January 1 – December 31, 2024

BlueCross BlueShield Minnesota

Evidence of Coverage:

Your Medicare Health Benefits and Services as a Member of Platinum Blue℠ Complete Plan (Cost)

This document gives you the details about your Medicare health care coverage from January 1 – December 31, 2024.

For questions about this document, please contact Customer Service at 1-866-340-8654. (TTY users should call 711). Hours are: 8:00 a.m. to 8:00 p.m. CT. We are available seven days a week October 1 through March 31 and available Monday through Friday the rest of the year. This call is free.

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

This plan, Platinum Blue Complete, is offered by Blue Cross and Blue Shield of Minnesota. (When this *Evidence of Coverage* says "we," "us," or "our," it means Blue Cross and Blue Shield of Minnesota. When it says "plan" or "our plan," it means Platinum Blue Complete.)

Upon request, we can give you information in braille, in large print, or other alternative formats if you need it.

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

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

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

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

2024 Evidence of Coverage

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CHAPTER 1:

Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in Platinum Blue Complete, which is a Medicare Cost Plan

You are covered by Medicare, and you have chosen to get your Medicare health care coverage through our plan, Platinum Blue Complete. We are required to cover all Part A and Part B services. However, cost sharing and provider access in this plan differ from Original Medicare.

Platinum Blue Complete is a Medicare Cost Plan. This plan does not include Part D prescription drug coverage. Like all Medicare health plans, this Medicare Cost Plan is approved by Medicare and run by a private company.

Coverage under this Plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at: irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

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

This *Evidence of Coverage* document tells you how to get your medical care. It explains your rights and responsibilities, what is covered, what you pay as a member of the plan, and how to file a complaint if you are not satisfied with a decision or treatment.

The words *coverage* and *covered services* refer to the medical care and services available to you as a member of Platinum Blue Complete.

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

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

Section 1.3 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how Platinum Blue Complete covers your care. Other parts of this contract include your enrollment form, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called *riders* or *amendments*.

The contract is in effect for months in which you are enrolled in Platinum Blue Complete between January 1, 2024, and December 31, 2024.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of Platinum Blue Complete after December 31, 2024. We can also choose to stop offering the plan in your service area, after December 31, 2024.

Medicare (the Centers for Medicare & Medicaid Services) must approve Platinum Blue Complete each year. You can continue each year to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

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

Section 2.1 Your eligibility requirements

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

- You have Medicare Part B (or you have both Part A and Part B)
- *and* -- you live in our geographic service area (Section 2.2 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- *and* -- you are a United States citizen or are lawfully present in the United States
- *and* -- you do *not* have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer.

Section 2.2 Here is the plan service area for Platinum Blue Complete

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

Our service area includes 21 counties in Minnesota: Aitkin, Carlton, Cook, Goodhue, Itasca, Kanabec, Koochiching, Lake, Le Sueur, McLeod, Meeker, Mille Lacs, Pine, Pipestone, Rice, Rock, Sibley, St Louis, Stevens, Traverse and Yellow Medicine Counties.

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

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

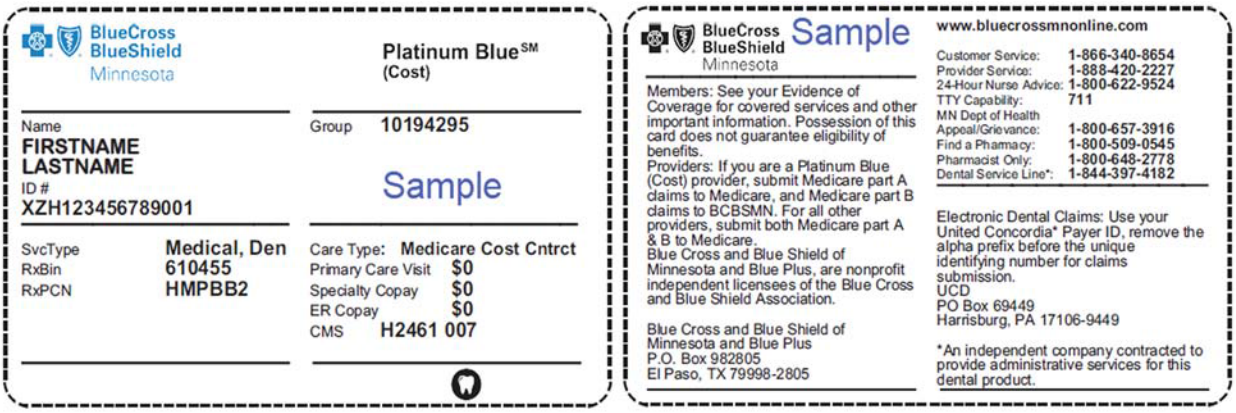
Section 2.3 U.S. Citizen or Lawful Presence

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

SECTION 3 Important membership materials you will receive

Section 3.1 Your plan membership card

We will send you a plan membership card. You should use this card whenever you get covered services from a Platinum Blue Complete network provider. You should also show the provider your Medicaid card, if applicable. Here's a sample membership card to show you what yours will look like:



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

Because Platinum Blue Complete is a Medicare Cost Plan, you should also **keep your red, white, and blue Medicare card with you**. As a Cost Plan member, if you receive Medicare-covered services (except for emergency or urgent care) from an out-of-network provider or when you are outside of our service area, these services will be paid for by Original Medicare, not Platinum Blue Complete. In these cases, you will be responsible for Original Medicare deductibles and coinsurance. (If you receive emergency or urgent care from an out-of-network provider or when you are outside of our service area, Platinum Blue Complete will pay for these services.) It is important that you keep your red, white, and blue Medicare card with you for when you receive services paid for under Original Medicare.

Section 3.2 Provider Directory

The *Provider Directory* lists our current network providers and durable medical equipment suppliers. **Network providers** are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full.

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization you will have to pay in full. The only exceptions are emergencies, urgently needed services when the network is not available (that is, in situations when it is

unreasonable or not possible to obtain services in-network), out-of-area dialysis services, and cases in which Platinum Blue Complete authorizes use of out-of-network providers.

The most recent list of providers and suppliers is available on our website at bluecrossmn.com/medicare-documents.

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

SECTION 4 Your monthly costs for Platinum Blue Complete

Your costs may include the following:

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

In some situations, your plan premium could be less

Medicare Part B and Part D premiums differ for people with different incomes. If you have questions about these premiums review your copy of *Medicare & You 2024* handbook, the section called *2024 Medicare Costs*. If you need a copy, you can download it from the Medicare website (medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.1 Plan premium

As a member of our plan, you pay a monthly plan premium. For 2024, the monthly premium for Platinum Blue Complete is $199.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, **you must continue paying your Medicare premiums to remain a member of the plan.** This includes your premium for Part B. It may also include a premium for Part A which affects members who aren't eligible for premium free Part A.

SECTION 5 More information about your monthly premium

Section 5.1 There are several ways you can pay your plan premium

There are three ways you can pay your plan premium.

Option 1: Paying by check

You can pay your premium monthly, quarterly, semiannually, or annually.

A bill for premiums will be received in the month before payment is due and will indicate the date that payment is due (the first of the month). Premium payments must be made payable to Blue Cross and Blue Shield of Minnesota and should be mailed to Blue Cross and Blue Shield of Minnesota, P.O. Box 860448, Minneapolis, MN 55486-0448. You may also pay your plan premium over the phone or through the member portal at bluecrossmn.com/login.

Option 2: You can pay your monthly premium through electronic funds transfer

Platinum Blue Complete also offers you the ability to use electronic funds transfer (EFT) through the Automatic Withdrawal option to have your premiums automatically withdrawn from your checking, savings or credit card account. An EFT form will be included with your first invoice, or you can sign up for EFT through the member portal at bluecrossmn.com/login.

Option 3: Having your plan premium taken out of your monthly Social Security check or Railroad Benefits

You can have the plan premium taken out of your monthly Social Security check or Railroad benefits. Contact Customer Service for more information on how to pay your monthly plan premium this way. We will be happy to help you set this up.

Changing the way you pay your plan premium. If you decide to change the option by which you pay your plan premium, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your plan premium is paid on time. You can call Customer Service to request information on how to change the way you pay your premium.

What to do if you are having trouble paying your plan premium

Your plan premium is due in our office by the first of the month. If we have not received your payment by the first day of the month, we will send you a notice telling you that your plan membership will end if we do not receive your premium within 90 days.

If you are having trouble paying your plan premium on time, please contact Customer Service to see if we can direct you to programs that will help with your costs.

If we end your membership because you did not pay your premiums, you will have health coverage under Original Medicare.

At the time we end your membership, you may still owe us for premiums you have not paid. We have the right to pursue collection of the amount you owe. In the future, if you want to enroll again in our plan (or another plan that we offer), you will need to pay the amount you owe before you can enroll.

If you think we have wrongfully ended your membership, you can make a complaint (also called a grievance); see Chapter 7 for how to file a complaint. If you had an emergency circumstance

that was out of your control and it caused you to not be able to pay your plan premium within our grace period, you can make a complaint. For complaints, we will review our decision again. Chapter 7, Section 9 of this document tells how to make a complaint, or you can call us at 1-866-340-8654 between the hours of 8:00 a.m. and 8:00 p.m. CT. We are available seven days a week October 1 through March 31 and available Monday through Friday the rest of the year. TTY users should call 711. You must make your request no later than 60 days after the date your membership ends.

Section 5.2 Can we change your monthly plan premium during the year?

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

SECTION 6 Keeping your plan membership record up to date

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

The doctors, hospitals, and other providers in the plan's network need to have correct information about you. **These network providers use your membership record to know what services are covered and the cost sharing amounts for you**. Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

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

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

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

SECTION 7 How other insurance works with our plan

Other insurance

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

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

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

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

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

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

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

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:

Important phone numbers and resources

SECTION 1 Platinum Blue Complete contacts (how to contact us, including how to reach Customer Service)

How to contact our plan's Customer Service

For assistance with claims, billing or member card questions, please call or write to Platinum Blue Complete Customer Service. We will be happy to help you.

Method	Customer Service – Contact Information
CALL	Toll-free 1-866-340-8654 Calls to this number are free. Hours of operation: 8:00 a.m. to 8:00 p.m. CT. We are available seven days a week October 1 through March 31 and available Monday through Friday the rest of the year. Customer Service also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. Hours of operation: 8:00 a.m. to 8:00 p.m. CT. We are available seven days a week October 1 through March 31 and available Monday through Friday the rest of the year.
FAX	(651) 662-7364
WRITE	Blue Cross and Blue Shield of Minnesota Platinum Blue P.O. Box 982801 El Paso, TX 79998-2801
WEBSITE	bluecrossmn.com

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

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on asking for coverage decisions or appeals about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Coverage Decisions for Medical Care – Contact Information
CALL	Toll-free 1-866-340-8654 Calls to this number are free. Hours of operation: 8:00 a.m. to 8:00 p.m. CT. We are available seven days a week October 1 through March 31 and available Monday through Friday the rest of the year.
TTY	711 Calls to this number are free. Hours of operation: 8:00 a.m. to 8:00 p.m. CT. We are available seven days a week October 1 through March 31 and available Monday through Friday the rest of the year.
FAX	(651) 662-9517 (metro) or toll-free 1-866-800-1665 **If you are requesting expedited review,** please write "Expedite" on the fax cover sheet.
WRITE	Blue Cross and Blue Shield of Minnesota Platinum Blue P.O. Box 982801 El Paso, TX 79998-2801

Method	Appeals for Medical Care – Contact Information
CALL	Toll-free 1-866-340-8654 Calls to this number are free. Hours of operation: 8:00 a.m. to 8:00 p.m. CT. We are available seven days a week October 1 through March 31 and available Monday through Friday the rest of the year.
TTY	711 Calls to this number are free. Hours of operation: 8:00 a.m. to 8:00 p.m. CT. We are available seven days a week October 1 through March 31 and available Monday through Friday the rest of the year.
FAX	(651) 662-9517 **If you are requesting expedited review,** please write "Expedite" on the fax cover sheet.

Method	Appeals for Medical Care – Contact Information
WRITE	Blue Cross and Blue Shield of Minnesota Consumer Service Center P.O. Box 982800 El Paso, TX 79998-2800

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

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. For more information on making a complaint about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Complaints about Medical Care – Contact Information
CALL	Toll-free 1-866-340-8654 Calls to this number are free. Hours of operation: 8:00 a.m. to 8:00 p.m. CT. We are available seven days a week October 1 through March 31 and available Monday through Friday the rest of the year.
TTY	711 Calls to this number are free. Hours of operation: 8:00 a.m. to 8:00 p.m. CT. We are available seven days a week October 1 through March 31 and available Monday through Friday the rest of the year.
FAX	(651) 662-9517 **If you are requesting expedited review,** please write “Expedite” on the fax cover sheet.
WRITE	Blue Cross and Blue Shield of Minnesota Platinum Blue P.O. Box 982800 El Paso, TX 79998-2800
MEDICARE WEBSITE	You can submit a complaint about Platinum Blue Complete directly to Medicare. To submit an online complaint to Medicare, go to medicare.gov/MedicareComplaintForm/home.aspx.

Where to send a request asking us to pay for our share of the cost for medical care you have received

If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. See Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) for more information.

Method	Payment Requests for Medical Care – Contact Information
CALL	Toll-free 1-866-340-8654 Calls to this number are free. Hours of operation: 8:00 a.m. to 8:00 p.m. CT. We are available seven days a week October 1 through March 31 and available Monday through Friday the rest of the year.
TTY	711 Calls to this number are free. Hours of operation: 8:00 a.m. to 8:00 p.m. CT. We are available seven days a week October 1 through March 31 and available Monday through Friday the rest of the year.
FAX	(651) 662-7364
WRITE	Blue Cross and Blue Shield of Minnesota Platinum Blue P.O. Box 982805 El Paso, TX 79998-2805
WEBSITE	bluecrossmn.com

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

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

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

Method	Medicare – Contact Information
CALL	1-800-MEDICARE, or 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 with hearing or speaking. Calls to this number are free.
WEBSITE	Medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about Platinum Blue Complete: • **Tell Medicare about your complaint:** You can submit a complaint about Platinum Blue Complete directly to Medicare. To submit a complaint to Medicare, go to medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

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

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

Senior LinkAge Line® is an independent (not connected with any insurance company or health plan) state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Senior LinkAge Line® counselors can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. Senior LinkAge Line® counselors can also help you with Medicare questions or problems and help you understand your Medicare plan choices and answer questions about switching plans.

METHOD TO ACCESS SHIP and OTHER RESOURCES:

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

Method	Senior LinkAge Line® (Minnesota's SHIP) – Contact Information
CALL	1-800-333-2433
TTY	711
WRITE	Senior LinkAge Line 540 Cedar Street St. Paul, MN 55164 Email: senior.linkage@state.mn.us
WEBSITE	mn.gov/senior-linkage-line/older-adults/medicare/

You may contact the Minnesota Department of Commerce at any time at:

Minnesota Department of Commerce
Main Office, Golden Rule Building
85 7th Place East, Suite 280
St. Paul, MN 55101
Telephone: 651-539-1500 (local)
651-539-1600 (complaints)
1-800-657-3602 (Greater MN only)
Email: consumer.protection@state.mn.us
Website: mn.gov/commerce/contact/

Mail written complaints to:

Minnesota Department of Commerce
Attn: Consumer Services Center
85 7th Place East, Suite 280
St. Paul, MN 55101
On-line complaints: mn.gov/commerce/consumers/file-a-complaint/

SECTION 4 Quality Improvement Organization

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For Minnesota, the Quality Improvement Organization is called Livanta BFCC-QIO Program.

