.

B. Where to get help

B1. For more information and help

Sometimes it’s confusing to start or follow the process for dealing with a problem. This can be especially true if you don’t feel well or have limited energy. Other times, you may not have the information you need to take the next step.

Help from our plan

You can call our plan at the numbers at the bottom of the page to help deal with a problem or answer questions.

This section is continued on next page

Help from the Tennessee State Health Insurance Assistance Program (TN SHIP)

You can call the TN SHIP program at 1-877-801-0044, TTY 1-800-848-0299. You can also review their website at www.tnmedicarehelp.com. TN SHIP counselors can answer your questions and help you understand what to do about your problem. TN SHIP isn't connected with us or with any insurance company or health plan. TN SHIP has trained counselors in every county, and services are free.

Help and information from Medicare

For more information and help, you can contact Medicare. Here are two ways to get help from Medicare:

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

Help and information from TennCare

Call TennCare 1-855-259-0701 or 1-800-848-0298 (TTY).

C. Understanding Medicare and TennCare complaints and appeals in our plan

You have Medicare and TennCare. Information in this chapter applies to **all** your Medicare and TennCare benefits. This is sometimes called an "integrated process" because it combines, or integrates, Medicare and TennCare processes.

Sometimes Medicare and TennCare processes can't be combined. In those situations, you use one process for a Medicare benefit and another process for a TennCare benefit. **Section F4** explains these situations.

D. Problems with your benefits

If you have a problem or concern, read the parts of this chapter that apply to your situation. The following chart helps you find the right section of this chapter for problems or complaints.

Is your problem or concern about your benefits or coverage? This includes problems about whether particular medical care (medical items, services and/or Part B drugs) are covered or not, the way they're covered, and problems about payment for medical care.	
Yes. My problem is about benefits or coverage. Refer to **Section E**, "Coverage decisions and appeals."	**No.** My problem isn't about benefits or coverage. Refer to **Section K**, "How to make a complaint."

E. Coverage decisions and appeals

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

E1. Coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services or drugs. For example, if your plan network provider refers you to a medical specialist outside of the network, this referral is considered a favorable decision unless either your network provider can show that you received a standard denial notice for this medical specialist, or the referred service is never covered under any condition (refer to **Chapter 4**, Section H of this *Evidence of Coverage*).

This section is continued on next page

You or your doctor can also contact us and ask for a coverage decision. You or your doctor may be unsure whether we cover a specific medical service or if we may refuse to provide medical care you think you need. **If you want to know if we'll cover a medical service before you get it, you can ask us to make a coverage decision for you.**

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

E2. Appeals

If we make a coverage decision and you aren't satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we made.

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 if we followed all rules properly. Different reviewers than those who made the original unfavorable decision handle your appeal.

When we complete the review, we give you our decision. Under certain circumstances, explained later in this chapter **Section F2**, you can ask for an expedited or "fast coverage decision" or "fast appeal" of a coverage decision.

If we say **No** to part or all of what you asked for, we'll send you a letter. If your problem is about coverage of a Medicare medical care, the letter will tell you that we sent your case to the Independent Review Organization (IRO) for a Level 2 Appeal. If your problem is about coverage of a Medicare Part D or Medicaid service or item, the letter will tell you how to file a Level 2 Appeal yourself. Refer to **Section F4** for more information about Level 2 Appeals. If your problem is about coverage of a service or item covered by both Medicare and Medicaid, the letter will give you information regarding both types of Level 2 Appeals.

If you aren't satisfied with the Level 2 Appeal decision, you may be able to go through additional levels of appeal.

E3. Help with coverage decisions and appeals

You can ask for help from any of the following:

- **Member Service** at the numbers at the bottom of the page.
- Tennessee State Health Insurance Assistance Program (TN SHIP) at 1-877-801-0044.
- **Your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.

This section is continued on next page

- **A friend or family member**. You can name another person to act for you as your "representative" and ask for a coverage decision or make an appeal.
- **A lawyer**. You have the right to a lawyer, but **you aren't required to have a lawyer** to ask for a coverage decision or make an appeal.
    - Call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify.

Fill out the Appointment of Representative form if you want a lawyer or someone else to act as your representative. The form gives someone permission to act for you.

Call Member Service at the numbers at the bottom of the page and ask for the "Appointment of Representative" form. You can also get the form by visiting www.cms.gov/medicare/cms-forms/cms-forms/downloads/cms1696.pdf or on our website at bluecareplus.bcbst.com. **You must give us a copy of the signed form.**

E4. Which section of this chapter can help you

There are four situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give details for each one in a separate section of this chapter. Refer to the section that applies:

- **Section F**, "Medical care" *F2, Asking for a coverage decision*
- **Section G**, "Medicare Part D drugs" *G1, Medicare Part D coverage decisions and appeals*
- **Section H**, "Asking us to cover a longer hospital stay" *H1, Learning about your Medicare Rights*
- **Section I**, "Asking us to continue covering certain medical services" *I1, Advance notice before your coverage ends* (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 to use, call Member Service at the numbers at the bottom of the page. You can get free help from your State Health Insurance Assistance Program, (TN SHIP) at 1-877-801-0044. Your doctor or other health care provider can make a request for you.

F. Medical care

This section explains what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care.

This section is about your benefits for medical care that's described in **Chapter 4** of this *Evidence of Coverage* in the benefits chart. In some cases, different rules may apply to a Medicare Part B drug. When they do, we explain how rules for Medicare Part B drugs differ from rules for medical services and items.

F1. Using this section

This section explains what you can do in any of the five following situations:

1. You think we cover medical care you need but aren't getting.

   What you can do: You can ask us to make a coverage decision. Refer to **Section F2**.

2. We didn't approve the medical care your doctor or other health care provider wants to give you, and you think we should.

   What you can do: You can appeal our decision. Refer to **Section F3**.

3. You got medical care that you think we cover, but we won't pay.

   What you can do: You can appeal our decision not to pay. Refer to **Section F5**.

4. You got and paid for medical care you thought we cover, and you want us to pay you back.

   What you can do: You can ask us to pay you back. Refer to **Section F5**.

5. We reduced or stopped your coverage for certain medical care, and you think our decision could harm your health.

   What you can do: You can appeal our decision to reduce or stop the medical care. Refer to **Section F4**.

   - If the coverage is for hospital care, home health care, skilled nursing facility care, or CORF services, special rules apply. Refer to **Section H, H1** *Learning about your Medicare rights* or **Section I, I1** *Advance notice before your coverage ends* to find out more.

   - For all other situations involving reducing or stopping your coverage for certain medical care, use this section (**Section F**) as your guide.

F2. Asking for a coverage decision

> When a coverage decision involves your medical care, it's called an **integrated organization determination**.

You, your doctor, or your representative can ask us for a coverage decision by:

- Calling: **1-800-332-5762**, TTY **711**. Calls to this number are **free**. From **Oct. 1 to Mar. 31**, you can call us seven days a week from 8 a.m. to 9 p.m. ET. From **April 1 to Sept. 30**, you can call us Monday through Friday from 8 a.m. to 9 p.m. ET.
- Faxing: 866-325-6698.
- Writing: BlueCare Plus Tennessee, 1 Cameron Hill Circle, Suite 0002, Chattanooga, TN 37402-0002.

Standard coverage decision

When we give you our decision, we use the "standard" deadlines unless we agree to use the "fast" deadlines. A standard coverage decision means we give you an answer within:

- **Seven calendar days** after we get your request **for a medical service or item that's subject to our prior authorization rules**
- **14 calendar days** after we get your request **for all other medical services or items**
- **72 hours** after we get your request for a **Medicare Part B drug**

For a medical item or service, we can take up to 14 more calendar days if you ask for more time or if we need more information that may benefit you (such as medical records from out-of-network providers). If we take extra days to make the decision, we'll tell you in writing. **We can't take extra days if your request is for a Medicare Part B drug.**

If you think we **shouldn't** take extra days, you can make a "fast complaint" about our decision to take extra days. When you make a fast complaint, we give you an answer to your complaint within 24 hours. The process for making a complaint is different from the process for coverage decisions and appeals. For more information about making a complaint, including a fast complaint, refer to **Section K, K1**. *What kinds of problems should be complaints*.

Fast coverage decision

> The legal term for fast coverage decision is **expedited determination**.

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When you ask us to make a coverage decision about your medical care and your health requires a quick response, ask us to make a "fast coverage decision." A fast coverage decision means we'll give you an answer within:

- **72 hours** after we get your request **for a medical service or item**.
- **24 hours** after we get your request **for a Medicare Part B drug**.

For a medical item or service, we can take up to 14 more calendar days if we find information that may benefit you is missing (such as medical records from out-of-network providers) or if you need time to get us information for the review. If we take extra days to make the decision, we'll tell you in writing. **We can't take extra time if your request is for a Medicare Part B drug**.

If you think we **shouldn't** take extra days to make the coverage decision, you can make a "fast complaint" about our decision to take extra days. For more information about making a complaint, including a fast complaint, refer to **Section K, K2** *Internal complaints*. We'll call you as soon as we make the decision.

To get a fast coverage decision, you must meet two requirements:

- You're asking for coverage for medical items and/or services that you **didn't get**. You can't ask for a fast coverage decision about payment for items or services you already got.
- Using the standard deadlines **could cause serious harm to your health** or hurt your ability to function.

We automatically give you a fast coverage decision if your doctor tells us your health requires it. If you ask without your doctor's support, we decide if you get a fast coverage decision.

- If we decide that your health doesn't meet the requirements for a fast coverage decision, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
    - We automatically give you a fast coverage decision if your doctor asks for it.

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- How you can file a "fast complaint" about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about making a complaint, including a fast complaint, refer to **Section K, K2** *Internal complaints*.

If we say No to part or all of your request, we send you a letter explaining the reasons.

- If we say **No**, you have the right to make an appeal. If you think we made a mistake, making an appeal is a formal way of asking us to review our decision and change it.
- If you decide to make an appeal, you'll go on to Level 1 of the appeals process (refer to **Section F3,** *Making a Level 1 Appeal*)**.**

In limited circumstances we may dismiss your request for a coverage decision, which means we won't review the request. Examples of when a request will be dismissed include:

- if the request is incomplete,
- if someone makes the request on your behalf but isn't legally authorized to do so, **or**
- if you ask for your request to be withdrawn.

