January 1 – December 31, 2027

Evidence of Coverage for Employer Groups for 2027:

Your Medicare Health Benefits and Services as a Member of Blue Cross Group Medicare Advantage Open Access (PPO)[SM]

This document gives the details of your Medicare health coverage from January 1 – December 31, 2027. **This is an important legal document. Keep it in a safe place.**

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

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

For questions about this document, call Customer Service at 1-866-390-4276 (TTY users should call 711). Hours are 8 a.m. – 8 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays. This call is free.

This plan, Blue Cross Group Medicare Advantage Open Access (PPO)[SM], is offered by Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). (When this *Evidence of Coverage* says "we," "us," or "our," it means Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). When it says "plan" or "our plan," it means Blue Cross Group Medicare Advantage Open Access (PPO).)

This document is available for free in Spanish. Please contact Blue Cross Group Medicare Advantage Open Access (PPO) if you need this information in another language or format (Spanish, braille, large print or alternate formats).

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

OMB Approval 0938-1051 (Expires: July 31, 2029)

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

PPO employer/union group plans provided by Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC)-H0107 and H8634, and HCSC Insurance Services Company (HISC)-H1666. HCSC and HISC are Independent Licensees of the Blue Cross and Blue Shield Association. HCSC and HISC are Medicare Advantage organizations with Medicare contracts. Enrollment in these plans depends on contract renewal.

Subscriber hereby expressly acknowledges its understanding this agreement constitutes a contract solely between Subscriber and BCBSIL, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association (the Association), permitting BCBSIL to use the Service Marks in the State, and that BCBSIL is not contracting as the agent of the Association. Subscriber further acknowledges and agrees that it has not entered into this agreement based upon representations by any person other than BCBSIL and that no person, entity, or organization other than BCBSIL shall be held accountable or liable to Subscriber for any of BCBSIL's obligations to Subscriber created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of BCBSIL other than those obligations created under other provisions of this agreement.

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CHAPTER 1: Get started as a member

SECTION 1 You're a member of Blue Cross Group Medicare Advantage Open Access (PPO)

Section 1.1 You're enrolled in Blue Cross Group Medicare Advantage Open Access (PPO), which is a Medicare PPO

You're covered by Medicare, and you chose to get your Medicare health coverage through our plan, Blue Cross Group Medicare Advantage Open Access (PPO). Our plan covers all Part A and Part B services. However, cost sharing and provider access in this plan are different from Original Medicare.

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

Section 1.2 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how Blue Cross Group Medicare Advantage Open Access (PPO) covers your care. Other parts of this contract include your enrollment form and any notices you get from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called *riders* or *amendments*.

The contract is in effect for the months you're enrolled in Blue Cross Group Medicare Advantage Open Access (PPO) between January 1, 2027 and December 31, 2027.

Medicare allows us to make changes to plans we offer each calendar year. This means we can change the costs and benefits of Blue Cross Group Medicare Advantage Open Access (PPO) after December 31, 2027. We can also choose to stop offering our plan, in your service area, after December 31, 2027.

Medicare (the Centers for Medicare & Medicaid Services) must approve Blue Cross Group Medicare Advantage Open Access (PPO) each year. You can continue to get

Medicare coverage as a member of our plan as long as we choose to continue offering our plan and Medicare renews approval of our plan.

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

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

- You have both Medicare Part A and Medicare Part B.
- You live in our geographic service area (described in Section 2.2). People who are incarcerated aren't considered to be in the geographic service area even if they're physically located in it.
- You're a United States citizen or national, or an eligible noncitizen.

Section 2.2 Plan service area for Blue Cross Group Medicare Advantage Open Access (PPO)

Blue Cross Group Medicare Advantage Open Access (PPO) is only available to people who live in our plan service area. To stay a member of our plan, you must continue to live in our plan service area. The service area is described below.

Because your coverage is provided through a contract with your current or former employer or union, your plan has a national service area, defined as anywhere in the United States. To remain a member of our plan, you must continue to reside in the national plan service area.

If you plan to move, please contact Customer Service (phone numbers are printed on the back cover of this document) to provide us with your new mailing address.

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

Section 2.3 U.S. citizen or national, or an eligible noncitizen

You must be a U.S. citizen or national, or an eligible noncitizen to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify Blue Cross Group Medicare Advantage Open Access (PPO) if you're not eligible to stay a member of our plan on this basis. Blue Cross Group Medicare Advantage Open Access (PPO) must disenroll you if you don't meet this requirement.

SECTION 3 Important membership materials

Section 3.1 Our plan membership card

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



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

If our plan membership card is damaged, lost, or stolen, call Customer Service at 1-866-390-4276 (TTY users call 711) right away and we'll send you a new card.

Section 3.2 Provider Finder

The *Provider Finder* lists our current network providers and durable medical equipment suppliers. **Network providers** are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The most recent list of providers and suppliers is located at bcbsil.com/retiree-medicare-coc.

Why do you need to know which providers are part of our network?

As a member of our plan, you can choose to get care from out-of-network providers. Our plan will cover services from either in-network or out-of-network

providers, as long as the services are covered benefits and medically necessary. Go to Chapter 3 for more specific information.

If you don't have a *Provider Directory*, you can ask for a copy from Customer Service at 1-866-390-4276 (TTY users call 711). You may ask Customer Service for more information about our network providers, including their qualifications. You can also see the *Provider Finder* located on our Blue Access for Members (BAM) portal. Customer Service can give you the most up-to-date information about changes in our network providers.

SECTION 4 Summary of Important Costs for 2027

	Your Costs in 2027
Monthly plan premium* *Your premium can be higher or lower than this amount. Go to Section 4.1 for details.	**$126.99** **You can get information regarding your premium by going through your employer group.**
Deductible	**$250 for in-network and out-of-network services, except for insulin furnished through an item of durable medical equipment.**
Maximum out-of-pocket amount This is the most you'll pay out of pocket for covered Part A and Part B services. (Go to Chapter 4 Section 1 for details.)	**From in-network providers: Not Applicable** **From in-network and out-of-network providers combined: $2,000**
Primary care office visits	**In-Network** **$25 copay per visit** **Out-of-Network**

	Your Costs in 2027
	$25 copay per visit
Specialist office visits	**In-Network** **$30 copay per visit** **Out-of-Network** **$30 copay per visit**
Inpatient hospital stays Includes various inpatient hospital stays such as acute care rehabilitation and long-term care. An inpatient hospital stay starts the day you're formally admitted with a doctor's order and ends the day before you're discharged.	**In-Network** **$0 copay per stay** **Out-of-Network** **$0 copay per stay**

Your costs may include the following:

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

Section 4.1 Plan premium

Your coverage is provided through a contract with your current employer or former employer or union. Contact the employer's or union's benefits administrator for information about our plan premium.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

Your coverage is provided through a contract with your current employer or former employer or union. Please contact the employer's or union's benefits administrator for information about your plan premium.

In addition to paying the monthly plan premium, **you must continue paying your Medicare premiums to stay a member of our plan.** This includes your premium

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

SECTION 5 More information about your monthly premium

Section 5.1 How to pay your plan premium

For information regarding the amount of premium for which you may be responsible and/or methods for paying your premium, please contact your employer/union benefits administrator.

Section 5.2 Your monthly plan premium won't change during the year

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

SECTION 6 Keep your plan membership record up to date

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

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

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

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

If any of this information changes, let us know by calling Customer Service at 1-866-390-4276 (TTY users call 711).

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

SECTION 7 How other insurance works with our plan

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

Once a year, we'll send you a letter that lists any other medical or drug coverage we know about. Read this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that is not listed, call Customer Service at 1-866-390-4276 (TTY users call 711). You may need to give our plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

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

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

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

- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

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

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

CHAPTER 2: Phone numbers and resources

SECTION 1 Blue Cross Group Medicare Advantage Open Access (PPO) contacts

For help with claims, billing or member card questions, call or write to Blue Cross Group Medicare Advantage Open Access (PPO) Customer Service. We'll be happy to help you.

Customer Service – Contact Information	
Call	1-866-390-4276 Calls to this number are free. Hours are 8 a.m. - 8 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays. Customer Service 1-866-390-4276 (TTY users call 711) also has free language interpreter services for non-English speakers.
TTY	711 Calls to this number are free. Hours are 8 a.m. - 8 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays.
Fax	1-855-895-4747
Write	Customer Service P.O. Box 4555 Scranton, PA 18505

How to ask for a coverage decision about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services. For more information on

how to ask for coverage decisions or appeals about your medical care, go to Chapter 7.

You may call us if you have questions about our coverage decision process.

Coverage Decisions for Medical Care – Contact Information	
Call	1-866-390-4276 Calls to this number are free. Hours are 8 a.m. - 8 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays.
TTY	711 Calls to this number are free. Hours are 8 a.m. - 8 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays.
Fax	1-855-874-4711
Write	Blue Cross Medicare Advantage c/o Coverage Decisions P.O. Box 4288 Scranton, PA 18505

How to ask for an appeal about your medical care

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

Appeals for Medical Care – Contact Information	
Call	1-866-390-4276 Calls to this number are free. Hours are 8 a.m. - 8 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays.

Appeals for Medical Care – Contact Information	
TTY	711 Calls to this number are free. Hours are 8 a.m. - 8 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays.
Fax	1-855-674-9185
Write	Blue Cross Medicare Advantage c/o Appeals P.O. Box 663099 Dallas, TX 75266

How to make a complaint about your medical care

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

Complaints about Medical Care – Contact Information	
Call	1-866-390-4276 Calls to this number are free. Hours are 8 a.m. - 8 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays.
TTY	711 Calls to this number are free. Hours are 8 a.m. - 8 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays.
Fax	1-855-674-9189

Complaints about Medical Care – Contact Information	
Write	Blue Cross Medicare Advantage c/o Grievances P.O. Box 4288 Scranton, PA 18505
Medicare website	To submit a complaint about Blue Cross Group Medicare Advantage Open Access (PPO) directly to Medicare, go to Medicare.gov/my/medicare-complaint.

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

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

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

Payment Requests – Contact Information	
Write	Medical Claims Payment Request P.O. Box 4195 Scranton, PA 18505

International Emergency/Urgent Care Payment Request – Contact Information	
Write	Blue Cross Blue Shield Global Core Service Center P.O. Box 2048 Southeastern, PA 19399
Website	bcbsglobalcore.com

SECTION 2 Get help from Medicare

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

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

Medicare – Contact Information	
Call	1-800-MEDICARE (1-800-633-4227) Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free.
Chat Live	Chat live at Medicare.gov/talk-to-someone.
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044
Website	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.

Medicare – Contact Information	
	You can also visit Medicare.gov to tell Medicare about any complaints you have about Blue Cross Group Medicare Advantage Open Access (PPO). **To submit a complaint to Medicare,** go to Medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

SECTION 3 State Health Insurance Assistance Program (SHIP)

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

The State Health Insurance Assistance Program (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.

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

See the appendix in the back of this document for a list of SHIP organizations.

SECTION 4 Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state. For Illinois, the Quality Improvement Organization is called Commence Health - BFCC-QIO Program.

Commence Health - BFCC-QIO Program has a group of doctors and other health care professionals who are paid by Medicare to check on and help improve the quality of care for people with Medicare. Commence Health - BFCC-QIO Program is an independent organization. It’s not connected with our plan.

Contact Commence Health - BFCC-QIO Program in any of these situations:

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

See the appendix in the back of this document for a list of Quality Improvement Organizations.

SECTION 5 Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment.

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

Social Security – Contact Information	
Call	1-800-772-1213 Calls to this number are free. Available 8 am to 7 pm, Monday through Friday. Use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8 am to 7 pm, Monday through Friday.
Website	SSA.gov

SECTION 6 Medicaid

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

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

To find out more about Medicaid and Medicare Savings Programs, contact the Medicaid agency for your state listed in the appendix in the back of this document.

SECTION 7 Railroad Retirement Board (RRB)

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

Railroad Retirement Board (RRB) – Contact Information	
Call	1-877-772-5772 Calls to this number are free. Press "0" to speak with an RRB representative from 9 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9 am to 12 pm on Wednesday.

Railroad Retirement Board (RRB) – Contact Information	
	Press “1” to access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number aren’t free.
Website	RRB.gov

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

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner’s) employer or retiree group as part of this plan, call the employer/union benefits administrator or Customer Service at 1-866-390-4276 (TTY users call 711) with any questions. You can ask about your (or your spouse or domestic partner’s) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Customer Service are printed on the back cover of this document.) You can call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2048.

CHAPTER 3: Using our plan for your medical services

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

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

Section 1.1 Network providers and covered services

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

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

As a Medicare health plan, Blue Cross Group Medicare Advantage Open Access (PPO) must cover all services covered by Original Medicare and follow Original Medicare's coverage rules.

Blue Cross Group Medicare Advantage Open Access (PPO) will generally cover your medical care as long as:

- **The care you get is included in our plan's Medical Benefits Chart** in Chapter 4.

- **The care you get is considered medically necessary**. Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You get your care from a provider who is eligible to provide services under Original Medicare.** As a member of our plan, you can get care from either a network provider or an out-of-network provider (go to Section 2 for more information).
    - The providers in our network are listed in the *Provider Finder* bcbsil.com/retiree-medicare-coc.
    - While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we can't pay a provider who is not eligible to participate in Medicare. If you go to a provider who is not eligible to participate in Medicare, you'll be responsible for the full cost of the services you receive. Check with your provider before getting services to confirm that they're eligible to participate in Medicare.

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

Section 2.1 How to get care from specialists and other network providers

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

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

Referrals to specialist and other network providers are not required. Members can self-refer (notification to the plan is not required).

For certain services, you or your provider will need to get approval from the plan before we can cover the service. This is called **"prior authorization."** Sometimes the requirement for getting approval in advance helps guide appropriate use of services that are medically necessary. If you do not get this approval, your service might not be covered by the plan. If you utilize an in-network provider, it is the responsibility of the contracted provider to follow our guidelines and seek the required prior authorization on your behalf while holding you harmless. PPO members choosing to receive out-of-network services are encouraged to notify the plan of such services, so that the plan may assist the member with care coordination. The services received out of network must be medically necessary.

You or your treating provider may request a medical necessity review in advance of receiving services.

- Refer to the Medical Benefits Chart in Chapter 4 (also available on our website at bcbsil.com/retiree-medicare-coc) to determine which services, devices and equipment need prior authorization as a condition of payment prior to the service being rendered. Prior authorization requests are reviewed and determined within the timeframe outlined by the CMS standards and must meet medical necessity criteria.
- Prior authorizations should be submitted by the requesting physician via telephone, fax, or the electronic provider portal, this contact information has been made available to all physicians. A member or member's representative may request a prior authorization; however, the requesting physician will need to be involved to complete the necessary information to process the prior authorization.
- The request for prior authorization is reviewed by a Blue Cross Group Medicare Advantage's clinician and/or a Medical Director (MD) with sufficient medical and other expertise, including knowledge of Medicare coverage criteria, before Blue Cross Group Medicare Advantage issues the decision for coverage.
- Blue Cross Group Medicare Advantage Open Access (PPO) requires that network providers submit requests for prior authorization prior to rendering the service. In the case of a need to receive emergency service(s), prior authorization is not required. A subsequent admission from the Emergency Room/Department will require prior authorization.
- Members utilizing their PPO option are not required to obtain authorization for out-of-network services; however, services must meet medical necessity criteria to be covered.
- Members choosing to receive out-of-network services are encouraged to notify the Plan of such services, so that the Plan may assist the member with care coordination.
- If you need medical care when you're outside of Illinois, our benefit offered through BlueCard® via the Blue Cross and Blue Shield Association allows you to receive preauthorized routine and follow-up care as necessary. If you have questions about pre-authorization when you travel, please call Customer Service.
- The Global Core program gives members traveling outside of the United States and its territories access to urgent and emergency medical assistance services and doctors and hospitals in more than 200 countries around the world. If you have questions about what medical care is covered when you

travel, please call Customer Service or access information at bcbsglobalcore.com.

When a specialist or another network provider leaves our plan

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

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

If you need assistance in finding a provider, please contact Customer Service (phone numbers are printed on the back cover of this document).

Section 2.2 How to get care from out-of-network providers

As a member of our plan, you can choose to get care from out-of-network providers. However, providers that don't contract with us are under no obligation to treat you, except in emergency situations. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and are medically necessary. Here are more important things to know about using out-of-network providers:

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

Member Liability Calculation

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

- The Medicare allowable amount for covered services; or
- The amount the Host Blue negotiates with its provider on behalf of our members. The amount negotiated may be either higher than, lower than, or equal to the Medicare allowable amount.

Nonparticipating Healthcare Providers Outside Our Service Area

When covered healthcare services are provided outside of our service area by nonparticipating healthcare providers, the amount(s) a member pays for such services will be based on either the Medicare's limiting charge where applicable or the provider's billed charge. Payments for out-of-network emergency services, certain services provided by out-of-network providers at in-network facilities, and out-of-network air ambulance services will be governed by applicable federal and state law.

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

Section 3.1 Get care if you have a medical emergency

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

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You don't need to get approval or a referral first from your PCP. You don't need to use a network doctor. You can get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they're not part of our network.
- **As soon as possible, make sure our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Please contact Customer Service at 1-866-390-4276 (TTY users call 711). Hours are 8 a.m. – 8 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays.

Covered services in a medical emergency

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

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

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

What if it wasn't a medical emergency?

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

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

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

What if you are in the plan's service area when you have an urgent need for care?

If an urgent situation occurs, you should go directly to the nearest care center for treatment. We will cover the service in accordance with your benefit. See Chapter 4, Medical Benefits chart for details.

What if you are outside the plan's service area when you have an urgent need for care?

As a member of our plan, you can choose to receive care from in- or out-of-network providers. Our plan will cover services from either in-network or out-of-network

providers as long as the services are covered benefits and medically necessary. Your cost sharing is the same for in- or out-of-network providers.

