2027 Summary of Benefits

BlueAdvantage Emerald (PPO)SM

A Medicare Advantage Plan with Part D prescription drug coverage

East Tennessee

BlueCross BlueShield Tennessee

SUMMARY OF BENEFITS	BlueAdvantage Emerald
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
Monthly Plan Premium	**$32** per month. In addition, you must keep paying your Medicare Part B premiums.
Deductible	Medical Deductible: **$315**. Until you've paid the deductible amount, you must pay the full cost for most of your covered services before we will start to pay our share of the costs for covered medical services. Prescription Drug Deductible: **$700** for Tiers 3-5.
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • **$5,900** for services you receive from in-network providers. • **$10,750** for services you receive from in- and out-of-network providers combined. If you reach the limit on hospital and medical out-of-pocket costs, you can keep getting covered hospital and medical services, and we will pay the full cost for those benefits for the rest of the year. Please note: You will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs and any other supplemental benefits.

HEALTH BENEFITS	
Inpatient Hospital and Inpatient Services in a Psychiatric Hospital Our Plan covers an unlimited number of days for an inpatient hospital stay. Our Plan covers a maximum of **190 days in a psychiatric hospital in a lifetime.** The **190-day** limit does not apply to mental health services provided in a psychiatric unit of a general hospital. Prior authorization is required. Medical deductible applies.	**In-Network:** **Inpatient Hospital Service** Days 1-7: **$255** copay per day Additional Days: **$0** copay per day **Inpatient Psychiatric Service** Days 1-7: **$255** copay per day **Out-of-Network:** **50%** of the Medicare-allowed amount per admission
Outpatient Surgical Services Prior authorization may be required. Medical deductible applies.	**In-Network:** Ambulatory Surgical Center: **$250** copay Outpatient hospital facility: **$375** copay **Out-of-Network:** Ambulatory Surgical Center: **50%** of the Medicare-allowed amount Outpatient hospital facility: **50%** of the Medicare-allowed amount
Doctor Visits Medical deductible applies to Specialist visit.	**In-Network:** Primary Care Provider visit: **$0** copay per visit Specialist visit: **$40** copay per visit **Out-of-Network:** Primary Care Provider visit: **50%** of the Medicare-allowed amount per visit Specialist visit: **50%** of the Medicare-allowed amount per visit
Preventive Care ***Our Plan covers many preventive services. For example:*** • Bone density screenings • Cardiovascular disease screenings	**In-Network:** **$0** copay **Out-of-Network:** **50%** of the Medicare-allowed amount

HEALTH BENEFITS	
• Cervical and vaginal cancer screenings • Colorectal cancer screenings • Diabetes screenings • Glaucoma tests • Mammogram screenings • Prostate cancer screenings • Vaccines: ‣ COVID-19 ‣ Flu ‣ Hepatitis B ‣ Pneumococcal Additional preventive services approved by Original Medicare will be covered for dates of services on or after approval by Original Medicare.	
Emergency Care Copay is waived if you are admitted to the hospital within 24 hours for the same condition. All emergency care is considered in-network.	**Domestic:** **$130** copay per visit **Worldwide:** **$90** copay per visit
Urgently Needed Services Copay is waived if you are admitted to the hospital within 24 hours for the same condition.	**Domestic:** **$50** copay per visit **Worldwide:** **$90** copay per visit
Diagnostic Services / Labs/ Imaging Prior authorization may be required. Medical deductible applies.	**In-Network:** Diagnostic tests and procedures: **$0** copay at a Primary Care Provider's office **$40** copay at a Specialist's office **$40** copay at a Free-Standing Facility **$100** copay at an Outpatient Hospital Lab services: **$0** copay at a Primary Care Provider's office **$0** copay at a Specialist's office

HEALTH BENEFITS	
	$0 copay at a Free-Standing Facility **$40** copay at an Outpatient Hospital X-rays: **$0** copay at a Primary Care Provider's office **$40** copay at a Specialist's office **$40** copay at a Free-Standing Facility **$50** copay at an Outpatient Hospital Therapeutic Radiology Services: **20%** of the Plan-allowed amount Advanced Imaging (such as MRI, CT scans): **$250** copay Coumadin Services: **$0** copay at a Primary Care Provider's office **$0** copay at a Specialist's office **$0** copay at a Free-Standing Facility **$10** copay at an Outpatient Hospital Sleep Studies: **$10** copay for in-home **$40** copay at an Outpatient Facility **Out-of-Network:** **50%** of the Medicare-allowed amount
Hearing Services Cost-sharing for hearing aids does not count toward the maximum out-of-pocket amount. Medical deductible applies to Medicare covered services.	**In-Network:** Medicare-covered exam to diagnose and treat hearing and balance issues: **$10** copay Routine hearing exam (1 visit per year): **$0** copay at a TruHearing® provider Hearing Aids: **$99** copay **(Standard)** **$299** copay **(Advanced)** **$599** copay **(Premium)** Your copay depends on the model. This benefit is limited to one per ear per year. This benefit is limited to TruHearing Standard, Advanced and Premium hearing aids, which come in various styles and colors. You must see a TruHearing provider to use this benefit. **Out-of-Network:**

