For more information, please write, call or visit our Web site:

BlueCross BlueShield of Tennessee
Attn: Community Programs 3G
1 Cameron Hill Circle
Chattanooga, TN 37402

1-800-292-5146
8 a.m. to 9 p.m. Eastern Time, 7 days a week

TTY/TDD: 1-877-664-6422

or visit www.bcbst-medicare.com

This document is available in alternate formats.
For more information, call the above listed number.

From March 2 to September 30, you may be required to leave a message on weekends and holidays. Your call will be returned the next business day.

For Medicare plan ratings of this plan, please refer to http://www.medicare.gov or you may contact us directly to request the ratings at the above numbers.

Members may enroll in the plan only during specific times of the year. Contact us for more information.

of Tennessee

1 Cameron Hill Circle
Chattanooga, TN 37402

BlueCross BlueShield of Tennessee is proud of its 30-year history as presenting sponsor of the Tennessee Senior Olympics. The Tennessee Senior Olympics exist to promote healthy lifestyles for senior adults through fitness, sports and an active involvement in life. For more information, visit www.tnseniorolympics.com.

BlueCross BlueShield of Tennessee is a health plan with a Medicare contract.

The benefit information provided herein is a brief summary, not a comprehensive description of available benefits. For more information, contact the plan.

This document has been classified as public information

of Tennessee

BlueAdvantage Gold PFFS℠

A Medicare Advantage Private Fee-for-Service (PFFS) plan that can help you stay well and feel secure

H5884_PFFS11_MB_FINAL CMS Approved 09092010

of Tennessee

1 Cameron Hill Circle
Chattanooga, TN 37402

Expect More, Stay Well, Feel Secure with BlueAdvantage Gold PFFS℠

Dear Medicare Beneficiary,

BlueCross BlueShield of Tennessee now offers more choices than ever for your Medicare medical and prescription drug coverage. With our BlueAdvantage family of Medicare Advantage plan options, you are sure to find one that fits your needs and your budget. With BlueAdvantage Gold PFFS, you get medical and hospital copays and a standard formulary (list of covered drugs). All backed by the strength and stability Tennesseans have been trusting for more than 60 years.

The enclosed information will explain more about this Medicare Advantage plan option, which is part of the Medicare program. If you have any questions about the BlueAdvantage Gold PFFS plan, please contact us:

BlueCross BlueShield of Tennessee
Attn: Community Programs 3G
1 Cameron Hill Circle
Chattanooga, TN 37402
1-800-292-5146
TTY/TDD users should call: 1-877-664-6422
8 a.m. to 9 p.m. ET, 7 days a week

From March 2 to September 30, you may be required to leave a message on weekends and holidays. Your call will be returned the next business day.

For more information about Medicare benefits and services, you may call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week, or visit ww.medicare.gov. TTY/TDD users can call 1-877-486-2048.

Best of health,

Sharon Dicorato
Sharon Dicorato
Manager Community Programs

A health plan with a Medicare contract.

BlueCross BlueShield of Tennessee, Inc., an independent Licensee of the BlueCross BlueShield Association

Why Choose Blue?

- **Over 60 years of experience –** For more than 60 years, BlueCross BlueShield of Tennessee has helped to care for the health and well being of Tennesseans. Today, nearly 3 million people across the state turn to us for health plan coverage, insurance products and services. As a Tennessee company, we live and work along side you and are committed to giving you service you can depend on.
- **Variety of products –** We offer a comprehensive portfolio of individual Medicare plans from which to choose: Medicare Advantage, Medicare Supplement (Medigap) and Prescription Drug Coverage.
- **Trusted advisors and advocates –** Our team's knowledgeable and caring approach allows you to make informed decisions as to which Medicare solution best meets your individual needs and budget.
- **Backed by one of the most respected names in the industry –** All of our plans are backed by one of the most familiar and trusted brands in the industry. You can rely on us for strength and stability.
- **More benefits and Value-Added Services Offered at No Extra Cost –** These include membership to the SilverSneakers® Fitness Program, an AirMed International membership, as well as savings of up to 50% on a variety of products and services with our *Blue*Perks discount program. Please see page 9 for additional details.

Table of Contents

BlueAdvantage PFFS Overview*

Figuring out which Medicare health plan is right for your particular needs can seem a bit overwhelming. At BlueCross BlueShield of Tennessee, we understand and want to help simplify the process for you. It's our goal to provide you with clear information that can help you make an informed decision about your health care coverage.

This guide helps explain our BlueAdvantage® Gold Private Fee-for-Service (PFFS) Medicare Advantage Plan. We hope the information presented here helps to guide you to a health plan that can help you stay well and feel more secure.

Get more benefits than Original Medicare

BlueAdvantage Gold PFFS is a Medicare Advantage plan we offer through our contract with the Medicare program. Medicare pays a set amount of money to BlueAdvantage Gold PFFS to arrange for health benefits for covered members of the plan. When you join the plan, you remain in Medicare. You continue to pay your Medicare Part B premium in addition to the affordable BlueAdvantage Gold PFFS premium.

Because the government pays BlueCross BlueShield of Tennessee to administer benefits for you, you are entitled to all the medically necessary health care services that are covered by Medicare, plus more. In fact, as a member of BlueAdvantage Gold PFFS you can take advantage of available benefits that go beyond what you can get with Original Medicare alone or a Medicare Supplement policy. BlueCross BlueShield of Tennessee also offers value-added services, including discounts of up to 50% on a variety of products and services not covered by Medicare.

*A Medicare Advantage Private Fee-for-Service plan works differently than a Medicare Supplement Plan. Your provider is not required to agree to accept the plan's terms and condition of payment, and thus may choose not to treat you, with the exception of emergencies. If your provider does not agree to accept our terms and conditions of payment, they may choose not to provide health care services to you, except in emergencies. If this happens, you will need to find another provider that will accept our terms and conditions of payment. Providers can find the plan's terms and conditions of payment on our website at: www.bcbst.com/providers/BenefitHighlights.shtml.

BlueAdvantage Gold PFFS may be right for you if...

You want prescription drug coverage included with your medical coverage...

BlueAdvantage Gold PFFS offers Medicare Part D prescription drug benefits as part of the plan.

You want lower monthly premiums...

BlueAdvantage Gold PFFS offers a premium that may be lower than what you're paying now. Plus, you pay the same affordable premium regardless of your age. (You must continue to pay your Medicare Part B premium if not otherwise paid for under Medicaid or by another third-party.)

You don't want any surprises when it comes to what you pay for medical expenses...

BlueAdvantage Gold PFFS offers fixed copays for most medical services and prescription drugs. You will know what you owe and be able to budget for your medical care.

You need more than the basic care covered by Original Medicare...

BlueAdvantage Gold PFFS offers added benefits for an annual physical and benefits for hearing, dental and vision care.

You want a single ID card...

BlueAdvantage Gold PFFS offers Medicare Parts A and B coverage, Medicare Part D prescription drug coverage and additional benefits in one plan. Just present your BlueAdvantage Gold PFFS ID card at your doctor's office, hospital or network pharmacy.

You're not alone when you're dealing with a health condition. Whether it's a minor condition such as a cold, a chronic illness such as diabetes or a life-threatening disease such as cancer, we are here to help. We have programs to help you stay healthy and personalized support to help you manage your health condition and answer your health questions. We also have programs to help you manage a chronic disease.

NEW!

At No Extra Cost

Healthways SilverSneakers® Fitness Program

AirMed International Membership • *Blue*Perks Discount Program

Is BlueAdvantage Gold PFFS right for you?

We want to help you make an informed decision about your healthcare coverage. The description below and the chart on Page 5 outlines the key benefits of our BlueAdvantage PFFS Gold plan.

Gold (PFFS)

If you are interested in a plan with no deductible for medical and Part D prescription drug benefits, consider the Gold (PFFS) plan. This plan also offers benefits for dental care, routine hearing tests, routine eye exams and eyewear.

2011 Benefits		Gold (PFFS)
Inpatient Hospital Copay		$100 per day for days 1-7; unlimited days
Office Visit	Primary Care	$20 copay per visit
	Specialist	$35 copay per visit
Dental		Plan pays $100
Routine Hearing Tests		$20 for exams and tests
Routine Eye Exams		$20 for eye exams Plan pays $100 towards eyewear costs
Formulary (List of covered drugs)		Standard
Medicare Part D Prescription Drug Coverage (Copays for a 30-day supply at a retail pharmacy)		**No Deductible Initial Coverage Limit** (Costs up to $2,840) $7 for Generic (Tier 1) $30 for Preferred Brand (Tier 2) $75 for Non-Preferred Brand (Tier 3) 33% for Specialty (Tier 4)
		Coverage Gap No coverage after your initial coverage limit has been met, until your out-of-pocket costs reach $4,550, including any copays you paid during your initial coverage. **Catastrophic Coverage** (Your out-of-pocket costs exceed $4,550) The greater of: $2.50 for generics and $6.30 for all other drugs **or** 5% coinsurance.