If we dismiss a request for a coverage decision, we'll send you a notice explaining why the request was dismissed and how to ask for a review of the dismissal. This review is called an appeal. Appeals are discussed in the next section.

F3. Making a Level 1 Appeal

To start an appeal related to a denied service or item, or to continue a service or item you're already receiving, you, your doctor, or your representative must contact us. Call us at **1-800-332-5762**, TTY **711**.

Ask for a standard appeal or a fast appeal in writing or by calling us at **1-800-332-5762**, TTY **711**.

- If your doctor or other prescriber asks to continue a service or item you're already getting during your appeal, you may need to name them as your representative to act on your behalf.
- If someone other than your doctor makes the appeal for you, include an Appointment of Representative form authorizing this person to represent you. You can get the form by visiting www.cms.gov/medicare/cms-forms/cms-forms/downloads/cms1696.pdf or on our website at bluecareplus.bcbst.com.

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- We can accept an appeal request without the form, but we can't begin or complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal:
    - We dismiss your request, and
    - We send you a written notice explaining your right to ask the IRO to review our decision to dismiss your appeal.
- You must ask for an appeal within 65 calendar days from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.
- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a fast appeal.

> The legal term for "fast appeal" is "**expedited reconsideration.**"

- If you appeal a decision we made about coverage for care, you and/or your doctor decide if you need a fast appeal.

We automatically give you a fast appeal if your doctor tells us your health requires it. If you ask without your doctor's support, we decide if you get a fast appeal.

- If we decide that your health doesn't meet the requirements for a fast appeal, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
    - We automatically give you a fast appeal if your doctor asks for it.
    - How you can file a "fast complaint" about our decision to give you a standard appeal instead of a fast appeal. For more information about making a complaint, including a fast complaint, refer to **Section K, K2** *Internal complaints.*

If we tell you we're stopping or reducing services or items that you already get, you may be able to continue those services or items during your appeal.

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- If we decide to change or stop coverage for a service or item that you get, we send you a notice before we take action.
- If you disagree with our decision, you can file a Level 1 Appeal.
- We continue covering the service or item if you ask for a Level 1 Appeal within ten calendar days of the date on our letter or by the intended effective date of the action, whichever is later.
    - If you meet this deadline, you'll get the service or item with no changes while your Level 1 appeal is pending.
    - You'll also get all other services or items (that aren't the subject of your appeal) with no changes.
    - If you don't appeal before these dates, then your service or item won't be continued while you wait for your appeal decision.

We consider your appeal and give you our answer.

- When we review your appeal, we take another careful look at all information about your request for coverage of medical care.
- We check if we followed all the rules when we said **No** to your request.
- We gather more information if we need it. We may contact you or your doctor to get more information.

There are deadlines for a fast appeal.

- When we use the fast deadlines, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires it. If we deny a fast appeal we'll give you, your doctor, prescriber, or representative verbal confirmation of the denial.
- 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 need extra days to make the decision, we tell you in writing.
    - If your request is for a Medicare Part B drug, we can't take extra time to make the decision.

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  - If we don't give you an answer within 72 hours or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An IRO then reviews it. The IRO will notify you in writing when it gets your appeal. Later in this chapter **Section F, F4** *Making a Level 2 Appeal*, we tell you about this organization and explain the Level 2 appeals process. If your problem is about coverage of a Medicaid service or item, you can file a Level 2 – Fair Hearing with the state yourself as soon as the time is up. In Tennessee a Fair Hearing is called an appeal.

- **If we say Yes to part or all of your request**, we must authorize or provide the coverage we agreed to provide within 72 hours after we get your appeal.
- **If we say No to part or all of your request**, we send your appeal to the IRO for a Level 2 Appeal.

There are deadlines for a standard appeal.

- When we use the standard deadlines, we must give you our answer **within 30 calendar days** after we get your appeal for coverage for services you didn't get.
- If your request is for a Medicare Part B drug you didn't get, we give you our answer **within seven calendar days** after we get your appeal or sooner if your health requires it.
- 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 need extra days to make the decision, we tell you in writing.
  - If your request is for a Medicare Part B drug, we can't take extra time to make the decision.
  - If you think we **shouldn't** take extra days, you can file a fast complaint about our decision. When you file a fast complaint, we give you an answer within 24 hours. For more information about making complaints, including fast complaints, refer to **Section K**.
  - If we don't give you an answer by the deadline or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An IRO then reviews it. The IRO will notify you in writing when it gets your appeal. Later in this chapter **Section F, F4** *Making a Level 2 Appeal*, we tell you about this organization and explain the Level 2 appeals process. If your problem is about

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coverage of a Medicaid service or item, you can file a Level 2 – Fair Hearing with the state yourself as soon as the time is up. In Tennessee a Fair Hearing is called an appeal.

If we say Yes to part or all of your request, we must authorize or provide the coverage we agreed to provide within 30 calendar days, or **within seven calendar days** if your request is for a Medicare Part B drug, after we get your appeal.

If we say **No** to part or all of your request, **you have additional appeal rights:**

- If we say **No** to part or all of what you asked for, we send you a letter.
- If your problem is about coverage of a Medicare service or item, the letter tells you that we sent your case to the IRO for a Level 2 Appeal. The IRO will notify you in writing when it gets your appeal.
- If your problem is about coverage of a TennCare service or item, the letter tells you how to file a Level 2 Appeal yourself.

F4. Making a Level 2 Appeal

If we say **No** to part or all of your Level 1 Appeal, we send you a letter. This letter tells you if Medicare, TennCare, or both programs usually cover the service or item.

- If your problem is about a service or item that Medicare usually covers, we 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 TennCare usually covers, you can file a Level 2 Appeal yourself. The letter tells you how to do this. We also include more information later in this chapter **Section F, F4** *Making a Level 2 Appeal*.
- If your problem is about a service or item that **both Medicare and TennCare** may cover, you automatically get a Level 2 Appeal with the IRO. You can also ask for a Fair Hearing with the state.

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. Refer to **Section F3,** *Making a Level 1 Appeal* for information about continuing your benefits during Level 1 Appeals.

- If your problem is about a service usually covered only by Medicare, your benefits for that service don't continue during the Level 2 appeals process with the IRO.

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- If your problem is about a service usually covered only by TennCare, your benefits for that service continue if you submit a Level 2 Appeal within ten calendar days after getting our decision letter.

When your problem is about a service or item Medicare usually covers

The IRO reviews your appeal. It's an independent organization hired by Medicare.

> The formal name for the **Independent Review Organization** (IRO) is the Independent Review Entity, sometimes called the **IRE**.

- This organization isn't connected with us and isn't a government agency. Medicare chose the company to be the IRO, and Medicare oversees their work.
- We send information about your appeal (your "case file") to this organization. You have the right to a free copy of your case file.
- You have a right to give the IRO additional information to support your appeal.
- Reviewers at the IRO take a careful look at all information related to your appeal.

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

- If you had a fast appeal to us at Level 1, you automatically get a fast appeal at Level 2. The IRO must give you an answer to your Level 2 Appeal **within 72 hours** of getting your appeal.
- If your request is for a medical item or service and the IRO needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The IRO can't take extra time to make a decision if your request is for a Medicare Part B drug.

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

- If you had a standard appeal to us at Level 1, you automatically get a standard appeal at Level 2.
- If your request is for a medical item or service, the IRO must give you an answer to your Level 2 Appeal **within 30 calendar days** of getting your appeal.
- If your request is for a Medicare Part B drug, the IRO must give you an answer to your Level 2 Appeal **within seven calendar days** of getting your appeal.

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- If your request is for a medical item or service and the IRO needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The IRO can't take extra time to make a decision if your request is for a Medicare Part B drug.

The IRO gives you their answer in writing and explains the reasons.

- **If the IRO says Yes to part or all of a request for a medical item or service,** we must:
  - Authorize the medical care coverage **within 72 hours, or**
  - Provide the service within **14 calendar days** after we get the IRO's decision for **standard requests, or**
  - Provide the service **within 72 hours** from the date we get the IRO's decision for **expedited requests**.
- **If the IRO says Yes to part or all of a request for a Medicare Part B drug, we must authorize or provide the Medicare Part B drug under dispute:**
  - **within 72 hours** after we get the IRO's decision for **standard requests, or**
  - **within 24 hours** from the date we get the IRO's decision for **expedited requests**.
- **If the IRO says No to part or all of your appeal,** it means they agree that we shouldn't approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."
  - 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.
  - If your Level 2 Appeal is turned down and you meet the requirements to continue the appeals process, you must decide whether to go on to Level 3 and make a third appeal. The details about how to do this are in the written notice you get after your Level 2 Appeal.
  - An Administrative Law Judge (ALJ) or attorney adjudicator handles a Level 3 Appeal. Refer to **Section J, J1** *Next Steps for Medicare Services and Items* for more information about Level 3, 4, and 5 Appeals.

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When your problem is about a service or item Medicaid usually covers, or that's covered by both Medicare and TennCare

A Level 2 Appeal for services that TennCare usually covers is a Fair Hearing with the state. You must ask for a Fair Hearing in writing or by phone **within 120 calendar days** of the date we sent the decision letter on your Level 1 Appeal. The letter you get from us tells you where to submit your request for a Fair Hearing.

You can file a Level 2 Appeal by calling TennCare Member Medical Appeals at 1-800-878-3192.

- If you have an emergency and your health plan agrees that you do, you will get an **expedited** appeal. An expedited appeal will be decided in about one week. It could take longer if your health plan needs more time to get your medical records.
- If you're already getting care, you may be able to keep getting it during your appeal. To keep getting care during your appeal, **all** of these things must be true:
  - You must appeal by the date your care will stop or change or within ten days of the date on the letter from your health plan (whichever date is later).
  - You must say in your appeal that you want to keep getting the care during the appeal.
  - The appeal must be for the **kind** and **amount** of care you've been getting that has been stopped or changed.
  - You must have a doctor's order for the care (if one is needed).
  - The care must be something that TennCare still covers.

IMPORTANT: What if you want to keep getting care **during** your appeal and you lose your appeal? You may have to pay TennCare back for the care you got during your appeal.

What does TennCare do when you appeal about a health care problem?

- When TennCare gets your appeal, they'll send you a letter that says they got your appeal. If you asked to keep getting your care during your appeal, it will say if you can keep getting your care. If you asked for an emergency appeal, it will say if you can have an emergency appeal.
- If TennCare needs more facts to work your appeal, you'll get a letter that says what facts they still need. You should give TennCare all of the facts that they ask for as soon as possible. If you don't, your appeal may end.