Livanta 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. Livanta BFCC-QIO Program is an independent organization. It is not connected with our plan.

You should contact Livanta BFCC-QIO Program in any of these situations:

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

Method	Livanta BFCC-QIO Program (Minnesota's Quality Improvement Organization) – Contact Information
CALL	1-888-524-9900 Monday-Friday: 9:00 a.m. to 5:00 p.m. CT Saturday-Sunday: 11:00 a.m. to 3:00 p.m. CT 24 hour voicemail service is available

Method	Livanta BFCC-QIO Program (Minnesota's Quality Improvement Organization) – Contact Information
TTY	1-888-985-8775 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	1-855-236-2423
WRITE	Livanta LLC BFCC-QIO 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701-1105
WEBSITE	livantaqio.com

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

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

Method	Social Security – Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
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 8:00 am to 7:00 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. The programs offered through Medicaid 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 its programs, contact Minnesota Department of Human Services.

Method	Minnesota Department of Human Services – Contact Information
CALL	651-297-3862 (in the Twin Cities Metro area) 800-657-3672 (toll free from outside the Twin Cities) 8 a.m. - 5 p.m., Monday - Friday.
TTY	1-800-627-3529 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Minnesota Department of Human Services P.O. Box 64252 St. Paul, MN 55164-0252
WEBSITE	mn.gov/dhs

SECTION 7 How to contact the Railroad Retirement Board

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

Method	Railroad Retirement Board – Contact Information
CALL	1-877-772-5772 Calls to this number are free. If you press "0", you may speak with an RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday. If you press "1", you may access the automated RRB HelpLine and 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 with hearing or speaking. Calls to this number are *not* free.
WEBSITE	rrb.gov/

SECTION 8 Do 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, you may call the employer/union benefits administrator or Customer Service if you have 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 may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

CHAPTER 3:

Using the plan for your medical services

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

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

For the details on what medical care is covered by our plan and how much you pay when you get this care, use the benefits chart in the next chapter, Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*).

Section 1.1 What are network providers and covered services?

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term providers also includes hospitals and other health care facilities.
- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan.
- **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 benefits chart in Chapter 4.

Section 1.2 Basic rules for getting your medical care covered by the plan

As a Medicare health plan, Platinum Blue Complete must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

Platinum Blue Complete will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this document).
- **The care you receive is considered medically necessary**. Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You generally must receive your care from a network provider** for Platinum Blue Complete to cover the services.
    - If we do not cover services you receive from an out-of-network provider, the services will be covered by Original Medicare if they are Medicare-covered services. Except for emergency or urgently needed services, if you get services covered by Original Medicare from an out-of-network provider then you must pay Original Medicare's cost sharing amounts. For information on Original Medicare's

cost sharing amounts, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

- If an out-of-network provider sends you a bill that you think we should pay, please contact Customer Service. Generally, it is best to ask an out-of-network provider to bill Original Medicare first, and then to bill us for the remaining amount. We may require the out-of-network provider to bill Original Medicare. We will then pay any applicable Medicare coinsurance and deductibles minus your copayments on your behalf.

SECTION 2 Use providers in the plan's network to get your 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. Here are a few examples:

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

You do not need a referral to see a specialist who is a network provider.

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

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

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will notify you that your provider is leaving our plan so that you have time to select a new provider.
  - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.
  - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.
- We will assist you in selecting a new qualified in-network provider that you may access for continued care.
- If you are currently undergoing medical treatment or therapies with your current provider, you have the right to request, and we will work with you to ensure, that the medically necessary treatment or therapies you are receiving continues.

- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file a quality of care complaint to the QIO, a quality of care grievance to the plan, or both. Please see Chapter 7.

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

Section 3.1 Getting care if you have a medical emergency

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

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

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval. You do not need to use a network doctor. You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they are not part of our network. Platinum Blue Complete includes coverage for emergency medical care and transportation worldwide. See Chapter 4 for more information.

What is covered if you have a medical emergency?

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

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

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us 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 was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor has said that it was *not* an emergency, we will cover additional care *only* if you go to a network provider to get the additional care. If you get additional care from an **out-of-network** provider after the doctor says it was not an emergency, you will normally have to pay Original Medicare's cost sharing.

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

What are urgently needed services?

An *urgently needed service* is a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. For example, an unforeseen flare-up of a known condition that you have or a severe sore throat that occurs over the weekend. Urgently needed services may be furnished by out-of-network providers when it is unreasonable, given your circumstances, to obtain immediate care from network providers.

For a list of the urgent care providers in the plan's network, see the Platinum Blue Complete *Provider Directory*. You can also call Customer Service (phone numbers are printed on the back cover of this document) or visit our website at bluecrossmn.com/medicare-documents.

When you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed services that you get from any provider.

Our plan covers worldwide emergency services outside of the United States.

Section 3.3 Getting care during a disaster

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

Please visit the following website: bluecrossmn.com for information on how to obtain needed care during a disaster.

If you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost sharing.

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

Section 4.1 You can ask us to pay our share of the cost of covered services

If you have paid more than your plan cost sharing for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services*) for information about what to do.

Section 4.2 If services are not covered by our plan or Original Medicare, you must pay the full cost

Platinum Blue Complete covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4 of this document. If you receive services not covered by our plan or services obtained out of network and were not authorized, you are responsible for paying the full cost of services. Prior authorization is not required for emergency services. You have the right to seek care from any provider that is qualified to treat Medicare members. However, Original Medicare pays your claims, and you must pay your cost sharing.

SECTION 5 How are your medical services covered when you are in a clinical research study?

Section 5.1 What is a clinical research study?

A clinical research study (also called a clinical trial) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically request volunteers to participate in the study.

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

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

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

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

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

Section 5.2 When you participate in a clinical research study, who pays for what?

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

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

After Medicare has paid 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 will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan. However, you are required to submit documentation showing how much cost sharing you paid. Please see Chapter 5 for more information for submitting requests for payments.

Here's an example of how the cost sharing works: Let's say that you have a lab test that costs $100 as part of the research study. Let's also say that your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan's benefits. 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 your plan that you received a qualified clinical trial service and submit documentation such as a provider bill to the plan. The plan would then directly pay you $10. Therefore, your net payment is $10, the same amount you would pay under our plan's benefits. Please note that in order to receive payment from your plan, you must submit documentation to your plan such as a provider bill.

We will pay the Medicare Part A or Part B deductible.

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

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

Do you want to know more?

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

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

Section 6.1 What is 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 will instead provide coverage for care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

Section 6.2 Receiving 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 are conscientiously opposed to getting medical treatment that is **non-excepted**.

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

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

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to *non-religious* aspects of care.

- If you get services from this institution that are provided to you in a facility, the following conditions apply:
    - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
    - *– and –* you must get approval in advance from our plan before you are admitted to the facility, or your stay will not be covered.

Medicare Inpatient Hospital coverage limits apply to services received in Religious Non-medical Health Care Institutions (see the benefits chart in Chapter 4 for more information).

SECTION 7 Rules for ownership of durable medical equipment

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

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

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of Platinum Blue Complete, however, you usually will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan, even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under certain limited circumstances we will transfer ownership of the DME item to you. Call Customer Service for more information.

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

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

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare do not count. You will have to make 13 payments to our plan before owning the item.

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

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage Platinum Blue Complete 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 repair of oxygen equipment

If you leave Platinum Blue Complete or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

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

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

CHAPTER 4:

Medical Benefits Chart (what is covered and what you pay)

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

This chapter provides a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of Platinum Blue Complete. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

Section 1.1 Types of out-of-pocket costs you may pay for your covered services

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- **Copayment** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- **Coinsurance** is 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 in Section 2 tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable.

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

There is a limit on the total amount you have to pay out-of-pocket each year for medical services that are covered under Medicare Part A and Part B. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. For calendar year 2024 this amount is $2,700.

The amounts you pay for copayments and coinsurance for covered services count toward this maximum out-of-pocket amount. (The amount you pay for your plan premium does not count toward your maximum out-of-pocket amount.) In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are marked with a checkmark in the Medical Benefits Chart. If you reach the maximum out-of-pocket amount of $2,700, you will not have to pay any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Our plan does not allow providers to balance bill you

As a member of Platinum Blue Complete, an important protection for you is that you only have to pay your cost sharing amount when you get services covered by our plan. Providers may not

add 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 is a dispute and we don't pay certain provider charges.

Here is how this protection works.

- If your cost sharing is a copayment (a set amount of dollars, for example, $15.00), then you pay only that amount for any covered services from a network provider.
- If your cost sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
    - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
    - If you receive 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. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral or for emergencies or urgently needed services).
    - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral, or for emergencies or outside the service area for urgently needed services).
- If you believe a provider has balance billed you, call Customer Service.

SECTION 2 Use the *Medical Benefits Chart* to find out what is covered and how much you will pay

Section 2.1 Your medical benefits and costs as a member of the plan

The Medical Benefits Chart on the following pages lists the services Platinum Blue Complete covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, equipment, and Part B prescription drugs) *must* be medically necessary. *Medically necessary* means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered by Platinum Blue Complete, unless it is emergent or urgent care or unless your plan or a network provider has given you a referral.
    - If you get Medicare-covered services from an out-of-network provider and we do not cover the services, Original Medicare will cover the services. For any services covered by Original Medicare instead of our plan, you must pay Original Medicare's cost sharing amounts.
- Some of the services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval in advance (sometimes called prior authorization) from us. Covered services that need approval in advance are marked in the Medical Benefits Chart by a footnote. Prior authorization is not required for emergency services.

Other important things to know about our coverage:

- 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*. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2024* handbook. View it online at medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- If Medicare adds coverage for any new services during 2024, either Medicare or our plan will cover those services.

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

✓ You will see this symbol next to a service that does not apply to the out-of-pocket maximum.

Medical Benefits Chart

Services that are covered for you	What you must pay when you get these services
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries 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; and • not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered every 12 months (11 full months must have passed since the last treatment). Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians are doctors of medicine (MD) or osteopathy (DO) (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the	$0 copayment for each Medicare-covered visit. There may also be additional Facility services copayments/ coinsurance. See "Outpatient hospital services" benefit.

Services that are covered for you	What you must pay when you get these services
Acupuncture for chronic low back pain (continued) Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a masters 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 at 42 CFR §§ 410.26 and 410.27.	
Acupuncture for non-Medicare-covered (routine) Pain Management Our plan covers: All types of acupuncture including dry needling for any pain related condition, limited to 12 total visits per calendar year (11 full months must have passed since the last visit).	$0 copayment for each non-Medicare-covered visit. There may also be additional Facility services copayments/ coinsurance. See "Outpatient hospital services" benefit.
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 only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. If the covered ambulance services are not for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. **Prior authorization is not required for emergency ambulance transportation services.**	$0 copayment for covered ambulance transportation, including emergency ambulance transportation needed while traveling in a foreign country.

Services that are covered for you	What you must pay when you get these services
Ambulance services (continued) **Prior authorization may be required for non-emergency ambulance transportation services. Call Customer Service for additional information.** Platinum Blue Complete follows Original Medicare and Original Medicare doesn't cover ambulance services if you're not transported to a medical facility. This means that we won't pay for ambulance services, including treatment performed, if one is dispatched for you and you're not transported to a medical facility. When multiple ground and/or air ambulance providers respond, we only pay for the ambulance provider that transports you to a medical facility.	
Annual physical examination An annual physical examination identifies potential health problems in the early stages. During an annual physical examination, a provider may discuss health concerns, review medications or request laboratory tests. Under the Platinum Blue Complete plan, you are allowed coverage for one non-Medicare covered annual physical examination per calendar year. This examination can be done by any primary care provider eligible to perform these services. **Note:** If you are also treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.	There is no coinsurance, copayment or deductible for one routine physical examination.
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 (11 full months must have passed since the last visit). **Note:** Your first annual wellness visit can't take place within 12 months of your Welcome to Medicare preventive visit.	There is no coinsurance, copayment, or deductible for the annual wellness visit.

Services that are covered for you	What you must pay when you get these services
Annual wellness visit (continued) 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 (11 full months must have passed since the last visit).	
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.
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 • Screening mammogram once every 12 months (11 full months must have passed since the last screening) Additional screenings: • There is no limit on the number of covered mammography screenings; 2 dimensional (2-D) or 3 dimensional (3-D), annual routine or Medically Necessary and Appropriate including being at risk for breast cancer. "At risk for breast cancer" means: 1. Having a family history with one or more first- or second-degree relatives with breast cancer; 2. Testing positive for BRCA1 or BRCA2 mutations; 3. Having heterogeneously dense breasts or extremely dense breasts based on the Breast Imaging Reporting and Data System established by the American College of Radiology; or 4. Having a previous diagnosis of breast cancer.	There is no coinsurance, copayment, or deductible for covered screening mammograms.

Services that are covered for you	What you must pay when you get these services
Breast cancer screening (mammograms) (continued) **Note:** If further testing is required based on a diagnosis from the screening, such as radiation therapy or surgery, please refer to "Outpatient diagnostic tests and therapeutic services and supplies" or "Outpatient surgery".	
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. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	$0 copayment for each Medicare-covered cardiac rehabilitation visit. There may also be additional Facility services copayments/ coinsurance. See "Outpatient hospital services" benefit.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) 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.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months). Covered tests include: Lipid Panel which must include cholesterol, serum, total Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol), triglycerides.	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years (60 months).
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months (23 full months must have passed since the last exam)	There is no coinsurance, copayment, or deductible for preventive Pap and pelvic exams.

Services that are covered for you	What you must pay when you get these services
Cervical and vaginal cancer screening (continued) • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months (11 full months must have passed since the last test) Additional screenings: • There is no limit on the number of cervical and vaginal cancer covered screenings	
Chiropractic services Covered services include: • We cover only manual manipulation of the spine to correct subluxation (when 1 or more of the bones in your spine move out of position).	$0 copayment for each Medicare-covered chiropractic visit. There may also be additional professional service copayments. For acupuncture services performed by a chiropractor, please see "Acupuncture" benefit. There may also be additional Facility services copayments/ coinsurance. See "Outpatient hospital services" benefit.
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam, excluding barium enemas, for which coinsurance applies. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a

Services that are covered for you	What you must pay when you get these services
Colorectal cancer screening (continued) 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patient not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result. Additional screenings: • There is no limit on the number of covered colorectal cancer screenings **Note:** If further testing is required based on a diagnosis from the screening, such as radiation therapy or surgery, please refer to "Outpatient diagnostic tests and therapeutic services and supplies" or "Outpatient surgery".	diagnostic exam and you pay 0% of the Medicare-approved amount for your doctors' services. In a hospital outpatient setting, you also pay the hospital a 0% coinsurance. The Part B deductible doesn't apply.
Dental services Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation.	$0 copayment for Medicare-covered dental services. There may also be additional Facility services copayments/ coinsurance. See "Outpatient hospital services" benefit.

Services that are covered for you	What you must pay when you get these services
Dental services (continued) In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. However, Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. In addition, we cover additional dental benefits that Original Medicare does not cover. These benefits are detailed separately at the end of this chart. Non-routine dental care also allows for non-Medicare-covered surgical and non-surgical treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder.	**Additional dental benefits** You are covered for additional dental benefits. See the additional dental benefit description at the end of this chart for details.
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, 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. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.