The prescription drug benefits above are available only to members of the BlueAdvantage Gold (PFFS) plan. If you are already enrolled in another Medicare Advantage plan with prescription drugs, you must get your prescription drug benefits from that plan.

Please review the Summary of Benefits booklet available online for more information on the benefits offered by BlueAdvantage PFFS. Call 1-800-292-5146 (TTY users call 1-877-664-6422) or visit www.bcbst-medicare.com to see if your medications are covered by the BlueAdvantage Gold (PFFS) plan.

For detailed information on this plan and any major limitations or exclusions, please review the Evidence of Coverage at www.bcbst-medicare.com.

Benefits, premiums, copays, coinsurance, formulary, pharmacy directory and provider directory may change on January 1, 2012.

Compare BlueAdvantage PFFS Options to a Medicare Supplement Plan

		BlueAdvantage PFFS℠	Medicare Supplement Plan
Covered Services		Gold (PFFS)	BlueElite Plan D
Inpatient Hospital		$100 per day for days 1-7 Unlimited days	$0 per stay up to 455 days
Skilled Nursing Facility		$75 per day for days 21-100	$0 per day for days 1-100
Home Health Care		$0 per visit	$0 per visit
Office Visit	Primary	$20 copay per visit	$155 Part B Deductible Plan pays Medicare coinsurance
	Specialist	$35 copay per visit	
Urgently Needed Care		$35 copay per visit	$155 Part B Deductible Plan pays Medicare coinsurance
Outpatient Rehabilitation		$20 copay per visit	$155 Part B Deductible Plan pays Medicare coinsurance
Outpatient Surgical Services		$200 per visit	$155 Part B Deductible Plan pays Medicare coinsurance
Ambulance		$100 per trip	$155 Part B Deductible Plan pays Medicare coinsurance
Emergency Care		$50 per visit Waived if admitted	$155 Part B Deductible Plan pays Medicare coinsurance
Durable Medical Equipment/Prosthetics		20% coinsurance	$155 Part B Deductible Plan pays Medicare coinsurance
Medicare Part B Diabetes Supplies		$0 copay	$155 Part B Deductible Plan pays Medicare coinsurance
Diagnostic Tests (X-rays and Lab Services)		$0 per test	$155 Part B Deductible Plan pays Medicare coinsurance
Advanced Imaging & Therapeutic Radiology Services		15% coinsurance	$155 Part B deductible Plan pays Medicare coinsurance
Preventive Services		$0 for most preventive services and screenings	$155 Part B Deductible Plan pays Medicare coinsurance
Annual Physical Exam		$0 per annual exam	No coverage
Prescription Drugs		See chart on Page 7	No coverage
Dental		Plan pays $100	No coverage
Routine Hearing Tests		$20 for exams and tests	$155 Part B Deductible No coverage for routine hearing exams
Routine Eye Exams		$20 for eye exams Plan pays $100 toward eyewear costs	Plan pays Medicare coinsurance for diagnosis and treatment of diseases and conditions of the eye No coverage for routine eye exams and eyewear
Maximum OOP†		$3,400	No limit on your out-of-pocket expenses

† Once your out-of-pocket expenses for most Medicare-covered services reach your plan's out-of-pocket amount in a calendar year, you will no longer be required to pay any copays or coinsurance for those services for the remainder of the year. Expenses that do not apply include: plan premiums, expenses for Medicare Part D-covered diabetic supplies, health expenses incurred during foreign travel or prescription drug expenses including copays.

This is just a sample of our benefits offered to you with our BlueAdvantage Gold PFFS Plan.

Compare BlueAdvantage Gold PFFS to Original Medicare

Covered Services		BlueAdvantage PFFS℠ Gold (PFFS)	Original Medicare* Parts A and B
Inpatient Hospital		$100 per day for days 1-7 Unlimited days	You pay for each benefit period: $1,100 initial deductible days 1-60; $275 per day for days 61-90; $550 per day for days 91-150
Skilled Nursing Facility		$75 per day for days 21-100	You pay for each benefit period: $0 per day for days 1-20; $137.50 per day for days 21-100
Home Health Care		$0 per visit	$0 per visit
Office Visit	Primary Care	$20 copay per visit	$155 Part B deductible 20% of Medicare-approved amounts
	Specialist	$35 copay per visit	
Urgently Needed Care		$35 copay per visit	$155 Part B deductible 20% of Medicare-approved amounts
Outpatient Rehabilitation		$20 copay per visit	$155 Part B deductible 20% of Medicare-approved amounts
Outpatient Surgical Services		$200 per visit	$155 Part B deductible 20% of Medicare-approved amounts
Ambulance		$100 per trip	$155 Part B deductible 20% of Medicare-approved amounts
Emergency Care		$50 per visit Waived if admitted	$155 Part B deductible 20% of Medicare-approved amounts
Durable Medical Equipment/Prosthetics		20% coinsurance	$155 Part B deductible 20% of Medicare-approved amounts
Medicare Part B Diabetes Supplies		$0 copay	$155 Part B deductible 20% of Medicare-approved amounts
Diagnostic Tests (X-rays and Lab Services)		$0 per test	$155 Part B deductible 20% of Medicare-approved amounts
Advanced Imaging & Therapeutic Radiology Services		15% coinsurance	$155 Part B deductible 20% of Medicare-approved amounts
Preventive Services		$0 for most preventive services and screenings	$155 Part B deductible 20% of Medicare-approved amounts
Annual Physical Exam		$0 per annual exam	No coverage
Prescription Drugs		See chart on Page 7	No coverage
Dental		Plan pays $100	No coverage
Routine Hearing Tests		$20 for exams and tests	$155 Part B deductible. 20% of Medicare-approved amounts for diagnostic hearing exams No coverage for routine hearing exams
Routine Eye Exams		$20 for eye exams Plan pays $100 toward eyewear costs	$155 Part B deductible 20% of Medicare-approved amounts for diagnosis and treatment of diseases and conditions of the eye No coverage for routine eye exams and eyewear
Maximum OOP†		$3,400	No limit on your out-of-pocket expenses

This is just a sample of our benefits offered to you with our BlueAdvantage PFFS plan.
* Original Medicare cost sharing amounts are for the year 2010.
† Once your out-of-pocket expenses for most Medicare-covered services reach your plan's out-of-pocket amount in a calendar year, you will no longer be required to pay any copays or coinsurance for those services for the remainder of the year. Expenses that do not apply include: plan premiums, expenses for Medicare Part D-covered diabetic supplies, health expenses incurred during foreign travel or prescription drug expenses including copays.

The chart below illustrates your drug coverage with BlueAdvantage PFFS Gold.

Medicare Part D: BlueAdvantage PFFS

Benefit Phase	Gold (PFFS)
Monthly Premium*	Included in the price of your Medicare Advantage Plan
Deductible	$0
Initial Coverage Limit Total drug costs up to $2,840, including what you and the plan pay	You Pay: - $7 for Generic (Tier 1) - $30 for Preferred Brand (Tier 2) - $75 for Non-Preferred (Tier 3) - 33% for Specialty (Tier 4)
Coverage Gap No coverage after your initial coverage limit has been met, until your out-of-pocket costs reach $4,550, including any copays you paid during your initial coverage phase	No coverage You receive some discounts when you use network pharmacies. Health care reform may enhance some discounts during the coverage gap.
Catastrophic Coverage Once your out-of-pocket costs reach $4,550	You pay the greater of: $2.50 for Tier 1 and $6.30 for all other drugs **or** 5% coinsurance
Formulary** (List of covered drugs)	Standard

* You must continue to pay your Plan B premium.
** An expanded formulary covers more drugs than the standard formulary.

Members must use network pharmacies to access their prescription drug benefit, except under non-routine circumstances, and quantity limitations and restrictions may apply.

Important prescription drug benefit information

Medicare Advantage plans with prescription drug coverage cover both brand name drugs and generic drugs. Generic drugs have the same active ingredient formula as a brand name drug. Generic drugs usually cost less than brand name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as brand name drugs.

Pharmacy networks include retail, mail order, long term care, and home infusion pharmacies. Generally, you must use network pharmacies to access your prescription drug benefits, except under non-routine circumstances, and quantity limitations and restrictions may apply. See a plan's Summary of Benefits for more information about out-of-network prescription drug benefits.

For more information on the pharmacies in BlueAdvantage Gold (PFFS)'s network, BlueAdvantage Gold (PFFS)'s mail order prescription drug program and a list of covered drugs, you can visit BlueAdvantage Gold (PFFS)'s Web site. You will receive a copy of the formulary (list of covered drugs) and the pharmacy directory when you enroll. If you would like a copy before you enroll, contact us.