Our plan covers worldwide emergency and urgent care services outside the United States under the following circumstances:

If outside the United States, enrollees may obtain only services that would be classified as emergency and urgently needed services had they been covered inside the United States. This coverage may also include ambulance services worldwide. Please contact the plan for details at 1-866-390-4276.

Section 3.3 Get care during a disaster

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

Visit bcbsil.com/retiree-medicare-coc for information on how to get needed care during a disaster.

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

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

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

Blue Cross Group Medicare Advantage Open Access (PPO) covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4. If you get services that aren't covered by our plan that are not emergency or urgently needed services, you're responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you use up your benefit for that type of covered service. Only Medicare-covered benefits count toward an out-of-pocket maximum.

SECTION 5 Medical services in a clinical research study

Section 5.1 What is a clinical research study

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

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

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

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

If you plan on participating in a clinical research study, contact Customer Service (phone numbers are printed on the back cover of this document) to let them know that you will be participating in a clinical trial and to find out more specific details about what your plan will pay.

Section 5.2 Who pays for services in a clinical research study

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

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.

- An operation or other medical procedure if it's part of the research study.
- Treatment of side effects and complications of the new care.

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

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

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

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

Get more information about joining a clinical research study

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

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

Section 6.1 A religious non-medical health care institution

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

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

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

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

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

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

There is no limit to the number of days covered by the plan per benefit period. Please see the Inpatient Hospital section in Chapter 4, Medical Benefits Chart for details.

SECTION 7 Rules for ownership of durable medical equipment

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

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

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. **As a member of Blue Cross Group Medicare Advantage Open Access (PPO), you usually won't get ownership of rented DME items no matter how many copayments you make for the item while a member of our plan.** You won't get ownership even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under some limited circumstances, we'll transfer ownership of the DME item to you. Call Customer Service at 1-866-390-4276 (TTY users call 711) for more information.

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

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

If you made fewer than 13 payments for the DME item under Original Medicare before you joined our plan, your previous payments also don't count toward the 13 consecutive payments. You will have to make 13 new consecutive payments after you return to Original Medicare in order to own the item. There are no exceptions to this case when you return to Original Medicare.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

If you qualify for Medicare oxygen equipment coverage Blue Cross Group Medicare Advantage Open Access (PPO) will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents

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

If you leave Blue Cross Group Medicare Advantage Open Access (PPO) or no longer medically require oxygen equipment, the oxygen equipment must be returned.

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

Original Medicare requires an oxygen supplier to provide you with services for 5 years. During the first 36 months, you rent the equipment. For the remaining 24 months, the supplier provides the equipment and maintenance (you're still responsible for applicable cost sharing for oxygen). After 5 years, you can choose to stay with the same company or go to another company. At this point, the 5-year cycle starts over again, even if you stay with the same company, and you're again required to pay copayments for the first 36 months. If you join or leave our plan, the 5-year cycle starts over.

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

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

The Medical Benefits Chart lists your covered services and shows how much you pay for each covered service as a member of Blue Cross Group Medicare Advantage Open Access (PPO). This section also gives information about medical services that aren't covered.

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

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

- **Deductible:** the amount you must pay for medical services before our plan begins to pay its share. (Section 1.2 tells you more about our plan deductible.)
- **Copayment:** the fixed amount you pay each time you get certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart tells you more about your copayments.)
- **Coinsurance:** the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart tells you more about your coinsurance.)

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

Section 1.2 Our plan deductible

Your deductible is $250 for in-network and out-of-network medical services with a coinsurance. (The deductible applies to the Out-of-Pocket Maximum.) This is the amount you have to pay out-of-pocket before we will pay our share for your covered in-network and out-of-network medical services with a coinsurance. Until you 've paid the deductible amount, you must pay the full cost for your covered in-network and out-of-network medical services with a coinsurance. (The

deductible does not apply to the services that are listed below.) After you pay your deductible, we'll begin to pay our share of the costs for covered medical services, and you'll pay your share (your copayment or coinsurance amount) for the rest of the calendar year. The deductible doesn't apply to some services, including certain in-network preventive services. This means that we pay our share of the costs for these services even if you haven't paid your deductible yet. The deductible doesn't apply to the following services:

- Ambulance services
- Emergency Room services
- Urgently Needed services at Urgent Care Centers

Section 1.3 What's the most you'll pay for covered medical services?

Because you are enrolled in a Medicare Advantage Plan, there is a limit to how much you have to pay out-of-pocket each year for in-network and out-of-network medical services that are covered by our plan. The most you will have to pay out-of-pocket for covered in-network and out-of-network services is listed below.

Your **combined maximum out-of-pocket amount** is $2,000. This is the most you pay during the calendar year for covered plan services you got from both in-network and out-of-network providers. The amounts you pay for deductibles (if your plan has a deductible), copayments, and coinsurance for covered services count toward this combined maximum out-of-pocket amount. The amounts you pay for our plan premiums don't count toward your combined maximum out-of-pocket amount. In addition, amounts you pay for some services, such as supplemental benefits and non-Medicare Part D drugs don't count toward your combined maximum out-of-pocket amount. If you pay $2,000 for covered services, you'll have 100% coverage and won't have any out-of-pocket costs for the rest of the year for covered services. However, you must continue to pay our plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.4 Providers aren't allowed to balance bill you

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

Here's how protection from balance billing works:

- If your cost sharing is a copayment (a set amount of dollars, for example, $15.00), you pay only that amount for any covered services from a network or out-of-network provider.
- If your cost sharing is a coinsurance (a percentage of the total charges), you never pay more than that percentage. However, your cost depends on which type of provider you see:
    - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (this is set in the contract between the provider and our plan).
    - If you get covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
    - If you get covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- If you think a provider has balance billed you, call Customer Service at 1-866-390-4276 (TTY users call 711).

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

The Medical Benefits Chart on the next pages lists the services Blue Cross Group Medicare Advantage Open Access (PPO) covers and what you pay out of pocket for each service. The services listed in the Medical Benefits Chart are covered only when these requirements are met:

- Your Medicare-covered services must be provided according to Medicare coverage guidelines.
- Your services (including medical care, services, supplies, equipment, and Part B drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan can't require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.

- Some services listed in the Medical Benefits Chart are covered as in-network services *only* if your doctor or other network provider gets approval from us in advance (sometimes called prior authorization).
  - Covered services that need approval in advance to be covered as in-network services are marked in **bold** in the Medical Benefits Chart.
  - You never need approval in advance for out-of-network services from out-of-network providers.
  - While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.
- If your coordinated care plan provides approval of a prior authorization request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, your medical history, and the treating provider's recommendation.

Other important things to know about our coverage:

- For benefits where your cost sharing is a coinsurance percentage, the amount you pay depends on what type of provider you get the services from:
  - If you get the covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (as determined in the contract between the provider and our plan).
  - If you get the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
  - If you get the covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (To learn more about the coverage and costs of Original Medicare, go to your Medicare & You 2027 handbook. View it online at Medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.)
- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you.

- If Medicare adds coverage for any new services during 2027, either Medicare or our plan will cover those services.



This apple shows preventive services in the Medical Benefits Chart.

Medical Benefits Chart

Covered Service	What you pay
24/7 Nurseline Support Call: 1-800-631-7023 TTY: 711; 24 hours a day, 7 days a week Nurses are available 24 hours a day, seven days a week. They can help you with health concerns and give general health tips. Get trusted guidance on possible emergency care, urgent care, family care and more.	$0 copay for nurse line support.
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS). ***Authorization rules may apply***	**In-Network** There is no coinsurance, copayment, or deductible for members eligible for this preventive screening. **Out-of-Network** $0 copay for Medicare-covered services.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer • Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.) • Not associated with surgery • Not associated with pregnancy	**In-Network** $0 copay for each Medicare-covered visit. **Out-of-Network** $0 copay for each Medicare-covered visit.

Covered Service	What you pay
An additional 8 sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. ***Authorization rules may apply*** **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 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.	
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be documented that the member's condition is such that other means of transportation	20% of the total cost for each one-way Medicare-covered ground transportation service. 20% of the total cost for each one-way Medicare-covered air transportation service.

Covered Service	What you pay
could endanger the person's health and that transportation by ambulance is medically required. ***Authorization rules may apply***	
Annual physical exam The routine physical examination is a comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, hands on examination, anticipatory guidance/ risk factor reduction interventions. ***Authorization rules may apply***	**In-Network** $0 copay for an annual physical exam. **Out-of-Network** $0 copay for an annual physical exam.
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note**: Your first annual wellness visit can't take place within 12 months of your *Welcome to Medicare* preventive visit. However, you don't need to have had a *Welcome to Medicare* visit to be covered for annual wellness visits after you've had Part B for 12 months. ***Authorization rules may apply***	**In-Network** There is no coinsurance, copayment, or deductible for the annual wellness visit. **Out-of-Network** $0 copay for Medicare-covered services.
Bone mass measurement For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results. ***Authorization rules may apply***	**In-Network** There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement. **Out-of-Network** $0 copay for Medicare-covered services.

Covered Service	What you pay
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women aged 40 and older • Clinical breast exams once every 24 months ***Authorization rules may apply***	**In-Network** There is no coinsurance, copayment, or deductible for covered screening mammograms. **Out-of-Network** $0 copay for Medicare-covered services.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. Our plan covers these comprehensive programs if you've had at least one of these conditions: • Heart attack in the last 12 months • Coronary artery bypass surgery • 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 2 sessions per day (each lasting 1 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. ***Authorization rules may apply***	**In-Network** 20% of the total cost for Medicare-covered cardiac rehabilitation services. 20% of the total cost for Medicare-covered intensive cardiac rehabilitation services. **Out-of-Network** 20% of the total cost for Medicare-covered cardiac rehabilitation services. 20% of the total cost for Medicare-covered intensive cardiac rehabilitation services.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)	**In-Network**

Covered Service	What you pay
We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy. ***Authorization rules may apply***	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit. **Out-of-Network** $0 copay for Medicare-covered services.
Cardiovascular disease screening tests Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months). ***Authorization rules may apply***	**In-Network** There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years. **Out-of-Network** $0 copay for Medicare-covered services.
Cervical and vaginal cancer screening Covered services include: • Pap tests and pelvic exams once every 24 months for all women • One pap test every 12 months if at high risk of cervical or vaginal cancer or if of childbearing age and have had an abnormal pap test within the past 3 years ***Authorization rules may apply***	**In-Network** There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams. **Out-of-Network** $0 copay for Medicare-covered services.
Chiropractic services Covered services include:	**In-Network**

Covered Service	What you pay
• *We cover only* manual manipulation of the spine to correct a vertebral subluxation ***Authorization rules may apply***	$20 copay for Medicare-covered services. **Out-of-Network** $20 copay for Medicare-covered services.
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who 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 are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, coverage of 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	**In-Network** There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. **Out-of-Network** $0 copay for each Medicare-covered colorectal cancer screening exam.

Covered Service	What you pay
patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high-risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high-risk criteria. Once every 3 years. • 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. • 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. ***Authorization rules may apply***	
Dental services (Medicare-covered) In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. ***Authorization rules may apply***	**In-Network** 20% of the total cost for Medicare-covered services. **Out-of-Network** 20% of the total cost for Medicare-covered services.
Depression screening	**In-Network** There is no coinsurance,

Covered Service	What you pay
We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals. ***Authorization rules may apply***	copayment, or deductible for an annual depression screening visit. **Out-of-Network** $0 copay for Medicare-covered services.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of these risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test. ***Authorization rules may apply***	**In-Network** There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests. **Out-of-Network** $0 copay for Medicare-covered services.
Diabetes self-management training, diabetic services, and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors • For people with diabetes who have severe diabetic foot disease 1 pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts, or one pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes) including fitting	**In-Network** You will pay 0% for diabetic testing supplies (meters and test strips) when obtained through the pharmacy for Ascensia or Abbott brands. Testing supplies from other brands will be subject to 20% cost sharing. Continuous Glucose Monitoring (CGM) products obtained through the

Covered Service	What you pay
• Diabetes self-management training under certain conditions ***Authorization rules may apply***	pharmacy require prior authorization, are subject to quantity limits, and have 20% cost sharing. Preferred CGM products include Dexcom G6, Dexcom G7 when used with a Dexcom receiver, and Abbott FreeStyle Libre 2/Plus and FreeStyle Libre 3/Plus when used with a FreeStyle Libre receiver. All other CGM products require prior approval, including trial and failure of a preferred CGM product first. 20% of the total cost for Medicare-covered diabetic therapeutic shoes or inserts. $0 copay for Medicare-covered diabetes self-management training services. 0% of the total cost for Medicare-covered Preferred diabetic monitors. 20% of the total cost for Medicare-covered Non Preferred diabetic monitors. **Out-of-Network** You will pay 0% for diabetic testing supplies (meters and

Covered Service	What you pay
	test strips) when obtained through the pharmacy for Ascensia or Abbott brands. Testing supplies from other brands will be subject to 20% cost sharing. Continuous Glucose Monitoring (CGM) products obtained through the pharmacy require prior authorization, are subject to quantity limits, and have 20% cost sharing. Preferred CGM products include Dexcom G6, Dexcom G7 when used with a Dexcom receiver, and Abbott FreeStyle Libre 2/Plus and FreeStyle Libre 3/Plus when used with a FreeStyle Libre receiver. All other CGM products require prior approval, including trial and failure of a preferred CGM product first. 20% of the total cost for Medicare-covered diabetic therapeutic shoes or inserts. $0 copay for Medicare-covered diabetes self-management training services. 0% of the total cost for Medicare-covered

Covered Service	What you pay
	Preferred diabetic monitors. 20% of the total cost for Medicare-covered Non Preferred diabetic monitors.
Durable medical equipment (DME) and related supplies (For a definition of durable medical equipment, go to Chapter 10 and Chapter 3.) Covered items include, but aren't limited to, wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area doesn't carry a particular brand or manufacturer, you can ask them if they can special order it for you. ***Authorization rules may apply***	**In-Network** 20% of the total cost for Medicare-covered durable medical equipment and supplies. **Out-of-Network** 20% of the total cost for Medicare-covered durable medical equipment and supplies.
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services • Needed to evaluate or stabilize an emergency medical condition A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.	**In-Network and Out-of-Network** $50 copay for Medicare-covered emergency room visits. Cost share is waived if you are admitted to the hospital within 3 days for the same condition. **Worldwide Coverage**

Covered Service	What you pay
Cost sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network. **Worldwide emergency care services are covered.**	$50 copay for emergency services. Cost share is waived if you are admitted to the hospital within 3 days for the same condition.
Health and wellness education programs **Fitness Program** The fitness benefit can help you live a healthier, more active life through fitness and social connection. You are covered for a fitness benefit both online and at participating locations[1]. You have access to a nationwide network of participating locations where you can take classes[2] and use exercise equipment and other amenities. Enroll in as many locations as you like, at any time. You also have access to instructors who lead specially designed group exercise online classes, seven days a week. Additionally, you have options to get active outside of traditional gyms at recreation centers, parks and other neighborhood locations. You can connect to a support network and online resources through On-Demand videos and the mobile app. Activate your online account at SilverSneakers.com to view your Member ID number and explore everything your fitness benefit has to offer. If you don't live near an authorized gym or prefer to workout at home, you can get one at-home fitness kit per year. Kits include your choice of one pedometer, exercise tube, fitness ball or yoga strap. For additional questions, visit SilverSneakers.com or call 1-888-423-4632 (TTY: 711) Monday through Friday, 8 a.m. to 8 p.m. ET. **Always talk with your doctor before starting an exercise program.**	$0 copay for this wellness program.

Covered Service	What you pay
[1]Use of participating locations (PL) facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL. [2]Membership includes instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location.	
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. We cover: • Medicare-covered services ***Authorization rules may apply***	***Medicare-Covered Services:*** **In-Network** 20% of the total cost for Medicare-covered hearing exam. **Out-of-Network** 20% of the total cost for Medicare-covered hearing exam.
HIV screening For people who ask for an HIV screening test or are at increased risk for HIV infection, we cover: • One screening exam every 12 months If you are pregnant, we cover: • Up to 3 screening exams during a pregnancy ***Authorization rules may apply***	**In-Network** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening. **Out-of-Network** $0 copay for Medicare-covered services.
Home health agency care Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort.	**In-Network** $0 copay for Medicare-covered services. **Out-of-Network**

Covered Service	What you pay
Covered services include, but aren't limited to: • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies ***Authorization rules may apply***	$0 copay for Medicare-covered services.
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but aren't limited to: • Professional services, including nursing services, furnished in accordance with our plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier ***Authorization rules may apply***	**In-Network** $0 copay for Medicare-covered professional services. 20% of the total cost for Medicare-covered supplies. 20% of the total cost for Medicare-covered home infusion drugs. **Out-of-Network** $0 copay for Medicare-covered professional services. 20% of the total cost for Medicare-covered supplies. 20% of the total cost for Medicare-covered home infusion drugs.
Hospice care	When you enroll in a Medicare-certified

Covered Service	What you pay
You're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you're admitted to a hospice, you have the right to stay in our plan; if you stay in our plan you must continue to pay plan premiums. **For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis:** Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost sharing. **For services covered by Medicare Part A or B not related to your terminal prognosis:** If you need non-emergency, non-urgently needed services covered under Medicare Part A or B that aren't related to your terminal prognosis, your cost for these services is the same whether or not you use a network provider. You may seek care from any provider that accepts Medicare. **For services covered by Blue Cross Group Medicare Advantage Open Access (PPO) but are not covered by Medicare Part A or B:** Blue Cross Group Medicare Advantage Open Access (PPO) will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal	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 Blue Cross Group Medicare Advantage Open Access (PPO).