Services that are covered for you	What you must pay when you get these 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. ◦ We cover all medically necessary diabetic supplies covered by Original Medicare. Coverage for test strips and meters is limited to Ascensia brands. If our supplier in your area does not carry the Ascensia brand, you may ask them if they can special order it for you. If they cannot get the Ascensia brand, you will pay the same cost sharing amount as for Ascensia brands. • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions. • Diabetes education, including medical nutrition therapy, that is provided by a certified, registered, or licensed health care professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. • Medicare-eligible, physician-prescribed supplies used for the management and treatment of gestational, type I or type II diabetes, including insulin (not on the formulary for use in a pump), needles and syringes, **not otherwise covered by the Medicare Part D Program.** Ascensia Diabetes Care US, Inc. is an independent company providing diabetic supplies.	$0 copayment for Medicare-covered diabetic supplies. $0 copayment for Medicare-covered therapeutic shoes or inserts. $0 copayment for members eligible for the diabetes self-management training preventive benefit.

Services that are covered for you	What you must pay when you get these services
Durable medical equipment (DME) and related supplies (For a definition of durable medical equipment, see Chapter 10 as well as Chapter 3, Section 7 of this document.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies (i.e. continuous glucose monitors, insulin pumps, and supplies), hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment and contents, nebulizers, and walkers. Continuous glucose monitoring (CGM) products obtained through the pharmacy may be subject to prior authorization/quantity limits. CGM preferred products are Dexcom G6, Dexcom G7 when used with a Dexcom Receiver, and Abbott Freestyle Libre and Freestyle Libre 2 products, and Freestyle Libre 3 when used with a Freestyle Libre receiver. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. You may also obtain any medically necessary DME from any supplier that contracts with Fee-for-Service Medicare (Original Medicare). However, if Platinum Blue Complete does not contract with this supplier you will have to pay the cost sharing under Fee-for-Service Medicare. Non-routine dental care allows for non-Medicare-covered durable medical equipment for treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder. **Prior authorization may be required. Call Customer Service for additional information.**	$0 copayment for each Medicare-covered durable medical equipment item and related supplies. Your cost sharing for Medicare oxygen equipment is $0, every month. If prior to enrolling in Platinum Blue Complete you had made 36 months of rental payment for oxygen equipment, your cost sharing in Platinum Blue Complete is $0.
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition.	$0 copayment for each emergency room visit. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return

Services that are covered for you	What you must pay when you get these services
Emergency care (continued) A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. Please refer to the section on emergency care in Chapter 3 for more information. Worldwide emergency care is covered outside the United States and its territories. Worldwide coverage includes: • Services furnished by a provider qualified to furnish emergency services and needed to evaluate or stabilize an emergency medical condition. • Services that are medically necessary and immediately required as a result of unforeseen illness, injury or condition. • Ground ambulance for emergency transportation to the nearest appropriate hospital for emergency care. Note: You may want to consider purchasing a separate, additional travel policy while traveling outside the U.S. and its territories. Worldwide coverage does not include continuing care after your emergency condition is stabilized as deemed by the treating physician. **Prior authorization is not required for emergency services.**	to a network hospital in order for your care to continue to be covered. If you get inpatient care at an out-of-network hospital after an emergency admission, your cost is the cost sharing you would pay at a network hospital. However, if you refuse reasonable, medically appropriate transfer to a network hospital, your cost sharing might be higher.
Health and wellness education programs Regular exercise through SilverSneakers® can have a positive effect on health conditions such as high blood pressure, heart disease, COPD and type 2 diabetes. It can also help with weight	$0 copayment to access SilverSneakers fitness program.

Services that are covered for you	What you must pay when you get these services
Health and wellness education programs (continued) management, stress management and overall physical and mental fitness, leading to a healthier lifestyle. SilverSneakers is a registered trademark of Tivity Health, Inc. © 2023 Tivity Health, Inc. All rights reserved. SilverSneakers can help you live a healthier, more active life through fitness and social connection. You are covered for a fitness benefit through SilverSneakers at participating locations[1]. You have access to instructors who lead specially designed group exercise classes[2]. At participating locations nationwide, you can take classes plus use exercise equipment and other amenities. Additionally, SilverSneakers Community gives you options to get active outside of traditional gyms (like recreation centers, malls and parks). SilverSneakers also connects you to a support network and virtual resources through SilverSneakers LIVE classes, SilverSneakers On-Demand videos and our mobile app, SilverSneakers GO. All you need to get started is your personal SilverSneakers ID number. Go to SilverSneakers.com to learn more about your benefit or call 1-833-226-1271 (TTY: 711) Monday through Friday, 8 a.m. to 8 p.m. ET. **Always talk with your doctor before starting an exercise program.** 1. Participating locations (“PL”) are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL. 2. Membership includes SilverSneakers 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	**Hearing Services:** $0 copayment for each Medicare-covered visit.

Services that are covered for you	What you must pay when you get these services
Hearing services (continued) as outpatient care when furnished by a physician, audiologist, or other qualified provider.	
Hearing Exam: Original Medicare does not cover hearing screenings. We cover one (1) non-Medicare-covered hearing exam per year. In general, Original Medicare does not cover hearing aids, hearing aid exams, or hearing aid fittings. We cover:	**Hearing Exam:** ✓ $0 copayment for one (1) non-Medicare-covered hearing screening. There may also be additional Facility services copayments/ coinsurance. See "Outpatient hospital services" benefit.
Hearing Aid Exam: One (1) non-Medicare-covered hearing aid exam through TruHearing. **You must see a TruHearing provider to use this benefit. Call 1-855-205-5137 to schedule an appointment.**	**Hearing Aid Exam:*** ✓ $0 copayment for one (1) non-Medicare-covered hearing aid exam per year.
Hearing Aids: We cover up to two (2) TruHearing-branded hearing aids every year (one per ear per year). *Benefit is limited to TruHearing's Advanced and Premium hearing aids, which come in various styles and colors. Rechargeable battery option is available on select styles for no additional cost. **You must see a TruHearing provider to use this benefit. Call 1-855-205-5137 to schedule an appointment.** **Hearing aid purchases includes:** • First year of follow-up provider visits • 60 day trial period • 3 year extended warranty • 80 batteries per aid for non-rechargeable models **Benefit does not include or cover any of the following:** • Ear Molds	**Hearing Aids:** ✓ $499 per aid for Advanced Hearing Aids.* ✓ $799 per aid for Premium Hearing Aids.*

Services that are covered for you	What you must pay when you get these services
Hearing services (continued) • Hearing aid accessories • Additional provider visits • Additional batteries; batteries when a rechargeable hearing aid is purchased • Hearing aids that are not TruHearing-branded hearing aids • Costs associated with loss & damage warranty claims Costs associated with excluded items are the responsibility of the member and not covered by the plan. TruHearing® is a registered trademark of TruHearing, Inc., an independent company who works with health plans to offer low out-of-pocket costs on hearing aids.	
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months (11 full months must have passed since the last screening) For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home health agency care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not 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	$0 copayment for Medicare-covered services. $0 copayment for each physician home health visit.

Services that are covered for you	What you must pay when you get these services
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to: • Professional services, including nursing services, furnished in accordance with the 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 For the drugs, equipment and non-drug supplies, please refer to "Durable medical equipment (DME) and related supplies."	$0 copayment for the professional services related to home infusion therapy.
Hospice care You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Platinum Blue Complete.

Services that are covered for you	What you must pay when you get these services
Hospice care (continued) When you are admitted to a hospice you have the right to remain in your plan; if you choose to remain in your plan you must continue to pay plan premiums. For hospice services and for services that are covered by Medicare Part A or B and 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 are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost sharing. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization). • If you obtain the covered services from a network provider and follow plan rules for obtaining service, you only pay the plan cost sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the cost sharing under Fee-for-Service Medicare (Original Medicare) **Note**: If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Getting your non-hospice care through our network providers will lower your share of the costs for the services.	
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines.

Services that are covered for you	What you must pay when you get these services
Immunizations (continued) • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccine • Other vaccines if you are at risk and they meet Medicare Part B coverage rules • Other vaccines directly related to the treatment of an injury or direct exposure to a disease or condition, such as rabies and tetanus	Refer to "Medicare Part B prescription drugs" in this Medical Benefits Chart.
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 are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. Plan covers unlimited days per benefit period. Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • 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 - Coverage includes mental health services ordered by a court. Substance use detoxification is only covered when it is part of an approved inpatient stay at an acute care hospital	$100 copayment for each Medicare-covered inpatient stay for days 1-90. The lifetime reserve days begin on day 91. $0 copayment per day for Medicare-covered lifetime reserve days 91-150. $0 copayment per day for days 151 and beyond.

Services that are covered for you	What you must pay when you get these services
Inpatient hospital care (continued) • 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 will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Platinum Blue Complete provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used • 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 are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	
Inpatient services in a psychiatric hospital • Covered services include mental health care services that require a hospital stay	$100 copayment for each Medicare-covered inpatient stay.

Services that are covered for you	What you must pay when you get these services
Inpatient services in a psychiatric hospital (continued) • There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital We provide coverage for mental health treatment ordered by a court of competent jurisdiction under a valid court order that is issued on the basis of a behavioral care evaluation performed by a licensed psychiatrist or doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment. These services are not subject to a separate medical necessity determination.	
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to:	When your stay is no longer covered, these services will be covered as described in the following sections found in this Medical Benefits Chart:
• Physician services	Please refer to "Physician/ Practitioner services, including doctor's visits." Please refer to "Outpatient mental health care" for outpatient Medicare Part B services.
• Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations	Please refer to "Outpatient diagnostic tests and therapeutic services and supplies".

Services that are covered for you	What you must pay when you get these services
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay (continued)	
• Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices	Please refer to "Prosthetic devices and related supplies".
• Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition	
• Physical therapy, speech therapy, and occupational therapy	Please refer to "Outpatient rehabilitation services".
Medical nutrition therapy 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 three hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and two hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year. We also cover diabetes education, including medical nutrition therapy, that is provided by a certified, registered, or licensed health care professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change,	There is no coinsurance, copayment, or deductible for the MDPP benefit.

Services that are covered for you	What you must pay when you get these services
Medicare Diabetes Prevention Program (MDPP) (continued) increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	
Medicare Part B prescription drugs These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases **Prior authorization may be required. Call Customer Service for additional information.**	20% coinsurance for Medicare-covered Part B chemotherapy prescription drugs and immunizations. Cost sharing for certain rebatable drugs that were authorized by the plan may be subject to a lower than 20% coinsurance. $0 copayment for Medicare-covered Part B drugs and biologicals that are not usually self-administered but are administered by a healthcare professional. $0 copayment for medications packaged for use in a nebulizer. $0 copayment for self-administered Erythropoietin (EPO) when provided to you in accordance with Medicare guidelines. Cost sharing for insulin use in pumps is subject to a cap of $35 for one-month's supply.

Services that are covered for you	What you must pay when you get these services
Nurse Line Nurse Line provides access to phone support from a registered nurse when you need care for yourself or family member. Nurse Line can be reached at 1-800-622-9524 24 hours/day, 7 days a week.	$0 copayment
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.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • 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 For services not associated with this program there may be additional copayments/coinsurance. See “Inpatient hospital care,” “Inpatient services in a psychiatric hospital,” “Medicare Part B prescription drugs”, “Outpatient hospital services,” “Outpatient mental health care,” and “Outpatient substance abuse services.”	$0 copayment per week for a Medicare-covered Opioid Treatment Program.

Services that are covered for you	What you must pay when you get these services
Outpatient diagnostic tests and therapeutic services and supplies	
Covered services include, but are not limited to:	
• X-rays	$0 copayment for Medicare-covered X-rays.
• Radiation (radium and isotope) therapy including technician materials and supplies. Examples include, but are not limited to, treatment of cancer.	$0 copayment for Medicare-covered radiation therapy services.
• Surgical supplies, such as dressings • Splints, casts, and other devices used to reduce fractures and dislocations	$0 copayment for Medicare-covered surgical supplies, splints and casts.
• Laboratory tests	$0 copayment for Medicare-covered laboratory tests.
• Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used	$0 copayment for Medicare-covered blood.
• Diagnostic advanced imaging. Examples include, but are not limited to, specialized scans, CT, SPECT, PET, MRI, MRA, ultrasounds and angiograms.	$0 copayment for Medicare-covered diagnostic advanced imaging.
• Diagnostic tests & procedures (excludes x-ray, labs and advanced imaging). Examples include, but are not limited to, EKG's, INR, pulmonary function tests, psychological/ neuropsychological testing, surgical pathology testing, home or lab-based sleep studies.	$0 copayment for Medicare-covered diagnostic tests & procedures.
• Diagnostic mammograms including diagnostic services or tests after a mammogram	$0 copayment for each Medicare-covered diagnostic mammogram and additional services or testing following a mammogram.
• Diagnostic colonoscopy	$0 copayment for diagnostic colonoscopy.

Services that are covered for you	What you must pay when you get these services
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 the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital 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 are an outpatient and pay the cost sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	$0 copayment for each Medicare-covered stay for outpatient hospital 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 are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery	$0 copayment for each Medicare-covered outpatient hospital facility visit. $0 copayment for Medicare-covered outpatient hospital facility surgery services.

Services that are covered for you	What you must pay when you get these services
Outpatient hospital services (continued)	
• Laboratory tests billed by the hospital	$0 copayment for Medicare-covered laboratory tests. There may be a copayment for some laboratory tests. Call Customer Service for additional information.
• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it	$0 copayment per day for Medicare-covered partial hospitalization program services.
• X-rays and other radiology services billed by the hospital	Please refer to "Outpatient diagnostic tests and therapeutic services and supplies."
• Medical supplies such as splints and casts	$0 copayment for Medicare-covered surgical supplies, splints and casts.
• Certain drugs and biologicals that you can't give yourself	Please refer to "Medicare Part B prescription drugs."
Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	Please refer to "Emergency care." There may also be additional professional copayments/coinsurance. See "Physician/ Practitioner services," "Podiatry services," "Vision care (Medicare-covered)," "Pulmonary rehabilitation services," "Hearing services (Medicare-covered)," "Chiropractic services," "Cardiac rehabilitation

Services that are covered for you	What you must pay when you get these services
Outpatient hospital services (continued)	services," "Supervised exercise therapy," "Acupuncture," or "Dental services (Medicare-covered)" benefit.
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws. We provide coverage for mental health treatment ordered by a court of competent jurisdiction under a valid court order that is issued on the basis of a behavioral care evaluation performed by a licensed psychiatrist or doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment. We also allow for non-Medicare qualified behavioral health professionals as allowed under applicable state laws.	$0 copayment for each Medicare-covered individual or group therapy visit. $0 copayment for each Medicare-covered individual or group therapy visit with a psychiatrist. There may also be additional facility copayments, refer to "outpatient hospital 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). Non-routine dental care allows for non-Medicare-covered durable medical equipment and surgical and non-surgical treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder.	$0 copayment for each Medicare-covered outpatient rehabilitation service visit. There may also be additional facility copayments, refer to "outpatient hospital services".