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- TennCare must decide a regular appeal in 90 days. If you have an emergency appeal, they'll try to decide your appeal in about one week (unless they need more time to get your medical records).

What happens at a fair hearing about health care problems?

- Your hearing can be by phone or in person. The different people who may be at your hearing include:
    - An administrative judge
    - A TennCare lawyer
    - A witness for TennCare (someone like a doctor or nurse from TennCare)
- You can talk for yourself. Or, you can bring someone else, like a friend or a lawyer, to talk for you.
- During the hearing, you get to tell the judge facts and proof about your health and medical care. The judge will listen to everyone's side.

The Fair Hearing office gives you their decision in writing and explain the reasons.

- 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 get their decision.
- If the Fair Hearing office says **No** to part or all of your appeal, it means they agree that we shouldn't approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."

If the IRO or Fair Hearing office decision is **No** for all or part of your request, you have additional appeal rights.

If your Level 2 Appeal went to the **IRO**, you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. An ALJ or attorney adjudicator handles a Level 3 Appeal. **The letter you get from the IRO explains additional appeal rights you may have**.

The letter you get from the Fair Hearing office describes the next appeal option.

Refer to **Section J, J3** *Appeal Levels 3, 4 and 5 for Medicare Part D Drug Requests* for more information about your appeal rights after Level 2.

F5. Payment problems

We don't allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You're never required to pay the balance of any bill. The only amount you should be asked to pay is the copay for a service, item or prescription that require a copay.

We can't reimburse you directly for a Medicaid service or item. If you get a bill that's more than your copay, for Medicaid covered services and items, send the bill to us. Don't pay the bill yourself. We'll contact the provider directly and take care of the problem. 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 item.

If you want us to reimburse you for a **Medicare** service or item or you're asking us to pay a health care provider for a Medicaid service or item you paid for, you'll ask us to make this a coverage decision. We'll check if the service or item you paid for is covered and if you followed all the rules for using your coverage. For more information, refer to **Chapter 7** of this *Evidence of Coverage.*

G. Medicare Part D drugs

Your benefits as a member of our plan include coverage for many drugs. Most of these are Medicare Part D drugs. There are a few drugs that Medicare Part D doesn't cover that TennCare may cover. **This section only applies to Medicare Part D drug appeals.** We'll say "drug" in the rest of this section instead of saying "Medicare Part D drug" every time.

To be covered, the drug must be used for a medically accepted indication. That means the drug is approved by the Food and Drug Administration (FDA) or supported by certain medical references. Refer to **Chapter 5** of this Evidence of Coverage for more information about a medically accepted indication.

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G1. Medicare Part D coverage decisions and appeals

Here are examples of coverage decisions you ask us to make about your Medicare Part D drugs:

- You ask us to make an exception, including asking us to:
  - cover a Medicare Part D drug that isn't on our plan's Drug List or
  - set aside a restriction on our coverage for a drug (such as limits on the amount you can get)
- You ask us if a drug is covered for you (such as when your drug is on our plan's Drug List but we must approve it for you before we cover it)

NOTE: If your pharmacy tells you that your prescription can't be filled as written, the pharmacy gives you a written notice explaining how to contact us to ask for a coverage decision.

> An initial coverage decision about your Medicare Part D drugs is called a **"coverage determination."**

- You ask us to pay for a drug you already bought. This is asking for a coverage decision about payment.

If you disagree with a coverage decision we made, you can appeal our decision. This section tells you both how to ask for coverage decisions and how to make an appeal. Use the chart below to help you.

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Which of these situations are you in?			
You need a drug that isn't on our *Drug List* or need us to set aside a rule or restriction on a drug we cover.	You want us to cover a drug on our *Drug List*, and you think you meet plan rules or restrictions (such as getting approval in advance) for the drug you need.	You want to ask us to pay you back for a drug you already got and paid for.	We told you that we won't cover or pay for a drug in the way that you want.
You can ask us to make an exception. (This is a type of coverage decision.)	**You can ask us for a coverage decision.**	**You can ask us to pay you back.** (This is a type of coverage decision.)	**You can make an appeal.** (This means you ask us to reconsider.)
Start with **Section G2**, then refer to **Sections G3 and G4:** **G2**. *Medicare Part D exceptions*, **G3**. *Important things to know about asking for an exception*, **G4.** *Asking for a coverage decision, including an exception*.	Refer to **Section G4:** **G4**. *Asking for a coverage decision, including an exception*	Refer to **Section G4:** **G4**. *Asking for a coverage decision, including an exception*	Refer to **Section G5:** **G5**. *Making a Level 1 Appeal*

G2. Medicare Part D exceptions

If we don't cover a drug in the way you would like, you can ask us to make an "exception." If we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber needs to explain the medical reasons why you need the exception.

> Asking for coverage of a drug not on our Drug List or for removal of a restriction on a drug is sometimes called asking for a **"formulary exception."**
>
> Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **"tiering exception."**

Here are some examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a drug that isn't on our Drug List**
   - If we agree to make an exception and cover a drug that isn't on our Drug List, you pay the copay that applies to the specific tier of the drug.
   - You can't get an exception to the required copay amount for the drug.
2. **Removing a restriction for a covered drug**
   - Extra rules or restrictions apply to certain drugs on our *Drug List* (refer to **Chapter 5** of this *Evidence of Coverage* for more information).
   - Extra rules and restrictions for certain drugs include:

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  - Being required to use the generic version of a drug instead of the brand name drug.
  - Getting our approval in advance before we agree to cover the drug for you. This is sometimes called "prior authorization (PA)."
  - Being required to try a different drug first before we agree to cover the drug you ask for. This is sometimes called "step therapy."
  - Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.

- If we agree to an exception for you and set aside a restriction, you can ask for an exception to the copay amount you're required to pay.

3. Changing coverage of a drug to a lower cost-sharing tier. Every drug on our *Drug List* is in one of 6 cost-sharing tiers.

- Our *Drug List* often includes more than one drug for treating a specific condition. These are called "alternative" drugs.
- If an alternative drug for your medical condition is in a lower cost-sharing tier than the drug you take, you can ask us to cover it at the cost-sharing amount for the alternative drug. This would lower your copay amount for the drug.
  - If the drug you take is a biological product, you can ask us to cover it at the cost-sharing amount for the lowest tier for biological product alternatives for your condition.
  - If the drug you take is a brand name drug, you can ask us to cover it at the cost-sharing amount for the lowest tier for brand name alternatives for your condition.
  - If the drug you take is a generic drug, you can ask us to cover it at the cost-sharing amount for the lowest tier for either brand or generic alternatives for your condition.
  - You can't ask us to change the cost-sharing tier for any drug in Tier 5, Specialty Drugs.
- If we approve your tiering exception request and there's more than one lower cost-sharing tier with alternative drugs you can't take, you usually pay the lowest amount.

G3. Important things to know about asking for an exception

Your doctor or other prescriber must tell us the medical reasons.

Your doctor or other prescriber must give us a statement explaining the medical reasons for asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Our Drug List often includes more than one drug for treating a specific condition. These are called "alternative" drugs. If an alternative drug is just as effective as the drug you ask for and wouldn't cause more side effects or other health problems, we generally **don't** approve your exception request. If you ask us for a tiering exception, we generally **don't** approve your exception request unless all alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say Yes or No to your request.

- If we say **Yes** to your exception request, the exception usually lasts until the end of the calendar 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 exception request, you can make an appeal. Refer to **Section G5** *Making a Level 1 Appeal* for information on making an appeal if we say **No**.

The next section tells you how to ask for a coverage decision, including an exception.

G4. Asking for a coverage decision, including an exception

- Ask for the type of coverage decision you want by calling 1-800-332-5762, TTY 711, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information about the claim.
- You or your doctor (or other prescriber) or someone else acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Refer to **Section E3,** *Help with coverage decisions and appeals* to find out how to name someone as your representative.
- You don't need to give written permission to your doctor or other prescriber to ask for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, refer to **Chapter 7** of this *Evidence of Coverage*.

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- If you ask for an exception, give us a "supporting statement." The supporting statement includes your doctor or other prescriber's medical reasons for the exception request.
- Your doctor or other prescriber can fax or mail us the supporting statement. They can also tell us by phone and then fax or mail the statement.
- You may submit a pharmacy request through our secure portal via our website 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.

If your health requires it, ask us for a "fast coverage decision."

We use the "standard deadlines" unless we agree to use the "fast deadlines."

- A **standard coverage decision** means we give you an answer within 72 hours after we get your doctor's statement.
- A **fast coverage decision** means we give you an answer within 24 hours after we get your doctor's statement.

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

You can get a fast coverage decision if:

- It's for a drug you didn't get. You can't get a fast coverage decision if you're asking us to pay you back for a drug you already bought.
- Your health or ability to function would be seriously harmed if we use the standard deadlines.

If your doctor or other prescriber tells us that your health requires a fast coverage decision, we agree and give it to you. We send you a letter that tells you.

- If you ask for a fast coverage decision without support from your doctor or other prescriber, we decide if you get a fast coverage decision.
- If we decide that your medical condition doesn't meet the requirements for a fast coverage decision, we use the standard deadlines instead.

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- We send you a letter that tells you. The letter also tells you how to make a complaint about our decision.
- You can file a fast complaint and get a response within 24 hours. For more information making complaints, including fast complaints, refer to **Section K**, **K2** *Internal complaints*.

Deadlines for a fast coverage decision

- If we use the fast deadlines, we must give you our answer within 24 hours after we get your request. If you ask for an exception, we give you our answer within 24 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO. Refer to **Section G6,** *Making a Level 2 Appeal* for more information about a Level 2 Appeal.
- If we say **Yes** to part or all of your request, we give you the coverage within 24 hours after we get your request or your doctor's supporting statement.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how you can make an appeal.

Deadlines for a standard coverage decision about a drug you didn't get

- If we use the standard deadlines, we must give you our answer within 72 hours after we get your request. If you ask for an exception, we give you our answer within 72 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.
- If we say **Yes** to part or all of your request, we give you the coverage within 72 hours after we get your request or your doctor's supporting statement for an exception.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

Deadlines for a standard coverage decision about a drug you already bought

- We must give you our answer within 14 calendar days after we get your request.