Save money and time with mail-order service

Have your medications delivered right to your door and save time and money. For mail order, you pay 2 ½ copays for a 90-day supply of Tier 1, 2, and 3 drugs. The prescription drug benefits above are only available to members of the BlueAdvantage Gold (PFFS) plan. You must use network pharmacies to access your prescription drug benefits, except under non-routine circumstances, and quantity limitations and restrictions may apply.

Financial help for prescription drug benefits

You may be able to get extra help to pay for your prescription drug premiums and costs. To see if you qualify for getting extra help, call:

- Medicare: 1-800-MEDICARE (1-800-633-4227), TTY/TDD users should call 1-877-486-2048, 24 hours a day, 7 days a week
- The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778; or your state Medicaid office

More Benefits At No Extra Cost

NEW!

Healthways SilverSneakers® Fitness Program

AirMed International Membership

*Blue*Perks Discount Program*

The SilverSneakers Fitness Program

All Medicare Advantage plans from BlueCross BlueShield of Tennessee entitle you to a SilverSneakers Fitness Program membership. At no additional cost, you get access to more than 10,000 participating locations across the country. Participating SilverSneakers locations offer amenities such as:

- Fitness equipment, treadmills, and free weights
- SilverSneakers fitness classes designed specifically for older adults and taught by certified instructors
- Health education seminars and fun social events

An AirMed International membership

This membership offers air medical transportation benefits not covered by Original Medicare and is available at no extra cost. If you are traveling and are hospitalized more than 150 miles from home, AirMed will arrange air transportation to a hospital facility of your choice in the U.S. or Canada. With this membership, you can travel with confidence knowing that care at a hospital facility close to home is just a phone call away.

Value-Added Service At No Extra Cost

Savings of up to 50% on a variety of products and services not covered by Medicare with *Blue*Perks®*

With our *Blue*Perks discount program, you can take steps to stay healthy while you save money. Simply show your BlueCross BlueShield of Tennessee member ID card at participating locations to receive discounts on a variety of services, including:

- Fitness memberships
- Vision care (including exams, glasses and contact lenses)
- Weight loss programs
- LASIK corrective vision surgery
- Vitamins, minerals and supplements
- And much more

* The products and services described are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services may not be subject to the BlueAdvantage PFFS grievance process.

Answers to Questions You May Have

As you consider which Medicare Advantage plan may best suit your needs, ask yourself these questions about BlueAdvantage Gold PFFS.

Q. *Are there tools available online that can help me manage my health plan and my good health?*

A. Yes. BlueAccess, our online **Member Self-Service** function, allows you to view your benefits, order replacement ID cards and check on the status of Medicare claims, while our **Personal Health Manager** home page offers you Medicare news, a library of health information, care guides for specific conditions, and tools to help record and track blood sugar readings, blood pressure, exercise and more.

The first time you use our BlueAccess site, you will be invited to complete a health survey about your current medical conditions. The survey can also help identify any conditions you may be at risk for in the future. All information you provide is kept confidential and you will receive a copy of the survey results. Based on the answers you give, the BlueAdvantage Health Management team will customize a home page in the Personal Health Manager just for you.

You also have the ability to:

- Look up drugs to see if they are on the formulary
- Compare prices at retail and mail-order pharmacies
- Find important information on drugs, including side effects and possible drug interactions
- Discover alternative drugs that could save you money
- Calculate savings using your plan versus paying out of your own pocket.

Q. *What are my protections in this plan?*

A. All Medicare Advantage Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

Part D Protections

As a member of BlueAdvantage Gold PFFS, you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered.

An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug.

If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision.

Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug.

When can you enroll in a Medicare Advantage Plan like BlueAdvantage Gold PFFS?

Enrollment Periods for Current Medicare Beneficiaries

Annual Election Period: Nov. 15 to Dec. 31

During this time in 2010, you can enroll in a new Medicare Advantage health plan or a standalone Prescription Drug Plan for coverage beginning on Jan. 1 of the following year.

Medicare Advantage Disenrollment Period: Jan. 1 to Feb. 14

If you are enrolled in a Medicare Advantage plan, you may change to Original Medicare during the Medicare Advantage Disenrollment Period. And, if you choose to make this change, regardless of whether or not you have a Medicare Part D Prescription Drug Plan, you will be given the option to choose a standalone Medicare Part D plan. The chart below explains what kind of changes you are allowed to make during this time.

Guide to Disenrollment Period Changes

If Your Current Coverage is:	You Can Change Your Plan to:	You Cannot Change Your Plan to:
Medicare Advantage with Prescription Drug Coverage (MA-PD)	Original Medicare plus a PDP or just Original Medicare	Medicare Advantage (MA)
Medicare Advantage without Prescription Drug Coverage (MA)	Original Medicare or Original Medicare plus a PDP	Medicare Advantage (MA)

Enrollment Period for New Medicare Beneficiaries

Initial Coverage Election Period

When you become eligible for Medicare because of your age or a disability, you have seven months to enroll in a Medicare Advantage Plan with or without drug coverage or a standalone Medicare Part D Prescription Drug Plan. You may enroll at any time during the month you turn 65 and the three months before and after. If you get Medicare due to a disability, you can join during the three months after your 25th month of disability benefits. If you do not choose to enroll in a plan with prescription drug coverage during this time period, you may have to pay a penalty in the form of a higher premium to enroll later.

Limitations on Enrollment Periods

Once your Initial Coverage Election Period ends, you may not change your coverage until the next Annual Election Period, unless you qualify for a Special Enrollment Period.

Special Enrollment Periods

After you have enrolled in a plan, you may become eligible for a Special Enrollment Period for one of the following reasons and others not noted here:

- You move out of your plan's service area
- Your plan does not renew its Medicare Advantage contract
- Your plan's Medicare Contract ends or it is no longer offered in your area
- You may also qualify for other Special Enrollment Periods if you are eligible for Medicaid, are a resident of an institution or are losing coverage provided by an employer or former employer

Plan Contract Guarantee

All health plans with a Medicare contract agree to stay with the Medicare program for a full year at a time. The availability of coverage from a particular plan beyond the current year is not guaranteed. If your plan leaves the Medicare program, or Medicare does not renew your plan's contract, you will not lose your Medicare coverage. You will receive notification 90 days in advance along with information about your other Medicare coverage options.

Disenrollment

If you choose to enroll in a different plan during the Medicare Advantage Disenrollment Period or at the next Annual Election Period, you will automatically be disenrolled from your current plan. There are several situations that may cause you to be disenrolled by your plan:

- You move out of your plan's service area
- Your plan's Medicare contract ends
- Your plan's service area changes and you do not live in the revised service area

Disenrollment due to any of the above reasons entitles you to a Special Enrollment Period. You will be given other Medicare options and the opportunity to enroll in a new plan. You can also be disenrolled by your plan if:

- You do not pay your premiums in a timely fashion
- You do not abide by the terms and conditions of your plan
- You knowingly provide false information on your enrollment application or permit another individual to use your member ID card to receive medical services under the plan.

In any of the above cases, you will be notified of your disenrollment, the effective date and the reason. You have a right to a hearing under the grievance procedures. See the Evidence of Coverage you receive when you enroll for more information.

Finally, you can be disenrolled if:

- You lose your entitlement to either Medicare Part A or Part B

If you lose your entitlement, you will be notified by the Centers for Medicare & Medicaid Services. Your Medicare Advantage plan will automatically end on the date your entitlement ends.

Glossary of Insurance Terms

We want to make sure you understand the insurance terms used to describe the features and benefits of Medicare Advantage plans. This glossary will help you have a clear understanding of how the plans work.

Advance Determination

A member or provider has the opportunity to seek a determination of coverage by requesting an advance determination. An advance determination will be reviewed for medical appropriateness to ensure members are receiving medically necessary services in the most appropriate settings.

Benefit

A financial payment made by the health plan for your services or drugs covered under the plan.

Catastrophic Coverage Threshold

Once your out-of-pocket costs reach $4,550 including any deductibles or copays you paid during your Initial Coverage phase, you enter the Catastrophic Coverage phase. You will pay lower copays for the rest of the calendar year.