Services that are covered for you	What you must pay when you get these services
Outpatient substance abuse services We cover services for the diagnosis and treatment of substance abuse when such services are medically necessary and in accordance with Medicare guidelines.	$0 copayment for each Medicare-covered individual or group therapy visit. There may also be additional facility coinsurance, refer to "outpatient hospital services". There may also be additional professional service copayments, refer to "Opioid treatment program services" and "Outpatient mental health care".
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you receive any services or items other than surgery, including but not limited to diagnostic tests, therapeutic services, prosthetics, orthotics, supplies or Part B drugs, there may be additional cost sharing for those services or items. Please refer to the appropriate section in this chart for the additional service or item you received for the specific cost sharing required. See "Colorectal cancer screening" earlier in this chart for screening and diagnostic colonoscopy benefit information.	$0 copayment for Medicare-covered surgeries performed in an ambulatory surgical center or outpatient hospital facility. There may also be additional professional service copayments, refer to "physician/practitioner services; including doctor's office visits".

Services that are covered for you	What you must pay when you get these services
Ovarian Cancer Screening Tests Routine cancer screening includes "surveillance tests for ovarian cancer" for women who are "at risk for ovarian cancer." Surveillance tests for ovarian cancer means annual screening using CA-125 serum tumor marker testing, transvaginal ultrasound, pelvic examinations or other proven ovarian cancer screening tests currently being evaluated by the FDA or by the National Cancer Institute. At risk for ovarian cancer means: 1) having a family history: a) with one (1) or more first or second degree relatives with ovarian cancer; b) of clusters of women relatives with breast cancer; or c) of nonpolyposis colorectal cancer; or 2) testing positive for BRCA1 or BRCA2 mutations	$0 copayment
Over-the-Counter (OTC) items You are entitled to an allowance each quarter to order covered over-the counter (OTC) health and wellness items through OTC Health Solutions. This benefit is limited to specific items listed in the catalog. A catalog of covered OTC items can be found at cvs.com/benefits **(Please note: This website will be active on 1/1/2024)**. Benefits are available at the beginning of each quarter of the calendar year (January, April, July, and October). The quarterly benefit expires at the end of each quarter (March 31st, June 30th, September 30th and December 31st). Unused OTC amounts do not roll to the next quarter. In store, you can pick up your OTC items at a CVS Pharmacy® store (excluding Target, Schnucks and select other CVS Pharmacy® locations). To find your nearest eligible location, go to cvs.com/benefits **(Please note: This website will be active on 1/1/2024)**. Items may be ordered online at cvs.com/benefits **(Please note: This website will be active on 1/1/2024)** or over the phone at 1-888-628-2770 Monday through Friday from 8 a.m. to 10 p.m. central time, to be shipped to your home at no cost to you. OTC Vendor: CVS. CVS Pharmacy, Inc. d/b/a OTC Health Solutions is an independent company providing OTC supplemental benefit administrative services.	✓ $50 per quarter for covered OTC items.* *This is not a reimbursement. **Note:** Must use OTC Health Solutions

Services that are covered for you	What you must pay when you get these 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 is more intense than the care received in your doctor's or therapist'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 is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization.	$0 copayment per day for Medicare-covered partial hospitalization program services. There may also be additional Physician/ Practitioner service copayments/coinsurance. See Physician/Practitioner services benefit.
Phenylketonuria Coverage is provided for special dietary treatment for phenylketonuria (PKU) when recommended by a physician.	$0 copayment
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services furnished 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 • Other health care professionals providing the professional service of home infusion therapy. • Coverage must be based on the same provider network as for in-person 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	$0 copayment for each Medicare-covered visit. There may also be additional professional service copayments. For Medicare-covered acupuncture services, please see "Acupuncture for chronic low back pain" benefit and for non-Medicare-covered acupuncture services, please see "Acupuncture for non-Medicare-covered (routine) pain management" benefit. Please refer to "Outpatient diagnostic tests and therapeutic services and supplies"

Services that are covered for you	What you must pay when you get these services
Physician/Practitioner services, including doctor's office visits (continued) network provider who is eligible to bill Medicare for telehealth services. • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • 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 if: ◦ You have an in-person visit within 6 months prior to your first telehealth visit ◦ You have an in-person visit every 12 months (11 full months must have passed since the last visit) while receiving these telehealth services ◦ Exceptions can be made to the above for certain circumstances • 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:** ◦ You're not a new patient **and** ◦ The check-in isn't related to an office visit in the past 7 days **and** ◦ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if:** ◦ You're not a new patient **and**	

Services that are covered for you	What you must pay when you get these services
Physician/Practitioner services, including doctor's office visits (continued) ◦ The evaluation isn't related to an office visit in the past 7 days **and** ◦ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion by another network provider prior to surgery • Medicare-covered non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) • Non-routine dental care also allows for non-Medicare-covered surgical and non-surgical treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder	
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	$0 copayment for each Medicare-covered visit. There may also be additional Facility services copayments/ coinsurance. See "Outpatient hospital services" benefit.
Prostate cancer screening exams For men aged 40 and older, covered services include the following: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for an annual PSA test and digital rectal exam.

Services that are covered for you	What you must pay when you get these services
Prostate cancer screening exams (continued) Additional screenings: • There is no limit on the number of covered prostate cancer screenings	
Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see **Vision Care** later in this section for more detail.	$0 copayment for Medicare-covered medical supplies related to prosthetics, splints, and other devices.
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.	$0 copayment for Medicare-covered pulmonary rehabilitation services. There may also be additional Facility services copayments/ coinsurance. See "Outpatient hospital services" benefit.
Residential Chemical Dependency and Mental Health Residential Treatment Programs Live-in, home-like, facility providing 24-hour monitoring, supervision, and therapeutic treatment for substance use disorders, eating disorders, addiction, and other behavioral conditions. Coverage includes room and board, individual and group therapy, and other evidence-based treatment along with non-medical life skills with a stay lasting anywhere from a month to six months or more to effect long lasting change and integration back into society. We provide coverage for chemical dependency treatment to a member by the Department of Corrections while the member is	$100 copayment per month for non-Medicare-covered treatment.

Services that are covered for you	What you must pay when you get these services
Residential Chemical Dependency and Mental Health Residential Treatment Programs (continued) committed to the custody of the commissioner of corrections following a conviction for a first-degree driving while impaired offense. A court of competent jurisdiction under a valid court order, makes a preliminary determination based on a chemical use assessment conducted by an assessor appointed by the court, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment. We provide coverage for mental health treatment ordered by a court of competent jurisdiction under a valid court order that is issued on the basis of a behavioral care evaluation performed by a licensed psychiatrist or doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment. These services are not subject to a separate medical necessity determination.	
Scalp Hair Prostheses (Wigs) Hair loss must be due to alopecia areata. The maximum is one (1) prosthesis per person per calendar year	$0 copayment
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to four brief face-to-face counseling sessions per year (11 full months must have passed since the last set of sessions) (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months (11 full months must have passed since the last screening).	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.

Services that are covered for you	What you must pay when you get these services
Screening for lung cancer with low dose computed tomography (LDCT) (continued) **Eligible members are**: people aged 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	
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 (11 full months must have passed since the last test) 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 (11 full months must have passed since the last session) for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.

Services that are covered for you	What you must pay when you get these services
Services to treat kidney disease Covered 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 cover up to six sessions of kidney disease education services per lifetime • Outpatient dialysis treatments • Inpatient dialysis treatments (if you are 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 your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, **Medicare Part B prescription drugs**. For inpatient dialysis treatment coverage, see "Inpatient Hospital care" earlier in this chart. For dialysis as part of a home health episode of care, please refer to "Home health agency care."	$0 copayment for kidney disease education services. $0 copayment for Medicare-covered renal dialysis services. $0 copayment for Medicare-covered equipment and supplies.
Skilled nursing facility (SNF) care (For a definition of **skilled nursing facility care**, see Chapter 10 of this document. Skilled nursing facilities are sometimes called SNFs.) 100 days per benefit period (3-day prior covered hospital stay required). Time spent in observation care does not count toward 3-day prior covered hospital stay. Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary)	$0 copayment per day for days 1-20. $0 copayment per day for days 21-100. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you have not been

Services that are covered for you	What you must pay when you get these services
Skilled nursing facility (SNF) care (continued) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (this includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used • 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	an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period (11 full months must have passed since the last counseling session) as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period (11 full months must have passed since the last counseling session), however, you will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.

Services that are covered for you	What you must pay when you get these services
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, or nurse practitioner/clinical nurse specialist 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.	$0 copayment for each Medicare-covered supervised exercise therapy visit for PAD. There may also be additional Facility services copayments/ coinsurance. See "Outpatient hospital services" benefit.
Treatment of Diagnosed Lyme Disease Coverage is provided on the same basis as any other illness	Please refer to "Medicare Part B prescription drugs," "Outpatient diagnostic tests and therapeutic services and supplies," "Physician/Practitioner services, including doctor's office visits"
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but, given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. If it is unreasonable given your	$0 copayment for each Medicare-covered urgent care visit.

Services that are covered for you	What you must pay when you get these services
Urgently needed services (continued) circumstances to immediately obtain the medical care from a network provider, then your plan will cover the urgently needed services from a provider out-of-network. Services must be immediately needed and medically necessary. Examples of urgently needed services that the plan must cover out of network occur if: You are temporarily outside the service area of the plan and require medically needed immediate services for an unforeseen condition but it is not a medical emergency; or it is unreasonable given your circumstances to immediately obtain the medical care from a network provider. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network Coverage is only provided while in the United States and its territories.	
Ventilator-Dependent Persons Services up to 120 hours per hospital admission for services that are provided by a private duty nurse or a personal care assistant for a ventilator-dependent person in a hospital licensed under Chapter 144. The private duty nurse or personal care assistant shall perform only the services of communicator or interpreter for the ventilator-dependent patient during the transition period to assure adequate training of hospital staff to communicate with the ventilator-dependent patient.	Please refer to "Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay"
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.	$0 copayment for Medicare-covered exams to diagnose and treat diseases and conditions of the eye.
• For people who are at high risk of glaucoma, we will cover one (1) glaucoma screening each year (11 full months must have passed since the last screening). People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African	$0 copayment for one (1) Medicare-covered glaucoma screening per year for people at risk.

Services that are covered for you	What you must pay when you get these services
Vision care (continued) 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 (11 full months must have passed since the last screening).	$0 copayment for one (1) Medicare-covered diabetic retinopathy exam per year.
• One (1) pair of Medicare-covered eyeglasses (standard frames and standard single vision, lined bifocal, or lined trifocal lenses) or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) You will pay any additional costs to frame and lens upgrades. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.	20% coinsurance for one (1) pair of Medicare-covered eyeglasses or contact lenses after each cataract surgery. There may also be additional Facility services copayments/ coinsurance. See "Outpatient hospital services" benefit.
• One (1) routine vision (eye) examination annually.	$0 copayment for one (1) non-Medicare-covered eye exams every year.
• Plan benefit allowance for non-Medicare covered eyewear every year (may not be applied to eyewear received after cataract surgery).	✓ $150 plan benefit allowance for non-Medicare covered eyewear every year.
***Welcome to Medicare* preventive visit** The 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 the preventive services you need (including certain screenings and shots), 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	There is no coinsurance, copayment, or deductible for the *Welcome to Medicare* preventive visit.

Services that are covered for you	What you must pay when you get these services
***Welcome to Medicare* preventive visit (continued)** know you would like to schedule your *Welcome to Medicare* preventive visit. Note: If you are outside of your first 12 months of having Medicare Part B, please see the Annual Wellness visit benefit.	
Women's Health and Cancer Rights Under the federal Women's Health and Cancer Rights Act of 1998 and Minnesota law you are entitled to the following reconstructive surgery services without limitation following a medically necessary mastectomy: 1. all stages of reconstruction of the breast on which the mastectomy has been performed; 2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3. prostheses and treatment for physical complications during all stages of mastectomy, including swelling of the lymph glands (lymphedema). Services are provided in a manner determined in consultation with the physician and patient and is determined to be medically necessary. Coverage is subject to annual deductible, copayment, and coinsurance provisions as appropriate and consistent with benefits under the plan.	Please refer to "Durable medical equipment (DME) and related supplies," "Inpatient hospital care," "Outpatient hospital services," "Physician/Practitioner services, including doctor's office visits"

Non-Medicare-covered (Routine) Dental Benefits*:

- In general, preventive and routine dental services are not covered under Original Medicare. Your Blue Cross Platinum Blue plan provides coverage for additional dental benefits.
- Below is a list of covered dental services. Any services not listed below are NOT covered. Procedure codes may be updated to meet American Dental Association (ADA) Current Dental Terminology (CDT) in accordance with national standards. Current Dental Terminology @2023 American Dental Association. All rights reserved.
- Talk to your dentist about treatment options, risks, benefit coverage and fees.
- Treatment plans presented by your provider showing coverage and cost may not accurately reflect coverage, benefits, and/or out-of-pocket costs. For verification of coverage and out-of-pocket costs, your provider may submit a pre-determination (e.g., an official pre-treatment estimate) to Blue Cross Medicare dental prior to services rendered. You and

your provider will receive a notice of pre-determination illustrating your coverage and possible out-of-pocket costs.

- For assistance finding an in-network provider or if you have questions, please contact dental customer service at 1-844-397-4182 Monday through Friday, 8 a.m. to 8 p.m., Central time. You may also use the dental provider search tool at bluecrossmn.com/medicaredental.

Dental services performed by out-of-network providers:**

- Your non-Medicare-covered (routine) dental benefits include out-of-network coverage. Please confirm with your out-of-network provider that he/she is eligible to receive Medicare payments from your Blue Cross Platinum Blue plan. Service(s) provided by a provider who is unable to accept Medicare payment will be denied and you may be responsible for the full cost of the service(s).
- You will be responsible for paying the difference between the dentist's fees and the Blue Cross Medicare fee schedule for covered dental services performed by a dentist outside of the Blue Cross and Blue Shield of Minnesota Medicare dental network, even for services listed as $0 copayment.
- Out-of-network services are subject to in-network benefit maximums, limitations and/or exclusions. For additional support, out-of-network providers may contact dental customer service at 1-844-397-4182 Monday through Friday, 8 a.m. to 8 p.m., Central time.
- If the out-of-network dental provider is unable to submit electronic claims on your behalf, please work with your provider to complete a dental claim form and submit to:

  United Concordia Dental Claims
  PO Box 69449
  Harrisburg, PA 17106-9449

  The dental claim form may be found at: bluecrossmn.com/dentalclaimform.

Waiting Periods: There are no waiting periods for covered services

Annual Deductible: $0 (There is no annual deductible)

Annual Maximum: $2,000

- $2,000 is the annual maximum amount the plan will pay for all in- and out-of-network covered dental services. Coinsurance and copayments also apply. After the annual maximum is met, all charges are your responsibility.

Coordination of Benefits (COB):

Coordination of benefits takes place when a member has more than one dental plan. Blue Cross Platinum Blue dental benefits will coordinate with stand-alone dental plans to eliminate over-insurance or duplication of benefits. The benefit coordination will follow Medicare guidelines. Medicare guidelines require individual dental be processed as primary and Medicare dental as secondary.

If you have dual dental coverage, please present both dental cards to your dental office at time of your appointment.

Chart header definitions:

***American Dental Association (ADA) codes:** Covered dental procedures are listed by ADA code. These codes are used by dentists to submit dental claims. Categories provide easy reference.