This section is continued on next page

- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.
- If we say **Yes** to part or all of your request, we pay you back within 14 calendar days.
- **If** we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

G5. Making a Level 1 Appeal

> An appeal to our plan about a Medicare Part D drug coverage decision is called a plan **"redetermination"**.

- Start your **standard** or **fast appeal** by calling 1-800-332-5762, TTY 711, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information regarding your appeal.
- You must ask for an appeal **within 65 calendar days** from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.
- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a fast appeal.

> A fast appeal is also called an **"expedited redetermination."**

- If you appeal a decision we made about a drug you didn't get, you and your doctor or other prescriber decide if you need a fast appeal.
- Requirements for a fast appeal are the same as those for a fast coverage decision. Refer to **Section G4,** *Asking for a coverage decision, including an exception* for more information.

We consider your appeal and give you our answer.

This section is continued on next page

- We review your appeal and take another careful look at all of the information about your coverage request.
- We check if we followed the rules when we said **No** to your request.
- We may contact you or your doctor or other prescriber to get more information.

Deadlines for a fast appeal at Level 1

- If we use the fast deadlines, we must give you our answer **within 72 hours** after we get your appeal.
    - We give you our answer sooner if your health requires it.
    - If we don't give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6,** *Making a Level 2 Appeal* for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must provide the coverage we agreed to provide within 72 hours after we get your appeal.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

Deadlines for a standard appeal at Level 1

- If we use the standard deadlines, we must give you our answer **within seven calendar days** after we get your appeal for a drug you didn't get.
- We give you our decision sooner if you didn't get the drug and your health condition requires it. If you believe your health requires it, ask for a fast appeal.
    - If we don't give you a decision within seven calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6,** *Making a Level 2 Appeal* for information about the review organization and the Level 2 appeals process.

If we say **Yes** to part or all of your request:

- We must **provide the coverage** we agreed to provide as quickly as your health requires, but **no later than seven calendar days** after we get your appeal.

This section is continued on next page

- We must **send payment to you** for a drug you bought **within 30 calendar days** after we get your appeal.

If we say **No** to part or all of your request:

- We send you a letter that explains the reasons and tells you how you can make an appeal.
- We must give you our answer about paying you back for a drug you bought **within 14 calendar days** after we get your appeal.
    - If we don't give you a decision within 14 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6,** *Making a Level 2 Appeal* for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must pay you within 30 calendar days after we get your request.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

G6. Making a Level 2 Appeal

If we say **No** to your Level 1 Appeal, you can accept our decision or make another appeal. If you decide to make another appeal, you use the Level 2 Appeal appeals process. The **IRO** reviews our decision when we said **No** to your first appeal. This organization decides if we should change our decision.

> The formal name for the "Independent Review Organization" (IRO) is the **"Independent Review Entity",** sometimes called the **"IRE"**.

To make a Level 2 Appeal, you, your representative, or your doctor or other prescriber must contact the IRO **in writing** and ask for a review of your case.

- If we say **No** to your Level 1 Appeal, the letter we send you includes **instructions about how to make a Level 2 Appeal** with the IRO. The instructions tell who can make the Level 2 Appeal, what deadlines you must follow, and how to reach the organization.
- When you make an appeal to the IRO, we send the information we have about your appeal to the organization. This information is called your "case file". **You have the right to a free copy of your case file**.

This section is continued on next page

- You have a right to give the IRO additional information to support your appeal.

The IRO reviews your Medicare Part D Level 2 Appeal and gives you an answer in writing. Refer to **Section F4,** *Making a Level 2 Appeal* for more information about the IRO.

Deadlines for a fast appeal at Level 2

If your health requires it, ask the IRO for a fast appeal.

- If they agree to a fast appeal, they must give you an answer **within 72 hours** after getting your appeal request.
- If they say **Yes** to part or all of your request, we must provide the approved drug coverage **within 24 hours** after getting the IRO's decision.

Deadlines for a standard appeal at Level 2

If you have a standard appeal at Level 2, the IRO must give you an answer:

- **within seven calendar days** after they get your appeal for a drug you didn't get.
- **within 14 calendar days** after getting your appeal for repayment for a drug you bought.

If the IRO says **Yes** to part or all of your request:

- We must provide the approved drug coverage **within 72 hours** after we get the IRO's decision.
- We must pay you back for a drug you bought within 30 calendar days after we get the IRO's decision.
- If the IRO says **No** to your appeal, it means they agree with our decision not to approve your request. This is called "upholding the decision" or "turning down your appeal".

If the IRO says **No** to your Level 2 Appeal, you have the right to a Level 3 Appeal if the dollar value of the drug coverage you ask for meets a minimum dollar value. If the dollar value of the drug coverage you ask for is less than the required minimum, you can't make another appeal. In that case, the Level 2 Appeal decision is final. The IRO sends you a letter that tells you the minimum dollar value needed to continue with a Level 3 Appeal.

If the dollar value of your request meets the requirement, you choose if you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2.

This section is continued on next page

- If the IRO says **No** to your Level 2 Appeal and you meet the requirement to continue the appeals process, you:
    - Decide if you want to make a Level 3 Appeal.
    - Refer to the letter the IRO sent you after your Level 2 Appeal for details about how to make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J**, **J3** *Appeals Levels 3, 4 and 5 for Medicare Part D Drug Requests* for information about Level 3, 4, and 5 Appeals.

H. Asking us to cover a longer hospital stay

When you're admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury. For more information about our plan's hospital coverage, refer to **Chapter 4** of this *Evidence of Coverage.*

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

- The day you leave the hospital is called your "discharge date."
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you're being asked to leave the hospital too soon or you're concerned about your care after you leave the hospital, you can ask for a longer hospital stay. This section tells you how to ask.

H1. Learning about your Medicare rights

Within two days after you're admitted to the hospital, someone at the hospital, such as a nurse or caseworker, will give you a written notice called "An Important Message from Medicare about Your Rights." Everyone with Medicare gets a copy of this notice whenever they're admitted to a hospital.

If you don't get the notice, ask any hospital employee for it. If you need help, call Member Service at the numbers at the bottom of the page. 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.

- **Read the notice** carefully and ask questions if you don't understand. The notice tells you about your rights as a hospital patient, including your rights to:
    - Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.

This section is continued on next page

  - Be a part of any decisions about the length of your hospital stay.
  - Know where to report any concerns you have about the quality of your hospital care.
  - Appeal if you think you're being discharged from the hospital too soon.
- **Sign the notice** to show that you got it and understand your rights.
  - You or someone acting on your behalf can sign the notice.
  - Signing the notice **only** shows that you got the information about your rights. Signing **doesn't** mean you agree to a discharge date your doctor or the hospital staff may have told you.
- **Keep your copy** of the signed notice so you have the information if you need it.

If you sign the notice more than two days before the day you leave the hospital, you'll get another copy before you're discharged.

You can look at a copy of the notice in advance if you:

- Call Member Service at the numbers at the bottom of the page
- Call Medicare at 1-800 MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Visit www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

H2. Making a Level 1 Appeal

To ask for us to cover your inpatient hospital services for a longer time, make an appeal. The Quality Improvement Organization (QIO) reviews the Level 1 Appeal to find out if your planned discharge date is medically appropriate for you.

The QIO is a group of doctors and other health care professionals paid by the federal government. These experts check and help improve the quality for people with Medicare. They aren't part of our plan.

In Tennessee the QIO is Acentra Health. Call them at 1-888-317-0751, TTY 711. Contact information is also in the notice, "An Important Message from Medicare about Your Rights," and in **Chapter 2**.

Call the QIO before you leave the hospital and no later than your planned discharge date.

This section is continued on next page

- **If you call before you leave**, you can stay in the hospital after your planned discharge date without paying for it while you wait for the QIO's decision about your appeal.
- **If you don't call to appeal**, and you decide to stay in the hospital after your planned discharge date, you may pay all costs for hospital care you get after your planned discharge date.

Ask for help if you need it. If you have questions or need help at any time:

- Call Member Service at the numbers at the bottom of the page.
- Call the Tennessee State Health Insurance Assistance Program (TN SHIP) at 1-877-801-0044.

Ask for a fast review. Act quickly and contact the QIO to ask for a fast review of your hospital discharge.

> The legal term for **"fast review"** is **"immediate review"** or **"expedited review."**

What happens during fast review

- Reviewers at the QIO ask you or your representative why you think coverage should continue after the planned discharge date. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that the hospital and our plan gave them.
- By noon of the day after reviewers tell our plan about your appeal, you get a letter with your planned discharge date. The letter also gives reasons why your doctor, the hospital, and we think that's the right discharge date that's medically appropriate for you.

> The legal term for this written explanation is the **"Detailed Notice of Discharge."** You can get a sample by calling Member Service at the numbers at the bottom of the page or 1-800-MEDICARE (1-800-633-4227). (TTY users should call 1-877-486-2048.) You can also refer to a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices

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Within one full day after getting all of the information it needs, the QIO give you their answer to your appeal.

If the QIO says **Yes** to your appeal:

- We'll provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They believe your planned discharge date is medically appropriate.
- Our coverage for your inpatient hospital services will end at noon on the day after the QIO gives you their answer to your appeal.
- You may have to pay the full cost of hospital care you get after noon on the day after the QIO gives you their answer to your appeal.
- You can make a Level 2 Appeal if the QIO turns down your Level 1 Appeal **and** you stay in the hospital after your planned discharge date.

H3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at 1-888-317-0751.

You must ask for this review **within 60 calendar days** after the day the QIO 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.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We must pay you back for our share of hospital care costs since noon on the day after the date the QIO turned down your Level 1 Appeal.
- We'll provide your covered inpatient hospital services for as long as the services are medically necessary.

This section is continued on next page

If the QIO says **No** to your appeal:

- They agree with their decision about your Level 1 Appeal and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J**, **J3** *Appeal Levels 3, 4 and 5 for Medicare Part D Drug Requests* for information about Level 3, 4, and 5 Appeals.

I. Asking us to continue covering certain medical services

This section is only about three types of services you may be getting:

- home health care services
- skilled nursing care in a skilled nursing facility, **and**
- rehabilitation care as an outpatient at a Medicare-approved CORF. This usually means you're getting treatment for an illness or accident or you're recovering from a major operation.

With any of these three types of services, you have the right to get covered services for as long as the doctor says you need them.