Covered Service	What you pay
prognosis. You pay our plan cost-sharing amount for these services. **Note:** If you need non-hospice care (care that's not related to your terminal prognosis), contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	
Immunizations Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you've never received a complete series, you don't know your vaccination 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 ***Authorization rules may apply***	**In-Network** There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines. **Out-of-Network** $0 copay for Medicare-covered services.
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. Plan covers an unlimited number of days per benefit period. Covered services include but aren't limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets	Our plan covers an unlimited number of days for an inpatient hospital stay. **In-Network** $0 copay per stay. **Out-of-Network** $0 copay per stay. If you get inpatient care at an out-of-

Covered Service	What you pay
• Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Blue Cross Group Medicare Advantage Open Access (PPO) provides transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion. • A $10,000 benefit is available if a member must travel 100+ miles from their home address for only Plan-approved transplant services while being a member of our plan. This includes the member and one companion/caregiver and covers transplant transportation (Airfare, rail, bus, car rental, taxi, shuttle, public transit, ferry, parking and gas (for rental/personal car) for the purposes of traveling to and from home, hospital/clinic and/or applicable temporary lodging only) and transplant lodging (Must be associated with visits or admissions to the	network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital.

Covered Service	What you pay
transplant clinic or transplant facility and only for the member and/or companion only. (Examples: Motel, Hotel, Extended Stay, Short-term housing rental, etc.)). The benefit is only for the items listed above, per Plan-approved transplant, and is available until you reach the maximum benefit amount or are no longer eligible for coverage. Please contact Customer Service for details and restrictions. • Blood - including storage and administration. Coverage of whole blood and packed red cells (as well as other components of blood) begins with the first pint of blood that you need. • 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. ***Authorization rules may apply***	
Inpatient services in a psychiatric hospital Covered services include mental health care services that require a hospital stay. Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit doesn't apply to inpatient mental health services provided in a general hospital. ***Authorization rules may apply***	**In-Network** $0 copay per stay. **Out-of-Network** $0 copay per stay.
Medical nutrition therapy	**In-Network** There is no coinsurance, copayment, or

Covered Service	What you pay
This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year. ***Authorization rules may apply***	deductible for members eligible for Medicare-covered medical nutrition therapy services. **Out-of-Network** $0 copay for Medicare-covered services.
Medicare Diabetes Prevention Program (MDPP) **MDPP services are covered for eligible people under all Medicare health plans** MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustain weight loss and a healthy lifestyle. ***Authorization rules may apply***	**In-Network** There is no coinsurance, copayment, or deductible for the MDPP benefit. **Out-of-Network** $0 copay for Medicare-covered services.
Medicare Part B drugs **These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include:** • Drugs that usually aren't self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump)	Part B drugs ***may*** be subject to step therapy requirements. **In-Network** 20% of the total cost for Medicare Part B chemo drugs. 20% of the total cost for other Medicare Part B drugs. You won't pay more than $35 for a one-

Covered Service	What you pay
• Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan • The Alzheimer's drug, Leqembi®, (generic name lecanemab) is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment • Clotting factors you give yourself by injection if you have hemophilia • Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs • Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug • Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are 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	month supply of each insulin product covered by our plan. **Out-of-Network** 20% of the total cost for Medicare Part B chemo drugs. 20% of the total cost for other Medicare Part B drugs. You won't pay more than $35 for a one-month supply of each insulin product covered by our plan. ***Prior authorization, and/or step therapy may be required.***

Covered Service	What you pay
intravenous medication Parsabiv® and the oral medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit® Epoetin Alfa, Aranesp®, Darbepoetin Alfa, Mircera®, or Methoxy polyethylene glycol-epoetin beta) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) For a list of Part B Drugs that may be subject to Step Therapy, contact Customer Service. We also cover some vaccines under our Part B drug benefit.	
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more. ***Authorization rules may apply***	**In-Network** There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy. **Out-of-Network** $0 copay for Medicare-covered services.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:	**In-Network** $0 copay for Medicare-covered opioid treatment program services.

Covered Service	What you pay
• U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments ***Authorization rules may apply***	**Out-of-Network** $0 copay for Medicare-covered opioid treatment program services.
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but aren't limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood – including storage and administration. Coverage of whole blood and packed red cells (as well as other components of blood) begins with the first pint of blood that you need. • Diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem • Other outpatient diagnostic tests ***Authorization rules may apply***	**In-Network** Medicare-covered outpatient X-ray services: 20% of the total cost Medicare-covered therapeutic radiology services (such as radiation treatment for cancer): 20% of the total cost Medicare-covered medical supplies: 20% of the total cost Medicare-covered outpatient lab services: $0 copay Medicare-covered outpatient blood services: $0 copay Medicare-covered diagnostic procedures/tests: $0 copay

Covered Service	What you pay
	Medicare-covered diagnostic radiology services (such as MRIs and CT scans): 20% of the total cost **Out-of-Network** Medicare-covered outpatient X-ray services: 20% of the total cost Medicare-covered therapeutic radiology services (such as radiation treatment for cancer): 20% of the total cost Medicare-covered medical supplies: 20% of the total cost Medicare-covered outpatient lab services: $0 copay Medicare-covered outpatient blood services: $0 copay Medicare-covered diagnostic procedures/tests: $0 copay Medicare-covered diagnostic radiology services (such as MRIs and CT scans): 20% of the total cost

Covered Service	What you pay
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure 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 and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff. 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. ***Authorization rules may apply***	**In-Network** $0 copay for Medicare-covered observation services. **Out-of-Network** $0 copay for Medicare-covered observation services.
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. Covered services include, but aren't limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial hospitalization program, if a doctor certifies that inpatient treatment would be required without it	**In-Network** $0 copay for Medicare-covered outpatient hospital services. $0 copay for Medicare-covered ambulatory surgical services. **Out-of-Network** $0 copay for Medicare-covered outpatient hospital services.

Covered Service	What you pay
• X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff. ***Authorization rules may apply***	$0 copay for Medicare-covered ambulatory surgical services.
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker (CSW), clinical nurse specialist (CNS), licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws. ***Authorization rules may apply***	**In-Network** 20% of the total cost for Medicare-covered individual psychiatric services. 20% of the total cost for Medicare-covered group psychiatric services. 20% of the total cost for Medicare-covered individual mental health services. 20% of the total cost for Medicare-covered group mental health services. **Out-of-Network** 20% of the total cost for Medicare-covered individual psychiatric services.

Covered Service	What you pay
	20% of the total cost for Medicare-covered group psychiatric services. 20% of the total cost for Medicare-covered individual mental health services. 20% of the total cost for Medicare-covered group mental health services.
Outpatient rehabilitation services Covered services include physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs). ***Authorization rules may apply***	**In-Network** 20% of the total cost for Medicare-covered occupational therapy services. 20% of the total cost for Medicare-covered speech and physical therapy services. **Out-of-Network** 20% of the total cost for Medicare-covered occupational therapy services. 20% of the total cost for Medicare-covered speech and physical therapy services.
Outpatient substance use disorder services Coverage under Medicare Part B is available for treatment services that are provided in the outpatient	**In-Network** 20% of the total cost for Medicare-covered

Covered Service	What you pay
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. ***Authorization rules may apply***	individual substance abuse treatment. 20% of the total cost for Medicare-covered group substance abuse treatment. $0 copay for Medicare-covered partial hospitalization services. **Out-of-Network** 20% of the total cost for Medicare-covered individual substance abuse treatment. 20% of the total cost for Medicare-covered group substance abuse treatment. $0 copay for Medicare-covered partial hospitalization services.
Outpatient surgery, including services provided 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 and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.	**In-Network** $0 copay for Medicare-covered ambulatory surgical services. $0 copay for Medicare-covered outpatient hospital services.

Covered Service	What you pay
Authorization rules may apply	$0 copay for Medicare-covered observation services. **Out-of-Network** $0 copay for Medicare-covered ambulatory surgical services. $0 copay for Medicare-covered outpatient hospital services. $0 copay for Medicare-covered observation services.
Partial hospitalization services and intensive outpatient services *Partial hospitalization* is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. *Intensive outpatient service* is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally Qualified Health Center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization. ***Authorization rules may apply***	**In-Network** $0 copay for Medicare-covered partial hospitalization services. $0 copay for Medicare-covered intensive outpatient services. **Out-of-Network** $0 copay for Medicare-covered partial hospitalization services. $0 copay for Medicare-covered intensive outpatient services.

Covered Service	What you pay
Physician/practitioner services, including doctor's office visits Covered services include: • Medically necessary medical care or surgery services you get in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment • Certain telehealth services, including sore throat, fever, cough, nausea and other non-emergency illnesses. o 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. o This telehealth service is offered through the HCSC telehealth vendor. Members will need to complete registration and be directed to complete a medical questionnaire upon first visit to the HCSC telehealth vendor portal. Please contact the HCSC telehealth vendor at 1-888-680-8646 or visit the HCSC telehealth vendor website at mdlive.com/bcbsil-medicare. Access to telehealth service can be completed through computer, tablet, smartphone, traditional phone and can include web-based video. • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal	**In-Network** $25 copay for Medicare-covered primary care physician services. $30 copay for Medicare-covered physician specialist services. $25 copay for services performed with a Primary Care Physician and $30 copay for services performed with a Specialist for Medicare-covered services or services provided by other health care professionals such as nurse practitioners, physician assistants, etc. **Out-of-Network** $25 copay for Medicare-covered primary care physician services. $30 copay for Medicare-covered physician specialist services. $25 copay for services performed with a Primary Care Physician and $30 copay for

Covered Service	What you pay
dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their 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 5-10 minutes **if**: o You're not a new patient **and** o The check-in isn't related to an office visit in the past 7 days **and** o 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**: o You're not a new patient **and** o The evaluation isn't related to an office visit in the past 7 days **and** o 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, internet, or electronic health record • Second opinion by another network provider prior to surgery If your provider bills us as part of a hospital system, you may also be responsible for the outpatient hospital setting cost-share for the services. Cost-share for other services performed in an outpatient setting are outlined in this chapter. Please check with your provider prior to	services performed with a Specialist for Medicare-covered services or services provided by other health care professionals such as nurse practitioners, physician assistants, etc.

Covered Service	What you pay
scheduling services to see if the site is identified as part of a hospital. ***Authorization rules may apply***	
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs ***Authorization rules may apply***	**In-Network** 20% of the total cost for Medicare-covered services. **Out-of-Network** 20% of the total cost for Medicare-covered services.
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 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months • Up to 8 HIV screenings every 12 months. • A one-time hepatitis B virus screening ***Authorization rules may apply***	**In-Network** There is no coinsurance, copayment, or deductible for the PrEP benefit. **Out-of-Network** $0 copay for Medicare-covered services.
Prostate cancer screening exams For men aged 50 and older, covered services include the following once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test ***Authorization rules may apply***	**In-Network** There is no coinsurance, copayment, or deductible for an annual PSA test.

Covered Service	What you pay
	$0 copay for an annual Medicare-covered digital rectal exam. **Out-of-Network** $0 copay for Medicare-covered services. $0 copay for an annual Medicare-covered digital rectal exam.
Prosthetic and orthotic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include but aren't limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to *Vision Care* later in this table for more detail. ***Authorization rules may apply***	**In-Network** 20% of the total cost for Medicare-covered prosthetic devices. 20% of the total cost for Medicare-covered medical supplies. **Out-of-Network** 20% of the total cost for Medicare-covered prosthetic devices. 20% of the total cost for Medicare-covered medical supplies.
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. ***Authorization rules may apply***	**In-Network** 20% of the total cost for Medicare-covered pulmonary rehab services. **Out-of-Network** 20% of the total cost for Medicare-covered pulmonary rehab services.
Rewards Program	Earn up to $100 annually in gift cards

Covered Service	What you pay
Rewards Program for Healthy Actions You can earn rewards for completing eligible Healthy Actions during the calendar year (January 1 - December 31). Earn up to $100 annually for completing Healthy Actions, such as: • Annual Wellness Visit • Annual flu vaccine • Colorectal screening (once every 5 years) • Diabetic retinal eye exam (available for members with a diabetes diagnosis every other year) • Mammogram screening (available for women once every other year) • And more This list is subject to change. The Rewards Program is open to all members. Some Healthy Actions are available to all members, while others are based on your unique needs. The amount of the reward is up to a maximum of $100 annually and will be triggered by submission of a claim. Once you complete a Healthy Action, you'll receive rewards in the form of a gift card that can be redeemed at select national retailers. A maximum of one reward for each specific Healthy Activity per year will be rewarded until you reach the $100 maximum. To register and determine the current list of Healthy Actions, go to BlueRewardsil.com. You will need your member ID card, date of birth and email address to register online if you have not already. You can also call the number on the back of your member ID card to learn more about the program and register. Customer Service will take your information to begin the process to set up your account. REGISTRATION IS REQUIRED.	for completing plan-approved Healthy Actions.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults (including pregnant women) who misuse alcohol but aren't alcohol dependent.	**In-Network** There is no coinsurance, copayment, or

Covered Service	What you pay
If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting. ***Authorization rules may apply***	deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit. **Out-of-Network** $0 copay for Medicare-covered services.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified people, an LDCT is covered every 12 months. **Eligible members are**: people age 50 – 77 who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who get an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the members must get an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide lung cancer screening counseling and shared decision-making visit for later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits. ***Authorization rules may apply***	**In-Network** There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT. **Out-of-Network** $0 copay for Medicare-covered services.
Screening for Hepatitis C virus infection	**In-Network** There is no coinsurance, copayment, or

Covered Service	What you pay
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. ***Authorization rules may apply***	deductible for the Medicare-covered screening for the Hepatitis C Virus. **Out-of-Network** $0 copay for Medicare-covered services.
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office. ***Authorization rules may apply***	**In-Network** There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit. **Out-of-Network** $0 copay for Medicare-covered services.
Services to treat kidney disease Kidney disease and dialysis services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we	**In-Network** $0 copay for Medicare-covered kidney disease education.

Covered Service	What you pay
cover up to 6 sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you're admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, go to **Medicare Part B drugs** in this table**.** ***Authorization rules may apply***	20% of the total cost for Medicare-covered dialysis services. **Out-of-Network** $0 copay for Medicare-covered kidney disease education. 20% of the total cost for Medicare-covered dialysis services.
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, go to Chapter 10. Skilled nursing facilities are sometimes called SNFs.) Plan covers 100 days per benefit period. Covered services include but aren't limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of our plan of care (this includes substances naturally present in the body, such as blood clotting factors) • Blood - including storage and administration. Coverage of whole blood and packed red cells (as	**In-Network** $0 copay per day for days 1-20. $178 copay per day for days 21-100. **Out-of-Network** $0 copay per day for days 1-20. $178 copay per day for days 21-100.

Covered Service	What you pay
well as other components of blood) begins with the first pint of blood that you need. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you get SNF care from network facilities. Under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital ***Authorization rules may apply***	
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients 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 provides counseling We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year). ***Authorization rules may apply***	**In-Network** There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits. **Out-of-Network** $0 copay for Medicare-covered services.

Covered Service	What you pay
Supervised exercise therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant (PA), or nurse practitioner (NP)/clinical nurse specialist (CNS) who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider. ***Authorization rules may apply***	**In-Network** 20% of the total cost for Medicare-covered supervised exercise therapy. **Out-of-Network** 20% of the total cost for Medicare-covered supervised exercise therapy.
Supplemental telehealth services Covered services include: • Certain telehealth services, including: urgent care and behavioral health 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 telehealth service is offered through the HCSC telehealth vendor. Members will need to complete registration and be directed to complete a medical questionnaire upon first visit to the HCSC telehealth vendor's portal.	**In-Network** Virtual Urgent Care - $10 copay (through the HCSC telehealth vendor only), Virtual Mental Health Specialty Services - $10 copay (through the HCSC telehealth vendor only), Virtual

Covered Service	What you pay
Please contact the HCSC telehealth vendor at 1-888-680-8646 or visit the HCSC telehealth vendor's website at mdlive.com/bcbsil-medicare. Access to telehealth service can be completed through computer, tablet, smartphone, traditional phone and can include web-based video.	Psychiatric Services - $10 copay (through the HCSC telehealth vendor only) **Out-of-Network** Not Covered
Urgently needed services A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or, even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable. **Worldwide urgent care services are covered.**	20% of the total cost (max of $65) for Medicare-covered services. $10 copay for each virtual visit through the HCSC telehealth vendor. **Worldwide coverage** 20% of the total cost (max of $65) for urgent services each visit. Cost share is waived if you are admitted to the hospital within 3 days for the same condition.
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high risk for glaucoma, we cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African	***Medicare-Covered Services:*** **In-Network** 20% of the total cost for Medicare-covered services. $0 copay for an annual glaucoma screening.

Covered Service	What you pay
Americans who are age 50 and older and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. If you have 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery ***Authorization rules may apply***	20% of the total cost for 1 pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery. **Out-of-Network** 20% of the total cost for Medicare-covered services. $0 copay for an annual glaucoma screening. 20% of the total cost for 1 pair of eyeglasses (lenses and frames) or contact lenses after cataract surgery.
Welcome to Medicare preventive visit Our plan covers the one-time *Welcome to Medicare* preventive visit. The visit includes a review of your health, as well as education and counseling about preventive services you need (including certain screenings and shots (and vaccines)), and referrals for other care if needed. **Important:** We cover the *Welcome to Medicare* preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you want to schedule your *Welcome to Medicare* preventive visit.	**In-Network** There is no coinsurance, copayment, or deductible for the *Welcome to Medicare* preventive visit. **Out-of-Network** $0 copay for Medicare-covered services.
Worldwide Emergency/Urgent Coverage Worldwide coverage is available for urgent and emergency services only. For information regarding international urgent or emergency services, visit the website at bcbsglobalcore.com or call toll free 1-800-810-Blue (2583) or call collect at 1-804-673-1177. In	$50 copay for Worldwide emergency care.