HEALTH BENEFITS	
	Medicare-covered exam to diagnose and treat hearing and balance issues: **$10** copay Routine hearing exam: **You must pay the full cost at the time of service.** The Plan will reimburse you for **10%** of the total cost after you submit proof of payment. Hearing Aids: **You must pay the full cost at the time of service.** The Plan will reimburse you for **10%** of the total cost after you submit proof of payment.
Dental Services Supplemental dental services outlined below are covered until the annual allowance is met. Below is a summary of covered benefits with service limits in this plan. **For more information about covered procedures, plan cost share, service limits, coordination of benefits, locating an In-Network Provider, Out-of-Network claims submission and exclusion details, please refer to the Dental Benefits Guide at medicare.bcbst.com/documents under Benefits and Coverage.** Medical deductible applies to Medicare covered services. **Adjunctive General Services:** • Covered services such as sedation	**In-Network:** Medicare-covered: **$40** copay **Out-of-Network:** Medicare-covered: **50%** of the Medicare-allowed amount **$1,000** combined total allowance for covered dental services. After the dental annual allowance is exhausted, any remaining charges are your responsibility. **Adjunctive General Services** **In-Network:** **20%** of the Plan-allowed amount for covered services through the annual allowance **Out-of-Network:** **50%** of the Plan-allowed amount for covered services through the annual allowance

HEALTH BENEFITS	
Diagnostic and Preventive: • Preventive dental services such as exams, cleanings and x-rays	**Diagnostic and Preventive** **In-Network:** **$0** copay through the annual allowance for covered services **Out-of-Network:** **50%** of the Plan-allowed amount for covered services through the annual allowance
Endodontics: • Covered services such as root canals	**Endodontics** **In-Network:** **$0** copay through the annual allowance for covered services **Out-of-Network:** **50%** of the Plan-allowed amount for covered services through the annual allowance
Oral and Maxillofacial Surgery: • Covered services such as extractions	**Oral and Maxillofacial Surgery** **In-Network:** **20%** of the Plan-allowed amount for covered services through the annual allowance **Out-of-Network:** **50%** of the Plan-allowed amount for covered services through the annual allowance
Periodontics: • Covered services such as deep cleanings and periodontal scaling	**Periodontics** **In-Network:** **$0** copay through the annual allowance for covered services **Out-of-Network:** **50%** of the Plan-allowed amount for covered services through the annual allowance
Prosthodontics, removable and fixed: • Covered services such as dentures, crowns and bridges	**Prosthodontics** **In-Network:** **50%** of the Plan-allowed amount for covered services through the annual allowance

HEALTH BENEFITS	
Restorative: • Covered services such as fillings Prior Authorization may be required.	**Out-of-Network:** **50%** of the Plan-allowed amount for covered services through the annual allowance **Restorative** **In-Network:** **20%** of the Plan-allowed amount for covered services through the annual allowance **Out-of-Network:** **50%** of the Plan-allowed amount for covered services through the annual allowance
Vision Services Members are encouraged to use the defined vision care network to obtain routine eye exam and eyewear benefit coverage. Routine eye exams and eyewear copays and coinsurance do not apply to the maximum out-of-pocket amount. Medical deductible applies to Medicare covered services.	**In- and Out-of-Network:** Medicare-covered exam to diagnose and treat diseases and conditions of the eye: **$0** copay Routine eye exam (1 per year): **$0** copay Eyeglasses or contact lenses after cataract surgery: **$0** copay Our plan pays a maximum of **$300** every two years for routine eyewear. If your total eyewear cost is more than **$300**, you will be required to pay the difference. For example, if your total cost for eyewear is **$350**, the Plan will pay **$300** and you will pay **$50**.
Outpatient Mental Health Care Prior authorization is required. Medical deductible applies.	**In-Network:** Outpatient group therapy visit: **$20** copay per visit Individual therapy visit: **$30** copay per visit **Out-of-Network:** Outpatient group therapy visit: **50%** of the Medicare-allowed amount per visit Individual therapy visit: **50%** of the Medicare-allowed amount per visit
Skilled Nursing Facility (SNF) Prior authorization is required. Medical deductible applies.	**In-Network:** Days 1-20: **$0** copay per day Days 21-100: **$221** copay per day **Out-of-Network:**