When we decide to stop covering any of these, we must tell you **before** your services end. When your coverage for that service ends, we stop paying for it.

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

I1. Advance notice before your coverage ends

We send you a written notice that you'll get at least two days before we stop paying for your care. This is called the "Notice of Medicare Non-Coverage." The notice tells you the date when we'll stop covering your care and how to appeal our decision.

You or your representative should sign the notice to show that you got it. Signing the notice **only** shows that you got the information. Signing **doesn't** mean you agree with our decision.

This section is continued on next page

I2. Making a Level 1 Appeal

If you think we're ending coverage of your care too soon, you can appeal our decision. This section tells you about the Level 1 Appeal process and what to do.

- **Meet the deadlines.** The deadlines are important. Understand and follow the deadlines that apply to things you must do. Our plan must follow deadlines too. If you think we're not meeting our deadlines, you can file a complaint. Refer to **Section K,** *What kinds of problems should be complaints* for more information about complaints.
- **Ask for help if you need it.** If you have questions or need help at any time:
  - Call Member Service at the numbers at the bottom of the page.
  - Call the TennCare Medical Appeal office at 1-800-878-3192 or 1-866-771-7042 (TTY).
- **Contact the QIO.**
  - Refer to **Section H2,** *Making a Level 1 Appeal* or refer to **Chapter 2** of this Evidence of Coverage for more information about the QIO and how to contact them.
  - Ask them to review your appeal and decide whether to change our plan's decision.
- **Act quickly and ask for a "fast-track appeal".** Ask the QIO if it's medically appropriate for us to end coverage of your medical services.

Your deadline for contacting this organization

- You must contact the QIO to start your appeal by noon of the day before the effective date on the Notice of Medicare Non-Coverage we sent you.
- If you miss the deadline for contacting the QIO, you can make your appeal directly to us instead. For details about how to do that, refer to **Section I3,** *Making a Level 2 Appeal*.

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The legal term for the written notice is **"Notice of Medicare Non-Coverage".** To get a sample copy, call Member Service at the numbers at the bottom of the page or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Or get a copy online at www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-Expedited-Determination-Notices.

What happens during a fast-track appeal

- Reviewers at the QIO ask you or your representative why you think coverage should continue. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that our plan gave them.
- Our plan also sends you a written notice that explains our reasons for ending coverage of your services. You get the notice by the end of the day the reviewers inform us of your appeal.

The legal term for the notice explanation is **"Detailed Explanation of Non-Coverage".**

- Reviewers tell you their decision within one full day after getting all the information they need.

If the QIO says **Yes** to your appeal:

- We'll provide your covered services for as long as they're medically necessary.

If the QIO says **No** to your appeal:

- Your coverage ends on the date we told you.
- We stop paying our share of the costs of this care on the date in the notice.
- You pay the full cost of this care yourself if you decide to continue the home health care, skilled nursing facility care, or CORF services after the date your coverage ends.
- You decide if you want to continue these services and make a Level 2 Appeal.

I3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at 1-888-317-0751.

You must ask for this review **within 60 calendar days** after the day the QIO said **No** to your Level 1 Appeal. You can ask for this review **only** if you continue care after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We pay you back for our share of the costs of care you got since the date when we said your coverage would end.
- We'll provide coverage for the care for as long as it's medically necessary.

If the QIO says **No** to your appeal:

- They agree with our decision to end your care and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J, J3** *Appeal Levels 3, 4 and 5 for Medicare Part D Drug Requests,* for information about Level 3, 4, and 5 Appeals.

J. Taking your appeal beyond Level 2

J1. Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both of your appeals were turned down, you may have the right to additional levels of appeal.

If the dollar value of the Medicare service or item you appealed doesn't meet a certain minimum dollar amount, you can't appeal any further. If the dollar value is high enough, you can continue the appeals process. The letter you get from the IRO for your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

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Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal, we have the right to appeal a Level 3 decision that's favorable to you.

- If we decide **to appeal** the decision, we 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 service in dispute.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the ALJ or attorney adjudicator's decision.
    - If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.
- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, 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) reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your Level 4 Appeal or denies our request to review a Level 3 Appeal decision favorable to you, we have the right to appeal to Level 5.

- If we decide **to appeal** the decision, we'll tell you in writing.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the Council's decision.

If the Council says **No** or denies our review request, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.

This section is continued on next page

- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

J2. Additional TennCare appeals

You also have other appeal rights if your appeal is about services or items that TennCare usually covers. The letter you get from the Fair Hearing office will tell you what to do if you want to continue the appeals process.

J3. Appeal Levels 3, 4 and 5 for Medicare Part D Drug Requests

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

If the value of the drug you appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. The written response you get to your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.

- If you decide **not to accept** this decision that turns down your appeal, 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 Council reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the Council says **No** to your appeal or if the Council denies the review request, the appeals process may not be over.

- If you decide **to accept** the decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

K. How to make a complaint

K1. What kinds of problems should be complaints

The complaint process is used for certain types of problems only, such as problems about quality of care, waiting times, coordination of care, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• You're unhappy with the quality of care, such as the care you got in the hospital.
Respecting your privacy	• You think that someone didn't respect your right to privacy or shared confidential information about you.
Disrespect, poor customer service, or other negative behaviors	• A health care provider or staff was rude or disrespectful to you. • Our staff treated you poorly. • You think you're being pushed out of our plan.
Accessibility and language assistance	• You can't physically access the health care services and facilities in a doctor or provider's office. • Your doctor or provider doesn't provide an interpreter for the non-English language you speak (such as American Sign Language or Spanish). • Your provider doesn't give you other reasonable accommodations you need and ask for. • For these types of complaints contact TennCare's Office of Civil Rights Compliance at www.tn.gov/tenncare/members-applicants/civil-rights-compliance or toll free at 855-857-1673. For TRS dial 711.

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Complaint	Example
Waiting times	• You have trouble getting an appointment or wait too long to get it. • Doctors, pharmacists, or other health professionals, Member Service, or other plan staff keep you waiting too long.
Cleanliness	• You think the clinic, hospital or doctor's office isn't clean.
Information you get from us	• You think we failed to give you a notice or letter that you should have received. • You think written information we sent you is too difficult to understand.
Timeliness related to coverage decisions or appeals	• You think we don't meet our deadlines for making a coverage decision or answering your appeal. • You think that, after getting a coverage or appeal decision in your favor, we don't meet the deadlines for approving or giving you the service or paying you back for certain medical services. • You don't think we sent your case to the IRO on time.

There are different kinds of complaints. You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization not affiliated with our plan. If you need help making an internal and/or external complaint, you can call the Long-Term Care Ombudsman Office at:

Tennessee Commission on Aging and Disability
Davy Crockett Tower, 2nd Floor
500 James Robertson Pkwy
Nashville, TN 37243
Tel: 615-253-5412
Fax: 615-741-3309

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Toll Free: 877-236-0013
TDD: 615-532-3893

> The legal term for a "complaint" is a **"grievance."**
>
> The legal term for "making a complaint" is **"filing a grievance."**

K2. Internal complaints

To make an internal complaint, call Member Service at **1-800-332-5762**, TTY **711**. You can make the complaint at any time unless it's about a Medicare Part D drug. If the complaint is about a Medicare Part D drug, you must make it **within 60 calendar days** after you had the problem you want to complain about.

- If there's anything else you need to do, Member Service will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we'll respond to your complaint in writing.
- **You may file a complaint by calling, writing, or faxing our plan.** See Chapter 2, Section A "*Important phone numbers and resources*" for contact information. We will investigate all grievances that we receive within 30 calendar days from the date we receive the grievance. If the grievance was not resolved during your call to the plan or it was received in writing, we will notify you of our decision within 30 calendar days from the date we receive the grievance. We may extend the 30-day timeframe by up to 14 days if you request an extension, or if we need additional information and an extension is in your best interest. We will respond to expedited grievances involving our decision to extend a timeframe related to an organization determination or reconsideration, or our decision not to grant an enrollee's request for an expedited initial organization/coverage determination or reconsideration/redetermination within 24 hours of receipt.
- The deadline for making a complaint about a Part D drug is 60 calendar days from the time you had the problem you want to complain about.

> **The legal term** for "fast complaint" is **"expedited grievance."**

If possible, we 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. If your health condition requires us to answer quickly, we'll do that.

This section is continued on next page

- We answer most complaints within 30 calendar days. If we don't make a decision within 30 calendar days because we need more information, we notify you in writing. We also provide a status update and estimated time for you to get the answer.
- If you make a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we automatically give you a "fast complaint" and respond to your complaint within 24 hours.
- If you make a complaint because we took extra time to make a coverage decision or appeal, we automatically give you a "fast complaint" and respond to your complaint within 24 hours.

If we don't agree with some or all of your complaint, we'll tell you and give you our reasons. We respond whether we agree with the complaint or not.

K3. External complaints

Medicare

You can tell Medicare about your complaint or send it to Medicare. The Medicare Complaint Form is available at: www.medicare.gov/my/medicare-complaint. You don't need to file a complaint with BlueCare Plus Choice before filing a complaint with Medicare.

Medicare takes your complaints seriously and uses this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the health plan isn't addressing your problem, you can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. The call is free.

Get services without being treated in a different way because of race, color, national origin (like your birthplace), language, sex, age, religion, disability, or other groups protected by the civil rights laws. You have a right to report or file a written complaint if you think you have been treated differently. Being treated differently means you've been discriminated against. If you complain, you have the right to keep getting care without fear of bad treatment from BlueCare Plus Tennessee, providers, or TennCare. To file a complaint or learn more about your rights visit:

TennCare's Office of Civil Rights Compliance at:

www.tn.gov/tenncare/members-applicants/civil-rights-compliance

Or call toll free at: 855-857-1673 (TTY 711)

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Office for Civil Rights (OCR)

You can make a complaint to the U.S. Department of Health and Human Services (HHS) OCR if you think you haven't been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the OCR is 1-800-368-1019. TTY users should call 1-800-537-7697. You can visit www.hhs.gov/ocr for more information.

You may also have rights under the Americans with Disability Act (ADA). You can contact the U.S. Department of Justice's Civil Rights Division at www.ada.gov/file-a-complaint or mail them at:

U.S. Department of Justice
Civil Rights Division
950 Pennsylvania Avenue, NW
Washington, DC 20530

QIO

When your complaint is about quality of care, you have two choices:

- You can make your complaint about the quality of care directly to the QIO.
- You can make your complaint to the QIO and to our plan. If you make a complaint to the QIO, we work with them to resolve your complaint.