Covered Service	What you pay
addition to contacting the Blue Cross Blue Shield Global Core, call your BCBS company for precertification or preauthorization. You may also contact the plan for more details on how to access this benefit.	20% of the total cost (max of $65) for Worldwide urgent care.

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

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

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

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

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

Services not covered by Medicare	Covered only under specific conditions
Experimental medical and surgical procedures, equipment and medications Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community	May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan (Go to Chapter 3, Section 5 for more information on clinical research studies)
Fees charged for care by your immediate relatives or members of your household	Not covered under any condition
Full-time nursing care in your home	Not covered under any condition
Home-delivered meals	Not covered under any condition
Home health services	Medicare covers medically necessary part-time or intermittent skilled nursing care
Homemaker services include basic household help, including light housekeeping or light meal preparation	Not covered under any condition
Naturopath services (uses natural or alternative treatments)	Not covered under any condition
Non-routine dental care	Dental care required to treat illness or injury may be covered as inpatient or outpatient care
Orthopedic shoes or supportive devices for the feet	Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease
Personal items in your room at a hospital or a skilled	Not covered under any condition

Services not covered by Medicare	Covered only under specific conditions
nursing facility, such as a telephone or a television	
Private room in a hospital	Covered only when medically necessary
Reversal of sterilization procedures and or non-prescription contraceptive supplies	Not covered under any condition
Routine dental care, such as cleanings, fillings, or dentures	Not covered under any condition
Routine chiropractic care	Manual manipulation of the spine to correct a subluxation is covered
Routine eye examinations, routine eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids	One pair of eyeglasses with standard frames (or one set of contact lenses) covered after each cataract surgery that implants an intraocular lens.
Routine foot care	Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes)
Routine hearing exams, hearing aids, or exams to fit hearing aids	Medicare covers diagnostic hearing exams and balance exams if ordered by a physician.
Services considered not reasonable and necessary, according to Original Medicare standards	Not covered under any condition

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

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

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

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

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

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

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

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

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

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

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

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

3. If you're retroactively enrolled in our plan

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

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

When you send us a request for payment, we'll review your request and decide whether the service or drug should be covered. This is called making a **coverage decision**. If we decide it should be covered, we'll pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 7 has information about how to make an appeal.

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

You can ask us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records. **You must submit your claim to us within 12 months** of the date you received the service, item, or drug.

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

- You don't have to use the form, but it'll help us process the information faster.
- Call Customer Service at 1-866-390-4276 (TTY users call 711) and ask for the form.

For **Medical claims**, mail your request for payment together with any bills or paid receipts to us at this address:

Medical Claims Payment Request
P.O. Box 4195
Scranton, PA 18505

For **International Emergency/Urgent care claims**, mail your request together with any bills or paid receipts to us at this address:

Blue Cross Blue Shield Global Care Service Center
P.O. Box 2048
Southeastern, PA 19399

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

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

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

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

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

CHAPTER 6: Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities

Section 1.1 We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, braille, large print, or other alternate formats, etc.) Debemos proporcionar información de una manera que funcione para usted y de acuerdo con sus sensibilidades culturales (en idiomas que no sean inglés, en braille, en español, en letra grande u otros formatos alternativos, etc.)

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

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in languages other than English including Spanish, and braille, in large print, or other alternate formats at no cost if you need it. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Customer Service at 1-866-390-4276 (TTY users call 711).

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

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

cover a service you need, call our plan for information on where to go to get this service at in-network cost sharing.

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with Blue Cross Group Medicare Advantage Open Access (PPO) at 1-866-390-4276. You can also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

Nuestro plan cuenta con servicios de intérpretes gratuitos disponibles para responder preguntas de miembros discapacitados y de aquellos que no hablan inglés. También podemos brindarle información en sistema braille, en español, en letra grande o en formatos alternativos de forma gratuita si lo requiere. Debemos brindarle información sobre los beneficios del plan en un formato que sea accesible y apropiado para usted. Para obtener información de nuestra parte de una manera que la pueda comprender, llame al Departamento de Servicios para Miembros (los números de teléfono están impresos en la contraportada de este documento).

Nuestra aseguradora cuenta con personas y servicios gratuitos de interpretación para responder preguntas de asegurados con alguna discapacidad o que no hablen inglés. Si lo necesita, también podemos proporcionarle sin costo información en braille, en letra grande u otros formatos. Tenemos la obligación de proporcionarle información sobre los beneficios de la cobertura en un formato accesible, eficaz y apropiado para usted. Comuníquese con Atención al Miembro para recibir información en un formato eficaz para usted (los números telefónicos aparecen en la contraportada de este folleto).

Nuestro plan debe brindar a las mujeres inscritas la opción de acceso directo a un especialista en salud de la mujer dentro de la red para los servicios de atención médica preventiva y de rutina de la mujer.

Si los proveedores de la red del plan para una especialidad no están disponibles, es responsabilidad del plan ubicar proveedores especializados fuera de la red que le brindarán la atención necesaria. En este caso, solo pagará el costo compartido dentro de la red. Si se encuentra en una situación en la que no hay especialistas en la red del plan que cubran un servicio que necesita, llame al plan para obtener información sobre dónde ir para obtener este servicio con costos compartidos dentro de la red.

Si tiene dificultades para acceder a la información sobre nuestro plan en un formato que sea accesible y apropiado para usted, llame para presentar un reclamo ante Blue Cross Group Medicare Advantage Open Access (PPO) al

1-866-390-4276. También puede presentar una queja con Medicare llamando al 1-800-MEDICARE (1-800-633-4227) o puede presentarla directamente en la Oficina de Derechos Civiles. La información de contacto está incluida en esta Evidencia de Cobertura, o puede comunicarse al 1-800-368-1019 o TTY 1-800-537-7697 para acceder a información adicional.

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

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

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

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

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

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

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

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, we're *required to get written permission from you or someone you have given legal power to make decisions for you first.*
- There are certain exceptions that don't require us to get your written permission first. These exceptions are allowed or required by law.

- We're required to release health information to government agencies that are checking on quality of care.
- Because you're a member of our plan through Medicare, we're required to give Medicare your health information. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

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

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

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

If you have questions or concerns about the privacy of your personal health information, call Customer Service at 1-866-390-4276 (TTY users call 711).

Blue Cross and Blue Shield of Illinois (BCBSIL) is required to provide you a HIPAA Notice of Privacy Practices as well as a State Notice of Privacy Practices. The HIPAA Notice of Privacy Practices describes how BCBSIL can use or disclose your protected health information and your rights to that information under federal law. The State Notice of Privacy Practices describes how BCBSIL can use or disclose your nonpublic personal financial information and your rights to that information under state law. Please take a few minutes and review these notices. Please contact Customer Service for more information.

HIPAA NOTICE OF PRIVACY PRACTICES

Effective 10/01/2022

PLEASE REVIEW THIS NOTICE CAREFULLY. IT DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Blue Cross and Blue Shield of Illinois (BCBSIL) is committed to protecting your privacy and understands the importance of safeguarding medical information. We are required by the Health Insurance Portability and Accountability Act (HIPAA) to maintain the privacy of your protected health information (PHI) that identifies you or could be used to identify you. HIPAA also requires that we provide you this Notice of Privacy Practices which explains our legal duties, our privacy practices and your rights regarding the PHI that BCBSIL collects and maintains about you. In addition, state law requires that we provide you a state notice that explains how BCBSIL can use or disclose your nonpublic personal financial information and describes your rights regarding this information.

To receive this notice electronically, go to the Blue Access for Members℠ (BAM℠) portal at BCBSIL.com and sign up.

This section explains the RIGHTS you have regarding your PHI and our obligations regarding these rights. You can exercise these rights by submitting a written request to us – the contact information is at the end of this notice.

Right to request an amendment to your PHI

- You can request an amendment to your PHI in a designated record if you believe it is incorrect or incomplete.
- We have 60 days to respond to your request; however, we can receive an additional 30-days if needed.
- We can deny your request, for example if we determine that your PHI is correct and complete or that we did not create the PHI. We will explain the reason for the denial in the response we send you and you have a right to submit a statement of disagreement.

Right to request confidential communications

- You can request that we contact you in a specific way or at an alternative address.
- We are required to accommodate reasonable requests; however, we do have the right to ask you for information about how your payment will be handled as well as specifics about your communication alternatives.

Right to request a list of individuals or entities who received your PHI

- You can request an accounting of disclosures which is a list of all the disclosures we made during the six years prior to your request date. The list will not contain all disclosures made for treatment, payment, health care operations as well as a couple of other situations (details about these situations are described later in the notice).
- You can request 1 accounting in any 12-month period - if you request additional ones in this time frame, we may charge a reasonable cost-based fee. We will notify you before charging you - you can then withdraw or modify your request to avoid a fee.
- We have 60 days to respond to your request; however, we have an additional 30 days if needed.

Right to request a copy of the Notice

- You can request a paper copy of this notice at any time. To request a copy, submit your written request using the contact information at the end of this notice.

Right to choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, this individual can act on your behalf and make choices for you.
- We will confirm that this individual has the right to act on your behalf before we release any of your PHI.

Right to file a complaint

- You can file a complaint directly with us if you believe we have violated your privacy rights by using the contact information at the end of this notice.
- You can also file a complaint with the Secretary of U.S. Department of Health and Human Services Office for Civil Rights by calling 1-877-696-6775; or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/ or by sending a letter to them at:
  200 Independence Ave., SW, Washington, D.C. 20201.
- We will not retaliate against you in any way for filing a complaint.

This section explains when we must receive your consent before sharing your PHI.

We can share your PHI for these purposes with your verbal or written consent.

- You can identify a relative, close friend, or other person to help you with your care decisions; we will disclose limited PHI needed to that person to assist you. (If you are unable to give your consent and we determine in our professional judgement that it is in your best interest, we can use or disclose your PHI to assist in notifying a family member, personal representative or other person that can help you.)
- For our fundraising efforts.

We cannot use or disclose PHI for these purposes without your written consent.

- To conduct marketing or for our financial benefit
- Release psychotherapy notes
  There may be other uses and disclosures of your PHI beyond those listed that may require your authorization if the use or disclosure is not permitted or required by law.
  You have the right to revoke your authorization, in writing at any time except to the extent that we have already used or disclosed your PHI based on that initial authorization.

This section describes the situations where we are permitted by federal laws to use or share your PHI.

Although not exhaustive, it will give you a good idea of the types of routine uses and disclosures we make.

Manage and support the health care you receive

- We can use your PHI and share it with the health professionals who are treating you, for example, when your provider sends us information about your diagnosis and treatment plan so we can arrange for additional services.

Run our organization

- We can use and disclose your PHI to help us manage our business operations and fulfill our obligations to our customers and members, for example, we use PHI for enrollment, health care programs, activities related to the creation, renewal, or replacement of a health plan, and development of better high quality healthcare services. (We can’t use genetic information to deny or refuse an individual health plan coverage).

Pay for your health services

- We can use and disclose your health information to process your claims and pay your provider, for example, when we share information about you to coordinate benefits between your dental plan and our medical plan.

Administer your plan

- We may disclose your health information to your health plan sponsor for plan administration purposes, for example, if your company contracts with us to provide their group health plan, we may need to provide them certain statistics to explain the premiums we charge.

The following are examples of when we are permitted to use or disclose your PHI without authorization and without your ability to object to its use or disclosure.

Public health activities

- We are permitted to disclose PHI for public health purposes. This includes disclosures to a public health authority or other government agency that has the authority to collect and receive such information (e.g., the Food and Drug Administration).

Health oversight activities

- We can use or disclose your PHI to the extent that it is required by federal, state, or local laws for health oversight.

Abuse, neglect, or serious threat to health or safety

- We can disclose PHI to a government agency or public health authority authorized by law to receive information about adults and children who are victims of abuse, neglect, or domestic violence.
- We also can disclose PHI, if in our professional opinion it is necessary to prevent a serious and imminent threat to the public health or safety; however, the PHI can only be disclosed to someone that we reasonably believe can prevent or lessen the threat.

Research Initiatives

- In certain situations, we are permitted to disclose a limited data set for research purposes.

Required by the Secretary of Health and Human Services

- We may be required to disclose PHI to the Secretary of Health and Human Services so that they can determine our compliance with the requirements of the final rule related to the Standards for Privacy of Individually Identifiable Health Information.

Comply with the law

- In some situations, we may be required by applicable federal, state, or local law to disclose your PHI.

Organ donors, coroners and funeral directors

- If you are an organ donor, we may disclose your PHI to an organ procurement organization if needed to facilitate organ donation or transplantation.
- We may disclose your PHI if it is needed by a medical examiner, coroner or funeral director to perform legally authorized duties.

Workers' Compensation

- We may be required to share PHI to comply with workers compensation laws and other similar programs.

Specialized Government Functions; National Security and Intelligence Activities

- We may be asked to disclose PHI in certain situations such as determining eligibility for benefits offered by the Department of Veterans Affairs.
- We may also be required by law to disclose PHI to authorized federal officials for national security concerns, intelligence or counterintelligence activities, the protection of the President, and other authorized persons or foreign heads of state as may be required by law.

Respond to lawsuits and legal actions

- We may disclose your PHI in response to an administrative or court order but only if the disclosure is expressly authorized.
- We may also be required to disclose PHI to respond to a subpoena, discovery request, or other similar request.

Law enforcement

- We may disclose PHI, if the applicable legal requirements are met, to law enforcement for the purposes of responding to a crime.

Inmates

- We may use or disclose the PHI we created or received in the course of paying for the healthcare services of inmates in a correctional facility.

Business Associates

- We may disclose PHI to a Business Associate which is an entity or person that performs activities or services on our behalf that involve the use, disclosure, access, creation, or storage of PHI. We require a Business Associate to execute appropriate agreements before they initiate these activities or services.

Additional Health information

- Some federal or state laws include additional requirements for the use or disclosure of certain health condition related information. We follow the applicable requirements of these laws.

We also have the following responsibilities and legal obligations to:

- Maintain the privacy and security of your PHI.
- Notify you in the event you are affected by a breach of unsecured PHI.
- Provide you a paper copy of this notice upon request.
- Abide by the terms of this current notice.
- Refrain from using or disclosing PHI in any manner not described in this notice unless you authorize us to do so in writing.

STATE PRIVACY NOTICE

Effective 10/01/2022

Blue Cross and Blue Shield of Illinois (BCBSIL) collects nonpublic personal information about you from your insurance application, healthcare claims, payment information and consumer reporting agencies. BCBSIL will:

- **Not** disclose this information, even if your customer relationship with us ends, to any non-affiliated third parties except with your consent or as permitted by law.
- **Restrict** access to this information to only those employees who perform functions necessary to administer our business and provide services to our customers.
- **Maintain** security and privacy practices that include physical, technical, and administrative safeguards to protect this information from unauthorized access.
- **Use** this information for the sole purpose of administering your insurance plan, processing your claims, ensuring proper billing, providing you with customer service and complying with the law.
- **Only** share this information as required or permitted by law and if needed with the following third parties:
  - Company affiliates
  - Business partners that provide services on our behalf (i.e., claims management, marketing, clinical support)
  - Insurance brokers or agents, financial services firms, stop-loss carriers Regulatory, governmental and law enforcement agencies
  - Your Employer Group Health plan.

You also have the right to ask what nonpublic financial information we have about you and to request a copy of it.

CHANGES TO THESE NOTICES

We reserve the right to change the privacy practices described in these notices and make the new practices apply to all the PHI we maintain about you. Should we make a change, we will post the revised notices on our website. You can always

request a paper copy using the contact information below. Depending on the changes made to the Notice, we may be required by applicable law to mail you a copy.

CONTACT INFORMATION FOR THESE NOTICES

If you would like general information about your privacy rights or would like a copy of these notices, go to: http://www.BCBSIL.com/legal-and-privacy/privacy-notice-and-forms. If you have any questions about this Notice or want to exercise a right described in the Notice, you can contact us by:
Calling: The toll-free number located on your member identification card or 1-877-361-7594.

Writing: Director,
Privacy Office
Blue Cross and Blue Shield of Illinois
300 East Randolph Street
Chicago, IL 60601-5099

REVIEWED: August 2026

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

As a member of Blue Cross Group Medicare Advantage Open Access (PPO), you have the right to get several kinds of information from us.

If you want any of the following kinds of information, call Customer Service at 1-866-390-4276 (TTY users call 711):

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

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

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

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

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

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

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

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

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

How to set up an advance directive to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance

directive forms from organizations that give people information about Medicare. You can also call Customer Service at 1-866-390-4276 (TTY users call 711) to ask for the forms.

- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people.** Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

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

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

If your instructions aren't followed

If you sign an advance directive and you believe that a doctor or hospital didn't follow the instructions in it, you can file a complaint with Illinois Department of Public Health.

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

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

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

If you believe you've been treated unfairly or your rights haven't been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, call the Department of Health and Human Services' **Office for Civil**

Rights at 1-800-368-1019 (TTY users call 1-800-537-7697), or call your local Office for Civil Rights.

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

- **Call Customer Service at 1-866-390-4276 (TTY users call 711)**
- **Call your local SHIP.** See the appendix in the back of this document to locate information for the SHIP in your state.
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

Section 1.8 How to get more information about your rights

Get more information about your rights from these places:

- **Call Customer Service at 1-866-390-4276 (TTY users call 711)**
- **Call your local SHIP.** See the appendix in the back of this document to locate information for the SHIP in your state.
- **Contact Medicare**
    - Visit Medicare.gov to read the publication *Medicare Rights & Protections* (available at Medicare Rights & Protections)
    - Call 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048).

SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, call Customer Service at 1-866-390-4276 (TTY users call 711).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* to learn what's covered and the rules you need to follow to get covered services.
    - Chapters 3 and 4 give details about medical services.
- **If you have any other health coverage in addition to our plan, or separate drug coverage, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.

- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show our plan membership card whenever you get your medical care.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
    - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions you and your doctors agree on.
    - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
    - If you have questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you're responsible for these payments:
    - You must pay our plan premiums.
    - You must continue to pay your Medicare Part B premiums to stay a member of our plan.
    - For some of your medical services covered by our plan, you must pay your share of the cost when you get the service.
    - If you get any medical services that are not covered by our plan or by other insurance you may have, you must pay the full cost.
    - If you disagree with our decision to deny coverage for a service, you can make an appeal. Please see Chapter 7 of this document for information about how to make an appeal.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you**.**
- **If you move, tell Social Security (or the Railroad Retirement Board).**

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

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

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

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

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

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

Section 1.1 Legal terms

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

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

SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Customer Service at 1-866-390-4276 (TTY users call 711) for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help are:

State Health Insurance Assistance Program (SHIP)

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

The services of SHIP counselors are free. You will find phone numbers and website URLs in the appendix in the back of this document.

Medicare

You can also contact Medicare for help:

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

SECTION 3 Which process to use for your problem

Is your problem or concern about your benefits or coverage?

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

Yes.

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

No.

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

Coverage decisions and appeals

SECTION 4 A guide to coverage decisions and appeals

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

Asking for coverage decisions before you get services

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

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

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we might decide medical care isn't covered or is no

longer covered for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

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

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

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

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

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

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

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

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

- **Call Customer Service at 1-866-390-4276 (TTY users call 711)**
- **Get free help** from your State Health Insurance Assistance Program.

- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call Customer Service at 1-866-390-4276 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.)
    - For medical care or Part B drugs, your doctor can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
- **You can ask someone to act on your behalf.** You can name another person to act for you as your *representative* to ask for a coverage decision or make an appeal.
    - If you want a friend, relative, or another person to be your representative, call Customer Service at 1-866-390-4276 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.) This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.
    - We can accept an appeal request from a representative without the form, but we can't begin or complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.2 Rules and deadlines for your different situations

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

- **Section 5:** Medical care: How to ask for a coverage decision or make an appeal

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

If you're not sure which information applies to you, call Customer Service at 1-866-390-4276 (TTY users call 711). You can also get help or information from your SHIP.

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

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

Your benefits for medical care are described in Chapter 4 in the Medical Benefits Chart. To keep things simple, we generally refer to "medical care coverage" or "medical care" which includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Part B drug. In those cases, we'll explain how the rules for Part B drugs are different from the rules for medical items and services.

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

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

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

Section 5.2 How to ask for a coverage decision

Legal Terms:

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

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

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

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

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

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

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

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

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

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

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

For standard coverage decisions we use the standard deadlines.

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

- **However,** if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. We'll give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. Go to Section 9 of this chapter for information on complaints.)

For fast coverage decisions we use an expedited timeframe.

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

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

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

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

Section 5.3 How to make a Level 1 appeal

Legal Terms:

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

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

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

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

- If you're appealing a decision we made about coverage for care, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we'll give you a fast appeal.
- The requirements for getting a *fast appeal* are the same as those for getting a fast coverage decision in Section 5.2 of this chapter.

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

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

- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.** We're allowed to charge a fee for copying and sending this information to you.

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

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

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
    - If you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time if your request is for a Part B drug.
    - If we don't give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we're required to automatically send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. The independent review organization will notify you in writing when it gets your appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for,** we'll send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if your health condition requires us to.
    - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your

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

- If you believe we shouldn't take extra days, you can file a fast complaint. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (Go to Section 9 of this chapter for information on complaints.)
- If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal, where an independent review organization will review the appeal. The independent review organization will notify you in writing when it gets your appeal. Section 5.4 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Part B drug.
- **If our plan says no to part or all of your appeal,** we'll automatically send your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Section 5.4 The Level 2 appeal process

Legal Term:

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

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

Step 1: The independent review organization reviews your appeal.

- We'll send the information about your appeal to this organization. This information is called your **case file. You have the right to ask us for a copy of your case file**. We're allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the independent review organization additional information to support your appeal.

- Reviewers at the independent review organization will take a careful look at all the information related to your appeal.

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

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

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

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

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

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

- **If the independent review organization says yes to part or all of a request for a medical item or service,** we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we get the decision from the independent review organization for **standard requests.** For **expedited requests**, we have **72 hours** from the date we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of a request for a Part B drug**, we must authorize or provide the Part B drug within **72 hours** after we get the decision from the independent review organization for **standard requests.** For **expedited requests** we have **24**

hours from the date we get the decision from the independent review organization.

- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care shouldn't be approved. (This is called **upholding the decision** or **turning down your appeal**.) In this case, the independent review organization will send you a letter that:
  - Explains the decision.
  - Lets you know about your right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
  - Tells you how to file a Level 3 appeal.

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

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

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

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

Asking for reimbursement is asking for a coverage decision from us

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

- **If we say yes to your request:** If the medical care is covered and you followed the rules, we'll send you the payment for our share of the cost typically within 30 calendar days, but no later than 60 calendar days after we get your request. If you haven't paid for the medical care, we'll send the payment directly to the provider.

- **If we say no to your request:** If the medical care is not covered, or you did not follow all the rules, we won't send payment. Instead, we'll send you a letter that says we won't pay for the medical care and the reasons why.

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

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

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

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

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

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

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

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

Within 2 calendar days of being admitted to the hospital, you'll be given a written notice called *An Important Message from Medicare about Your Rights.* Everyone with

Medicare gets a copy of this notice. If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Customer Service at 1-866-390-4276 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:
   - Your right to get Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay.
   - Where to report any concerns you have about the quality of your hospital care.
   - Your right to **request an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date, so we'll cover your hospital care for a longer time.
2. **You'll be asked to sign the written notice to show that you got it and understand your rights.**
   - You or someone who is acting on your behalf will be asked to sign the notice.
   - Signing the notice shows *only* that you got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date.
3. **Keep your copy** of the notice so you'll have the information about making an appeal (or reporting a concern about quality of care) if you need it.
   - If you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
   - To look at a copy of this notice in advance, call Customer Service at 1-866-390-4276 (TTY users call 711) or 1-800 MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can also get the notice online at CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

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

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

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it**. If you have questions or need help, call Customer Service at 1-866-390-4276 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. SHIP contact information is available in the appendix in the back of this document.

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

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

How can you contact this organization?

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

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge.**
    - **If you meet this deadline,** you can stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
    - **If you don't meet this deadline, contact us.** If you decide to stay in the hospital after your planned discharge date, *you may have to pay all the costs* for hospital care you get after your planned discharge date.

Once you ask for an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we're contacted, we'll give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it's right (medically appropriate) for you to be discharged on that date.

You can get a sample of the **Detailed Notice of Discharge** by calling Customer Service at 1-866-390-4276 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227). (TTY users call 1-877-486-2048.) Or you can get a sample notice online at CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

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

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

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

What happens if the answer is yes?

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

What happens if the answer is no?

- If the independent review organization says *no*, they're saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day

after the Quality Improvement Organization gives you its answer to your appeal.

- If the independent review organization says *no* to your appeal and you decide to stay in the hospital, **you may have to pay the full cost** of hospital care you get after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

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

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

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

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

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

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

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

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

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you its decision.

If the independent review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you got since noon on the day after the date your first appeal was turned down by the

Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it's medically necessary.**

- You must continue to pay your share of the costs and coverage limitations may apply.

If the independent review organization says no:

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

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

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

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

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

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

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

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

Legal Term:

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

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

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

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

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it**. If you have questions or need help, call Customer Service at 1-866-390-4276 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. SHIP contact information is available in the appendix in the back of this document.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate. The **Quality Improvement Organization** is a group of doctors and other health care experts who are paid by the federal government to check on and improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts aren't part of our plan.

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

How can you contact this organization?

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

Act quickly:

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

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

Legal Term:

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

What happens during this review?

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

Step 3: Within one full day after they have all the information they need; the reviewers will tell you its decision.

What happens if the reviewers say yes?

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

What happens if the reviewers say no?

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

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

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

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

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

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

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

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

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

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

What happens if the independent review organization says yes?

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

What happens if the independent review organization says no?

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

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

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

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

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

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

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

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

Level 3 appeal

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

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

Level 4 appeal

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

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may* or *may not* be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4

decision that is favorable to you. We'll decide whether to appeal this decision to Level 5.

- If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after getting the Council's decision.
- If we decide to appeal the decision, we'll let you know in writing.

- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal

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

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

Making complaints

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

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

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

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you got (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Customer Service? • Do you feel you're being encouraged to leave our plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Customer Service or other staff at our plan? ○ Examples include waiting too long on the phone, in the waiting or exam room.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals)	If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples:

Complaint	Example
	• You asked us for a *fast coverage decision* or a *fast appeal*, and we said no; you can make a complaint. • You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we aren't meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 9.2 How to make a complaint

Legal Terms:

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

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

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

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

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

- **Calling Customer Service at 1-866-390-4276 (TTY users call 711) is usually the first step.** If there's anything else you need to do, Customer Service will let you know.

- **If you don't want to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing.
- Grievances received verbally will be responded to in writing, unless you request a verbal response.
- Although we may verbally contact you to discuss your grievance and/or the resolution, grievances received in writing will be responded to in writing.
- Grievances related to quality of care, regardless of how the grievance is filed, will be responded to in writing, including a description of your right to file a written complaint with the Quality Improvement Organization (QIO).
- All grievances (verbal and written), will be responded to within the following timeframes:
    - Standard Grievances (any complaint other than an expedited grievance defined above) will be responded to as expeditiously as your case requires, based on your health status, but no later than 30 days after receipt of your grievance. Blue Cross Group Medicare Advantage Open Access (PPO) may extend the 30-day timeframe by up to 14 days if either you request the extension or if Blue Cross Group Medicare Advantage Open Access (PPO) determines additional information is needed and that the delay is in your best interest. If there is a delay, Blue Cross Group Medicare Advantage Open Access (PPO) will notify you in writing of the reason for the delay.
    - Expedited Grievances may only be filed if Blue Cross Group Medicare Advantage Open Access (PPO) denies your request for an expedited coverage determination or expedited redetermination. Expedited Grievances will be responded to within 24 hours.
- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

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

- **If possible, we'll answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, **we can take up to 14 more calendar days** (44 calendar days total) to answer your complaint. If we decide to take extra days, we'll tell you in writing.

- **If you're making a complaint because we denied your request for a fast coverage decision or a fast appeal, we'll automatically give you a fast complaint.** If you have a fast complaint, it means we'll give you **an answer within 24 hours.**
- **If we don't agree** with some or all of your complaint or don't take responsibility for the problem you're complaining about, we'll include our reasons in our response to you.

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

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

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

Or

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

Section 9.4 You can also tell Medicare about your complaint

You can submit a complaint about Blue Cross Group Medicare Advantage Open Access (PPO) directly to Medicare. To submit a complaint to Medicare, go to Medicare.gov/my/medicare-complaint. You can also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048.

CHAPTER 8: Ending membership in our plan

SECTION 1 Ending your membership in our plan

Ending your membership in Blue Cross Group Medicare Advantage Open Access (PPO) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

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

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

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

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

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

- **Check with your employer/group administrator to understand the group's Annual Open Enrollment Period.**
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year**. If you decide to change to a new plan, you can choose any of the following types of coverage:
    - Another Medicare health plan, with or without drug coverage,
    - Original Medicare *with* a separate Medicare drug plan, or
    - Original Medicare *without* a separate Medicare drug plan.
- **Your membership will end in our plan** when your new plan's coverage starts on January 1.

Section 2.2 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of Blue Cross Group Medicare Advantage Open Access (PPO) may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply to you. These are just examples. For the full list you can contact our plan, call Medicare, or visit (Medicare.gov):

- Usually, when you move
- If you have Medicaid through the Illinois Department of Human Services
- If we violate our contract with you
- If you're getting care in an institution, such as a nursing home or long-term care (LTC) hospital
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE)

Enrollment time periods vary depending on your situation.

To find out if you're eligible for a Special Enrollment Period, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. If you're eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and drug coverage. You can choose:

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

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

Section 2.3 Get more information about when you can end your membership

If you have questions about ending your membership you can:

- **Call Customer Service at 1-866-390-4276 (TTY users call 711)**.
- Find the information in the ***Medicare & You 2027*** handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

SECTION 3 How to end your membership in our plan

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

To switch from our plan to:	Here's what to do:
Another Medicare health plan	• Enroll in the new Medicare health plan. • You'll automatically be disenrolled from Blue Cross Group Medicare Advantage Open Access (PPO) when your new plan's coverage starts.
Original Medicare *with* a separate Medicare drug plan	• Enroll in the new Medicare drug plan. • You'll automatically be disenrolled from Blue Cross Group Medicare Advantage Open Access (PPO) when your new drug plan's coverage starts.
Original Medicare *without* a separate Medicare drug plan	• **Send us a written request to disenroll.** Contact Customer Service at 1-866-390-4276 (TTY users call 711) if you need more information on how to do this. • You can also call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users call 1-877-486-2048. • You'll be disenrolled from Blue Cross Group Medicare Advantage Open Access (PPO) when your coverage in Original Medicare starts.

Note: If you have other creditable drug coverage and disenroll from that coverage, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later after going without creditable drug coverage for 63 days or more in a row.

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

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

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

SECTION 5 Blue Cross Group Medicare Advantage Open Access (PPO) must end your plan membership in certain situations

Blue Cross Group Medicare Advantage Open Access (PPO) must end your membership in our plan if any of the following happen:

- If you no longer have Medicare Part A and Part B
- If you become incarcerated (go to prison)
- If you're no longer a United States citizen or national, or an eligible noncitizen
- If you intentionally give us incorrect information when you're enrolling in our plan, and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

If you have questions or want more information on when we can end your membership, call Customer Service at 1-866-390-4276 (TTY users call 711).

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

Blue Cross Group Medicare Advantage Open Access (PPO) isn’t allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

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

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

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

CHAPTER 9: Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about nondiscrimination

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

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

If you have a disability and need help with access to care, call Customer Service at 1-866-390-4276 (TTY users call 711). If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Blue Cross Group Medicare Advantage Open Access (PPO), as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

CHAPTER 10: Definitions

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center doesn't exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or payment for services you already got. You may also make an appeal if you disagree with our decision to stop services that you're getting.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than our plan's allowed cost-sharing amount. As a member of Blue Cross Group Medicare Advantage Open Access (PPO), you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We don't allow providers to **balance bill** or otherwise charge you more than the amount of cost sharing our plan says you must pay.

Benefit Period – The way that both our plan and Original Medicare measure your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't gotten any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There's no limit to the number of benefit periods.

Centers for Medicare & Medicaid Services (CMS) – The federal agency that administers Medicare.

Chronic-Care Special Needs Plan – C-SNPs are SNPs that restrict enrollment to MA eligible people who have specific severe and chronic diseases.

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services after you pay your deductible.

Combined Maximum Out-of-Pocket Amount – This is the most you will pay in a year for all services from both network (preferred) providers and out-of-network

(non-preferred) providers. In addition to the maximum out-of-pocket amount for covered medical services, we also have a maximum out-of-pocket amount for certain types of services. Go to Chapter 4, Section 1, Subsection 1.3 for information about your combined maximum out-of-pocket amount.

Complaint – The formal name for making a complaint is **filing a grievance.** The complaint process is used *only* for certain types of problems. This includes problems about quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or copay) – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription. A copayment is a set amount (for example $10), rather than a percentage.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services are gotten. (This is in addition to our plan's monthly premium.) Cost sharing includes any combination of the following 3 types of payments: 1) any deductible amount a plan may impose before services are covered; 2) any fixed copayment amount that a plan requires when a specific service is gotten; or 3) any coinsurance amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is gotten.

Covered Services – The term we use to mean all the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you don't need skilled medical care or skilled nursing care. Custodial care, provided by people who don't have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may

also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Customer Service – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Deductible – The amount you must pay for health care before our plan pays.

Disenroll or **Disenrollment** – The process of ending your membership in our plan.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll people who are entitled to both Medicare (Title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (Title XIX). States cover some Medicare costs, depending on the state and person's eligibility.

Dually Eligible Individual – A person who is eligible for Medicare and Medicaid coverage.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

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

Emergency Care – Covered services that are: 1) provided by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Grievance – A type of complaint you make about our plan or providers including a complaint concerning the quality of your care. This doesn't involve coverage or payment disputes.

Home Health Aide – A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. Our plan must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you're still a member of our plan. You can still get all medically necessary services as well as the supplemental benefits we offer.

Hospital Inpatient Stay – A hospital stay when you've been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an outpatient.

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Initial Enrollment Period – When you're first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

In-Network Maximum Out-of-Pocket Amount – The most you'll pay for covered services gotten from network (preferred) providers. After you have reached this limit, you won't have to pay anything when you get covered services from network providers for the rest of the contract year. However, until you reach your combined out-of-pocket amount, you must continue to pay your share of the costs when you seek care from an out-of-network (non-preferred) provider. In addition to the maximum out-of-pocket amount for covered medical services, we also have a maximum out-of-pocket amount for certain types of services.

Institutional Special Needs Plan (SNP) – A plan that enrolls eligible individuals who continuously reside or are expected to continuously reside for 90 days or longer in a long-term care (LTC) facility. These facilities may include a skilled nursing

facility (SNF), nursing facility (NF), (SNF/NF), an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), an inpatient psychiatric facility, and/or facilities approved by CMS that furnishes similar long-term, healthcare services that are covered under Medicare Part A, Medicare Part B, or Medicaid; and whose residents have similar needs and healthcare status to the other named facility types. An institutional Special Needs Plan must have a contractual arrangement with (or own and operate) the specific LTC facility(ies).