HEALTH BENEFITS	
	50% of the Medicare-allowed amount per stay The amounts above apply per benefit period. Our plan covers up to 100 days in a SNF per benefit period. A benefit period begins the day you go into a SNF. The benefit period will accumulate one day for each day you are inpatient at a SNF. The benefit period ends when you haven't received any inpatient hospital care or skilled care in a SNF for 60 days in a row. If you go into a SNF after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.
Outpatient Rehabilitation Services Prior authorization is required. Medical deductible applies.	**In-Network:** Occupational therapy visit: **$25** copay per visit Physical therapy visit: **$25** copay per visit Speech and language therapy visit: **$25** copay per visit **Out-of-Network:** Occupational therapy visit: **50%** of the Medicare-allowed amount per visit Physical therapy visit: **50%** of the Medicare-allowed amount per visit Speech and language therapy visit: **50%** of the Medicare-allowed amount per visit
Ambulance Prior authorization is required for all non-emergency ambulance transport. Medical deductible applies.	**Domestic:** Ground ambulance: **$325** copay per one-way trip Air ambulance: **20%** of the Medicare-allowed amount per one-way trip **Worldwide:** Ground ambulance: **$325** copay per one-way trip Air ambulance: **20%** of the Plan-allowed amount per one-way trip
Transportation	Not covered

HEALTH BENEFITS	
Medicare Part B Drugs Prior authorization may be required.	**In-Network:** Part B chemotherapy drugs: **20%** of the Plan-allowed amount Other Part B drugs: **20%** of the Plan-allowed amount Part B insulin: **20%** of the Plan-allowed amount, with a **$35** maximum copay for a one-month supply of each covered insulin product **Out-of-Network:** Part B chemotherapy drugs: **50%** of the Medicare-allowed amount Other Part B drugs: **50%** of the Medicare-allowed amount Part B insulin: **20%** of the Medicare-allowed amount, with a **$35** maximum copay for a one-month supply of each covered insulin product

PRESCRIPTION DRUG BENEFITS		
Deductible	Prescription Drug Deductible: **$700** for Tiers 3, 4 and 5, excluding Tier 3 Insulins.	
Initial Coverage	You pay the following until your total yearly drug costs reach **$2,400**. Total yearly drug costs are the drug costs paid by both you and our Part D plan.	
	Preferred Retail and Mail Order Pharmacy 30 / 100 Day Supply	**Standard Retail and Mail Order Pharmacy 30 / 100 Day Supply**
Tier 1: Preferred Generic	**$0 / $0**	**$6 / $15**
Tier 2: Generic	**$10 / $10**	**$15 / $35**
	Preferred Retail and Mail Order Pharmacy 30 / 90 Day Supply	**Standard Retail and Mail Order Pharmacy 30 / 90 Day Supply**
Tier 3: Preferred Brand and covered Insulins	**18% coinsurance**	**18% coinsurance**
Tier 4: Non-Preferred Drugs (limited to a 30-day supply)	**40% coinsurance**	**40% coinsurance**
Tier 5: Specialty Drugs (limited to a 30-day supply)	**25% coinsurance**	**25% coinsurance**
	You won't pay more than **$35** for a one-month supply of each covered insulin product regardless of the cost-sharing tier.	
Catastrophic Coverage	After your yearly out-of-pocket drug costs reach the **$2,400** limit for the calendar year, your Part D-covered prescription drugs will be covered at no cost to you.	
	Cost sharing may change depending on the pharmacy you choose, when you enter another phase of the Part D benefit and if you qualify for "Extra Help." To find out if you qualify for "Extra Help," please contact the Social Security Office at **800-772-1213** Monday–Friday, 7 a.m.–7 p.m. TTY users should call **800-325-0778**.	

Additional Health Benefits	
24/7 NurseLine Medical deductible applies.	**In-Network:** **$0** copay **Out-of-Network:** Not covered
Acupuncture for Chronic Low Back Pain We cover 12 visits in 90 days for Medicare-approved services. Prior authorization is required. Medical deductible applies.	**In-Network:** **$20** copay per visit **Out-of-Network:** **50%** of the Medicare-allowed amount per visit
Chiropractic Care Manual manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position). Prior authorization is required. Medical deductible applies.	**In-Network:** **$15** copay per visit **Out-of-Network:** **50%** of the Medicare-allowed amount per visit
Diabetic Supplies and Services	**Diabetes self-management training** **In-Network:** **$0** copay **Out-of-Network:** **20%** of the Medicare-allowed amount **Diabetic testing supplies** **In-Network:** Preferred: **$0** copay Non-Preferred: **20%** of the Plan-allowed amount