The QIO 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. To learn more about the QIO, refer to **Section H2,** *Making a Level 1 Appeal* or refer to **Chapter 2** of this *Evidence of Coverage*.

In Tennessee, the QIO is called Acentra Health. The phone number for Acentra Health is 1-888-317-0751.

Chapter 10: Ending your membership in our plan

Introduction

This chapter explains how you can end your membership with our plan and your health coverage options after you leave our plan. If you leave our plan, you'll still be in the Medicare and TennCare (Medicaid) programs as long as you're eligible. Key terms and their definitions appear in alphabetical order in the last chapter of this *Evidence of Coverage.*

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A. When you can end your membership in our plan

Most people with Medicare can end their membership during certain times of the year. Since you have TennCare you have some choices to end your membership with our plan.

If you want to join a Dual Eligible Special Needs Plan (D-SNP) from our organization, you must first be enrolled in our Medicaid health plan (also called a Managed Care Organization, or MCO). Once you're enrolled in our Medicaid plan, you can then join our D-SNP.

For your TennCare plan, TennCare members may change their Medicaid MCO one time within the initial 90 calendar days from the date of the letter informing them of their MCO assignment. You'll remain a member of the designated MCO until you're given an opportunity to change once each year during an annual change period. The annual change period will occur each year in March for members in West Tennessee (Benton, Carroll, Chester, Crockett, Decatur, Dyer, Fayette, Gibson, Hardeman, Hardin, Haywood, Henderson, Henry, Lake, Lauderdale, Madison, McNairy, Obion, Shelby, Tipton and Weakley Counties) with changes effective May 1, in May for members in Middle Tennessee (Bedford, Cannon, Cheatham, Clay, Coffee, Cumberland, Davidson, DeKalb, Dickson, Fentress, Giles, Hickman, Houston, Humphreys, Jackson, Lawrence, Lewis, Lincoln, Macon, Marshall, Maury, Montgomery, Moore, Overton, Perry, Pickett, Putnam, Robertson, Rutherford, Smith, Stewart, Sumner, Trousdale, Van Buren, Warren, Wayne, White, Williamson and Wilson Counties) with changes effective July 1, and in July for members in East Tennessee (Anderson, Bledsoe, Blount, Bradley, Campbell, Carter, Claiborne, Cocke, Franklin, Grainger, Greene, Grundy, Hamblen, Hamilton, Hancock, Hawkins, Jefferson, Johnson, Knox, Loudon, Marion, McMinn, Meigs, Monroe, Morgan, Polk, Rhea, Roane, Scott, Sequatchie, Sevier, Sullivan, Unicoi, Union and Washington Counties) with changes effective September 1.

In addition, you may end your membership in our plan during the following periods each year:

- The **Annual Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
- The **Medicare Advantage (MA) Open Enrollment Period**, which lasts from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in a plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you're eligible to make a change to your enrollment. For example, when:

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- you move out of our service area,
- your eligibility for TennCare or Extra Help changed, **or**
- if you recently moved into, currently are getting care in, or just moved out of a nursing facility or a long-term care hospital.

Your Medicare membership ends on the last day of the month that we get your request to leave our plan. For example, if we get your request on January 18, your coverage with our plan ends on January 31. If you enroll in another plan, your new coverage begins the first day of the next month (February 1, in this example). Your TennCare (Medicaid) coverage ends the date you are determined to no longer be eligible.

If you leave our plan, you can get information about your:

- Medicare options in the table in **Section C1** Your Medicare services.
- Medicaid services in **Section C2** Your TennCare services.

You can get more information about how you can end your membership by calling:

- Member Service at the number at the bottom of this page. The number for TTY users is listed too.
- Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- The State Health Insurance Assistance Program (SHIP), TN SHIP at 1-877-801-0044.

B. How to end your membership in our plan

If you decide to end your membership you can do so by enrolling in another Medicare plan or switch to Original Medicare. However, if you want to switch from our plan to Original Medicare but you haven't selected a separate Medicare drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Member Service at the number at the bottom of this page if you need more information on how to do this.
- Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users (people who have difficulty with hearing or speaking) should call 1-877-486-2048. When you call 1-800-MEDICARE, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart in **Section C1**.

C. How to get Medicare and TennCare services separately

You have choices about getting your Medicare and Medicaid services if you choose to leave our plan.

C1. Your Medicare services

You have three options for getting your Medicare services listed below any month of the year. You have an additional option listed below during certain times of the year including the **Annual Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in **Section A**. By choosing one of these options, you automatically end your membership in our plan.

1. You can change to:	Here is what to do:
Program of All-inclusive Care for the Elderly (PACE) plan, if you qualify.	For Program of All-Inclusive Care for the Elderly (PACE) inquiries visit, www.tn.gov/tenncare/long-term-services-supports/the-program-for-all-inclusive-care-for-the-elderly-pace-program.html

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2. You can change to:	Here is what to do:
Original Medicare with a separate Medicare drug plan	Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: • Call the TN SHIP at the Department of Disability and Aging 1-877-801-0044 or TTY 1-800-848-0299, In Tennessee, the SHIP is called TN SHIP. For more information or to find a local TN SHIP office in your area, please visit www.tn.gov/disability-and-aging/disability-aging-programs/tn-ship.html. **AND** Enroll in a new Medicare drug plan. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins. Your TennCare enrollment may not be affected by this change.

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3. You can change to:	Here is what to do:
Original Medicare without a separate Medicare drug plan if you have a valid disenrollment reason. **NOTE:** If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call the TN SHIP at the Department of Disability and Aging 1-877-801-0044 or TTY 1-800-848-0299, www.tn.gov/disability-and-aging/disability-aging-programs/tn-ship.html.	Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: • Call the TN SHIP at the Department of Disability and Aging at 1-877-801-0044 or TTY 1-800-848-0299 or visit www.tn.gov/disability-and-aging/disability-aging-programs/tn-ship.html. In Tennessee, the SHIP is called TN SHIP. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins. Your TennCare enrollment may not be affected by this change.

This section is continued on next page

4. You can change to:	Here is what to do:
Any Medicare Advantage health plan except for those D-SNPs that are exclusive aligned with a Medicaid MCO (they are operated by the same organization) during certain times of the year including the **Annual Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in **Section A**.	Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. For Program of All-Inclusive Care for the Elderly (PACE) inquiries visit, www.tn.gov/tenncare/long-term-services-supports/the-program-for-all-inclusive-care-for-the-elderly-pace-program.html. If you need help or more information: • Call the TN SHIP at the Department of Disability and Aging 1-877-801-0044. TTY 1-800-848-0299, www.tn.gov/disability-and-aging/disability-aging-programs/tn-ship.html **OR** Enroll in a new Medicare plan. You'll automatically be disenrolled from our Medicare plan when your new plan's coverage begins. Your TennCare enrollment may not be affected by this change.

C2. Your TennCare services

To get different TennCare services within the first 90 days of your approval, call TennCare Member Medical Appeals at **1-800-878-3192** for free.

Tell them you just got your TennCare and you want to change your health plan. After 90 days, it's harder to change your health plan. Call TennCare Connect at **1-855-259-0701** for free. We'll help you fix the problem.

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If you change your Medicare MCO, you can change your Medicaid MCO to align with your D-SNP MCO during the Medicaid open enrollment period:

- For West TN: Open Enrollment is March with changes effective May 1
- For Middle TN: Open Enrollment is May with changes effective July 1
- For East TN: Open Enrollment is July with changes effective September 1

D. Your medical items, services and drugs until your membership in our plan ends

If you leave our plan, it may take time before your membership ends and your new Medicare and Medicaid coverage begins. During this time, you keep getting your drugs and health care through our plan until your new plan begins.

- Use our network providers to receive medical care.
- Use our network pharmacies including through our mail-order pharmacy services to get your prescriptions filled.
- If you're hospitalized on the day that your membership in BlueCare Plus Choice ends, our plan will cover your hospital stay until you're discharged. This will happen even if your new health coverage begins before you're discharged.

E. Other situations when your membership in our plan ends

These are cases when we must end your membership in our plan:

- If there's a break in your Medicare Part A and Medicare Part B coverage.
- If you are no longer eligible for TennCare (Medicaid) as stated in **Chapter 1, Section E**. Our plan is for people who are eligible for both Medicare and TennCare (Medicaid). If you lose your TennCare (Medicaid) coverage, we are required to disenroll you from our plan.
- If you move out of our service area.
- If you're 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 where you're moving or traveling to is in our plan's service area.
- If you go to jail or prison for a criminal offense.

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- If you lie about or withhold information about other insurance you have for drugs.
- If you're not a United States citizen or national, or an eligible non-citizen.
    - You must be a United States citizen or national, or an eligible non-citizen to be a member of our plan.
    - The Centers for Medicare & Medicaid Services (CMS) notify us if you're not eligible to remain a member on this basis.
    - We must disenroll you if you don't meet this requirement.

If you lose your TennCare eligibility but can be expected to regain it within six months, we'll continue to provide all Medicare benefits covered by BlueCare Plus Choice. When your TennCare coverage ends, we won't pay for your TennCare benefits. You will be responsible for any cost share that TennCare coverage would have normally paid.

If your TennCare eligibility is restored while you're still enrolled with us for your Medicare coverage, we'll resume paying for your TennCare benefits and your enrollment with us will continue. If you can't regain TennCare within six months, we'll disenroll you from BlueCare Plus Choice. If you regain TennCare eligibility after being disenrolled, you'll need to contact us to reenroll in the plan.

We can make you leave our plan for the following reasons only if we get permission from Medicare and Medicaid first:

- If you intentionally give us incorrect information when you're enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
- If you let someone else use your Member ID Card to get medical care. (Medicare may ask the Inspector General to investigate your case if we end your membership for this reason.)

F. Rules against asking you to leave our plan for any health-related reason

We can't ask you to leave our plan for any reason related to your health. If you think we're asking you to leave our plan for a health-related reason, **call Medicare** at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

G. Your right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also refer to **Chapter 9** of this *Evidence of Coverage* for information about how to make a complaint.

H. How to get more information about ending your plan membership

If you have questions or would like more information on ending your membership, you can call Member Service at the number at the bottom of this page.