Institutional Equivalent Special Needs Plan (SNP) – A plan that enrolls eligible individuals living in the community but requiring an institutional level of care based on the State assessment. The assessment must be performed using the same respective State level of care assessment tool and administered by an entity other than the organization offering the plan. This type of Special Needs Plan may restrict enrollment to individuals that reside in a contracted assisted living facility (ALF) if necessary to ensure uniform delivery of specialized care.

Low Income Subsidy (LIS) – Go to Extra Help.

Medicaid (or Medical Assistance) – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Open Enrollment Period – The time period from January 1 to March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan or get coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after a person is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a Medicare Medical

Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all the services that are covered by Medicare Part A and B. The term Medicare-Covered Services doesn't include the extra benefits, such as vision, dental, or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in our plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill *gaps* in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or Plan Member) – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network Provider – Provider is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. **Network providers** have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called **plan providers**.

Open Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called coverage decisions in this document.

Original Medicare (Traditional Medicare or Fee-for-Service Medicare) – Original Medicare is offered by the government, and not a private health plan such as Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that doesn't have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that aren't employed, owned, or operated by our plan.

Out-of-Pocket Costs – Go to the definition for *cost sharing* above. A member's cost-sharing requirement to pay for a portion of services gotten is also referred to as the member's out-of-pocket cost requirement.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Part C – Go to Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Preferred Provider Organization (PPO) plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they're gotten from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are gotten from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services gotten from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Preventive Services – Health care to services that help you stay healthy, detect health problems early, determine the most effective treatments, and prevent certain diseases. Preventive services include exams, shots, lab tests, and screenings. They also include programs for health monitoring, and counseling and education to help you take care of your own health.

Prior Authorization – Approval in advance to get covered services based on specific criteria. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other network provider gets prior authorization from our plan. In a PPO, you don't need prior authorization to get out-of-network services. However, you may want to check with our plan before getting services from out-of-network providers to confirm that the service is covered by our plan and what your cost-sharing responsibility is. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4.

Prosthetics and Orthotics – Medical devices including, but not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.

Referral – A written order from your primary care doctor for you to visit a specialist or get certain medical services. Without a referral, our plan may not pay for services from a specialist.

Rehabilitation Services – These services include inpatient rehabilitation care, physical therapy (outpatient), speech and language therapy, and occupational therapy.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. Our plan must disenroll you if you permanently move out of our plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you move into a nursing home, or if we violate our contract with you.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who live in a nursing home, or who have certain chronic medical conditions.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits aren't the same as Social Security benefits.

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

State Health Insurance Assistance Programs (SHIPs)

State	Ship Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Alabama	State Health Insurance Assistance Program	201 Monroe Street, Suite 350	Montgomery, AL 36104	1-800-243-5463 TTY: 711	alabamaageline.gov
Alaska	Alaska State Health Insurance Assistance Program	550 W. 8th Avenue	Anchorage, AK 99501	1-800-478-6065 TTY: 1-800-770-8973	shiphelp.org/about-medicare/regional-ship-location/alaska
Arizona	Arizona State Health Insurance Assistance Program	1789 W Jefferson Street, Site Code 950A	Phoenix, AZ 85007	1-800-432-4040 TTY: 711	des.az.gov
Arkansas	Senior Health Insurance Information Program	1 Commerce Way	Little Rock, AR 72202	1-800-224-6330 TTY: 711	insurance.arkansas.gov/pages/consumer-services/senior-health/
California	Health Insurance Counseling & Advocacy Program (HICAP)	1300 National Drive, Suite 200	Sacramento, CA 95834	1-800-434-0222 TTY: 711	aging.ca.gov/Programs_and_Services/Medicare_Counseling/
Colorado	State Health Insurance Assistance Program	1560 Broadway, Suite 850	Denver, CO 80202	1-888-696-7213 TTY: 711	colorado.gov/dora/seniorhealthcare-medicare

State	Ship Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Connecticut	CHOICES	55 Farmington Avenue, 12th Floor	Hartford, CT 06105	1-800-994-9422 TTY: 1-800-842-4524	portal.ct.gov/AgingAndDisability
Delaware	Delaware Medicare Assistance Bureau	841 Silver Lake Boulevard	Dover, DE 19904	1-800-336-9500 TTY: 711	insurance.delaware.gov/divisions/dmab/
District of Columbia	Health Insurance Counseling Project (HICP)	Dept. of Aging and Community Living 500 K Street NE	Washington, DC 20002	1-202-724-5626 TTY: 711	dcoa.dc.gov/service/dc-state-healthinsurance-assistanceprogram-ship
Florida	Serving Health Insurance Needs of Elders (SHINE)	4040 Esplanade Way, Suite 270	Tallahassee, FL 32399	1-800-963-5337 TTY: 1-800-955-8771	floridashine.org/
Georgia	Georgia SHIP	2 Peachtree Street, NW, Suite 33-101	Atlanta, GA 30303	1-866-552-4464 TTY: 711	aging.georgia.gov/georgia-ship
Hawaii	Hawaii State Health Insurance Assistance Program	250 S Hotel Street, Suite 406	Honolulu, HI 96813	1-888-875-9229 TTY: 1-866-810-4379	hawaiiship.org/
Idaho	Senior Health Insurance Benefits Advisors (SHIBA)	700 West State Street, P.O. Box 83720	Boise, ID 83720	1-800-247-4422 TTY: 711	doi.idaho.gov/shiba/

State	Ship Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Illinois	Senior Health Insurance Program	320 W Washington Street, 5th Floor	Springfield, IL 62767	1-800-252-8966 TTY: 1-888-206-1327	illinois.gov/aging/ship/Pages/default.aspx
Indiana	State Health Insurance Assistance Program	311 W. Washington Street, Suite 300	Indianapolis, IN 46204-2787	1-800-452-4800 TTY: 1-866-846-0139	in.gov/ship/index.htm
Iowa	Senior Health Insurance Information Program	601 Locust Street, 4th Floor	Des Moines, IA 50309	1-800-351-4664 TTY: 1-800-735-2942	shiip.iowa.gov/
Kansas	Senior Health Insurance Counseling for Kansas (SHICK)	New England Building, 503 S. Kansas Avenue	Topeka KS 66603-3404	1-800-860-5260 TTY: 711	kdads.ks.gov
Kentucky	State Health Insurance Assistance Program	275 E. Main Street, 3E-E	Frankfort, KY 40621	1-877-293-7447 TTY: 1-888-642-1137	chfs.ky.gov/agencies/dail/Pages/ship.aspx
Louisiana	State Health Insurance Assistance Program	P.O. Box 94214	Baton Rouge, LA 70804	1-800-259-5300 TTY: 711	ldi.la.gov/consumers/senior-health-shiip
Maine	Maine State Health Insurance Assistance Program	41 Anthony Avenue	Augusta, ME 04333	1-800-262-2232 TTY: 1-800-606-0215	maine.gov/dhhs/oads/get-support/older-adults-disabilities/older-adult-

State	Ship Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
					services/ship-medicare-assistance
Maryland	State Health Insurance Assistance Program	301 W Preston Street, Suite 1007	Baltimore, MD 21201	1-800-243-3425 TTY: 1-800-637-4113	aging.maryland.gov/Pages/state-health-insurance-program.aspx
Massachusetts	Serving the Health Insurance Needs of Everyone (SHINE)	1 Ashburton Place, 5th Floor	Boston, MA 02108	1-800-243-4636 TTY: 1-800-610-0241	mass.gov/info-details/serving-the-health-insurance-needs-of-everyone-shine-program
Michigan	Medicare/Medicaid Assistance Program (MMAP)	6105 W St. Joseph Highway, Suite 204	Lansing, MI 48917	1-800-803-7174 TTY: 711	michigan.gov/mdhhs/doing-business/providers/integrated/other/michigan-medicare-medicaid-assistance-program-mmap
Minnesota	Senior LinkAge Line	540 Cedar Street, P.O. Box 64976	Saint Paul, MN 55164	1-800-333-2433 TTY: 711	mn.gov/senior-linkage-line/

State	Ship Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Mississippi	State Health Insurance Assistance Program	200 South Lamar Street	Jackson, MS 39201	1-800-948-3090 TTY: 711	shiphelp.org/ships/mississippi/
Missouri	CLAIM	200 North Keene Street, Suite 101	Columbia, MO 65201	1-800-390-3330 TTY: 711	missouriclaim.org/
Montana	State Health Insurance Assistance Program	2030 11th Avenue, P.O. Box 4210	Helena, MT 59604	1-800-551-3191 TTY: 711	dphhs.mt.gov/SLTC/aging/SHIP
Nebraska	Senior Health Insurance Information Program	1526 K Street, Suite 201	Lincoln, NE 68508	1-800-234-7119 TTY: 1-800-833-7352	doi.nebraska.gov/ship-smp
Nevada	State Health Insurance Assistance Program	3416 Goni Road, Suite D-132	Carson City, NV 89706	1-800-307-4444 TTY: 711	adsd.nv.gov/Programs/Seniors/Medicare_Assistance_Program_(MAP)/MAP_Prog/
New Hampshire	ServiceLink Resource Center	Gallen State Office Park, 129 Pleasant Street	Concord, NH 03301	1-866-634-9412 TTY: 1-800-735-2964	servicelink.nh.gov/medicare/index.htm
New Jersey	State Health Insurance Assistance Program	P.O. Box 807	Trenton, NJ 08625	1-800-792-8820 TTY: 711	nj.gov/humanservices/doas/services/q-z/ship/index.shtml

State	Ship Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
New Mexico	New Mexico ADRC	2550 Cerrillos Road	Santa Fe, NM 87505	1-800-432-2080 TTY: 1-505-476-3628	aging.nm.gov/
New York	Health Insurance Information Counseling and Assistance Program (HIICAP)	2 Empire State Plaza, Agency Bldg. #2, 4th Floor	Albany, NY 12223	1-800-701-0501 TTY: 711	aging.ny.gov/health-insurance-information-counseling-and-assistance-program-hiicap
North Carolina	Seniors' Health Insurance Information Program	325 N. Salisbury Street	Raleigh, NC 27603	1-855-408-1212 TTY: 1-800-735-2962	ncdoi.gov/consumers/medicare-and-seniors-health-insurance-information-program-shiip
North Dakota	State Health Insurance Counseling (SHIC)	600 East Blvd, State Capitol, Dept 401	Bismarck, ND 58505	1-888-575-6611 TTY: 1-800-366-6888	insurance.nd.gov/shic-medicare
Ohio	Ohio Senior Health Insurance Information Program (OSHIIP)	50 West Town Street, 3rd Floor, Suite 300	Columbus, OH 43215	1-800-686-1578 TTY: 1-614-644-3745	insurance.ohio.gov/consumers/medicare/01-oshiip
Oklahoma	Oklahoma Insurance Department	400 NE 50th Street	Oklahoma City, OK 73105	1-800-522-0071 TTY: 711	oid.ok.gov/consumers/information-for-seniors/senior-health-insurance-

State	Ship Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
					counseling-program-ship/
Oregon	Senior Health Insurance Benefits Assistance (SHIBA)	P.O Box 14480	Salem, OR 97309	1-800-722-4134 TTY: 711	healthcare.oregon.gov/shiba/pages/index.aspx
Pennsylvania	PA MEDI	555 Walnut Street, 5th Floor	Harrisburg, PA 17101	1-800-783-7067 TTY: 711	aging.pa.gov/aging-services/medicare-counseling/Pages/default.aspx
Rhode Island	Senior Health Insurance Program	Office of Healthy Aging 25 Howard Ave, Building 57	Cranston, RI 02920	1-401-462-3000 TTY: 1-401-462-0740	oha.ri.gov/Medicare
South Carolina	Insurance Counseling Assistance and Referrals for Elders (I-CARE)	1301 Gervais Street., Suite 350	Columbia, SC 29202	1-800-868-9095 TTY: 711	aging.sc.gov/
South Dakota	Senior Health Information & Insurance Education (SHIINE)	Center for Active Generations, 700 Governors Drive	Pierre, SD 57501	1-877-331-4834 TTY: 711	shiine.net/

State	Ship Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Tennessee	State Health Insurance Assistance Program	502 Deaderick Street, 9th Floor	Nashville, TN 37243-0860	1-877-801-0044 TTY: 711	tn.gov/disability-and-aging/disability-aging-programs/tn-ship.html
Texas	Health Information Counseling and Advocacy Program (HICAP)	701 West 51st Street, MC: W352	Austin, TX 78751	1-800-252-9240 TTY: 1-800-735-2989	hhs.texas.gov/services/health/medicare
Utah	Senior Health Insurance Information Program	195 North 1950 West	Salt Lake City, UT 84116	1-800-541-7735 TTY: 711	daas.utah.gov/seniors/
Vermont	The Vermont State Health Insurance Assistance Program	HC 2 South 280 State Drive	Waterbury, VT 05671-2070	1-800-642-5119 TTY: 711	asd.vermont.gov/services/ship
Virginia	Virginia Insurance Counseling and Assistance Program (VICAP)	1610 Forest Avenue, Suite 100	Richmond, VA 23229	1-800-552-3402 TTY: 711	vda.virginia.gov/vicap.htm
Washington	Statewide Health Insurance Benefits Advisors (SHIBA)	5000 Capital Boulevard SE	Tumwater, WA 98501	1-800-562-6900 TTY: 1-360-586-0241	insurance.wa.gov/statewide-health-insurance-

State	Ship Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
					benefits-advisors-shiba
West Virginia	West Virginia State Health Insurance Assistance Program	1900 Kanawha Boulevard, E, 3rd Floor	Charleston, WV 25305	1-877-987-4463 TTY: 711	wvship.org/
Wisconsin	State Health Insurance Assistance Program	1 West Wilson Street	Madison, WI 53703	1-800-242-1060 TTY: 1-888-758-6049	dhs.wisconsin.gov/benefit-specialists/medicare-counseling.htm
Wyoming	Wyoming State Health Insurance Information Program	106 West Adams Avenue	Riverton, WY 82001	1-800-856-4398 TTY: 711	wyomingseniors.com/services/wyoming-state-health-insurance-information-program

Quality Improvement Organization (QIOs)

States	QIO Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Alabama Florida Georgia Kentucky	Acentra Health	1650 Summit Lake Dr., Suite 102	Tallahassee, FL 32317	1-888-317-0751 TTY: 711	acentraqio.com/

States	QIO Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Mississippi North Carolina South Carolina Tennessee					
Alaska Idaho Oregon Washington	Acentra Health	1650 Summit Lake Dr., Suite 102	Tallahassee, FL 32317	1-888-305-6759 TTY: 711	acentraqio.com/
Arizona California Hawaii Nevada	Commence Health-BFCC-QIO Program	PO Box 2687	Virginia Beach, VA 23454	1-877-588-1123 TTY: 711	commencehealthqio.cms.gov/en
Arkansas Louisiana New Mexico Oklahoma Texas	Acentra Health	1650 Summit Lake Dr., Suite 102	Tallahassee, FL 32317	1-888-315-0636 TTY: 711	acentraqio.com/
Colorado Montana North Dakota South Dakota Utah Wyoming	Acentra Health	1650 Summit Lake Dr., Suite 102	Tallahassee, FL 32317	1-888-317-0891 TTY: 711	acentraqio.com/
Connecticut Maine Massachusetts New Hampshire Rhode Island Vermont	Acentra Health	1650 Summit Lake Dr., Suite 102	Tallahassee, FL 32317	1-888-319-8452 TTY: 711	acentraqio.com/

States	QIO Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Delaware District of Columbia Maryland Pennsylvania Virginia West Virginia	Commence Health-BFCC-QIO Program	PO Box 2687	Virginia Beach, VA 23454	1-888-396-4646 TTY:711	commencehealthqio.cms.gov/en
Illinois Indiana Michigan Minnesota Ohio Wisconsin	Commence Health-BFCC-QIO Program	PO Box 2687	Virginia Beach, VA 23454	1-888-524-9900 TTY: 711	commencehealthqio.cms.gov/en
Iowa Kansas Missouri Nebraska	Commence Health-BFCC-QIO Program	PO Box 2687	Virginia Beach, VA 23454	1-888-755-5580 TTY: 711	commencehealthqio.cms.gov/en
New Jersey New York Puerto Rico Virgin Islands	Commence Health-BFCC-QIO Program	PO Box 2687	Virginia Beach, VA 23454	1-866-815-5440 TTY: 711	commencehealthqio.cms.gov/en

Medicaid State Agencies

States	Medicaid Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Alabama	Alabama Medicaid Agency	501 Dexter Avenue, P.O. Box 5624	Montgomery, AL 36104	1-800-362-1504 TTY: 711 8 am - 5 pm CST	medicaid.alabama.gov/
Alaska	Alaska Department of Health and Social Services	3601 C Street, Suite 902	Anchorage, AK 99503-5923	1-800-770-5650 TTY: 1-907-586-4265 8 am - 5 pm AKST	dhss.alaska.gov/Pages/default.aspx
Arizona	Arizona Health Care Cost Containment System (AHCCCS)	801 E. Jefferson Street, MD 4100	Phoenix, AZ 85034	1-800-654-8713 TTY: 1-800-842-6520 8 am - 5 pm MST	azahcccs.gov/
Arkansas	Arkansas Department of Human Services	Donaghey Plaza, P.O. Box 1437 - slot S401	Little Rock, AR 72203	1-800-482-5431 TTY: 1-800-285-1131 8 am - 4:30 pm CST	humanservices.arkansas.gov/divisions-shared-services/medical-services/helpful-information-for-clients/
California	Medi-Cal	P.O. Box 997413, MS 4400	Sacramento CA 95899-7413	1-800-541-5555 TTY: 1-800-896-2512 8 am - 5 pm PST	dhcs.ca.gov/individuals