Additional Health Benefits	
For Continuous Glucose Monitors (CGM): Brand restrictions apply. Prior authorization may be required for diabetic supplies and services. Medical deductible applies.	**Out-of-Network:** **50%** of the Medicare-allowed amount **Continuous Glucose Monitors (CGM)** **In-Network:** Preferred: **20%** of the Plan-allowed amount Non-preferred: **50%** of the Plan-allowed amount **Out-of-Network:** **50%** of the Medicare-allowed amount **Therapeutic shoes/inserts** **In-Network:** **$10** copay **Out-of-Network:** **50%** of the Medicare-allowed amount
Durable Medical Equipment Prior authorization may be required.	**In-Network:** **20%** of the Plan-allowed amount **Out-of-Network:** **50%** of the Medicare-allowed amount
Home Health Care Prior authorization is required. Medical deductible applies.	**In-Network:** **$0** copay **Out-of-Network:** **50%** of the Medicare-allowed amount
Meal Benefit This benefit provides 14 meals after discharge from an acute inpatient hospital, SNF, or observation stay to a home setting.	**In-Network:** **$0** copay **Out-of-Network:** **You must pay the full cost at time of service.** The Plan will reimburse you for **20%** of the total cost after you submit proof of payment for qualifying meals.

Additional Health Benefits	
Outpatient Rehabilitation (Cardiac and Pulmonary) Prior authorization is required. Medical deductible applies.	**Cardiac (heart) rehab services** **In-Network:** **$25** copay per visit **Out-of-Network:** **50%** of the Medicare-allowed amount per visit **Pulmonary (lung) rehab services** **In-Network:** **$25** copay per visit **Out-of-Network:** **50%** of the Medicare-allowed amount per visit
Over-the-Counter (OTC) Items The plan pays a set amount per quarter (no roll-over) for certain OTC items such as vitamins, cough/cold/allergy medications, dental products and skin care items.	**In-Network:** **$45** per quarter (combined In- and Out-of-Network) **Out-of-Network:** **You must pay the full cost at time of service.** The Plan will reimburse you for **20%** of the total cost after you submit proof of payment. To be eligible for reimbursement, Out-of-Network purchases must be made at authorized retailers with itemized receipts for qualifying OTC items in accordance with CMS covered items.
Prosthetic Devices and Related Medical Supplies Prior authorization may be required. Medical deductible applies.	**In-Network:** **20%** of the Plan-allowed amount **Out-of-Network:** **50%** of the Medicare-allowed amount
Renal Dialysis Medical deductible applies.	**In-Network:** **20%** of the Plan-allowed amount **Out-of-Network:** **20%** of the Medicare-allowed amount

Additional Health Benefits	
Fitness Program	**In-Network:** **You pay nothing.** This plan includes a free standard fitness center membership, tools and online resources. **Out-of-Network:** **You must pay the full cost at the time of service.** The Plan will reimburse you for **20%** of the total cost, up to **$150** annually. Out-of-Network services will be reviewed after the service is rendered to verify it is a qualifying fitness facility.

For more details, refer to the Evidence of Coverage (EOC) online at **medicare.bcbst.com/documents.**

DISCLAIMERS

This is a summary of drugs and health services covered by BlueAdvantage Preferred Provider Organization (PPO) Emerald East health plan from January 1, 2027 through December 31, 2027.

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

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, go to **medicare.bcbst.com** or call us and ask for the "**Evidence of Coverage**."

To join BlueAdvantage, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area.

Our service area includes these counties in Tennessee: Anderson, Blount, Campbell, Claiborne, Cocke, Grainger, Hamblen, Jefferson, Knox, Loudon, Monroe, Morgan, Roane, Scott, Sevier and Union.

This document is available in other alternate formats.

This document may be available in a non-English language. For additional information, call us at **800-292-5146**, TTY **711**.

BlueAdvantage plans have a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network, you may pay less for your covered services.

Out-of-network/non-contracted providers are under no obligation to treat BlueCross BlueShield of Tennessee members, except in emergency situations. Please call our Member Service number (see back cover) or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

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

Notes

Here when you need us.

Medicare.bcbst.com

Members
800-831-2583, TTY **711**.

Not a member yet?
800-292-5146, TTY **711**.

Oct. 1 to March 31, 8 a.m. to 9 p.m. ET, seven days a week
April 1 to Sept. 30, 8 a.m. to 9 p.m. ET, Monday through Friday

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