Coinsurance

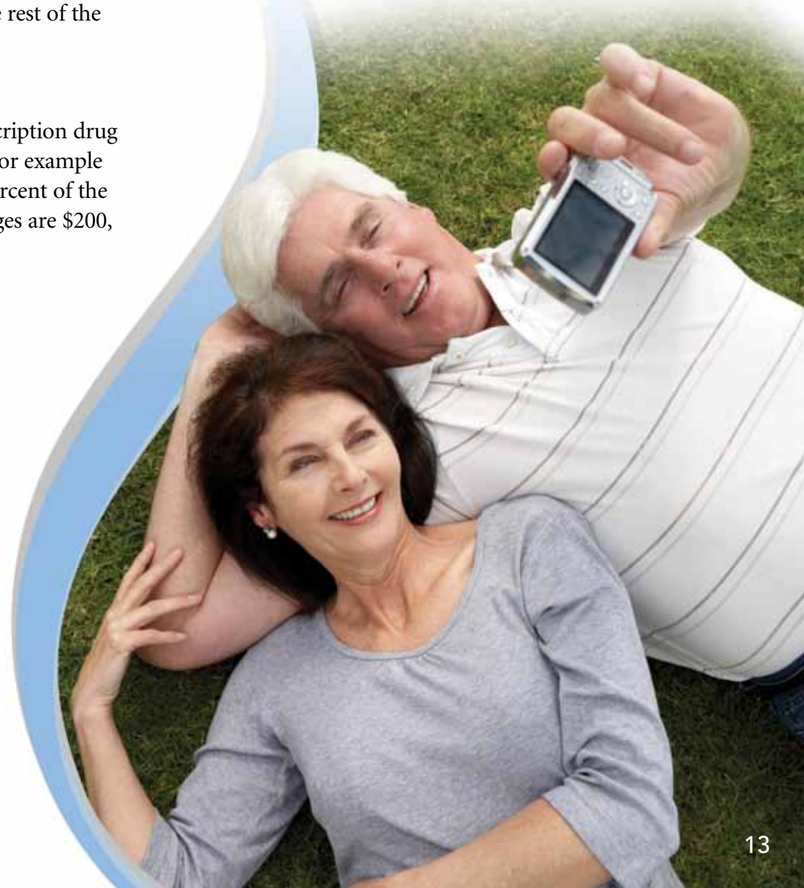
The percentage of your medical or prescription drug expenses that you are required to pay. For example under Original Medicare, you pay 20 percent of the cost of a doctor's office visit. If the charges are $200, your coinsurance would be $40.

Copay or Copayment

A flat fee that you are required to pay for a medical service or prescription drug. For example, you might pay $30 for a doctor's office visit under your plan.

Cost Sharing

A term for how you and your insurance company work together to pay your medical and prescription drug expenses. Coinsurance and copays are examples of cost sharing. You pay a copay and your plan covers the rest of the expense.



Coverage
The costs that your insurance company or Medicare pays for your medical services or prescription drugs.

Coverage Gap
The middle portion of your prescription drug expenses during which your plan may not cover or may provide limited coverage. Health care reform may enhance some discounts during the coverage gap. You may also hear this called the "doughnut hole."

Covered Services
A medically necessary service or supply shown in the Evidence of Coverage for which benefits may be available.

Creditable Coverage
Prescription drug coverage offered by a plan, other than a Part D plan, that is as good as or better than the minimum benefit standard required by Medicare. If you are currently enrolled in a plan that provides drug coverage, that plan is required to tell you if it meets these standards for creditable coverage.

Deductible
The amount of your medical or prescription drug expenses that you must pay for yourself each year before your plan starts to pay. For example, a plan may require you to pay $250 of your drug expenses before the plan pays anything during the calendar year.

Exclusions
Items that are not covered by a health plan. Health plans may exclude certain prescription drugs or medical services.

Explanation of Benefits (EOB) or Monthly Claim Statement
A statement from your insurance company that shows what your plan has paid for medical services on your behalf and what you should owe your health care provider. For plans that include prescription drug coverage, you will receive a separate EOB that lists your drug purchases for the month. This EOB will help you know when you have met your deductible (if applicable), your Initial Coverage Limit, and your Catastrophic Coverage Threshold.

Formulary
A list of prescription drugs covered by a Part D plan. The formulary may consist of multiple tiers or levels of coinsurance or copays you are required to pay.

Generic Drugs
Prescription drugs that have the same active ingredient formula as brand-name drugs. Generic drugs usually cost less than brand name drugs. They are also rated by the Food and Drug Administration (FDA) to be as safe and effective as their brand-name counterparts.

Initial Coverage Limit
The first phase of your prescription drug coverage. Your drug costs between $0 and $2,840, including your out-of-pocket costs (such as deductibles and copays or coinsurance) and what your plan pays for your medications.

Medicaid
The state's medical assistance program for low-income people.

Medicare Beneficiary
A person who is eligible for the Medicare program because he or she is 65 years or older or has a qualifying disability.

Medicare Limiting Charge
The highest amount of money you can be charged for a covered service by doctors and other health care providers who don't accept the Medicare payment in full. The limiting charge is 15% over Medicare's approved amount. The limiting charge only applies to certain services and doesn't apply to supplies or equipment.

Medicare-Allowed Amount
The amount of money Medicare will pay a provider for a particular covered service.

Medicare Supplement or Medigap Plan
A plan offered by a private insurance company to pay the beneficiary's out-of-pocket expenses such as Medicare Parts A and B deductibles and coinsurance amounts. The beneficiary's medical claims are paid by Original Medicare first and the Medicare Supplement plan second.

Network
A list of doctors, hospitals or pharmacies that have contracts with an insurance plan to provide care for the plan's members. If your plan has a network, you must use a provider or pharmacy in the plan's network or you may be required to pay more for your care or prescription drugs.

Non-Preferred Brand Drugs
Primarily brand-named drugs that are covered by your formulary but may not be as cost-effective as similar preferred brand drugs.

Out-of-Pocket Costs
The amount you must pay out of your own pocket of your medical or prescription drug expenses. These costs include things such as deductibles, coinsurance or copays.

Out-of-Pocket Maximum
Some plans set a maximum limit on your out-of pocket costs for your medical expenses. This amount is the maximum you will have to pay in that calendar year for your medical expenses. Once you reach the out-of-pocket maximum, your plan pays 100 percent of your covered expenses.

Preferred Brand Drug
Brand-name drugs that are medically sound, cost-effective alternatives to higher-priced drugs.

Premium
The monthly fee you pay for your health insurance policy.

Prior Authorization
Before performing some medical services or prescribing certain drugs, your doctor must notify your insurance plan. If the service or drug meets the plan's medical policy, it will be covered under your plan. If not, an alternate service or drug may be used.

Preventive Service
A service such as a cancer screening or a flu vaccine that is given to prevent or detect a condition at an early stage.

Provider
This term refers to any doctor, practitioner, hospital, facility or pharmacy that provides you with medical services or prescription drugs.

Service Area Reduction
This term refers to a situation in which a Medicare Advantage or Medicare Part D plan is no longer offered in a portion of the geographic area it served the previous year. As a result, members who live in the area that has been eliminated will be disenrolled from the plan.

Specialty Drugs
Certain highly specialized drugs that require special handling and administering by the patient or provider.

Stand-alone Medicare Part D Prescription Drug Plan
A plan that covers just prescription drug benefits for Medicare Part D-approved drugs.

Step Therapy
Some health or prescription drug plans may require you to try a drug on a lower tier first. If the lower tier drug does not work, you may advance to a higher tier drug.

Tier
A tier is a copay or coinsurance level that applies to drugs on the plan's formulary.

Value-Added Item or Service
The products and services that are not part of your medical or prescription drug benefits. These products and services are not offered nor guaranteed under the plan's contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the plan's grievance process. Other terms and conditions may apply.

Are you eligible for BlueAdvantage Gold PFFS?

You may enroll in a BlueAdvantage Gold PFFS plan if:

- You are entitled to Medicare Part A and enrolled in Part B due to your age or disability
- You are a resident of Tennessee in either Clay, Cumberland, Fentress, Jackson or Putnam counties.
- You are enrolling during one of the enrollment periods
- You are not medically determined to have chronic End-Stage Renal Disease (ESRD) on the date you sign your enrollment form. ESRD means that your kidneys are permanently and irreversibly damaged requiring regular dialysis or transplantation.

Exceptions to the ESRD Restriction

You may be eligible if one of the following applies:

- You are currently a non-Medicare member of a BlueCross BlueShield of Tennessee health plan
- You are affected by the termination, non-renewal or service area reduction of your current Medicare Advantage plan
- You have had a successful kidney transplant and no longer require dialysis
- You started dialysis treatments for ESRD, but recovered original kidney function and no longer require dialysis

Note: If you develop a kidney disease after you enroll, you cannot be asked to leave or be disenrolled for any health-related reason. However, if you develop ESRD while on a BlueAdvantage Gold PFFS plan, you are not eligible to enroll in another Medicare Advantage plan from a different company.

Follow these instructions to enroll in BlueAdvantage Gold PFFS

Have your Medicare ID card available

1. Find the BlueAdvantage Enrollment Request Form located in this package. An extra copy of this form has been included.
2. Complete the Personal Information and Medicare Information sections. Please print clearly.
3. Select the plan in which you wish to enroll by checking the box to the left of the plan name.
4. Select your method of payment. Do not send payment with your enrollment.
5. Answer the questions on the enrollment request form.
6. Carefully read the rest of the enrollment request form, sign and date it.
7. The bottom copy of the form is yours to keep. Return the top copy to your BlueAdvantage Gold PFFS insurance agent or mail it to BlueCross BlueShield of Tennessee in the envelope provided. You may also fax it to (423) 591-9344 or 1-888-832-9613.