Frequency: How often Blue Cross Platinum Blue will pay for the dental procedure

Criteria and exclusions: Conditions under which Blue Cross Platinum Blue would pay for this procedure and situations where Blue Cross Platinum Blue would NOT pay for the procedure

****Member out-of-network copayment/coinsurance:** If your dental services are performed by a dentist outside of the Medicare dental network you will be responsible for paying the difference between the dentist's fees and the Blue Cross Medicare fee, even for services listed as $0 copayment

American Dental Association (ADA) codes*	Description of dental procedure	Frequency	Criteria and exclusions	Member in-network copayment/ coinsurance	Member out-of-network copayment/ coinsurance **
Exams					
D0120	Routine periodic exam	2 per calendar year	Two routine oral evaluations (D0120, D0150, D0R180) are eligible during a calendar year period. One compre-hensive periodontal evaluation (D0180) is eligible within a 3-year period.	$0 copayment	$0 copayment**
D0150	Compre-hensive oral evaluation	2 per calendar year		$0 copayment	$0 copayment**
D0180	Compre-hensive periodontal evaluation	1 per 3 years		$0 copayment	$0 copayment**

American Dental Association (ADA) codes*	Description of dental procedure	Frequency	Criteria and exclusions	Member in-network copayment/ coinsurance	Member out-of-network copayment/ coinsurance **
D0140	Limited problem-focused exam	1 per patient per provider per 12 months in combination with consultations (D9310)	The combination of a consultation (D9310) and a limited oral evaluation (D0140) is limited to one per patient, per provider, per 12 months	$0 copayment	$0 copayment**
D9310	Consultations	1 per patient per provider per 12 months in combination with limited evaluation (D0140)		$0 copayment	$0 copayment**
D0160	Detailed and extensive oral evaluation – problem-focused, by report	1 per patient per provider per 12 months per eligible diagnosis	One detailed and extensive oral evaluation problem-focused (D0160), per patient, per provider is eligible in a 12-month period	$0 copayment	$0 copayment**
Cleanings					
D1110	Adult dental cleanings	2 per calendar year	Two routine cleanings (D1110) are eligible per	$0 copayment	$0 copayment**

American Dental Association (ADA) codes*	Description of dental procedure	Frequency	Criteria and exclusions	Member in-network copayment/ coinsurance	Member out-of-network copayment/ coinsurance **
			calendar year period. If a member has periodontal benefits, the combination of a routine cleaning (D1110) and periodontal scaling with gingival inflammation (D4346) is limited to 2 in a calendar year.		
X-rays					
D0210	Full mouth – complete series	1 per 5 years	One full mouth radiograph series (D0210) or panoramic radiograph (D0330) is eligible in any 5-year period. Not covered in the same year as an occurrence of bitewing (D0270, D0272,	$0 copayment	$0 copayment**
D0330	Panoramic x-ray	1 per 5 years		$0 copayment	$0 copayment**

American Dental Association (ADA) codes*	Description of dental procedure	Frequency	Criteria and exclusions	Member in-network copayment/ coinsurance	Member out-of-network copayment/ coinsurance **
			D0273, D0274, D0277).		
D0220, D0230	Intraoral periapical images	4 images per 12 months	Four peripheral images (D0220, D0230) are eligible during a twelve (12) consecutive month period. Not covered on the same day as a full mouth set (D0210) or panoramic x-rays (D0330).	$0 copayment	$0 copayment**
D0270, D0272, D0273, D0274, D0277	Bitewing x-rays	Maximum of 4 bitewings per occurrence; 1 occurrence per calendar year	A maximum of 4 bitewing radiograph views (D0270, D0272, D0273, D0274, D0277) are eligible during a calendar year period. Only one occurrence of 2, 3 or 4	$0 copayment	$0 copayment**

American Dental Association (ADA) codes*	Description of dental procedure	Frequency	Criteria and exclusions	Member in-network copayment/ coinsurance	Member out-of-network copayment/ coinsurance **
			bitewing radiograph views will be allowed. Not covered in the same year as a full mouth set (D0210) or panoramic x-rays (D0330).		
Fluoride					
D1206, D1208	Fluoride	2 per calendar year	Two topical applications of fluoride (D1206, D1208) are eligible in a calendar year.	$0 copayment	$0 copayment**
Periodontal services					
D4910	Periodontal cleaning (deep cleaning of gums)	2 per calendar year	Periodontal cleaning is in addition to two standard cleanings (D1110); not covered on same date of service; no coverage for additional periodontal cleaning (D4910) beyond the	$0 copayment	$0 copayment**

American Dental Association (ADA) codes*	Description of dental procedure	Frequency	Criteria and exclusions	Member in-network copayment/ coinsurance	Member out-of-network copayment/ coinsurance **
			allowed two (2) per calendar year.		
Emergency treatment of pain					
D9110	Palliative emergency treatment	2 per 12 months	Subject to the application of dental policy, two palliative treatments (D9110) are eligible in a 12-month period in combination with pulpal debridement (D3221).	$0 copayment	$0 copayment**

Exclusions:

The following services, supplies or charges are excluded:

1. Treatment started prior to the individual's effective date or after the termination date of coverage under this contract.
2. Services that are not listed as covered in above chart.
3. House or hospital calls for dental services and for hospitalization costs (facility-use fees). Charges that are eligible, paid or payable under any medical payment automobile personal injury protection that is payable without regard to fault, including charges for services that are applied toward any deductible, copay, or coinsurance requirement of such a policy.
4. Prescription and non-prescription drugs, vitamins or dietary supplements.
5. Administration of nitrous oxide and/or IV sedation, unless specifically indicated on the schedule of benefits.
6. Treatments which are cosmetic in nature as determined by Blue Cross (for example but not limited to, bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures).

7. Elective procedures (for example but not limited to, the prophylactic extraction of third molars).
8. Dental implants and any related surgery, placement, restoration, prosthetics (except single implant crowns), maintenance and removal of implants unless specifically covered under the schedule of benefits or a rider.
9. Treatment of fractures and dislocations of the jaw.
10. Treatment of malignancies or neoplasms.
11. Services and/or appliances that alter the vertical dimension (for example but not limited to, full-mouth rehabilitation, splinting, fillings) to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.
12. Replacement or repair of lost, stolen or damaged prosthetic or orthodontic appliances.
13. Preventive restorations.
14. Periodontal splinting of teeth by any method.
15. Duplicate dentures, prosthetic devices or any other duplicative device.
16. Plaque control programs, tobacco counseling, oral hygiene and dietary instructions.
17. Treatment for any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the National Guard or in the Armed Forces of any country or international authority.
18. Treatment and appliances for bruxism (night grinding of teeth).
19. Any claims submitted to Blue Cross by the individual in or on behalf of the individual in excess of twelve (12) months after the date of service.
20. Incomplete treatment (for example but not limited to, patient does not return to complete treatment) and temporary services (for example but not limited to, temporary restorations).
21. Procedures that are:
    a. part of a service but are reported as separate services; or
    b. reported in a treatment sequence that is not appropriate; or
    c. misreported or that represent a procedure other than the one reported.
22. Specialized procedures and techniques (for example but not limited to, precision attachments, copings and intentional root canal treatment).
23. Fees for failure to keep scheduled visits.
24. Those specifically listed on the schedule of benefits as “not covered” or “plan pays 0%”.
25. Treatment, services, or supplies which are not dentally necessary or not deemed to be generally accepted standards of dental treatment. If no clear or generally accepted standard exists, or there are varying positions within the professional community, the opinion of Blue Cross will apply.
26. Services that are prohibited by law or regulation.

27. Services which are not within the scope of licensure or certification of a provider.
28. Charges for furnishing medical and dental records or reports and associated delivery charges.

Section 2.2 Getting care using our plan's optional extended absence benefit

If you do not permanently move, but you are continuously away from our plan's service area for more than three months, we usually must disenroll you from our plan. However, we offer an extended absence program which will allow you to remain enrolled when you are outside of our service area for up to 9 months.

If you are in the extended absence area, you can stay enrolled in our plan for up to 9 months. If you have not returned to the plan's service area within 9 months, you will be disenrolled from the plan.

SECTION 3 What services are not covered by the plan?

Section 3.1 Services we do *not* cover (exclusions)

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

The chart below lists services and items that either are not 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 receive the excluded services at an emergency facility, the excluded services are still not covered, and our plan will not pay for them. The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 7, Section 5.3 in this document.)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Adult foster care	**Not covered under any condition**	
Ambulance services without transportation to a medical facility	**Not covered under any condition**	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Automatic blood pressure monitor.		See "Over-the-Counter (OTC) items" section in Medical Benefits Chart above for details.
Autopsy/Necropsy	**Not covered under any condition**	
Blood ketone test or Reagent strips	**Not covered under any condition**	
Blood typing, for paternity testing.	**Not covered under any condition**	
Charges for equipment which is primarily and customarily used for a non-medical purpose, even though the item has some remote medically-related use.		Covered only when medically necessary.
Charges for sales tax	**Not covered under any condition**	
Commercial weight loss programs and commercial exercise programs, such as Weight Watchers, Jenny Craig, Nutrisystem, Noom, or any of the available exercise programs like Transform 20, Beachbody, Mirror, Tonal, or Peloton.	**Not covered under any condition**	
Computed tomographic (CT) colonography (virtual colonoscopy)		Covered only when medically necessary according to Medicare guidelines
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

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
		as for the unaffected breast to produce a symmetrical appearance.
Custodial care Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.	**Not covered under any condition**	
Durable items that are not primarily designed to serve a medical purpose (e.g., exercise equipment), even if ordered by a doctor, equipment that is not designed primarily for medical use.	**Not covered under any condition**	
Durable Medical Equipment (DME) is not covered when the member resides in an institution that is an acute hospital or skilled nursing facility and the member has exhausted the 100-day skilled nursing facility benefit.	**Not covered under any condition**	
Elective or voluntary enhancement procedures or services (including hair growth, sexual performance, athletic performance, anti-aging, and mental performance).	**Not covered under any condition**	
Examination to qualify for life insurance policy.	**Not covered under any condition**	
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and		May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
procedures determined by Original Medicare to not be generally accepted by the medical community.		(See Chapter 3, Section 5 for more information on clinical research studies.)
Eye refractions without an eye exam	**Not covered under any condition**	
Fees charged for care by your immediate relatives or members of your household.	**Not covered under any condition**	
Fluoride application for dental		See "Dental services" section in Medical Benefits Chart above for details.
Full-time nursing care in your home.	**Not covered under any condition**	
Genetic counseling and genetics studies except when the results would influence a treatment or management of a condition.		Covered only when medically necessary to treat or manage a condition and is not for predictive purposes according to Medicare guidelines
Halfway houses and residential treatment facilities		Except as covered under state-mandated benefits listed in this Evidence of Coverage
Hearing aids and provider visits to service hearing aids (except as specifically described in the Covered Benefits), ear molds, hearing aid accessories, warranty claim fees, and hearing aid batteries (beyond the 80 free batteries per non-rechargeable aid purchased).		Covered as shown in Section 2.1 of this chapter when purchased from TruHearing.
Home-delivered meals	**Not covered under any condition**	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Homemaker services including basic household assistance, such as light housekeeping or light meal preparation.		When receiving a skilled service such as skilled nursing care, a home health aide may also perform some incidental services such as light cleaning, preparation of a meal, taking out the trash, or light shopping. However, a home health aide is never covered solely for the purpose of providing household assistance
If you are not entitled to, or have not purchased Medicare Part A, and you are only enrolled in Medicare Part B, you will only have Medicare Part B coverage under our plan. You will not have coverage for services that would be covered under Medicare Part A such as inpatient hospital and skilled nursing facility stays.	**Not covered under any condition**	
Immunizations for travel purposes.		May be covered under Part D drug plan.
Intermittent limb compression device (including all accessories).		Covered only when medically necessary according to Medicare guidelines
Medical cannabis	**Not covered under any condition**	
Naturopath services (uses natural or alternative treatments).	**Not covered under any condition**	
Needle-free injection device.	**Not covered under any condition**	
Non-durable items (i.e., items that cannot be re-used) such as incontinence garments/ products		See “Over-the-Counter (OTC) items” section in Medical Benefits Chart above for details.
Non-emergency wheelchair van transportation	**Not covered under any condition**	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Non-medical administrative fees and charges including but not limited to medical record preparation charges, appointment cancellation fees, after hours appointment charges, and interest charges.	**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. Non-routine dental care also allows for non-Medicare-covered surgical and non-surgical treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder. Refer to "Physician/Practitioner" section in Medical Benefits Chart above.
Nutritional supplementation (e.g., Boost, Ensure)		See "Over-the-Counter (OTC) items" section in Medical Benefits Chart above for details.
Open and/or laparoscopic vertical banded gastroplasty	**Not covered under any condition**	
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.
Outpatient prescription drugs		Covered as shown in the Benefits Chart under "Medicare Part B prescription drugs"
Personal comfort/hygiene items at home or in any place of service (e.g., radio, television, razor, toothbrush, personal grabbing device, any type, any length, cold		See "Over-the-Counter (OTC) items" section in Medical Benefits Chart above for details.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
or hot fluid bottle, ice cap or collar, heat and/or cold wrap, any type).		
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	**Not covered under any condition**	
Private room in a hospital.		Covered only when medically necessary.
Professional services associated with substance abuse interventions. A "substance abuse intervention" is a gathering of family and/or friends to encourage a person covered under this Evidence of Coverage to seek substance abuse treatment.	**Not covered under any condition**	
Radial keratotomy, Keratomileusis, Keratophakia, Epikeratoplasty, LASIK surgery and other low vision aids.	**Not covered under any condition**	
Recreational or educational therapy Recreational therapy is therapy provided solely for the purpose of recreation, including but not limited to: (a) requests for physical therapy or occupational therapy to improve athletic ability, and (b) braces or guards to prevent sports injuries.	**Not covered under any condition**	
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	**Not covered under any condition**	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Routine (non-Medicare-covered) acupuncture		See "Acupuncture for non-Medicare-covered (routine) Pain Management" section in Medical Benefits chart above for details.
Routine (non-Medicare-covered) chiropractic services	**Not covered under any condition**	
Routine dental care, such as cleanings, fillings or dentures.		See "Dental services" section in Medical Benefits Chart above for details.
Routine eye examinations and eyeglasses not related to cataract surgery.		See the "Vision care" section in the Medical Benefits Chart above for details.
Routine foot care		Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes or neuropathy).
Routine hearing exams, hearing aids, or exams to fit hearing aids.		See the "Hearing services" section in the Medical Benefits Chart above for details.
Services considered not reasonable and necessary, according to Original Medicare standards		Except as covered under state-mandated benefits listed in this Evidence of Coverage
Services provided to veterans in Veterans Affairs (VA) facilities		Covered only when medically necessary. When emergency services are received at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for the applicable deductible, copayment or coinsurance.
Services statutorily excluded from Medicare coverage, unless offered as part of a supplemental benefit.		Except as otherwise noted in the "Medical Benefits Chart" above.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Spacer, bag or reservoir, with or without mask, for use with metered dose inhaler.	**Not covered under any condition**	
Surgical treatment for morbid obesity.		Except when it is considered medically necessary and covered under Original Medicare
Tests and treatment for infertility when fertility is not expected due to usual state of health; or infertility due to illness or injury.	**Not covered under any condition**	
Treatment, procedures or services which are provided when you are not covered under this Evidence of Coverage, unless eligible for an extension of benefits.	**Not covered under any condition**	
Urine test strips	**Not covered under any condition**	

CHAPTER 5:

Asking us to pay our share of a bill you have received for covered medical services

SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered services

Sometimes when you get medical care, you may need to pay the full cost. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. Or you may receive a bill from a provider. In these cases, you can ask our plan to pay you back (paying you back is often called *reimbursing* you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services that are covered by our plan. There may be deadlines that you must meet to get paid back. Please see Section 2 of this chapter.