States	Medicaid Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Colorado	Health First Colorado (Department of Health Care Policy and Financing)	1570 Grant Street	Denver, CO 80203	1-800-221-3943 TTY: 711 7:30 a.m. - 5:15 p.m. MST	healthfirstcolorado.com/
Connecticut	Connecticut Department of Social Services	55 Farmington Avenue	Hartford, CT 06105-3730	1-800-842-1508 TTY: 1-800-842-4524 7:30 am - 4:00 pm EST	portal.ct.gov/dss
Delaware	Delaware Health and Social Services	1901 N. Du Pont Highway, Main Bldg.	New Castle, DE 19720	1-800-372-2022 TTY: 711 9 am - 8 pm EST	dhss.delaware.gov/dhss/dss/medicaid.html
District of Columbia	DC Department of Health Care Finance (DHCF)	441 4th St NW - 900S	Washington, DC 20001	1-202-442-5988 TTY: 711 8:15 am - 4:45 pm EST	dhcf.dc.gov/
Florida	Florida Agency for Health Care Administration	2727 Mahan Drive Mail Stop #8	Tallahassee, FL 32308	1-888-419-3456 TTY: 1-800-955-8771 8 am - 5 pm EST	ahca.myflorida.com/index.html
Georgia	Georgia Medicaid (Georgia Department of Community Health)	2 Peachtree Street NW	Atlanta, GA 30303	1-877-423-4746 TTY: 711 8 am - 5 pm EST	medicaid.georgia.gov/

States	Medicaid Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Hawaii	Department of Human Services, Med-QUEST Division	1404 Kilauea Avenue	Hilo, HI 96720	1-800-316-8005 TTY: 1-800-603-1201 9:00 am - 4:30 pm HST	medquest.hawaii.gov/
Idaho	Idaho Department of Health and Welfare	150 Shoup Ave #19	Idaho Falls, ID 83402	1-877-456-1233 TTY: 711 8 am - 5 pm MST	healthandwelfare.idaho.gov/Medical/Medicaid/tabid/123/Default.aspx
Illinois	Illinois Department of Healthcare and Family Services	201 South Grand Avenue East	Springfield, IL 62763-0001	1-800-843-6154 TTY: 1-866-324-5553 8 am - 5 pm CST	illinois.gov/hfs/Pages/default.aspx
Indiana	Office of Medicaid Policy and Planning (OMPP), Family and Social Services Administration (FSSA)	402 W. Washington Street P.O. Box 7083	Indianapolis, IN 46207-7083	1-800-457-8283 TTY: 711 8 am - 4:30 pm EST	in.gov/fssa/2408.htm
Iowa	Iowa Medicaid Enterprise	P.O. Box 36510	Des Moines, IA 50315	1-800-338-8366 TTY: 1-800-735-2942 8 am - 5 pm CST	hhs.iowa.gov/medicaid/member-services

States	Medicaid Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Kansas	KanCare [Kansas Department of Health and Environment (KDHE), Division of Health Care Finance (DHCF)]	1000 SW Jackson, Suite 900 N	Topeka, KS 66612	1-888-369-4777 TTY: 1-800-766-3777 8 am - 5 pm CST	kancare.ks.gov/
Kentucky	Kentucky Medicaid [Cabinet for Health and Family Services, Department for Medicaid Services (DMS)]	275 East Main Street 1E-B	Frankfort, KY 40621	1-800-372-2973 TTY: 1-800-627-4702 8 am - 4:30 pm EST	chfs.ky.gov/agencies/dms/Pages/default.aspx
Louisiana	Department of Health & Hospitals	P.O. Box 91278	Baton Rouge, LA 70821	1-888-342-6207 TTY: 711 8 am - 4:30 pm CST	ldh.la.gov/index.cfm/subhome/1/n/10
Maine	MaineCare (Department of Health and Human Services)	Office of MaineCare Services, 11 State House Station	Augusta, ME 04333	1-800-977-6740 TTY: 711 8 am - 5 pm EST	maine.gov/dhhs/ofi/programs-services/health-care-assistance
Maryland	Department of Health and Mental Hygiene, Health Care Financing	201 West Preston Street	Baltimore, MD 21201	1-877- 463-3464 TTY: 1-800-735-2258 8:30 am - 5 pm EST	mmcp.health.maryland.gov/Pages/home.aspx

States	Medicaid Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Massachusetts	MassHealth, Health and Human Services	One Ashburton Place 11th Floor	Boston, MA 02108	1-800-841-2900 TTY: 1-800-497-4648 8 am - 5 pm EST	mass.gov/topics/masshealth
Michigan	Michigan Department of Community Health (MDCH)	333 S. Grand Ave, P.O. Box 30195	Lansing, MI 48909	1-517-241-3740 TTY: 711 8 am - 5 pm EST	michigan.gov/medicaid
Minnesota	Minnesota Department of Human Services	P.O. Box 64249	St. Paul, MN 55164	1-800-657-3739 TTY: 1-800-627-3529 8 am - 5 pm CST	mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/programs-and-services/medical-assistance.jsp mn.gov/dhs/
Mississippi	Mississippi Division of Medicaid	550 High Street, Suite 1000	Jackson, MS 39201	1-800-421-2408 TTY: 711 8 am - 5 pm CST	medicaid.ms.gov/
Missouri	MO HealthNet (Medicaid) (Missouri Department of Social Services)	615 Howerton Court, P.O. Box 6500	Jefferson City, MO 65102-6500	1-800-348-6627 TTY: 1-800-735-2966 7 am - 6 pm CST	mydss.mo.gov/healthcare dss.mo.gov/mhd/index.htm

States	Medicaid Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Montana	Montana Department of Public Health and Human Services (DPHHS)	111 North Sanders, Helena	Helena, MT 59601	1-800-362-8312 TTY: 711 8 am - 5 pm MST	dphhs.mt.gov/MontanaHealthcarePrograms/MemberServices dphhs.mt.gov/
Nebraska	ACCESSNebraska (Department of Health and Human Services, Division of Medicaid and Long-Term Care)	301 Centennial Mall South, P.O. Box 95026	Lincoln, NE 68509	1-855-632-7633 TTY: 711 8 am - 5 pm CST	dhhs.ne.gov/pages/accessnebraska.aspx
Nevada	Nevada Dept. of Health & Human Services, Division of Health Care Financing and Policy (DHCFP)	3416 Goni Rd – Ste D-132	Carson City, NV 89706	1-800-992-0900 TTY: 711 8 am - 5 pm PST	dhcfp.nv.gov/
New Hampshire	NH Medicaid [New Hampshire Department of Health and Human Services (DHHS)]	129 Pleasant Street	Concord, NH 03301-3857	1-800-852-3345 ext. 4344 TTY: 1-800-735-2964 8 am - 4:30 M-F EST	dhhs.nh.gov/programs-services/medicaid

States	Medicaid Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
New Jersey	Dept. of Human Services, Division of Medical Assistance & Health Services	Quakerbridge Plaza, P.O. Box 712	Trenton, NJ 08625-0712	1-800-356-1561 TTY: 1-877-294-4356 8 am - 5 pm EST	nj.gov/humanservices/dmahs/home/
New Mexico	New Mexico Human Services Department's Medical Assistance Division (MAD)	P.O. Box 2348	Santa Fe, NM 87504	1-800-283-4465 TTY: 711 7 am – 6:30 pm	hsd.state.nm.us/new-mexico-medicaid-state-plan/
New York	New York State Department of Health	Corning Tower, Empire State Plaza	Albany, NY 12237	1-800-541-2831 TTY: 711 8 am - 5 pm EST	health.ny.gov/
North Carolina	NC Department of Health and Human Services, Division of Medical Assistance	1985 Umstead Dr.	Raleigh, NC 27603-2001	1-800-662-7030 TTY: 711 8 am - 5 pm EST	medicaid.ncdhhs.gov/beneficiaries
North Dakota	North Dakota Department of Human Services, Medical Services	600 E Boulevard Ave, Dept 325	Bismarck, ND 58505-0250	1-800-472-2622 TTY: 711 or Relay 800-366-6888 8 am - 5 pm CST	nd.gov/dhs/services/medicalserv/medicaid/

States	Medicaid Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Ohio	Ohio Department Medicaid	50 West Town Street, Suite 400	Columbus, OH 43215	1-800-324-8680 TTY: 711 Monday - Friday 7 am - 8 pm Saturday 8am - 5pm	medicaid.ohio.gov/
Oklahoma	Oklahoma Health Care Authority	4345 N. Lincoln Blvd.	Oklahoma City, OK 73105	1-800-987-7767 TTY: 711 8 am - 5 pm CST	okhca.org/
Oregon	Oregon Health Plan (OHP), Div. of Medical Assistance Programs (DMAP)	500 Summer Street NE, E-20	Salem, OR 97301-1079	1-800-273-0557 TTY: 711 8 am - 5 pm PST	oregon.gov/oha/hsd/ohp/Pages/index.aspx
Pennsylvania	Medical Assistance (Department of Health)	Health and Welfare Building 8th Floor West 625 Forster St.	Harrisburg, PA 17120	1-877-395-8930 TTY: 1-800-451-5886 8 am - 5 pm EST	dhs.pa.gov/Services/Assistance/Pages/Medical-Assistance.aspx
Rhode Island	Rhode Island Department of Human Services	57 Howard Avenue	Cranstom, RI 02920	1-855-840-4774 TTY: 711 Monday - Friday 8:30 a.m. - 3:30 p.m.	dhs.ri.gov/
South Carolina	South Carolina Department of Health and Human Services	SCDHHS P.O. Box 100101	Columbia, SC 29202	1-888-549-0820 TTY: 1-888-842-3620	scdhhs.gov/

States	Medicaid Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
				8 am - 5 pm EST	
South Dakota	South Dakota Medicaid (South Dakota Department of Social Services, The Division of Medical Services)	700 Governors Drive	Pierre, SD 57501	1-800-597-1603 8 am - 5 pm	dss.sd.gov/medicaid/
Tennessee	TennCare	310 Great Circle Rd	Nashville, TN 37243	1-800-342-3145 TTY: 711 8 am - 5 pm CST	tn.gov/tenncare/
Texas	Texas Health and Human Services Commission	North Austin Complex Building 4601 W. Guadalupe St. P.O. Box 13247	Austin, TX 78751-3146	211 TTY: 1-512-424-6597 8 am - 5 pm CST	hhs.texas.gov/services/health/medicaid-chip
Utah	Utah Department of Human Services	P.O. Box 143106	Salt Lake City, UT 84114	1-800-662-9651 TTY: 711 8 am - 5 pm MST	medicaid.utah.gov/
Vermont	Green Mountain Care [Department of Vermont	280 State Drive	Waterbury, Vermont 05671	1-800-250-8427 TTY: 1-888-834-7898 7:45am -	greenmountaincare.org/health-plans/medicaid

States	Medicaid Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
	Health Access (DVHA)]			4:30pm EST	
Virginia	Department of Medical Assistance Services (DMAS)	600 East Broad Street	Richmond, VA 23219	1-804-786-7933 TTY: 1-800-343-0634 8 am - 5 pm MST	bms.wv.gov/
Washington	Apple Health (Washington State Department of Social and Health Services)	626 8th Avenue SE Mailing Address: P.O. Box 45531	Olympia, WA 98501	1-877-501-2233 TTY: 711 8 am - 5 pm PST	hca.wa.gov/about-hca/programs-and-initiatives/apple-health-medicaid
West Virginia	Department of Health and Human Resources	350 Capitol Street, Room 251	Charleston, WV 25301	1-304-558-1700 TTY: 711 8 am - 5 pm EST	bms.wv.gov/
Wisconsin	Wisconsin Department of Health and Family Services	1 West Wilson Street	Madison, WI 53703	1-800-362-3002 or 608-266-1865 TTY: 711 8 am - 6 pm CST	dhs.wisconsin.gov/ dhs.wisconsin.gov/medicaid/index.htm
Wyoming	Wyoming Medicaid (Wyoming Department of Health,	401 Hathaway Building	Cheyenne, WY 82002	1-866-571-0944 TTY: 711 8 am - 5 pm MST	health.wyo.gov/publichealth/communicable-disease-unit/hiv-treatment-program/hiv-

States	Medicaid Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
	Healthcare Financing)				treatment-resources-for-patients/

State Pharmaceutical Assistance Programs (SPAPs)

States	SPAP Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Colorado	Ryan White State Drug Assistance Program (SDAP)	CDPHE Care and Treatment Program ADAP-3800, 4300 Cherry Creek Drive South	Denver, CO 80246	1-303-692-2716 TTY: 711 Mon-Fri, 8 a.m. to 5 p.m.	colorado.gov/pacific/cdphe/state-drug-assistance-program
Delaware	Chronic Renal Disease Program (CRDP)	Riverwalk, 253 NE Front Street	Milford, DE 19963	1-800-464-4357 or 1-302-424-7180	dhss.delaware.gov/dhss/dmma/crdprog.html
Idaho	Idaho HIV State Prescription Assistance Program (IDAGAP)	450 W. State Street, P.O. Box 83720	Boise, ID 83720-0036	1-208-334-5612 TTY: 711 Mon-Fri, 8 a.m. to 5 p.m.	healthandwelfare.idaho.gov/Health/FamilyPlanningSTDHIV/HIVCareandTreatment/tabid/391/Default.aspx
Indiana	Indiana HoosierRx	P.O. Box 6224	Indianapolis IN 46206-6224	1-866-267-4679 TTY: 711 Mon-Fri, 7 a.m. to 3 p.m.	in.gov/medicaid/members/26.htm
Maine	Maine Low Cost Drugs for the Elderly and Disabled Program Office of MaineCare Services	242 State Street	Augusta, ME 04333	1-866-796-2463 TTY: 1-800-606-0215 Mon-Fri, 8 a.m. to 5 p.m.	q1medicare.com/PartD-SPAPMaineLowCstRxElderlyDisabled.php

States	SPAP Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Maryland	Maryland Senior Prescription Drug Assistance Program (SPDAP)	c/o Pool Administrators, 628 Hebron Avenue, Suite 502	Glastonbury, CT 06033	1-800-551-5995 TTY: 1-800-877-5156 Mon-Fri, 8 a.m. to 5 p.m.	marylandspdap.com/
Massachusetts	Massachusetts Prescription Advantage	P.O. Box 15153	Worcester, MA 01615-0153	1-800-243-4636 ext 2 TTY: 1-877-610-0241 Mon-Fri, 8 a.m. to 5 p.m.	mass.gov/prescription-drug-assistance
Montana	Montana Big Sky Rx Program	P.O. Box 202915	Helena, MT 59620-2915	1-866-369-1233 TTY: 711 Mon-Fri, 8 a.m. to 5 p.m.	dphhs.mt.gov/SLTC/aging/BigSky
Nevada	Nevada Senior Rx, Department of Health and Human Services	3320 W. Sahara Ave, Suite 100	Las Vegas, NV 89102	1-866-303-6323 (option 2) TTY: 711 Mon-Fri, 8 a.m. to 5 p.m.	adsd.nv.gov/Programs/Seniors/SeniorRx/SrRxProg/
New Jersey	New Jersey Department of Health and Senior Services Pharmaceutical Assistance to the Aged and	P.O. Box 715	Trenton, NJ 08625-0715	1-800-792-9745 TTY: 711 Mon-Fri, 8 a.m. to 5 p.m.	nj.gov/humanservices/doas/services/l-p/paad/

States	SPAP Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
	Disabled Program (PAAD)				
New York	New York Elderly Pharmaceutical Insurance Coverage Program (EPIC)	P.O. Box 15018	Albany, NY 12212-5018	1-800-332-3742 TTY: 1-800-290-9138 Mon-Fri, 8 a.m. to 5 p.m.	health.ny.gov/health_care/epic/
Pennsylvania	Pennsylvania Department of Aging PACE and PACENET Programs	P.O. Box 8806	Harrisburg, PA 17105-8806	1-800-225-7223 TTY: 711 Mon-Fri, 8 a.m. to 5 p.m.	aging.pa.gov/aging-services/prescriptions/Pages/default.aspx
Rhode Island	Rhode Island Pharmaceutical Assistance to the Elderly (RIPAE)	Division of Elderly Affairs, 57 Howard Ave, Louis Pasteur Bldg, 2nd Floor	Cranston, RI 02920-3039	1-401-462-3000 TTY: 1-401-462-0740 Mon-Fri, 8 a.m. to 5 p.m.	payingforseniorcare.com/rhode-island/ripae
Texas	Texas Kidney Health Care Program (KHC)	Kidney Health Care Mail Code 1938 P.O. Box 149030	Austin, TX 78714-9947	1-800-222-3986 TTY: 711 Mon-Fri, 8 a.m. to 5 p.m.	hhs.texas.gov/services/health/chronic-kidney-disease/kidney-health-care

States	SPAP Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Vermont	Department of Vermont Health Access Vermont VPharm	Application & Document Processing Center 280 State Drive	Waterbury, VT 05671-1500	1-800-250-8427 TTY: 711 Mon-Fri, 8 a.m. to 5 p.m.	greenmountaincare.org/
Virginia	Virginia Medication Assistance Program (MAP)	Virginia Department of Health, HCS Unit, 1st Floor, James Madison Building, 109 Governor Street	Richmond, VA 23219	1-855-362-0658 TTY: 711	vdh.virginia.gov/disease-prevention/vamap/
Washington	Washington State Health Insurance State Pharmacy Assistance Program	P.O. Box 1090	Great Bend, KS, 67530	1-800-877-5187 TTY: 711 Mon-Fri, 8 a.m. to 5 p.m. Pacific	insurance.wa.gov/washington-state-health-insurance-pool-wship
Wisconsin	Wisconsin Senior Care	1 West Wilson Street	Madison, WI 53703	1-608-266-1865 TTY: 1-800-947-3529 or 711 Mon-Fri, 8 a.m. to 5 p.m.	dhs.wisconsin.gov/seniorcare/index.htm

AIDS Drug Assistance Programs (ADAP)