Note: If you are applying during the Annual Election Period, please do not submit your enrollment form until November 15.

Online Enrollment Request Form

You may enroll online at www.bcbst-medicare.com or through the Centers for Medicare & Medicaid Services Online Enrollment Center located at www.medicare.gov.

It's Quick and Easy to Enroll by Phone

To enroll by phone, call 1-866-902-2121 8:00 a.m. to 9:00 p.m. ET, 7 days a week (TTY users should call: 1-877-664-6422).

Coverage Effective Dates

- If you enroll during the Annual Election Period, your coverage will begin on January 1 of next year.

For New Medicare Beneficiaries

- If your enrollment request form is received within the three months prior to the month you become eligible, your coverage will begin on the first day of the month you become eligible for Medicare.
- If your enrollment request form is received during the month you become eligible or the following three months, your coverage will become effective the first day of the next month after your enrollment request form has been received.

For Enrollment During Special Enrollment Periods

- Your coverage will become effective the first day of the month after your enrollment request form has been received.

Note: We recommend that you submit your enrollment request form as early in the month as possible. By doing so, you are more likely to have your BlueAdvantage Gold PFFS ID card in time for easy access to your benefits when your coverage begins.

What People on Medicare Need to Know About Private Fee-For-Service Plans

BlueAdvantage Gold PFFS is a Medicare Advantage Private Fee-for-Service (PFFS) plan authorized by the Centers for Medicare & Medicaid Services (CMS). A PFFS plan is different than Original Medicare or an HMO, PPO or Medicare supplement plan.

BlueAdvantage Gold PFFS gives you the ability to choose your health care provider. However not all providers may accept this plan, even Medicare providers may not accept this plan. If you choose this plan, it is very important that all the providers you choose know, before providing services to you, that you have BlueAdvantage Gold PFFS coverage in place of Medicare. This gives your provider the right to choose whether or not to accept BlueAdvantage Gold PFFS terms and conditions of payment for treating you. Providers have the right to decide if they will accept BlueAdvantage Gold PFFS each time they see you. This is why you must show your BlueAdvantage PFFS ID card every time you visit a health care provider.

If your provider agrees to BlueAdvantage PFFS terms and conditions of payment

If your provider decides to accept the BlueAdvantage Gold PFFS plan, they must follow our plan's terms and conditions for payment. They must thereafter bill BlueAdvantage Gold PFFS for those services. However, providers have the right to decide if they will accept BlueAdvantage Gold PFFS each time they see you.

If your provider does not agree to BlueAdvantage Gold PFFS terms and conditions of payment

A provider may decide not to accept BlueAdvantage Gold PFFS terms and conditions of payment. If this happens, you will need to find another provider that will. You may contact us at 1-800-841-7434 (TTY/TDD 1-888-423-9490) for assistance locating another provider in your area willing to accept our plan's terms and conditions of payment.

What happens if a provider declines to accept BlueAdvantage Gold PFFS terms and conditions of payment?

1. They should not provide services to you except for emergencies.
2. If they choose to provide services, they may not bill you. They must bill BlueAdvantage Gold PFFS for your covered health care services. You must pay the appropriate copays or coinsurance at the time of service.

For more information about PFFS plans see Beneficiary Qs & As at CMS's web site http://www.cms.hhs.gov/PrivateFeeforServicePlans/. If you have questions about BlueAdvantage, please call our Customer Service department at 1-800-841-7434. Hours are 8 a.m. to 9 p.m. Eastern Time, 7 days a week. From March 2 to September 30 you may be required to leave a message on weekends and holidays. Calls will be returned the next business day. Hearing impaired members may call the TTY/TDD number, 1-888-423-9490.

Service Area and Premium

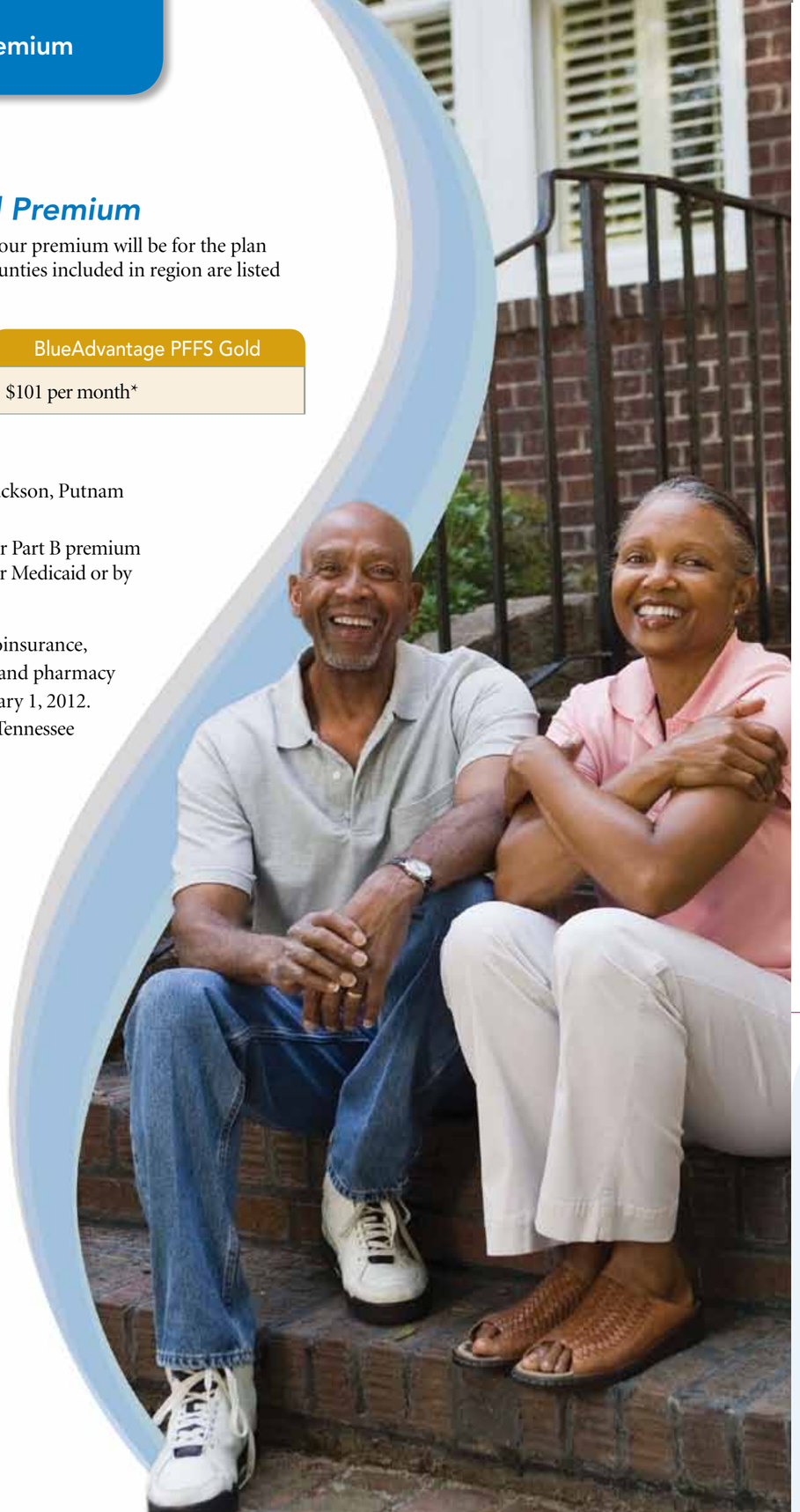
The chart below shows what your premium will be for the plan offered in your region. The counties included in region are listed below the chart.

Region	BlueAdvantage PFFS Gold
Northeast	$101 per month*

Northeast Tennessee Region
Clay, Cumberland, Fentress, Jackson, Putnam

*You must continue to pay your Part B premium if not otherwise paid for under Medicaid or by another third-party.

Benefits, premiums, copays, coinsurance, provider directory formulary, and pharmacy directory may change on January 1, 2012. Call Blue Cross Blue Shield of Tennessee for more information.



of Tennessee
plans for better health. plans for a better life.™

2011 Summary of Benefits

BlueAdvantage Gold℠ (PFFS)

A health plan with a Medicare Contract.

H5884_GLSB11 CMS Approved 10012010

Medicare Contract Number: H5884

Section I
Introduction to the Summary of Benefits for BlueAdvantage Gold (PFFS)
January 1, 2011 – December 31, 2011
East Tennessee

Thank you for your interest in BlueAdvantage Gold (PFFS). Our plan is offered by BlueCross BlueShield of Tennessee, a Medicare Advantage Private Fee-for-Service. This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call BlueAdvantage Gold (PFFS) and ask for the "Evidence of Coverage".