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

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received:

1. When you've received emergency or urgently needed medical care from a provider who is not in our plan's network

Outside the service area, you can receive emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases,

- You are only responsible for paying your share of the cost. Ask the provider to bill the plan for our share of the cost.
- If you pay the entire amount yourself at the time you receive 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 have made.
- You may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
    - If the provider is owed anything, we will pay the provider directly.
    - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.

2. When a network provider sends you a bill you think you should not pay

Network providers should always bill the 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 do not 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 is a dispute and we don't pay certain provider charges.

- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. If you are retroactively enrolled in our plan

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

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

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 of this document has information about how to make an appeal.

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

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

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

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website (bluecrossmn.com/medicare-documents) or call Customer Service and ask for the form.

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

Blue Cross and Blue Shield of Minnesota
Platinum Blue
P.O. Box 982805
El Paso, TX 79998-2805

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

Section 3.1 We check to see whether we should cover the service and how much we owe

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

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

Section 3.2 If we tell you that we will not pay for all or part of the medical care, you can make an appeal

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

CHAPTER 6:

Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities as a member of the plan

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, in braille, in large print, or other alternate formats, etc.)

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

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Customer Service.

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

If providers in the plan's network for a specialty are not available, it is the plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you will only pay in-network cost sharing. If you find yourself in a situation where there are no specialists in the plan's network that cover a service you need, call the plan for information on where to go to obtain this service at in-network cost sharing.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Customer Service. You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

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

You have the right to choose a provider in the plan's network to provide and arrange for your covered services. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral. We do not require you to get referrals to go to network providers.

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

If you think that you are not 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 Practices,* that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you or someone you have given legal power to make decisions for you first*.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - We are required to release health information to government agencies that are checking on quality of care.
    - Because you are a member of our plan through Medicare, we are required to give Medicare your health information. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

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

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

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

If you have questions or concerns about the privacy of your personal health information, please call Customer Service.

NOTICE OF PRIVACY PRACTICES

Effective April 24, 2023

BlueCross BlueShield Minnesota

FOR YOUR PROTECTION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY. Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) have always been committed to maintaining the security and confidentiality of the information we receive from our members. Whether it's your medical information or other identifiable information (such as your name, address, phone number or member identification number) ("protected health information"), or information about race, ethnicity, gender, gender identity, sexual orientation or language, we maintain policies and procedures, and other electronic controls, to guard against unauthorized access and use, and unnecessary collection of information. You should know that we are required by law to provide you this notice about our legal duties and privacy practices. We hope that this notice will clarify our responsibilities to you and provide you with a good understanding of your rights.

Please note: This notice does not apply to members whose employers are self-insured. If your employer is self-insured, you need to contact your employer for more information about your health plan's privacy practices.

HOW BLUE CROSS SAFEGUARDS YOUR PROTECTED HEALTH INFORMATION

Our privacy officer has the overall responsibility to implement and enforce privacy policies and procedures to protect your protected health information. You can be assured that every effort is taken to comply with federal and state laws — physically, electronically and procedurally — to safeguard your information. In some situations, where state laws provide greater protection for your privacy, we will follow the provisions of that state law Blue Cross requires all of its employees, business associates (such as Prime Therapeutics), providers and vendors to adhere to federal and state privacy laws. Following are descriptions of how your protected health information is handled throughout our administration of your health plan.

PERMITTED HANDLING OF PROTECTED HEALTH INFORMATION

At Blue Cross, your protected health information is handled in a number of different ways as we administer your health plan benefits. The following examples show you the various uses we are permitted by law to make without your authorization:

Treatment. We may disclose your protected health information to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers) who request it to aid in your treatment. We may also disclose your protected health information to these health care providers in our effort to provide you with preventive health, early detection and disease and case management programs.

Payment. To administer your health benefits, policy or contract, we must use and disclose your protected health information to determine:

- Eligibility
- Claims payment
- Utilization and management of your benefits
- Medical necessity of your treatment
- Coordination of your care, benefits and other services
- Responses to complaints, appeals and external review requests

We may also use and disclose your protected health information to determine premium costs, underwriting, rates and cost-sharing amounts, provided that no genetic information may be used for underwriting purposes.

Health care operations. To perform our health plan functions, we may use and disclose your protected health information to provide programs and evaluations, such as:

- Health improvement or health care cost-reduction programs
- Competence or qualification reviews of health care professionals
- Fraud and abuse detection and compliance programs
- Quality assessment and improvement activities and outcomes evaluation

- Performance measurement and outcome assessments, health claims analysis and health services outreach
- Case management, disease management and care coordination services

We may also disclose your protected health information to Blue Cross affiliates and business associates (such as Delta Dental or Prime Therapeutics) that perform payment activities and conduct health care operations on our behalf.

Service reminders. We may contact you to remind you to obtain preventive health services or to inform you of treatment alternatives and/or health-related benefits and services, which may be of interest to you.

ADDITIONAL USES AND DISCLOSURES

In certain situations, the law permits us to use or disclose your protected health information without your authorization. These situations include:

Required by law. We may use or disclose your protected health information, as we are required to do so by state or federal law, including disclosures to the U.S. Department of Health and Human Services. Also, we are required to disclose your protected health information to you in accordance with the law.

Public health issues. We may disclose your protected health information to an authorized public health authority for public health activities in controlling disease, injury or disability. For example, we may disclose your protected health information to the childhood immunization registry.

Abuse or neglect. We may make disclosures to government authorities concerning abuse, neglect or domestic violence as required by law.

Health oversight activities. We may disclose your protected health information to a government agency authorized to conduct health care system or governmental procedures such as audits, examinations, investigations, inspections and licensure activity.

Legal proceedings. We may disclose your protected health information in the course of any legal proceeding, in response to a court order or administrative judge and, in certain cases, in response to a subpoena, discovery request or other lawful process.

Law enforcement. We may disclose your protected health information to law enforcement officials. For example, disclosures may be made in response to a warrant or subpoena or for the purpose of identifying or locating a suspect, witness or missing persons or to provide information concerning victims of crimes.

Coroners, medical examiners, funeral directors and organ donations. We may disclose your protected health information in certain instances to coroners and medical examiners during their investigations. We may also disclose protected health information to funeral directors so that they may carry out their duties. We may disclose protected health information to organizations that handle donations of organs, eyes or tissue and transplantations. For example, if you are an organ donor, we can release records to an organ donation facility.

Research. We may disclose your protected health information to researchers only if certain established measures are taken to protect your privacy. For example, we may disclose to a teaching university to conduct medical research.

To prevent a serious threat to health or safety. We may disclose your protected health information to the extent necessary to avoid a serious and imminent threat to your health or safety or to the health or safety of others.

Military activity and national security. We may disclose your protected health information to armed forces personnel under certain circumstances, and to authorized federal officials for national security and intelligence activities.

Correctional institutions. If you are an inmate, we may disclose your protected health information to your correctional facility to help provide you health care or to provide safety to you or others.

Workers' compensation. We may disclose your protected health information as required by workers' compensation laws.

Others involved in your health care. Unless you notify us in writing, we may disclose certain billing information to a family member who calls on your behalf. The kind of information we will disclose is the status of a claim, amount paid and payment date. We will not, however, disclose medical information, such as diagnosis or the name of the provider.

Your employer. If your coverage is through your employer, we may disclose information to your employer to review group claims data or to conduct an audit. All information that could be used to identify specific participants is removed unless such identification is necessary.

YOUR AUTHORIZATION

Any uses and disclosures not described in this notice, including most uses and disclosures of psychotherapy notes, the use and disclosure of protected health information for marketing purposes, and the sale of any protected health information, will require your written authorization except where permitted by law. Keep in mind that you may cancel your authorization in writing at any time.

YOUR RIGHTS

Blue Cross would like you to know that you have additional rights regarding your protected health information. Your additional rights are described below:

Your right to request restrictions. You have the right to request restrictions on the way we handle your protected health information for treatment, payment or health care operations as described in the "Permitted handling of protected health information" section of this notice. The law, however, does not require us to agree to these restrictions. If we do agree to a restriction, we will send you a written confirmation and will not use or disclose your protected health information in violation of that restriction. If we don't agree, we will notify you in writing.

Your right to confidential communications. We will make every effort to accommodate reasonable requests to communicate with you about your protected health information at an alternative location. For our records, we need your request in writing, except in emergency situations where verbal requests will be accepted. It is important that you understand that any payment or payment information may be sent to the original address in our records.

Your right to access. You have the right to receive (or request that a designated person receive), by written request, a copy of your protected health information that is contained in a "designated record set," with some specified exceptions. For example, if your doctor determines that your records are sensitive, we may not give you access to your records. You also have the right to request an electronic copy of protected health information that is maintained electronically.

What is a designated record set?

It's a group of records used to administer your health benefits, including:

- Enrollment
- Payment
- Claims adjudication
- Case or medical management records

Your right to amend your protected health information. You have the right to ask us to amend any protected health information that is contained in a "designated record set." For our records, your request for an amendment must be in writing. Blue Cross will not amend records in the following situations:

- Blue Cross does not have the records you want amended
- Blue Cross did not create the records that you want amended
- Blue Cross has determined that the records are accurate and complete
- The records have been compiled in anticipation of a civil, criminal or administrative action or proceeding
- The records are covered by the federal Clinical Laboratory Improvement Act

If you have requested an amendment under any of these situations, we will notify you in writing that we are denying your request. You have the right to file a written statement of disagreement with us, and we have the right to rebut that statement. Please note that changes of addresses are not required in writing.

Your right to information about certain disclosures. You have the right to request (in writing) information about any times we have disclosed your protected health information for any purpose other than the following exceptions:

- Treatment, payment, or health care operations as described in the "Permitted handling of protected health information" section of this notice
- Disclosures that you or your personal representative have authorized
- Certain other disclosures, such as disclosures for national security purposes

The requirement that we provide you with information about any times we have disclosed your protected health information applies for six years from the date of the disclosure. This applies only to disclosures made on or after April 14, 2003.

Your right to receive notifications of breaches of protected health information. In the event of any unauthorized acquisition, use or disclosure of your unsecured protected health information (a "breach"), Blue Cross will notify you of such breach, unless there is a low probability that your protected health information has been compromised.

FUTURE CHANGES

Although Blue Cross follows the privacy practices described in this notice, you should know that under certain circumstances these practices could change in the future. For example, if privacy laws change, we will change our practices to comply with the law. Should this occur:

- We will post a new notice on our website **bluecrossmn.com** by the effective date of the new notice and will also provide a copy of the new notice, or information about the new notice and how to obtain the new notice, in our next annual mailing to members
- The changes will apply to all protected health information we have in our possession, including any information created or received before we change the notice

QUESTIONS & ANSWERS

Q: Will you give my protected health information to my family or others?

A. We will share your protected health information with others only if either of these apply: 1. You are present, in person or on the telephone, and give us permission to talk to the other person, or 2. You sign an authorization form. You should know, however, that state laws do not allow us to disclose certain information about minors — even to their parents.

Q: Who should I contact to get more information or to get an additional copy of this notice?

A: For additional information, questions about this Notice of Privacy Practices, or if you want another copy, please visit the Blue Cross website at **bluecrossmn.com**. You may also call us at **(651) 662-8000** with questions or to obtain forms.

Q: What should I do if I believe my privacy rights have been violated?

A: If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information, you may either:

1. Call us at the number listed above
2. File a written complaint with our Privacy Officer at the following address:

   Privacy Officer
   Blue Cross and Blue Shield of Minnesota
   3400 Yankee Doodle Road P-32
   Eagan, MN 55121
3. Contact the Minnesota Department of Commerce at **(651) 539-1500** or **800-657-3602**
4. Contact the Minnesota Department of Health toll free **1-800-657-3916**
5. Notify the Secretary of the U.S. Department of Health and Human Services (HHS). Send your complaint to:

   Office for Civil Rights
   U.S. Department of Health and Human Services
   233 N. Michigan Ave., Suite 240
   Chicago, IL 60601
   Voice Phone **(312) 886-2359**,
   toll free **1-800-368-1019**
   Fax **(312) 886-1807** or TTY **(312) 353-5693**.
6. Call the HHS Voice Hotline number at **1-800-368-1019**

Please be assured that we will not take retaliatory action against you if you file a complaint about our privacy practices either with us or HHS.

Delta Dental of Minnesota is independent from Blue Cross and Blue Shield of Minnesota. Delta Dental® provides administrative services for dental benefits.

Prime Therapeutics LLC is an independent company providing pharmacy benefit management services.

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

As a member of Platinum Blue Complete, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call Customer Service:

- **Information about our plan.** This includes, for example, information about the 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 is not 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 We must support your right to make decisions about your care

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

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

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

- **To know about all of your choices.** You have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan.
- **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. Of course, 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 is to be done if you are not able to make medical decisions for yourself

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

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

The legal documents that you can use to give your directions in advance of these situations are called **advance directives.** There are different types of advance directives and different names for them. Documents called **living will** and **power of attorney for health care** are examples of advance directives.

If you want to use an **advance directive** to give your instructions, here is what to do:

- **Get the form**. You can get an advance directive form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill it out and sign it**. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people**. You should give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the Office of Health Facility Complaints by calling (651) 201-4200 (metro area) or 1-800-369-7994.

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

If you have any problems, concerns, or complaints and need to request coverage, or make an appeal, Chapter 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 are required to treat you fairly.**

Section 1.7 What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, sexual orientation, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you are having:

- You can **call Customer Service**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

Section 1.8 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call Customer Service**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- You can contact **Medicare**.
    - You can visit the Medicare website to read or download the publication "Medicare Rights & Protections." (The publication is available at: medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
    - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

SECTION 2 You have some responsibilities as a member of the plan

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Service.

- **Get familiar with your covered services and the rules you must follow to get these covered services**. Use this *Evidence of Coverage* to learn what is covered for you and the rules you need to follow to get your covered services.
    - Chapters 3 and 4 give the details about your medical services.
- **If you have any other health insurance coverage in addition to our plan, you are required to tell us**. Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you are enrolled in our plan**. Show your plan membership card whenever you get your medical care.
    - Notifying out-of-network providers when seeking care (unless it is an emergency) that although you are enrolled in our plan, the provider should bill Original Medicare. You should present your membership card and your Medicare card.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care**.
    - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
    - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
    - If you have any questions, be sure to ask and get an answer you can understand.
- **Be considerate**. We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe**. As a plan member, you are responsible for these payments:
    - You must pay your plan premiums.
    - You must continue to pay a premium for your Medicare Part B to remain a member of the plan.
    - For most of your medical services covered by the plan, you must pay your share of the cost when you get the service.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* of our plan service area, you cannot remain a member of our plan**.
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

CHAPTER 7:

What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

This chapter explains two 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 of these 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 guide in Section 3 will help you identify the right process to use and what you should do.

Section 1.2 What about the legal terms?