Chapter 11: Legal notices

Introduction

This chapter includes legal notices that apply to your membership in our plan. Key terms and their definitions appear in alphabetical order in the last chapter of this *Evidence of Coverage*.

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A. Notice about laws

Many laws apply to this *Evidence of Coverage.* These laws may affect your rights and responsibilities even if the laws aren't included or explained in this *Evidence of Coverage.* The main laws that apply are federal laws about the Medicare and TennCare (Medicaid) programs. Other federal and state laws may apply too.

B. Notice about nondiscrimination

We don't discriminate or treat you differently because of your race, ethnicity, national origin, color, religion, sex, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment:

- Call TennCare's Office of Civil Rights Compliance. To learn more about your rights or to file a complaint go to: www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html. Or call 855-857-1673 (TRS 711).
- Call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users can call 1-800-537-7697. You can also visit www.hhs.gov/ocr for more information.
- If you have a disability and need help accessing health care services or a provider, call Member Service. If you have a complaint, such as a problem with wheelchair access, Member Service can help.

C. Notice about Medicare as a second payer and TennCare as a payer of last resort

Sometimes someone else must pay first for the services we provide you. For example, if you're in a car accident or if you're injured at work, insurance or Workers Compensation must pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare isn't the first payer.

We comply with federal and state laws and regulations relating to the legal liability of third parties for health care services to members. We take all reasonable measures to ensure that TennCare is the payer of last resort.

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.

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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.

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

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

D. 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

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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.

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 Chapter 7, *Asking us to pay a bill you have gotten for covered services or drugs* and Chapter 9, *What to do if you have a problem or complaint (coverage decisions, appeals, complaints).*

E. Nondiscrimination Notice and Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

BlueCare Plus Tennessee

Nondiscrimination Notice

BlueCross BlueShield of Tennessee, Inc. (BlueCross), including its subsidiary 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[1]. BlueCross does not exclude people or treat them less favorably because of race, color, national origin, age, disability or sex.

BlueCross:

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

If you need these reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Member Service at the number on the back of your Member ID card or call **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 **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 Grievance; c/o Manager, Operations, Member Benefits Administration; 1 Cameron Hill Circle, Suite 0019, Chattanooga, TN 37402-0019; 423-591-9208 (fax); Nondiscrimination_OfficeGM@bcbst.com (email).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 800-368-1019, 800-537-7697 (TDD), Monday through Friday, 8:00am to 6:00 pm, ET. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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

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

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

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

1 Cameron Hill Circle | Chattanooga, TN 37402 | bluecareplus.bcbst.com

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

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 800-332-5762 (TTY: 711) or speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 800-332-5762 (TTY: 711) o hable con su proveedor.

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 800-332-5762 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 800-332-5762 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.

注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 800-332-5762（文本电话：711）或咨询您的服务提供商。

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્ય ઉપલબ્ધ છે. 800-332-5762 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 800-332-5762 (TTY : 711) ou parlez à votre fournisseur.

ማሳሰቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ ድጋፍ አገልግሎት በነፃ ይቀርብልዎታል። መረጃን በተደራሽ ቅርጸት ለማቅረብ ተገቢ የሆኑ ተጨማሪ እገዛዎች እና አገልግሎቶች እንዲሁ በነፃ ይገኛሉ። በስልክ ቁጥር 800-332-5762 (TTY: 711) ይደውሉ ወይም አገልግሎት አቅራቢዎን ያናግሩ።

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 800-332-5762 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

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تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجاناً. اتصل على الرقم 800-332-5762 (الهاتف النصي: 711) أو تحدث إلى مقدم الخدمة.

توجه: اگر [وارد کردن زبان] صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس،به‌طور رایگان موجود می‌باشند. با شماره 800-332-5762 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 800-332-5762 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.

注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。800-332-5762（TTY：711）までお電話ください。または、ご利用の事業者にご相談ください。

ເຊີນຊາບ: ຖ້າທ່ານເວົ້າພາສາ ລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍ ແລະ ການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 800-332-5762 (TTY: 711) ຫຼື ລົມກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 800-332-5762 (TTY: 711) o makipag-usap sa iyong provider.

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Chapter 12: Definitions of important words

Introduction

This chapter includes key terms used throughout this *Evidence of Coverage* with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Member Service.

Activities of daily living (ADL): The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing teeth.

Administrative law judge: A judge that reviews a level 3 appeal.

AIDS drug assistance program (ADAP): A program that helps eligible individuals living with HIV/AIDS have access to life-saving HIV medications.

Ambulatory surgical center: A facility that provides outpatient surgery to patients who don't need hospital care and who aren't expected to need more than 24 hours of care.

Annual Enrollment Period: The time period from October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

Appeal: A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. **Chapter 9** of this *Evidence of Coverage* explains appeals, including how to make an appeal.

Behavioral health: An all-inclusive term referring to mental health and substance use disorders.

Biological product: A drug that's made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can't be copied exactly, so alternative forms are called biosimilars. (See also "Original biological product" and "Biosimilar").

Biosimilar: A biological product that's very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription. (Go to "Interchangeable biosimilar").

Brand name drug: A drug that's made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are usually made and sold by other drug companies and are generally not available until the patent on the brand name drug has ended.

Care plan: Refer to "Individualized care plan."

Care team: Refer to "Interdisciplinary care team."

Catastrophic coverage stage: The stage in the Medicare Part D drug benefit where our plan pays all costs of your drugs until the end of the year. You begin this stage when you (or other qualified parties on your behalf) have spent **$2,400** for Part D covered drugs during the year. You pay nothing.

This section is continued on next page

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. **Chapter 2** of this Evidence of Coverage explains how to contact CMS.

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 facility if it's needed.

Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of service, quality of your care, our network providers, or our network pharmacies. The formal name for "making a complaint" is "filing a grievance".

Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

Coordinator: One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need.

Copay: A fixed amount you pay as your share of the cost each time you get certain services or drugs. For example, you might pay $2 or $5 for a service or a drug.

Cost-sharing: Amounts you have to pay when you get certain services or drugs. Cost-sharing includes copays.

Cost-sharing tier: A group of drugs with the same copay. Every drug on the *List of Covered Drugs* (also known as the *Drug List*) is in one of 6 cost-sharing tiers.

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we pay for your health services. **Chapter 9** of this *Evidence of Coverage* explains how to ask us for a coverage decision.

Covered drugs: The term we use to mean all of the prescription and over-the-counter (OTC) drugs covered by our plan.

Covered services: The general term we use to mean all the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services our plan covers.

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Cultural competence training: Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

Daily cost-sharing rate: A rate that may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you're required to pay a copay. A daily cost-sharing rate is the copay divided by the number of days in a month's supply.

- Here is an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is $1.35. This means that the amount you pay for your drug is less than $0.05 per day. If you get a seven-day supply of the drug, your payment is less than $0.05 per day multiplied by seven days, for a total payment less than $0.35.

Disenrollment: The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Drug Management Program (DMP): A program that helps make sure members safely use prescription opioids and other frequently abused medications.

Drug tiers: Groups of drugs on our Drug List. Generic or brand name drugs are examples of drug tiers. Every drug on the Drug List is in one of 6 tiers.

Dual eligible special needs plan (D-SNP): Health plan that serves individuals who are eligible for both Medicare and Medicaid. Our plan is a D-SNP.

Durable medical equipment (DME): Certain items your doctor orders for use in your own home. Examples of these items are 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 and supplies, nebulizers, and walkers.

Emergency: A medical emergency when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of or serious impairment to a bodily function (and if you're a pregnant woman, loss of an unborn child). The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.

Emergency care: Covered services given by a provider trained to give emergency services and needed to treat a medical or behavioral health emergency.

Employment and Community First CHOICES (ECF CHOICES): ECF CHOICES is for people of all ages who have an intellectual or developmental disability (I/DD). This includes people who have significant disabilities. Services help people with I/DD gain as much independence as possible.

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People are supported to live with their family or in the community, not in an institution. Residential services are available for adults with I/DD who don't live with family but need supports where they live.

***Evidence of Coverage* and disclosure information:** This document, along with your enrollment form and any other attachments, or riders, which explain your coverage, what we must do, your rights, and what you must do as a member of our plan.

Exception: Permission to get coverage for a drug not normally covered or to use the drug without certain rules and limitations.

Excluded services: Services that aren't covered by this health plan.

Extra Help: Medicare program that helps people with limited incomes and resources reduce Medicare Part D drug costs, such as premiums, deductibles, and copays. Extra Help is also called the "Low-Income Subsidy", or "LIS".

Fully Integrated Dual Eligible or "FIDE" SNP plan: Manages both Medicare and Medicaid benefits under one healthcare provider. A FIDE SNP is the most integrated D-SNP option for dually eligible individuals. Members receive a single member card, one handbook, an integrated provider directory, combined notices, and access to a unified appeals process. This plan is also known as an "aligned plan."

Generic drug: A drug approved by the FDA to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It's usually cheaper and works just as well as the brand name drug.

Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care or the quality of service provided by your health plan.

Health plan, also known as a Managed Care Organization (MCO): An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has coordinators to help you manage all your providers and services. All of them work together to provide the care you need.

Health risk assessment (HRA): A review of your medical history and current condition. It's used to learn about your health and how it might change in the future.

Home health aide: A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides don't have a nursing license or provide therapy.

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Hospice: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has been medically certified as terminally ill, meaning having a life expectancy of six months or less.

- An enrollee who has a terminal prognosis has the right to elect hospice.
- A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
- We're required to give you a list of hospice providers in your geographic area.

Improper/inappropriate billing: A situation when a provider (such as a doctor or hospital) bills you more than our cost-sharing amount for services. Call Member Service if you get any bills you don't understand.

- As a plan member, you only pay our plan's cost-sharing amounts when you get services we cover. We **don't** allow providers to bill you more than this amount.

Independent review organization (IRO): An independent organization hired by Medicare that reviews a level 2 appeal. It isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work. The formal name is the **Independent Review Entity**.

Individualized care plan (ICP or Care Plan or Person-Centered Support Plan): A plan for what services you'll get and how you'll get them. Your plan may include medical services, behavioral health services, and long-term services and supports.

Initial coverage stage: The stage before your total Medicare Part D drug expenses reach $**2,400** . This includes amounts you paid, what our plan paid on your behalf, and the low-income subsidy. You begin in this stage when you fill your first prescription of the year. During this stage, we pay part of the costs of your drugs, and you pay your share.