YOU HAVE CHOICES IN YOUR HEALTH CARE

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare plan. Another option is a Medicare Advantage Private Fee-for-Service plan, like BlueAdvantage Gold (PFFS). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare program.

You may join or leave a plan only at certain times. Please call BlueAdvantage Gold (PFFS) at the telephone number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY/TDD users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

HOW CAN I COMPARE MY OPTIONS?

You can compare BlueAdvantage Gold (PFFS) and the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers.

WHERE IS BLUEADVANTGE GOLD (PFFS) AVAILABLE?

The service area for this plan includes: Clay, Cumberland, Fentress, Jackson, Putnam Counties, TN. You must live in one of these areas to join the plan.

WHO IS ELIGIBLE TO JOIN BLUEADVANTGE GOLD (PFFS)?

You can join BlueAdvantage Gold (PFFS) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End Stage Renal Disease are generally not eligible to enroll in BlueAdvantage Gold (PFFS) unless they are members of our organization and have been since their dialysis began.

WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN THIS PLAN?

BlueAdvantage Gold (PFFS) has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at www.bcbst-medicare.com. Our customer service number is listed at the end of this introduction.

HOW DO I GET MEDICAL CARE THAT IS COVERED BY THE PLAN?

You can receive your care from any provider, such as a doctor or hospital, in the United States, if the provider is eligible to be paid by Medicare and agrees to accept our plan's terms and conditions of payment before providing services to you. A provider can decide at every visit to accept our plan's terms and conditions, and thus treat you.

Not all providers accept our plan's terms and conditions of payment or agree to treat you. If a provider from whom you seek care decides not to accept our plan's terms and conditions of payment or refuses to treat you, then you will need to find another provider that will accept our plan's terms and conditions of payment. A provider that decides not to accept our plan's terms and conditions of payment should not provide services to you, except in emergencies. If you need emergency care, it is covered whether a provider agrees to accept our plan's payment terms or not.

DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?

BlueAdvantage Gold (PFFS) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

BlueAdvantage Gold (PFFS) uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the affected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our Web site at www.bcbst-medicare.com.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

HOW CAN I GET EXTRA HELP WITH MY PRESCRIPTION DRUG PLAN COSTS OR GET EXTRA HELP WITH OTHER MEDICARE COSTS?

You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare costs. To see if you qualify for getting extra help, call:

*1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week and see www.medicare.gov 'Programs for People with Limited Income and Resources' in the publication Medicare You.
*The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778 or
*Your State Medicaid Office.

WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of BlueAdvantage Gold (PFFS), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

As a member of BlueAdvantage Gold (PFFS), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we may offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact BlueAdvantage Gold (PFFS) for more details.

WHAT TYPES OF DRUGS MAY BE COVERED UNDER MEDICARE PART B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact BlueAdvantage Gold (PFFS) for more details.

-- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.

-- Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.

-- Erythropoietin (Epoetin Alfa or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.

-- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.

-- Injectable Drugs: Most injectable drugs administered incident to a physician¿s service.

-- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.

-- Some Oral Cancer Drugs: If the same drug is available in injectable form.

-- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.

-- Inhalation and Infusion Drugs provided through DME.

WHERE CAN I FIND INFORMATION ON PLAN RATINGS?

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on www.medicare.gov and select "Compare Medicare Prescription Drug Plans" or "Compare Health Plans and Medigap Policies in Your Area" to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for this plan. Our customer service number is listed below.

Please call BlueCross BlueShield of Tennessee for more information about BlueAdvantage Gold (PFFS).

Visit us at www.bcbst-medicare.com or, call us:

Customer Service Hours:
Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday,
8:00 a.m. - 9:00 p.m. Eastern

Current members should call toll-free (800)-841-7434 for questions related to the Medicare Advantage Program. (TTY/TDD (888)-423-9490)

Prospective members should call toll-free (800)-292-5146 for questions related to the Medicare Advantage Program. (TTY/TDD (877)-664-6422)

Current members should call locally (800)-841-7434 for questions related to the Medicare Advantage Program. (TTY/TDD (888)-423-9490)

Prospective members should call locally (800)-292-5146 for questions related to the Medicare Advantage Program. (TTY/TDD (877)-664-6422)

Current members should call toll-free (800)-841-7434 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (888)-423-9490)

Prospective members should call toll-free (800)-292-5146 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (877)-664-6422)

Current members should call locally (800)-841-7434 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (888)-423-9490)

Prospective members should call locally
(800)-292-5146 for questions related to the Medicare Part D Prescription Drug program.
(TTY/TDD (877)-664-6422)

For more information about Medicare, please call Medicare at
1-800-MEDICARE (1-800-633-4227).

TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.
Or, visit www.medicare.gov on the web.

This document may be available in a different formats or language. For more information, call customer service at the phone number listed above.

Section II
Summary of Benefits

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

Benefit	Original Medicare	BlueAdvantage Gold (PFFS)
IMPORTANT INFORMATION		
1 - Premium and Other Important Information	In 2010 the monthly Part B Premium was $96.40 and may change for 2011 and the yearly Part B deductible amount was $155 and may change for 2011. If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more. Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.	General $101 monthly plan premium in addition to your monthly Medicare Part B premium. Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. This plan covers all Medicare-covered preventive services with zero cost sharing. This plan does not allow providers to balance bill (charging more than your cost share amount). $3,400 out-of-pocket limit. This limit includes only Medicare-covered services.
2 - Doctor and Hospital Choice (For more information, see Emergency Care - #15 and Urgently Needed Care - #16.)	You may go to any doctor, specialist or hospital that accepts Medicare.	You may go to any doctor, specialist, or hospital that accepts the plan's terms and conditions of payment.

SUMMARY OF BENEFITS		
Benefit	**Original Medicare**	**BlueAdvantage Gold (PFFS)**
INPATIENT CARE		
3 - Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)	In 2010 the amounts for each benefit period were: Days 1 - 60: $1100 deductible Days 61 - 90: $275 per day Days 91 - 150: $550 per lifetime reserve day These amounts will change for 2011. Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. Lifetime reserve days can only be used once. A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	General You may go to any doctor, specialist, or hospital that accepts the plan's terms and conditions of payment except in emergencies. No limit to the number of days covered by the plan each benefit period. For Medicare-covered hospital stays: Days 1 - 7: $100 copay per day Days 8 - 90: $0 copay per day $0 copay for additional hospital days $700 out-of-pocket limit every stay.
4 - Inpatient Mental Health Care	Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care" above). 190 day lifetime limit in a Psychiatric Hospital.	You get up to 190 days in a Psychiatric Hospital in a lifetime. For Medicare-covered hospital stays: Days 1 - 7: $100 copay per day Days 8 - 90: $0 copay per day $700 out-of-pocket limit every stay.

Benefit	Original Medicare	BlueAdvantage Gold (PFFS)
5 - Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)	In 2010 the amounts for each benefit period after at least a 3-day covered hospital stay were: Days 1 - 20: $0 per day Days 21 - 100: $137.50 per day These amounts will change for 2011. 100 days for each benefit period. A "benefit period" starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.	Plan covers up to 100 days each benefit period No prior hospital stay is required. For SNF stays: Days 1 - 20: $0 copay per day Days 21 - 100: $75 copay per day
6 - Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	$0 copay.	$0 copay for Medicare-covered home health visits.
7 - Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice.	General You must get care from a Medicare-certified hospice.

Benefit	Original Medicare	BlueAdvantage Gold (PFFS)
OUTPATIENT CARE		
8 - Doctor Office Visits	20% coinsurance	General You may go to any doctor, specialist, or hospital that accepts the plan's terms and conditions of payment. See "Welcome to Medicare; and Annual Wellness Visit", for more information. $20 copay for each primary care doctor visit for Medicare-covered benefits. $35 copay for each specialist visit for Medicare-covered benefits.
9 - Chiropractic Services	Routine care not covered 20% coinsurance for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.	$20 copay for each Medicare-covered visit. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.
10 - Podiatry Services	Routine care not covered. 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	$35 copay for each Medicare-covered visit. Medicare-covered podiatry benefits are for medically-necessary foot care.
11 - Outpatient Mental Health Care	45% coinsurance for most outpatient mental health services.	$20 copay for each Medicare-covered individual or group therapy visit.
12 - Outpatient Substance Abuse Care	20% coinsurance	$20 copay for Medicare-covered individual or group visits.
13 - Outpatient Services/Surgery	20% coinsurance for the doctor Specified copayment for outpatient hospital facility charges. Copay cannot exceed than Part A inpatient hospital deductible. 20% coinsurance for ambulatory surgical center facility charges	$200 copay for each Medicare-covered ambulatory surgical center visit. $200 copay for each Medicare-covered outpatient hospital facility visit.