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand. To make things easier, this chapter:

- Uses simpler words in place of certain legal terms. For example, this chapter generally says, making a complaint rather than filing a grievance, coverage decision rather than organization determination or at-risk determination, and independent review organization instead of Independent Review Entity.
- It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms. Knowing which terms to use will help you communicate more accurately to get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 Where to get more information and personalized assistance

We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. Therefore, you should always reach out to Customer Service for help. But in some situations, you may also want help or guidance from someone who is not connected with us. **Below are two entities that can assist you**.

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help

you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers and website URLs in Chapter 2, Section 3 of this document.

Medicare

You can also contact Medicare to get help. To contact Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can also visit the Medicare website (medicare.gov).

SECTION 3 To deal with your problem, which process should you use?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

Is your problem or concern about your benefits or coverage?

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

Yes.

Go on to the next section of this chapter, **Section 4**, **A guide to the basics of coverage decisions and appeals.**

No.

Skip ahead to **Section 9** at the end of this chapter: **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 the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals: the big picture

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

Asking for coverage decisions prior to receiving benefits

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical care. For example, if your plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either your network doctor can show that you received a standard denial notice for this medical specialist, or the Evidence of Coverage makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical care before you receive it, you can ask us to make a coverage decision for you. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal. Prior authorization is not required for emergency services.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide a service is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after a benefit is received, and you are not satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

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

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

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

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

If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 8 in this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

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

- You **can call us at Customer Service**.
- You **can 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 will need to be appointed as your representative. Please call Customer Service and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at bluecrossmn.com/medicare-documents.)
    - For medical care or Part B prescription drugs, your doctor can request a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your *representative* to ask for a coverage decision or make an appeal.
    - There may be someone who is already legally authorized to act as your representative under State law.

- If you want a friend, relative, or other person to be your representative, call Customer Service and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at bluecrossmn.com/medicare-documents). The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
- While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.

- **You also have the right to hire a lawyer.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.3 Which section of this chapter gives the details for your situation?

There are three different situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 5** of this chapter: **Your medical care: How to ask for a coverage decision or make an appeal**
- **Section 6** of this chapter: **How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon**
- **Section 7** of this chapter: **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 section you should be using, please call Customer Service. You can also get help or information from government organizations such as your SHIP.

SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal of a coverage decision

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

This section is about your benefits for medical care. These benefits are described in Chapter 4 of this document: *Medical Benefits Chart (what is covered and what you pay)*. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

This section tells what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that this is covered by our plan. **Ask for a coverage decision. Section 5.2**.
2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan. **Ask for a coverage decision. Section 5.2**.
3. You have received medical care that you believe should be covered by the plan, but we have said we will not pay for this care. **Make an appeal. Section 5.3**.
4. You have received and paid for medical care that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5**.
5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 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, you need to read Sections 6 and 7 of this Chapter. Special rules apply to these types of care.

Section 5.2 Step-by-step: How to ask for a coverage decision

Legal Terms
When a coverage decision involves your medical care, it is called an **organization determination.** A *fast coverage decision* is called an **expedited determination.**

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

A standard coverage decision is usually made within 14 days or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. In order to get a fast coverage decision, you must meet two requirements:

- You may *only ask* for coverage for medical items and/or services (not requests for payment for items and/or services already received).
- You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor tells us that your health requires a fast coverage decision, we will automatically agree to give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
  - Explains that we will use the standard deadlines.
  - Explains if your doctor asks for the fast coverage decision, we will automatically give you a fast coverage decision.
  - Explains that you can file a *fast complaint* about our decision to give you a standard coverage decision instead of the fast coverage decision you requested.

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

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

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

For standard coverage decisions we use the standard deadlines. **This means we will give you an answer within 14 calendar days** after we receive your request **for a medical item or service**. If your request is for a **Medicare Part B prescription drug**, we will give you an answer **within 72 hours** after we receive your request.

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

For Fast Coverage decisions we use an expedited timeframe

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

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

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

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

Section 5.3 Step-by-step: How to make a Level 1 appeal

Legal Terms
An appeal to the plan about a medical care coverage decision is called a plan **reconsideration.** A fast appeal is also called an **expedited reconsideration.**

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

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

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we will give you a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 5.2 of this chapter.

Step 2: Ask our plan for an Appeal or a Fast Appeal

- **If you are asking for a standard appeal, submit your standard appeal in writing.** Chapter 2 has contact information.

- **If you are asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.** We are 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 we are reviewing your appeal, we take a careful look at all of the information. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if needed, possibly contacting you or your doctor.

Deadlines for a fast appeal

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

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have

not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.

- However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a fast complaint. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (see Section 9 of this chapter for information on complaints.)
    - For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.
    - If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug.
- **If our plan says no to part or all of what you requested,** we will automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 5.4 Step-by-step: How a Level 2 appeal is done

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

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

Step 1: The independent review organization reviews your appeal.

- We will send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file**. We are 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 of the information related to your appeal.

If you had a fast appeal at Level 1, you will also have a fast appeal at Level 2

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

If you had a standard appeal at Level 1, you will also have a standard appeal at Level 2

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

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

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

- **If the review organization says yes to part or all of a request for a medical item or service,** we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization for standard requests. For expedited requests, we have 72 hours from the date we receive the decision from the review organization.
- **If the review organization says yes to part or all of a request for a Medicare Part B prescription drug**, we must authorize or provide the Part B prescription drug within **72 hours** after we receive the decision from the review organization for **standard requests**. For **expedited requests** we have **24 hours** from the date we receive the decision from the 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 should not be approved. (This is called upholding the decision or turning down your appeal). In this case, the independent review organization will send you a letter:
    - Explaining its decision.
    - Notifying you of the right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.

- Telling you how to file a Level 3 appeal.

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go 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 in this chapter explains the Level 3, 4, and 5 appeals processes.

Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?

Chapter 5 describes when you may need to ask for reimbursement or to pay a bill you have received 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 are asking for a coverage decision. To make this decision, we will check to see if the medical care you paid for is a covered service. We will also check to see if you followed all the rules for using your coverage for medical care.

- **If we say yes to your request**: If the medical care is covered and you followed all the rules, we will send you the payment for our share of the cost within 60 calendar days after we receive your request. If you haven't paid for the medical care, we will 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 will not send payment. Instead, we will send you a letter that says we will not pay for the medical care and the reasons why.

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

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

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

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

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

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

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

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

Within two days of being admitted to the hospital, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice. If you do not get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, please call Customer Service or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:
    - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
    - Your right to be involved in any decisions about your hospital stay.
    - Where to report any concerns you have about the quality of your hospital care.
    - Your right to **request an immediate review** of the decision to discharge you if you think you are being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time.
2. **You will be asked to sign the written notice to show that you received it and understand your rights.**
    - You or someone who is acting on your behalf will be asked to sign the notice.
    - Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does *not* mean** you are agreeing on a discharge date.

3. **Keep your copy** of the notice handy so you will have the information about making an appeal (or reporting a concern about quality of care) if you need it.
    - If you sign the notice more than two days before your discharge date, you will get another copy before you are scheduled to be discharged.
    - To look at a copy of this notice in advance, you can call Customer Service or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see the notice online at cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

Section 6.2 Step-by-step: How to make a Level 1 appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Service. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts are not part of our plan.

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

How can you contact this organization?

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

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge.**
    - **If you meet this deadline,** you may stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.

- **If you do *not* meet this deadline,** and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.

- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see Section 6.4.

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

You can get a sample of the **Detailed Notice of Discharge** by calling Customer Service or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

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

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

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

What happens if the answer is yes?

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

What happens if the answer is no?

- If the review organization says *no*, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services**

will end at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.

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

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

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

Section 6.3 Step-by-step: 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 their decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

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

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

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

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

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

If the review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

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

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

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

Section 6.4 What if you miss the deadline for making your Level 1 appeal to change your hospital discharge date?

Legal Term
A fast review (or fast appeal) is also called an **expedited appeal.**

You can appeal to us instead

As explained above, you must act quickly to start your Level 1 appeal of your hospital discharge. If you miss the deadline for contacting the Quality Improvement Organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

Step 1: Contact us and ask for a fast review.

- **Ask for a fast review.** This means you are asking us to give you an answer using the *fast* deadlines rather than the *standard* deadlines. Chapter 2 has contact information.

Step 2: We do a fast review of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We see if the decision about when you should leave the hospital was fair and followed all the rules.

Step 3: We give you our decision within 72 hours after you ask for a fast review.

- **If we say yes to your appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date. We will keep providing your covered inpatient hospital services for as long as they are medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)

- **If we say no to your appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
    - If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

Step 4: If we say *no* to your appeal, your case will *automatically* be sent on to the next level of the appeals process.

Step-by-Step: Level 2 *Alternate* Appeal Process

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

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

Step 1: We will automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 9 of this chapter tells how to make a complaint.)

Step 2: The independent review organization does a fast review of your appeal. The reviewers give you an answer within 72 hours.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says *yes* to your appeal,** then we must pay you back for our share of the costs of hospital care you received since the date of your planned discharge. We must also continue the plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree that your planned hospital discharge date was medically appropriate.
    - The written notice you get from the independent review organization will tell how to start a Level 3 appeal with the review process, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 3: If the independent review organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 appeal, you decide whether to accept their decision or go on to Level 3 appeal.
- Section 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

Section 7.1 *This section is only about three services:* Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

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

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *we will stop paying our share of the cost for your care.*

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

Section 7.2 We will tell you in advance when your coverage will be ending

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

1. **You receive a notice in writing** at least two days before our plan is going to stop covering your care. The notice tells you:
   - The date when we will stop covering the care for you.
   - How to request a fast track appeal to request us to keep covering your care for a longer period of time.
2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you received it.** Signing the notice shows *only* that you have

received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan's decision to stop care.

Section 7.3 Step-by-step: How to make a Level 1 appeal to have our plan cover your care for a longer time

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

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Service. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate.

The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts are not part of our plan.

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

How can you contact this organization?

- The written notice you received (*Notice of Medicare Non-Coverage*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the Notice of Medicare Non-Coverage.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see Section 7.5.

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

Legal Term
Detailed Explanation of Non-Coverage. Notice that provides details on reasons for ending coverage.

What happens during this review?

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

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

What happens if the reviewers say yes?

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

What happens if the reviewers say no?

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

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

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

Section 7.4 Step-by-step: How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your

Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

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

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

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

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

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

What happens if the review organization says yes?

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

What happens if the review organization says no?

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

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

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision. 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 7.5 What if you miss the deadline for making your Level 1 appeal?

You can appeal to us instead

As explained above, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

Legal Term
A fast review (or *fast appeal*) is also called an **expedited appeal**.

Step 1: Contact us and ask for a fast review.

- **Ask for a fast review.** This means you are asking us to give you an answer using the *fast* deadlines rather than the *standard* deadlines. Chapter 2 has contact information.

Step 2: We do a fast review of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan's coverage for services you were receiving.

Step 3: We give you our decision within 72 hours after you ask for a fast review.

- **If we say yes to your appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your appeal,** then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end, then **you will have to pay the full cost** of this care.

Step 4: If we say *no* to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

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

Step-by-Step: Level 2 *Alternate* Appeal Process

During the Level 2 appeal, the **independent review organization** reviews the decision we made to your *fast appeal.* This organization decides whether the decision should be changed. **The independent review organization is an independent organization that is hired by Medicare**. This organization is not connected with our plan, and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the independent review organization. Medicare oversees its work.

Step 1: We automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 9 of this chapter tells how to make a complaint.)

Step 2: The independent review organization does a fast review of your appeal. The reviewers give you an answer within 72 hours.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.
- **If this organization says *yes* to your appeal,** then we must pay you back for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover services.
- **If this organization says *no* to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
- The notice you get from the independent review organization will tell you in writing what you can do if you wish to go on to a Level 3 appeal.

Step 3: If the independent review organization says no to your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.

- A Level 3 appeal is reviewed 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 Level 3 and beyond

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

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

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

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 appeal	**An Administrative Law Judge or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

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

Level 4 appeal	The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may* or *may not* be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We will decide whether to appeal this decision to Level 5.
    - If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after receiving the Council's decision.
    - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over.**
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal	A judge at the **Federal District Court** will review your appeal.

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

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 the customer service you receive.

If you have a complaint regarding a service provided by a hospital or skilled nursing facility that is not part of the plan network, follow the complaint process established by Original Medicare. However, if you have a complaint involving a plan network hospital or skilled nursing facility (or you were directed to go to an out-of-network hospital or skilled nursing facility by the plan or one of the network providers), you will follow the instructions contained in this section. This is true even if you received a Medicare Summary Notice indicating that a claim was processed but

not covered by Original Medicare. Furthermore, if you have a complaint regarding an emergency or urgently needed service, or the cost sharing for hospital or skilled nursing facility services, you will follow the instructions contained in this section. If you have complaints about optional supplemental benefits, you may also file an appeal.

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 have received (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 are being encouraged to leave the 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, or other health professionals? Or by our Customer Service or other staff at the 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 have asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a *fast coverage decision* or a *fast appeal,* and we have said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals you can make a complaint. • You believe we are not meeting deadlines for covering or reimbursing you for certain medical items or services, that were approved; you can make a complaint.

Complaint	Example
	• 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 also called **filing a grievance.** • **Using the process for complaints** is also called **using the process for filing a grievance.** • A **fast complaint** is also called an **expedited grievance.**

Section 9.3 Step-by-step: Making a complaint

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

- **Usually, calling Customer Service is the first step.** If there is anything else you need to do, Customer Service will let you know.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- If you do this, it means that we will use our formal procedure for answering grievances. Here's how it works:
    - Prepare a written description of why you are dissatisfied and request that we resolve the issue (please include as much detail as possible in your description). You must submit the complaint within 60 days of the event or incident.
    - Mail the complaint to:
      Blue Cross and Blue Shield of Minnesota
      Platinum Blue
      P.O. Box 982800
      El Paso, TX 79998-2800
    - We will review your complaint as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the time frame by up to 14 calendar days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest.

- In certain cases, you have the right to ask for a fast grievance, meaning that we will answer your complaint within 24 hours. You may only ask for a fast decision if you or your doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. A fast decision can only be requested when your complaint involves health care that you have NOT yet received. You cannot ask for a fast decision for complaints such as asking us to pay for care already received.
- We will send you a written notice of our decision. If we deny your grievance in whole or in part, our written decision will explain why we denied it, and will tell you about any dispute resolution options that you may have.

- 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 will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If you are making a complaint because we denied your request for a fast coverage decision or a fast appeal, we will automatically give you a fast complaint.** If you have a *fast complaint*, it means we will give you **an answer within 24 hours**.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

Section 9.4 You can also make complaints about quality of care to the Quality Improvement Organization

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

- **You can make your complaint directly to the Quality Improvement Organization.** The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

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

Section 9.5 You can also tell Medicare about your complaint

You can submit a complaint about Platinum Blue Complete directly to Medicare. To submit a complaint to Medicare, go to medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 8:

Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in Platinum Blue Complete may be **voluntary** (your own choice) or **involuntary** (not your own choice):

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

If you are leaving our plan, our plan must continue to provide your medical care and you will 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 at any time

You can disenroll from this plan at any time. You may switch to Original Medicare or, if you have an enrollment period, you may enroll in a Medicare Advantage or another Medicare prescription drug plan. Your membership will usually end on the last day of the month in which we receive your request to change your plan.

Section 2.2 Where can you get more information about when you can end your membership?