States	ADAP Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Alabama	Alabama Department of Public Health AIDS Drug Assistance Program HIV/AIDS Division	The RSA Tower, 201 Monroe Street, Suite 1400	Montgomery, AL 36104-3773	1-866-574-9964 TTY: 711	alabamapublichealth.gov/hiv/adap.html
Alaska	Alaska Aids Assistance Association	1057 W. Fireweed Lane, Suite 102	Anchorage, AK 99503	1-800-478-AIDS TTY: 711	alaskanaids.org/
Arizona	Arizona Department of Health Services (ADHS) Office of Disease Integration and Services	150 N. 18th Avenue	Phoenix, AZ 85007	1-800-334-1540 TTY: 711	azdhs.gov/
Arkansas	Arkansas HIV/STD/ Hepatitis C ADAP Division	4815 W. Markham Street Slot 33	Little Rock, AR 72205	1-501-661-2408 TTY: 711	adap.directory/arkansas
California	California Department of Public Health Office of AIDS	Office of AIDS Center for Infectious Diseases California Department of	Sacramento, CA 95899-7426	1-916-558-1784 TTY: 711	cdph.ca.gov/Programs/CID/DOA/Pages/OAmain.aspx

States	ADAP Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
		Public Health, MS 7700 P.O. Box 997426			
Colorado	Ryan White State Drug Assistance Program (SDAP)	CDPHE Care and Treatment Program ADAP-3800, 4300 Cherry Creek Drive South	Denver, CO 80246	1-303-692-2716 TTY: 711 Monday-Friday 8 a.m. to 5 p.m.	cdphe.colorado.gov/state-drug-assistance-program
Connecticut	Connecticut AIDS Drug Assistance Program (CADAP)	State of Connecticut Department of Public Health c/o Magellan P.O. Box 13001	Albany, NY 11212-3001	1-800-424-3310 TTY: 1-800-842-4524	portal.ct.gov/DSS/Health-And-Home-Care/CADAP/Connecticut-AIDS-Drug-Assistance-Program-CADAP
Delaware	Ryan White Program (Delaware AIDS Drug Assistance	540 S. DuPont Highway	Dover, DE 19901	1-302-744-1000 TTY: 711	dhss.delaware.gov/dhss/dph/dpc/hivtreatment.html
District of Columbia	District of Columbia AIDS Drug Assistance Program (DC ADAP)	899 N. Capitol Street NE	Washington, DC 20002	1-202-671-4900 TTY: 711	dchealth.dc.gov/DC-ADAP

States	ADAP Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Florida	Florida AIDS Drug Assistance Program	HIV/AIDS Section 4052 Bald Cypress Way	Tallahassee, FL 32399	1-850-245-4422 TTY: 711	floridahealth.gov/diseases-and-conditions/aids/adap/adap-enrollment.html
Georgia	Georgia Department of Public Health, Health Protection, Office of HIV/AIDS	2 Peachtree Street, NW, 15th Floor	Atlanta, GA 30303-3186	404-656-9805 TTY: 711	dph.georgia.gov/hiv-care/aids-drug-assistance-program-adap
Hawaii	Harm Reduction Services Branch	3627 Kilauea Avenue, Suite 306	Honolulu, HI 96816	1-808-733-9010 TTY: 711	health.hawaii.gov/harmreduction/about-us/hiv-programs/hiv-case-management/
Idaho	Idaho HIV State Prescription Assistance Program (IDAGAP)	450 W. State Street, P.O. Box 83720	Boise, ID 83720-0036	1-208-334-5612 TTY: 711 Mon-Fri, 8 a.m. to 5 p.m.	healthandwelfare.idaho.gov/Health/FamilyPlanningSTDHIV/HIVCareandTreatment/tabid/391/Default.aspx
Illinois	Illinois Department of Public Health AIDS Drug Assistance Program	525 W. Jefferson Street, First Floor	Springfield, IL 62761	1-217-782-4977 TTY: 1-800-547-0466	dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids/ryan-white-

States	ADAP Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
					care-and-hopwa-services.html
Indiana	Indiana State Department of Health and Human Services Division HIV Medical Services Program	2 N Meridian St Suite 6C	Indianapolis, IN 46204	1-866-588-4948, Option 1 TTY: 711	in.gov/health/hiv-std-viral-hepatitis/
Iowa	Iowa Department of Public Health Bureau of HIV, STD and Hepatitis	321 E. 12th Street	Des Moines, IA, 50319-0075	515-204-3746 TTY: 711 or 1-800-735-2942	hhs.iowa.gov/public-health/hiv-stis-and-hepatitis
Kansas	Kansas AIDS Drug Assistance Program	1000 SW Jackson Street, Suite 210	Topeka, KS 66612	1-785-296-6174 TTY: 711	kdhe.ks.gov/359/AIDS-Drug-Assistance-Program
Kentucky	Kentucky AIDS Drug Assistance Program (KADAP)	275 E. Main St., HS2E-C	Frankfort, KY 40621	1-800-420-7431 TTY: 711	chfs.ky.gov/agencies/dph/dehp/hab/Pages/services.aspx
Louisiana	Louisiana Health Access Program (LAHAP)	1450 Poydras Street, Suite 2136	New Orleans, LA 70112	1-504-568-7474 TTY: 711	lahap.org/

States	ADAP Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
Maine	Maine AIDS Drug Assistance Program	286 Water Street, State House Station 11	Augusta, ME 04333	1-207-287-3747 TTY: 711	adap.directory/maine
Maryland	Maryland AIDS Drug Assistance Program (MADAP)	201 W. Preston Street	Baltimore, MD 21201-2399	1-800-205-6308 TTY: 711	health.maryland.gov/phpa/OIDPCS/Pages/MADAP.aspx
Massachusetts	Massachusetts HIV Drug Assistance Program (HDAP)	Schrafft's Center, 529 Main Street, Suite 301	Charlestown, MA 02129	1-800-228-2714 TTY: 711	crine.org/hdap/
Michigan	Michigan HIV/AIDS Drug Assistance Program (MIDAP)	109 Michigan Avenue, 9th Floor	Lansing, MI 48913	1-888-826-6565 TTY: 711	michigan.gov/mdhhs/keep-mi-healthy/chronicdiseases/hivsti/michigan-drug-assistance-program
Minnesota	Minnesota HIV/ AIDS Program Department of Human Services	HIV/AIDS Programs Department of Human Services, P.O. Box 64972	St. Paul, MN 55164-0972	1-800-657-3761 TTY: 711 or 1-800-627-3529	mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/programs-services/medications.jsp
Mississippi	Mississippi AIDS Drug	570 E. Woodrow Wilson Drive	Jackson, MS 39216	1-888-343-7373 TTY: 711	msdh.ms.gov/msdhsite/_static/14,13047,150.html

States	ADAP Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
	Assistance Program				
Missouri	Missouri AIDS Drug Assistance Program	Bureau of HIV, STD, and Hepatitis Missouri Department of Health and Senior Services, P.O. Box 570	Jefferson City, MO 65102	1-573-751-6439 TTY: 711	health.mo.gov/living/healthcondiseases/communicable/hivaids/
Montana	Montana Ryan White HIV Care Program (Montana AIDS Drug Assistance Program, DPHHS)	Cogswell Building Room C-211, 1400 Broadway	Helena, MT 59620	1-406-444-3565 TTY: 711	dphhs.mt.gov/publichealth/hivstd/treatment/mtryanwhiteprog
Nebraska	Nebraska AIDS Drug Assistance Program	P.O. Box 95044, 301 Centennial Mall South	Lincoln, NE 68509	1-402-559-4673 TTY: 711	adap.directory/nebraska
Nevada	Nevada AIDS Drug Assistance Program	Office of HIV/AIDS 4126 Technology Way, Suite 200	Carson City, NV 89706	1-775-684-5928 TTY: 711	dpbh.nv.gov/Programs/HIV-Ryan/Ryan_White_Part_B_-_Home/
New Hampshire	New Hampshire Department of	New Hampshire Department of Health and	Concord, NH 03301-3852	1-800-852-3345 ext 4502 TTY: 1-800-735-2964	dhhs.nh.gov/

States	ADAP Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
	Health & Human Services	Human Services 129 Pleasant Street			
New Jersey	New Jersey Department of Health	P.O. Box 360	Trenton, NJ 08625-0360	1-800-624-2377 TTY: 711	nj.gov/health/hivstdtb/hiv-aids/medications.shtml
New Mexico	New Mexico Department of Health HIV/AIDS Services Program	1190 St. Francis Drive, Suite S1200	Santa Fe, NM 87502	1-505-476-3628 TTY: 711	nmhealth.org/about/phd/idb/hats/
New York	New York HIV Uninsured Care Programs	Empire Station, P.O. Box 2052	Albany, NY 12220-0052	1-800-542-2437 TTY: 1-518-459-0121	health.ny.gov/diseases/aids/general/resources/adap/
North Carolina	North Carolina Department of Health and Human Services	Communicable Disease Branch, Epidemiology Section Division of Public Health, N.C. Dept of Health and Human Services 1902 Mail Service Center	Raleigh, NC 27699-1902	1-919-733-3419 TTY: 711	epi.dph.ncdhhs.gov/cd/hiv/hmap.html
North Dakota	North Dakota Department of Health HIV/AIDS Program	North Dakota Department of Health Division of Disease Control,	Bismarck, ND 58505	1-800-472-2180 TTY: 711	ndhealth.gov/hiv/RyanWhite/

States	ADAP Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
		2635 East Main Ave			
Ohio	Ohio AIDS Drug Assistance Program	246 N. High Street	Columbus, OH 43215	1-614-995-5599 TTY: 711	odh.ohio.gov/know-our-programs/Ryan-White-Part-B-HIV-Client-Services/AIDS-Drug-Assistance-Program/
Oklahoma	HIV/STD Services Division, Oklahoma State Department of Health	1000 N.E. Tenth St, Mail Drop 0308	Oklahoma City, OK 73117-1299	405-271-4636 TTY: 711	adap.directory/oklahoma
Oregon	Oregon CAREAssist Program	800 NE Oregon Street, Suite 1105	Portland, OR 97232	1-971-673-0144 TTY: 711	oregon.gov/oha/ph/DiseasesConditions/HIVSTDViralHepatitis/HIVCareTreatment/CAREAssist/Pages/index.aspx
Pennsylvania	Pennsylvania Department of Health	Pennsylvania Department of Health, Special Pharmaceutical Benefits	Harrisburg, PA 17105-8808	1-800-922-9384 TTY: 711	health.pa.gov/topics/programs/HIV/Pages/Special-Pharmaceutical-Benefits.aspx

States	ADAP Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
		Program, P.O. Box 8808			
Rhode Island	Rhode Island Aids Drug Assistance Program	3 Capitol Hill	Providence, RI 02908	1-401-222-5960 TTY: 711	health.ri.gov/diseases/hivaids/about/stayinghealthy/
South Carolina	South Carolina AIDS Drug Assistance Program	2600 Bull Street	Columbia, SC 29201	1-800-322-2437 TTY: 711	scdhec.gov/aids-drug-assistance-program
South Dakota	Ryan White Part B CARE Program, South Dakota Department of Health	615 E. 4th Street	Pierre, SD 57501-1700	1-800-592-1861 TTY: 711	doh.sd.gov/topics/diseases/infectious/reportable-communicable-diseases/hivaids/ryan-white-part-b-program/
Tennessee	Tennessee HIV Drug Assistance Program (HDAP)	Tennessee Department of Health HIV/STD Program Administrative Offices: 4th Floor, Andrew Johnson Tower, 710 James	Nashville, TN 37243	1-800-525-2437 TTY: 711	adap.directory/tennessee

States	ADAP Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
		Robertson Pkwy			
Texas	Texas HIV/STD Medication Program (THMP)	Texas HIV Medication Program ATTN: MSJA, MC 1873, Post Office Box 149347	Austin, TX 78714-9347	1-800-255-1090 TTY: 711	dshs.state.tx.us/hivstd/meds/default.shtm
Utah	Utah AIDS Drug Assistance Program	288 North 1460 West, P.O. Box 142104	Salt Lake City, UT 84114-2104	1-801-538-6191 TTY: 711	adap.directory/utah
Vermont	Vermont Medication Assistance Program (VMAP)	AIDS Medication Assistance Program, 108 Cherry Street	Burlington, VT 05402-0070	1-800-464-4343 TTY: 711	healthvermont.gov/disease-control/hiv/hiv-care
Virginia	Virginia Department of Health (VDH) AIDS Drug Assistance Program	Virginia Department of Health, HCS Unit, 1st Floor James Madison Building, 109 Governor Street	Richmond, VA 23219	1-855-362-0658 TTY: 711	vdh.virginia.gov/disease-prevention/vamap/
Washington	Washington State's AIDS Drug Assistance	P.O. Box 47841	Olympia, WA, 98504-7841	1-877-376-9316 TTY: 711	doh.wa.gov/YouandYourFamily/IllnessandDisease/HI

States	ADAP Agency	Address	City, State, Zip	Phone Number/TTY	Web Address
					V/ClientServices/ADAPandEIP
West Virginia	West Virginia AIDS Drug Assistance Program	350 Capitol Street, Room 125	Charleston, WV 25301	1-800-642-8244 TTY: 711	oeps.wv.gov/rwp/pages/default.aspx
Wisconsin	Wisconsin AIDS/ HIV Drug Assistance Program	1 West Wilson Street	Madison, WI 53703	1-608-266-1865 TTY: 711 or 1-800-947-3529	dhs.wisconsin.gov/hiv/adap.htm
Wyoming	Wyoming Department of Health AIDS Drug Assistance Program	401 Hathaway Building	Cheyenne, WY 82002	1-307-777-5856 TTY: 711	health.wyo.gov/publichealth/communicable-disease-unit/hiv-treatment-program/hiv-treatment-resources-for-patients/

Non-Discrimination Notice

Health Care Coverage Is Important For Everyone

We do not discriminate on the basis of race, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

To receive reasonable modifications, communication aids or language assistance free of charge, please call us at 1-866-390-4276 (TTY: 711).

If you believe we have failed to provide a service, or think we have discriminated in another way, you can file a grievance with:

Office of Civil Rights Coordinator	Phone:	1-855-664-7270 (voicemail)
Attn: Office of Civil Rights Coordinator	TTY/TDD:	1-855-661-6965
300 E. Randolph St., 35th Floor	Fax:	1-855-661-6960
Chicago, IL 60601	Email:	civilrightscoordinator@hcsc.com

You can file a grievance by mail, fax or email. If you need help filing a grievance, please call the toll-free phone number listed on the back of your ID card (TTY: 711).

You may file a civil rights complaint with the US Department of Health and Human Services, Office for Civil Rights, at:

US Dept of Health & Human Services	Phone:	1-800-368-1019
200 Independence Avenue SW	TTY/TDD:	1-800-537-7697
Room 509F, HHH Building	Complaint Portal:	
Washington, DC 20201	ocrportal.hhs.gov/ocr/smartscreen/main.jsf	
	Complaint Forms:	
	hhs.gov/civil-rights/filing-a-complaint/index.html	

This notice is available on our website at bcbsil.com/legal-and-privacy/non-discrimination-notice.

Blue Cross Blue Shield of Illinois, A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-866-390-4276 (TTY: 711). Hours are 8 a.m. – 8 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays. Or speak to your provider.

Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-866-390-4276 (TTY: 711) o hable con su proveedor.
العربية Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرق 1-866-390-4276 (TTY: 711) أو تحدث إلى مقدم الخدمة.
中文 Chinese	注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-866-390-4276 文本电话：711）或咨询您的服务提供商。
Français French	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-866-390-4276 (TTY : 711) ou parlez à votre fournisseur.
Deutsch German	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 1-866-390-4276 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
ગુજરાતી Gujarati	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 સવના મૂલ્યે ઉપલબ્ધ છે. 1-866-390-4276 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
हिंदी Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएँ उपलब्ध हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयोगी सामाजिक उपकरण और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-866-390-4276 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Italiano Italian	ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'1-866-390-4276 (TTY: 711) o parla con il tuo fornitore.
한국어 Korean	주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-866-390-4276 (TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.
Diné Navajo	SHOOH: Diné bee yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 1-866-390-4276 (TTY: 711) hodíilnih doodago nika'análwo'í bich'į' hanidziih.
فارسی Farsi	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 1-866-390-4276 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود
Polski	UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy

Polish	językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-866-390-4276 (TTY: 711) lub porozmawiaj ze swoim dostawcą.
Русский Russian	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-866-390-4276 (TTY: 711) или обратитесь к своему поставщику услуг.
Tagalog Tagalog	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 1-866-390-4276 (TTY: 711) o makipag-usap sa iyong provider.
اردو Urdu	توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ (TTY: 711 ،1-866-390-4276) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
Ελληνικά Greek	ΠΡΟΣΟΧΗ: Εάν μιλάτε ελληνικά, υπάρχουν διαθέσιμες δωρεάν υπηρεσίες υποστήριξης στη συγκεκριμένη γλώσσα. Διατίθενται δωρεάν κατάλληλα βοηθήματα και υπηρεσίες για παροχή πληροφοριών σε προσβάσιμες μορφές. Καλέστε το 1-866-390-4276 (TTY: 711) ή απευθυνθείτε στον πάροχό σας.
Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-866-390-4276 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

Blue Cross Group Medicare Advantage Open Access (PPO) Customer Service

Method	Customer Service – Contact Information
Call	1-866-390-4276 Calls to this number are free. Hours are 8 a.m. - 8 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays. Customer Service 1-866-390-4276 (TTY users call 711) also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. Hours are 8 a.m. - 8 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays.
Write	Customer Service P.O. Box 4555 Scranton, PA 18505

State Health Insurance Assistance Program

The State Health Insurance Assistance Program (SHIP) is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

You can find contact information for the State Health Insurance Assistance Program (SHIP) in your state in the appendix in the back of this document.

PRA Disclosure Statement *According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*