Benefit	Original Medicare	BlueAdvantage Gold (PFFS)
14 - Ambulance Services (medically necessary ambulance services)	20% coinsurance	$100 copay for Medicare-covered ambulance benefits.
15 - Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	20% coinsurance for the doctor Specified copayment for outpatient hospital emergency room (ER) facility charge. ER Copay cannot exceed Part A inpatient hospital deductible. You don't have to pay the emergency room copay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit. NOT covered outside the U.S. except under limited circumstances.	General $50 copay for Medicare-covered emergency room visits. Worldwide coverage. If you are admitted to the hospital within 3-day(s) for the same condition, you pay $0 for the emergency room visit
16 - Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)	20% coinsurance, or a set copay NOT covered outside the U.S. except under limited circumstances.	General Cost sharing is the same as Doctor Office Visit cost sharing.
17 - Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy, Respiratory Therapy Services, Social/Psychological Services, and more)	20% coinsurance	$20 copay for Medicare-covered Occupational Therapy visits. $20 copay for Medicare-covered Physical and/or Speech and Language Therapy visits. $20 copay for Medicare-covered Cardiac Rehab services.

Benefit	Original Medicare	BlueAdvantage Gold (PFFS)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
18 - Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	20% coinsurance	20% of the cost for Medicare-covered items.
19 - Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	20% coinsurance	20% of the cost for Medicare-covered items.
20 - Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies (includes coverage for glucose monitors, test strips, lancets, screening tests, self-management training, retinal exam/glaucoma test, and foot exam/therapeutic soft shoes)	20% coinsurance Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.	$0 copay for Diabetes self-monitoring training. $0 copay for Nutrition Therapy for Diabetes. $0 copay for Diabetes supplies.
21 - Diagnostic Tests, X-Rays, Lab Services, and Radiology Services	20% coinsurance for diagnostic tests and x-rays $0 copay for Medicare-covered lab services Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.	$0 copay for Medicare-covered lab services. $0 copay for Medicare-covered diagnostic procedures and tests. 0% of the cost for Medicare-covered X-rays. 15% of the cost for Medicare-covered diagnostic radiology services (not including x-rays). 15% of the cost for Medicare-covered therapeutic radiology services.

Benefit	Original Medicare	BlueAdvantage Gold (PFFS)
PREVENTIVE SERVICES		
22 - Bone Mass Measurement (for people with Medicare who are at risk)	No coinsurance, copayment or deductible. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.	$0 copay for Medicare-covered bone mass measurement. Separate Office Visit cost sharing of $20 to $35 may apply.
23 - Colorectal Screening Exams (for people with Medicare age 50 and older)	No coinsurance, copayment or deductible for screening colonoscopy or screening flexible sigmoidoscopy. Covered when you are high risk or when you are age 50 and older.	$0 copay for Medicare-covered colorectal screenings. Separate Office Visit cost sharing of $20 to $35 may apply.
24 - Immunizations (Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine)	$0 copay for Flu, Pneumonia, and Hepatitis B vaccines. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.	$0 copay for Flu and Pneumonia vaccines. $0 copay for Hepatitis B vaccine.
25 - Mammograms (Annual Screening) (for women with Medicare age 40 and older)	No coinsurance, copayment or deductible. No referral needed. Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.	$0 copay for Medicare-covered screening mammograms. Separate Office Visit cost sharing of $20 to $35 may apply.
26 - Pap Smears and Pelvic Exams (for women with Medicare)	No coinsurance, copayment, or deductible for Pap smears. No coinsurance, copayment, or deductible for Pelvic and clinical breast exams. Covered once every 2 years. Covered once a year for women with Medicare at high risk.	$0 copay for Medicare-covered pap smears and pelvic exams Separate Office Visit cost sharing of $20 to $35 may apply.

Benefit	Original Medicare	BlueAdvantage Gold (PFFS)
27 - Prostate Cancer Screening Exams (for men with Medicare age 50 and older)	20% coinsurance for the digital rectal exam. $0 for the PSA test; 20% coinsurance for other related services. Covered once a year for all men with Medicare over age 50.	$0 copay for Medicare-covered prostate cancer screening. Separate Office Visit cost sharing of $20 to $35 may apply.
28 - End-Stage Renal Disease	20% coinsurance for renal dialysis 20% coinsurance for Nutrition Therapy for End-Stage Renal Disease Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.	$10 copay for renal dialysis $0 copay for Nutrition Therapy for End-Stage Renal Disease.
29 - Prescription Drugs	Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.	Drugs covered under Medicare Part B General 0% of the cost for Part B-covered drugs (not including Part B-covered chemotherapy drugs). 20% of the cost for Part B-covered chemotherapy drugs. Drugs covered under Medicare Part D General This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at www.bcbst-medicare.com on the web. Different out-of-pocket costs may apply for people who - have limited incomes, - live in long term care facilities, or - have access to Indian/Tribal/Urban (Indian Health Service).

Benefit	Original Medicare	BlueAdvantage Gold (PFFS)
		The plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and the plan. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. Some drugs have quantity limits. Your provider must get prior authorization from BlueAdvantage Gold (PFFS) for certain drugs. You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount. If you request a formulary exception for a drug and BlueAdvantage Gold (PFFS) approves the exception, you will pay Tier 4: Specialty Tier Drugs cost sharing for that drug. $0 deductible. Initial Coverage You pay the following until total yearly drug costs reach $2,840:

Benefit	Original Medicare	BlueAdvantage Gold (PFFS)
		Retail Pharmacy Tier 1: Generic Drugs - $7 copay for a one-month (30-day) supply of drugs in this tier - $21 copay for a three-month (90-day) supply of drugs in this tier Tier 2: Preferred Brand Drugs - $30 copay for a one-month (30-day) supply of drugs in this tier - $90 copay for a three-month (90-day) supply of drugs in this tier Tier 3: Brand Drugs - $75 copay for a one-month (30-day) supply of drugs in this tier - $225 copay for a three-month (90-day) supply of drugs in this tier Tier 4: Specialty Tier Drugs - 33% coinsurance for a one-month (30-day) supply of drugs in this tier - 33% coinsurance for a three-month (90-day) supply of drugs in this tier Long Term Care Pharmacy Tier 1: Generic Drugs - $7 copay for a one-month (31-day) supply of drugs in this tier Tier 2: Preferred Brand Drugs - $30 copay for a one-month (31-day) supply of drugs in this tier Tier 3: Brand Drugs - $75 copay for a one-month (31-day) supply of drugs in this tier Tier 4: Specialty Tier Drugs - 33% coinsurance for a one-month (31-day) supply of drugs in this tier

Benefit	Original Medicare	BlueAdvantage Gold (PFFS)
		Mail Order Tier 1: Generic Drugs - $7 copay for a one-month (30-day) supply of drugs in this tier - $17.50 copay for a three-month (90-day) supply of drugs in this tier Tier 2: Preferred Brand Drugs - $30 copay for a one-month (30-day) supply of drugs in this tier - $75 copay for a three-month (90-day) supply of drugs in this tier Tier 3: Brand Drugs - $75 copay for a one-month (30-day) supply of drugs in this tier - $187.50 copay for a three-month (90-day) supply of drugs in this tier Tier 4: Specialty Tier Drugs - 33% coinsurance for a one-month (30-day) supply of drugs in this tier - 33% coinsurance for a three-month (90-day) supply of drugs in this tier Coverage Gap After your total yearly drug costs reach $2,840, you receive a discount on brand name drugs and pay 93% of the plan's costs for all generic drugs, until your yearly out-of-pocket drug costs reach $4,550. Catastrophic Coverage After your yearly out-of-pocket drug costs reach $ 4,550, you pay the greater of: - A $ 2.50 copay for generic (including brand drugs treated as generic) and a $6.30 copay for all other drugs, or - 5% coinsurance.

Benefit	Original Medicare	BlueAdvantage Gold (PFFS)
		Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from BlueAdvantage Gold (PFFS). Out-of-Network Initial Coverage You will be reimbursed up to the full cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,840: Tier 1: Generic Drugs - $7 copay for a one-month (30-day) supply of drugs in this tier - Tier 2: Preferred Brand Drugs - $30 copay for a one-month (30-day) supply of drugs in this tier Tier 3: Brand Drugs - $75 copay for a one-month (30-day) supply of drugs in this tier Tier 4: Specialty Tier Drugs - 33% coinsurance for a one-month (30-day) supply of drugs in this tier You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. Out-of-Network Coverage Gap You will be reimbursed up to 7% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,550.

Benefit	Original Medicare	BlueAdvantage Gold (PFFS)
		You will be reimbursed up to the discounted price for brand name drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,550. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach $ 4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus your cost share, which is the greater of: - A $ 2.50 copay for generic (including brand drugs treated as generic) and a $ 6.30 copay for all other drugs, or - 5% coinsurance. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.
30 - Dental Services	Preventive dental services (such as cleaning) not covered.	$0 copay for Medicare-covered dental benefits. $0 copay for the following preventive dental benefits: - oral exams - cleanings - fluoride treatments - dental x-rays Plan offers additional comprehensive dental benefits. $100 plan coverage limit for dental benefits every year.