If you have any questions about ending your membership you can:

- **Call Customer Service.**
- Find the information in the ***Medicare & You 2024*** handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

SECTION 3 How do you end your membership in our plan?

Section 3.1 To end your membership, you must ask us in writing

You may end your membership in our plan at any time during the year and change to Original Medicare. To end your membership, you must make a request in writing to us. **Your membership will end on the last day of the month in which we receive your request.** Contact us if you need more information on how to do this.

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

If you would like to switch from our plan to:	This is what you should do:
• Another Medicare health plan.	• Enroll in the Medicare health plan. You will automatically be disenrolled from Platinum Blue Complete when your new plan's coverage begins.
• Original Medicare *with* a separate Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from Platinum Blue Complete when your new plan's coverage begins.
• Original Medicare *without* a separate Medicare prescription drug plan.	• **Send us a written request to disenroll**. Contact Customer Service if you need more information on how to do this • You can also contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from Platinum Blue Complete when your coverage in Original Medicare begins.

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

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

- **Continue to use our network providers to receive medical care**.
- **If you are hospitalized on the day that your membership ends, your hospital stay will be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).
- If you use out-of-network providers to obtain medical services, the services are covered under Original Medicare. You will be responsible for Original Medicare's cost sharing for such services, with the exception of emergency and urgently needed services.

SECTION 5 Platinum Blue Complete must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

Platinum Blue Complete must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part B. Members must stay continuously enrolled in Medicare Part B.
- If you move out of our service area or you are away from our service area for more than 9 months.
    - If you move or take a long trip, call Customer Service to find out if the place you are moving or traveling to is in our plan's area.
- If you are no longer a United States citizen or lawfully present in the United States.
- If you become incarcerated (go to prison).
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you do not pay the plan premiums.

Where can you get more information?

If you have questions or would like more information on when we can end your membership call Customer Service.

Section 5.2 We cannot ask you to leave our plan for any health-related reason

Platinum Blue Complete is not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

Section 5.3 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, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws are not included or explained in this document.

SECTION 2 Notice about nondiscrimination

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

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

If you have a disability and need help with access to care, please call us at Customer Service. 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, Platinum Blue Complete, as a Medicare cost plan sponsor, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

SECTION 4 Notice of nondiscrimination and grievance procedures

NOTICE OF NONDISCRIMINATION PRACTICES
Effective July 18, 2016

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin,

age, disability, or gender. Blue Cross does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

Blue Cross provides resources to access information in alternative formats and languages:

- Auxiliary aids and services, such as qualified interpreters and written information available in other formats, are available free of charge to people with disabilities to assist in communicating with us.
- Language services, such as qualified interpreters and information written in other languages, are available free of charge to people whose primary language is not English.

If you need these services, contact us at 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711.

If you believe that Blue Cross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can file a grievance with the Nondiscrimination Civil Rights Coordinator

- by email at: Civil.Rights.Coord@bluecrossmn.com
- by mail at:
  Blue Cross and Blue Shield of Minnesota and Blue Plus
  Attn: Civil Rights Coordinator P3-2
  PO Box 64560
  Eagan, MN 55164-0560
- or by phone at: 1-800-509-5312

Grievance forms are available by contacting us at the contacts listed above, by calling 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711. If you need help filing a grievance, assistance is available by contacting us at the numbers listed above.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights

- electronically through the Office for Civil Rights Complaint Portal, available at: ocrportal.hhs.gov/ocr/portal/lobby.jsf
- by phone at:
  1-800-368-1019 or 1-800-537-7697 (TDD)
- or by mail at:
  U.S. Department of Health and Human Services
  200 Independence Avenue SW
  Room 509F HHH Building
  Washington, DC 20201

Complaint forms are available at hhs.gov/ocr/office/file/index.html.

This information is available in other languages. Free language assistance services are available by calling the toll free number below. For TTY, call 711.

Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al 1-855-903-2583. Para TTY, llame al 711.

Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-793-6931. Rau TTY, hu rau 711.

Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaa caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

နမ့်ကတိၤကညီကျိာ်ဒီး, တ်ကဟ့ဉ်နၤကျိာ်တ်မၤစၢၤကလိတဖဉ်နူဉ်လိၤ. ကိး 1-866-251-6744 လၢ TTY အဂိၢ်, ကိး 711 တကှ်.

إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 1-866-569-9123. للهاتف النصي اتصل بالرقم 711.

Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi số 1-855-315-4015. Người dùng TTY xin gọi 711.

Afaan Oromoo dubbattu yoo ta’e, tajaajila gargaarsa afaan hiikuu kaffaltii malee. Argachuuf 1-855-315-4016 bilbilaa. TTY dhaaf, 711 bilbilaa.

如果您說中文，我們可以為您提供免費的語言協助服務。請撥打 1-855-315-4017。聽語障專 (TTY)，請撥打 711。

Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Звоните 1-855-315-4028. Для использования телефонного аппарата с текстовым выходом звоните 711.

Si vous parlez français, des services d’assistance linguistique sont disponibles gratuitement. Appelez le +1-855-315-4029. Pour les personnes malentendantes, appelez le 711.

አማርኛ የሚናገሩ ከሆነ፣ ነጻ የቋንቋ አገልግሎት እርዳ አለሎት። በ 1-855-315-4030 ይደውሉ ለ TTY በ 711።

한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 1-855-904-2583 으로 전화하십시오. TTY 사용자는 711 로 전화하십시오.

ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃຫ້ເຈົ້າຟຣີ. ໃຫ້ໂທຫາ 1-866-356-2423 ສຳລັບ. TTY, ໃຫ້ໂທຫາ 711.

Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo sa wika. Tumawag sa 1-866-537-7720. Para sa TTY, tumawag sa 711.

Wenn Sie Deutsch sprechen, steht Ihnen fremdsprachliche Unterstützung zur Verfügung. Wählen Sie 1-866-289-7402. Für TTY wählen Sie 711.

ប្រសិនបើអ្នកនិយាយភាសាខ្មែរមន អ្នកអាចរកបានសេវាជំនួយភាសាឥតគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-855-906-2583។ សម្រាប់ TTY សូមទូរស័ព្ទមកលេខ 711។

Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Kojį éí béésh bee hodíílnih 1-855-902-2583. TTY biniiyégo éí 711 jį’ béésh bee hodíílnih.

CHAPTER 10:

Definitions of important words

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

Annual Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans. (As a member of a Medicare Cost Plan, you can switch to Original Medicare at any time. But you can only join a new Medicare health or drug plan during certain times of the year, such as the Annual Enrollment Period.)

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost sharing amount. As a member of Platinum Blue Complete, you only have to pay our plan's cost sharing amounts when you get services covered by our plan. We do not allow providers to *balance bill* or otherwise charge you more than the amount of cost sharing your plan says you must pay.

Benefit Period – The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility and ends when you are discharged. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. If you are transferred from one hospital to a different hospital or from a one SNF to a different SNF or if you are transferred from a hospital to an inpatient rehabilitation facility you remain in the same benefit period. There is no limit to the number of benefit periods.

Blue Cross – Blue Cross and Blue Shield of Minnesota; an independent licensee of the Blue Cross and Blue Shield Association.

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

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

Complaint – The formal name for *making a complaint* is *filing a grievance.* The complaint process is *only* used for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

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

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

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services are received. (This is in addition to the plan's monthly premium.) Cost sharing includes any combination of the following three 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 received; or (3) any *coinsurance* amount, a percentage of the total amount paid for a service is received.

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

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

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care provided by people who do not have professional skills or training includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

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

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

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

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

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

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

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

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

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

Hospital-based billing – Medical services rendered in an on-site hospital operated outpatient clinic or other hospital affiliated clinic location. If your provider utilizes Hospital-based billing is when you receive services in a hospital-based outpatient clinic and you are considered to be treated within the hospital rather than a physician's office. You may be charged a professional copayment for the doctor you saw and a separate facility copayment for the use of the space.

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

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

Lifetime reserve days—In Original Medicare, these are additional days that Medicare will pay for when you're in a hospital for more than 90 days. You have a total of 60 reserve days that can be used during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance.

Long-Term Care Hospital (LTCH) - Long-term care hospitals (LTCHs) are certified as acute-care hospitals, but LTCHs focus on patients who, on average, stay more than 25 days. Many of the patients in LTCHs are transferred there from an intensive or critical care unit. LTCHs specialize in treating patients who may have more than one serious condition, but who may improve with time and care, and return home. LTCHs typically give services like comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management.

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for covered Part A and Part B services. Amounts you pay for your plan premiums and Medicare Part A and Part B premiums do not count toward the maximum out-of-pocket amount.

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

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books.

Medically Necessary – Eligible medical and hospital services that we determine are appropriate and necessary based on our internal standards. In disputed cases, we use the standard peer review process. For purposes of mental health care services, the following medically necessary definition applies: Health care services appropriate in terms of type, frequency, level, setting, and duration to the individual's diagnosis or condition, diagnostic testing and preventive services. Medically necessary care must:

A. be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the conditions, procedures, or treatment at issue; and

B. help restore or maintain the individual's health; or

C. prevent deterioration of the individual's condition; or

D. prevent the reasonable likely onset of a health problem or detect an incipient problem.

For Medicare-covered services, Medicare determines whether services are appropriate and necessary.

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 (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an i) HMO, ii) PPO, iii) a Private Fee-for-Service (PFFS) plan, or a iv) Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

Medicare Cost Plan – A Medicare Cost Plan is a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under Section 1876(h) of the Act.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and B. (For

members who have only Medicare Part B, the plan covers only Part B services.) The term Medicare-Covered Services does not include the extra benefits, such as vision, dental or hearing, that a Medicare Advantage plan may offer.

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

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

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill *gaps* in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Cost 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*.

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 like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

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

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

Part C – see 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 are received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (non-preferred) providers.

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

Primary Care Provider - The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization – Approval in advance to get services or certain drugs. In a Medicare Cost Plan, you need prior authorization to obtain out-of-network services. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. Prior authorization is not required for emergency services. Covered drugs that need prior authorization are marked in the formulary.

Prosthetics and Orthotics – Medical devices including, but are 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.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

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

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

Special 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 reside 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 are not the same as Social Security benefits.

Surgical procedure – A surgical procedure is invasive and one that involves the removal or modification/alteration of a part of your body. This can be done by the use of lasers, ultrasound, ionizing radiation, scalpels, probes, and needles. Surgical services are also defined by the American Medical Association by the use of the Current Procedural Terminology (CPT) code. CPT codes are used to describe tests, surgeries, evaluations, and any other medical procedure performed by a healthcare provider on a patient.

Telehealth – "Telehealth" means the delivery of health care services or consultations through the use of real time two-way interactive audio and visual communications to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. Telehealth includes the application of secure video conferencing, store-and-forward technology, and synchronous interactions between a patient located at an originating site and a health care provider located at a distant site. Until July 1, 2025, telehealth also includes audio-only communication between a health care provider and a patient. Telehealth does not include communication between health care providers that consists solely of a telephone conversation, email, or facsimile transmission. Telehealth does not include communication between a health care provider and a patient that consists solely of an email or facsimile transmission. Telehealth does not include telemonitoring services as defined.

Telemonitoring services – "Telemonitoring services" means the remote monitoring of clinical data related to the enrollee's vital signs or biometric data by a monitoring device or equipment that transmits the data electronically to a health care provider for analysis. Telemonitoring is intended to collect an enrollee's health-related data for the purpose of assisting a health care provider in assessing and monitoring the enrollee's medical condition or status.

Urgently Needed Services – Covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.

Acceptance of the Contract

IN WITNESS WHEREOF, our President and CEO; and Deputy General Counsel and Assistant Secretary hereby sign your contract.

Dana Erickson
President and CEO

Alicia Reuter
Deputy General Counsel and Assistant Secretary

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CONTACT SHEET
Medicare Cost (Platinum Blue)

Contacts	Number	Hours of Operation
Blue Cross Blue Shield Customer Service:	1-866-340-8654 TTY 711	Monday - Friday 8 a.m. - 8 p.m. *
Pharmacy Questions	1-800-489-7336 TTY 711 **This phone number will be active on 1/1/2024**	Monday - Friday 8 a.m. - 8 p.m. *
To Make a Payment Directly to Blue Cross by: Card or bank account 24 Hour Automated System (IVR)	1-866-790-5951 TTY 711	Monday - Friday 8 a.m. - 8 p.m. * 24 hours a day
SilverSneakers:	1-833-226-1271 TTY 711	Monday - Friday 8 a.m. - 8 p.m. ET
Nurse Line:	1-800-622-9524 TTY 711	24 hours a day/ 7 days a week
Quitting Tobacco (BCBSMN):	1-888-662-2583 TTY 711	Monday - Thursday 8 a.m. - 8 p.m. Friday 8 a.m. - 6 p.m. Saturday 9 a.m. - 1 p.m.
TruHearing:	1-855-205-5137 TTY 711	Monday - Friday 8 a.m. - 8 p.m.
OTC (CVS):	1-888-628-2770 TTY 711	Monday - Friday 8 a.m. - 10 p.m. CT
United Concordia: (Embedded Dental Administrator) (Excludes Individual Core and Employer Group Plans)	1-844-397-4182 TTY 711	Monday - Friday 8 a.m. - 8 p.m.
Senior LinkAge Line®:	1-800-333-2433 TTY 711	Monday - Friday 8 a.m. - 4:30 p.m.
Medicare:	1-800-633-4227 TTY 1-877-486-2048	24 hours a day/ 7 days a week
Social Security:	1-800-772-1213 TTY 1-800-325-0778	Monday - Friday 8 a.m. - 7 p.m.
Railroad Retirement Board:	1-877-772-5772 TTY 1-312-751-4701	Monday, Tuesday, Thursday, Friday 9 a.m. - 3:30 p.m. and Wednesday 9 a.m. - 12 p.m.

* We are available seven days a week October 1 through March 31 and available Monday through Friday the rest of the year.

Platinum Blue Complete Customer Service

Method	Customer Service – Contact Information
CALL	Toll-free 1-866-340-8654 Calls to this number are free. Hours of operation: 8:00 a.m. to 8:00 p.m. CT. We are available seven days a week October 1 through March 31 and available Monday through Friday the rest of the year. Customer Service also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. Hours of operation: 8:00 a.m. to 8:00 p.m. CT. We are available seven days a week October 1 through March 31 and available Monday through Friday the rest of the year.
FAX	(651) 662-7364
WRITE	Blue Cross and Blue Shield of Minnesota Platinum Blue P.O. Box 982801 El Paso, TX 79998-2801
WEBSITE	bluecrossmn.com

Minnesota Department of Commerce

Method	Minnesota Department of Commerce
CALL	(651) 539-1500 (Local) 1-800-657-3602 (Greater MN only)
WRITE	Minnesota Department of Commerce Attn: Consumer Services Center 85 7th Place East, Suite 280 St. Paul, MN 55101 **For On-line complaints:** mn.gov/commerce/consumers/file-a-complaint/
WEBSITE	mn.gov/commerce/contact/

Senior LinkAge Line®

Method	Senior LinkAge Line® (Minnesota's SHIP) – Contact Information
CALL	1-800-333-2433
TTY	711
WRITE	Senior LinkAge Line 540 Cedar Street St. Paul, MN 55164 Email: senior.linkage@state.mn.us
WEBSITE	mn.gov/senior-linkage-line/older-adults/medicare/