Inpatient: A term used when you're formally admitted to the hospital for skilled medical services. If you're not formally admitted, you may still be considered an outpatient instead of an inpatient even if you stay overnight.

Integrated D-SNP: A dual-eligible special needs plan that covers Medicare and most or all Medicaid services under a single health plan for certain groups of individuals eligible for both Medicare and Medicaid. These individuals are known as full-benefit dually eligible individuals.

Interchangeable biosimilar: A biosimilar that may be substituted at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

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Interdisciplinary care team (ICT or Care team): A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team also helps you make a care plan.

List of Covered Drugs (Drug List): A list of prescription drugs we cover. We choose the drugs on this list with the help of doctors and pharmacists. The *Drug List* tells you if there are any rules you need to follow to get your drugs. The *Drug List* is sometimes called a "formulary".

Long-term services and supports (LTSS): Long-term services and supports help improve a long-term medical condition. Most of these services help you stay in your home so you don't have to go to a nursing facility or hospital. LTSS include Community-Based Services and Nursing Facilities (NF). You must meet eligibility requirements and be enrolled to receive LTSS services in Tennessee.

Low-income subsidy (LIS): Refer to "Extra Help"

Medicaid (or Medical Assistance): A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs.

Medically necessary: This describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs 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). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (refer to "Health plan").

Medicare Advantage: A Medicare program, also known as "Medicare Part C" or "MA", that offers MA plans through private companies. Medicare pays these companies to cover your Medicare benefits.

Medicare Appeals Council (Council): A council that reviews a level 4 appeal. The Council is part of the Federal government.

Medicare-covered services: Services covered by Medicare Part A and Medicare Part B. All Medicare health plans, including our plan, must cover all the services covered by Medicare Part A and Medicare Part B.

Medicare Diabetes Prevention Program (MDPP): A structured health behavior change program that provides training in long-term dietary change, increased physical activity, and strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.

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Medicare-Medicaid enrollee: A person who qualifies for Medicare and Medicaid coverage. A Medicare- Medicaid enrollee is also called a “dually eligible individual”.

Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

Medicare Part B: The Medicare program that covers services (such as lab tests, surgeries, and doctor visits) and supplies (such as wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

Medicare Part C: The Medicare program, also known as “Medicare Advantage” or “MA”, that lets private health insurance companies provide Medicare benefits through an MA Plan.

Medicare Part D: The Medicare drug benefit program. We call this program “Part D” for short. Medicare Part D covers outpatient drugs, vaccines, and some supplies not covered by Medicare Part A or Medicare Part B or Medicaid. Our plan includes Medicare Part D.

Medicare Part D drugs: Drugs covered under Medicare Part D. Congress specifically excludes certain categories of drugs from coverage under Medicare Part D. Medicaid may cover some of these drugs.

Medication Therapy Management (MTM): A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications. Refer to **Chapter 5** of this *Evidence of Coverage* for more information.

Member (member of our plan, or plan member): A person with Medicare and Medicaid who qualifies to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the state.

Member Service: A department in our plan responsible for answering your questions about membership, benefits, grievances, and appeals. Refer to **Chapter 2** of this *Evidence of Coverage* for more information about Member Service.

Network pharmacy: A pharmacy (drug store) that agreed to fill prescriptions for our plan members. We call them “network pharmacies” because they agreed to work with our plan. In most cases, we cover your prescriptions only when filled at one of our network pharmacies.

Network provider: “Provider” is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

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- They're licensed or certified by Medicare and by the state to provide health care services.
- We call them "network providers" when they agree to work with our health plan, accept our payment, and don't charge members an extra amount.
- While you're a member of our plan, you must use network providers to get covered services. Network providers are also called "plan providers".

Nursing home or facility: A place that provides care for people who can't get their care at home but don't need to be in the hospital.

Ombudsman: An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsperson's services are free. You can find more information in **Chapters 2 and Chapter 9** of this *Evidence of Coverage.*

Organization determination: Our plan makes an organization determination when we, or one of our providers, decide about whether services are covered or how much you pay for covered services. Organization determinations are called "coverage decisions". **Chapter 9** of this *Evidence of Coverage* explains coverage decisions.

Original biological product: A biological product that has been approved by the FDA and serves as the comparison for manufacturers making a biosimilar version. It's also called a reference product.

Original Medicare (traditional Medicare or fee-for-service Medicare): The government offers Original Medicare. Under Original Medicare, services are covered by paying doctors, hospitals, and other health care providers amounts that Congress determines.

- You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Medicare Part A (hospital insurance) and Medicare Part B (medical insurance).
- Original Medicare is available everywhere in the United States.
- If you don't want to be in our plan, you can choose Original Medicare.

Out-of-network pharmacy: A pharmacy that hasn't agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Our plan doesn't cover most drugs you get from out-of-network pharmacies unless certain conditions apply.

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Out-of-network provider or Out-of-network facility: A provider or facility that isn't employed, owned, or operated by our plan and isn't under contract to provide covered services to members of our plan. **Chapter 3** of this *Evidence of Coverage* explains out-of-network providers or facilities.

Out-of-pocket costs: The cost- sharing requirement for members to pay for part of the services or drugs they get is also called the "out-of-pocket" cost requirement. Refer to the definition for "cost-sharing" above.

Over-the-counter (OTC) drugs: Over-the-counter drugs are drugs or medicines that a person can buy without a prescription from a health care professional.

Part A: Refer to "Medicare Part A."

Part B: Refer to "Medicare Part B."

Part C: Refer to "Medicare Part C."

Part D: Refer to "Medicare Part D."

Part D drugs: Refer to "Medicare Part D drugs."

Personal health information (also called Protected Health Information, or PHI): Information about you and your health, such as your name, address, social security number, physician visits, and medical history. Refer to our Notice of Privacy Practices for more information about how we protect, use, and disclose your PHI, as well as your rights with respect to your PHI.

Preventive services: Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

Primary care provider (PCP): The doctor or other provider you use first for most health problems. They make sure you get the care you need to stay healthy.

- They also may talk with other doctors and health care providers about your care and refer you to them.
- In many Medicare health plans, you must use your primary care provider before you use any other health care provider.
- Refer to **Chapter 3** of this *Evidence of Coverage* for information about getting care from primary care providers.

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Prior authorization (PA): An approval you must get from us before you can get a specific service or drug or use an out-of-network provider. Our plan may not cover the service or drug if you don't get approval first.

Our plan covers some network medical services only if your doctor or other network provider gets PA from us.

- Covered services that need our plan's PA are marked in **Chapter 4** of this *Evidence of Coverage.*

Our plan covers some drugs only if you get PA from us.

- Covered drugs that need our plan's PA are marked in the *List of Covered Drugs* and the rules are posted on our website.

Program of All-Inclusive Care for the Elderly (PACE): A program that covers Medicare and Medicaid benefits together for people age 55 and over who need a higher level of care to live at home.

Prosthetics and orthotics: Medical devices ordered by your doctor or other health care provider that include, but aren't 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 doctors and other health care experts who help improve the quality of care for people with Medicare. The federal government pays the QIO to check and improve the care given to patients. Refer to **Chapter 2** of this *Evidence of Coverage* for information about the QIO.

Quantity limits: A limit on the amount of a drug you can have. We may limit the amount of the drug that we cover per prescription.

Real Time Benefit Tool: A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific covered drugs and benefit information. This includes cost-sharing amounts, alternative drugs 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 drugs.

Rehabilitation services: Treatment you get to help you recover from an illness, accident or major operation. These services include inpatient rehabilitation care, physical therapy (outpatient), speech and language therapy, and occupational therapy. Refer to **Chapter 4** of this *Evidence of Coverage* to learn more about rehabilitation services.

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Service area: A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's generally the area where you can get routine (non-emergency) services. Only people who live in our service area can enroll in our plan.

Skilled nursing facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

Skilled nursing facility (SNF) care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Specialist: A doctor who provides health care for a specific disease or part of the body.

State hearing: If your doctor or other provider asks for a Medicaid service that we won't approve, or we won't continue to pay for a Medicaid service you already have, you can ask for a State hearing. If the State hearing is decided in your favor, we must give you the service you asked for.

Step therapy: A coverage rule that requires you to try another drug before we cover the drug you ask for.

Supplemental Security Income (SSI): A monthly benefit Social Security pays to people with limited incomes and resources who are disabled, blind, or age 65 and over. SSI benefits aren't the same as Social Security benefits.

TennCare: This is the name of Tennessee Medicaid program. TennCare is run by the state and is paid for by the state and the federal government. It helps people with limited incomes and resources pay for long-term services and supports and medical costs.

- It covers extra services and some drugs not covered by Medicare.
- Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Urgently needed care: Care you get for an unforeseen illness, injury, or condition that isn't an emergency but needs care right away. You can get urgently needed care from out-of-network providers when you can't get to them because given your time, place, or circumstances, it isn't possible, or it's unreasonable to obtain services from network providers (for example when you're outside our plan's service area and you require medically needed immediate services for an unseen condition but it isn't a medical emergency).

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BlueCare Plus Choice Member Service

Method	Member Service – Contact Information
CALL	1-800-332-5762 Calls to this number are free. **From Oct. 1 to Mar. 31**, you can call us 7 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. Members can Chat-on-line with a specialist from 8:00 a.m. to 6:00 p.m. ET, by logging into the Member Portal on bluecareplus.bcbst.com. Member Service also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. From **Oct. 1 to March 31**, you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From **April 1 to Sept. 30,** you can call us Monday through Friday from 8 a.m. to 9 p.m. ET.
FAX	1-888-725-6849
WRITE	BlueCare Plus Tennessee 1 Cameron Hill Circle, Suite 0002 Chattanooga, TN 37402-0002
WEBSITE	bluecareplus.bcbst.com

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
CALL	Toll Free 1-877-801-0044
TTY	1-800-848-0299 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Tennessee State Health Insurance Assistance Program Davy Crockett Tower, 2nd Floor 500 James Robertson Pkwy Nashville, TN 37243

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Method	Contact Information
WEBSITE	You will find the website for the Tennessee State Health Insurance Assistance Program at www.medicare.gov under Search Tools by selecting Helpful Phone Numbers and Websites. https://www.tn.gov/disability-and-aging/disability-aging-programs/tn-ship.html

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