Benefit	Original Medicare	BlueAdvantage Gold (PFFS)
31 - Hearing Services	Routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams.	Hearing aids not covered. - $20 copay for Medicare-covered diagnostic hearing exams - $20 copay for up to 1 routine hearing test(s) every two years
32 - Vision Services	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. Routine eye exams and glasses not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. Annual glaucoma screenings covered for people at risk.	$0 copay for - one pair of eyeglasses or contact lenses after cataract surgery - glasses - contacts - lenses - frames - $0 to $20 copay for exams to diagnose and treat diseases and conditions of the eye. - $20 copay for up to 1 routine eye exam(s) every year $100 plan coverage limit for eye wear every year.
33 - Welcome to Medicare; and Annual Wellness Visit	When you join Medicare Part B, then you are eligible as follows. During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare exam or an Annual Wellness visit. After your first 12 months, you can get one Annual Wellness visit every 12 months. There is no coinsurance, copayment or deductible for either the Welcome to Medicare exam or the Annual Wellness visit. The Welcome to Medicare exam does not include lab tests.	$0 copay for routine exams. $0 copay for the required Medicare-covered initial preventive physical exam and annual wellness visits. Limited to 1 exam(s) every year. $0 copay for the required Medicare-covered initial preventive physical exam and annual wellness visits.

Benefit	Original Medicare	BlueAdvantage Gold (PFFS)
34 - Health/Wellness Education	Smoking Cessation: Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies. $0 copay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor's visit. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy.	The plan covers the following health/wellness education benefits: - Written health education materials, including Newsletters - Nutritional benefit - Health Club Membership/Fitness Classes - Nursing Hotline - Other Wellness Benefits $0 copay for each Medicare-covered smoking cessation counseling session. $0 copay for each Medicare-covered HIV screening. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy.
Transportation (Routine)	Not covered.	This plan does not cover routine transportation.
Acupuncture Not	covered.	This plan does not cover Acupuncture.

One Cameron Hill Circle
Chattanooga, TN 37402

www.bcbst-medicare.com

A health plan with a Medicare contract.

This document has been classified as public information.

H5884_GLSB11 CMS Approved 10012010

of Tennessee

What **People on Medicare** need to know about

Private Fee-for-Service plans

BlueAdvantage PFFS is a Medicare Advantage Private Fee-for-Service (PFFS) plan authorized by the Centers for Medicare & Medicaid Services (CMS). A PFFS plan is different than Original Medicare or an HMO, PPO, or Medicare supplement plan.

BlueAdvantage PFFS gives you the ability to choose your health care provider. However not all providers may accept this plan, even Medicare providers may not accept this plan. If you choose this plan, it is very important that all the providers you choose know, before providing services to you, that you have BlueAdvantage PFFS coverage in place of Medicare. This gives your provider the right to choose whether or not to accept BlueAdvantage PFFS terms and conditions of payment for treating you. Providers have the right to decide if they will accept BlueAdvantage PFFS each time they see you. This is why you must show your BlueAdvantage PFFS ID card every time you visit a health care provider.

If your provider agrees to BlueAdvantage PFFS terms and conditions of payment
If your provider decides to accept the BlueAdvantage PFFS plan, they must follow our plan's terms and conditions for payment. They must thereafter bill BlueAdvantage PFFS for those services. However, providers have the right to decide if they will accept BlueAdvantage PFFS each time they see you.

If your provider does not agree to BlueAdvantage PFFS terms and conditions of payment
A provider may decide not to accept BlueAdvantage PFFS terms and conditions of payment. If this happens, you will need to find another provider that will. You may contact us at 1-800-841-7434 (TTY/TDD 1-888-423-9490) for assistance locating another provider in your area willing to accept our plan's terms and conditions of payment.

What happens if a provider declines to accept BlueAdvantage PFFS terms and conditions of payment?

1. They should not provide services to you except for emergencies.

2. If they choose to provide services, they may not bill you. They must bill BlueAdvantage PFFS for your covered health care services. You must pay the appropriate copays or coinsurance at the time of service.

For more information about PFFS plans see Beneficiary Qs & As at CMS's web site http://www.cms.hhs.gov/PrivateFeeforServicePlans/. If you have questions about BlueAdvantage, please call our customer service department at 1-800-841-7434. Hours are 8 a.m. to 9 p.m. Eastern Time, 7 days a week. From March 2 to September 30 you may be required to leave a message on weekends and holidays. Calls will be returned the next business day. Hearing impaired members may call the TTY/TDD number, 1-888-423-9490.

(over)

What **Health Care Providers** need to know about

Private Fee-for-Service plans

BlueAdvantage PFFS is a Medicare Advantage Private Fee-for-Service (PFFS) plan authorized by the Centers for Medicare & Medicaid Services (CMS). A PFFS plan is different than an an HMO, PPO, or Medicare supplement plan.

A beneficiary who enrolls in a Medicare Advantage PFFS plan is free to use any provider willing to treat the enrollee and accept our plan's terms and conditions of payment. You can view our terms and conditions of payment by visiting our website at www.bcbst-medicare.com, and if you have questions, then you can call 1-800-841-7434. Enrollees must inform you, before obtaining services from you, that they have purchased BlueAdvantage PFFS for their Medicare coverage. This gives you the right to choose to accept BlueAdvantage PFFS enrollees. You have a right to make that choice each time service is needed by a BlueAdvantage PFFS enrollee. You do not have to sign a contract to see BlueAdvantage enrollees.

If you decide to accept BlueAdvantage PFFS terms and conditions of payment
Your agreement to our plan's terms and conditions of payment is inherent in your decision to treat a BlueAdvantage PFFS enrollee. If you decide to treat a BlueAdvantage PFFS enrollee, you will be subject to our plan's terms and conditions of payment and must bill BlueAdvantage PFFS for covered services. However, you have the right to decide, on a patient-by-patient and visit-by-visit basis, whether to treat BlueAdvantage PFFS enrollees. You may learn our terms and conditions of payment and other information about our plan on our Web site at www.bcbst.com/providers/BenefitHighlights.shtml/ or by calling 1-800-841-7434.

If you decide not to accept BlueAdvantage PFFS terms and conditions of payment
If you decide not to treat a BlueAdvantage PFFS enrollee, you should not provide services to the enrollee, except for emergencies.

If you choose to provide services, then you have by default agreed to our terms and conditions of payment and you must bill BlueAdvantage PFFS for covered health care services. You must collect from the enrollee only the appropriate BlueAdvantage PFFS copays or coinsurance at the time of service. You may at any time, on a patient-by-patient and visit-by-visit basis, decide that you do not want to treat a BlueAdvantage PFFS enrollee.

We will follow CMS requirements for timely payment of claims. You may learn our billing requirements on our Web site at http://www.bcbst.com/providers/BenefitHighlights.shtml/ or by calling 1-800-841-7434. Hours are 8 a.m. to 9 p.m. Eastern Time, 7 days a week. From March 2 to September 30 you may be required to leave a message on weekends and holidays. Calls will be returned the next business day.

For more information about PFFS plans see Provider Qs & As at CMS's web site http://www.cms.hhs.gov/PrivateFeeForServicePlans/. If you have questions, please call 1-800-841-7434. Hours are 8 a.m. to 9 p.m. Eastern Time, 7 days a week. From March 2 to September 30 you may be required to leave a message on weekends and holidays. Calls will be returned the next business day.

BlueCross BlueShield of Tennessee is a health plan with a Medicare contract.

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plans for better health. plans for a better life.™

One Cameron Hill Circle
Chattanooga, TN 37402

H5884/H4979_PFFS10_MPI (9.18.2009)

BlueCross BlueShield of Tennessee - H5884

Medicare Health Plan Ratings

The Medicare Program rates how well Medicare Advantage performs in different categories (for example, detecting and preventing illness, rating from patients, patient safety and customer service). The information provided below is a summary rating of our plan's overall performance. This information is available to help you make the best choice. If you would like to get additional information on our plan's performance please contact us at 800-292-5146 (toll-free) or 877-664-6422 (TTY/TDD) for prospective members, 800-841-7434 (toll-free) or 888-423-9490 (TTY/TDD) for current members, or you may visit www.medicare.gov.

Below is a summary of how our plan rated in quality and performance.

The number of stars show how well our plans perform.

★★★★★	means excellent
★★★★	means very good
★★★	means good
★★	means fair
★	means poor

BlueCross BlueShield of Tennessee - H5884	
Summary Rating of Health Plan Quality	★★★½ 3.5 stars
	This summary rating gives an **overall score** on the health plan's quality and performance on **33 different topics in 5 categories**: • **Staying healthy: screenings, tests, and vaccines.** Includes how often members got various screening tests, vaccines, and other check-ups that help them stay healthy. • **Managing chronic (long-term) conditions.** Includes how often members with different conditions got certain tests and treatments that help them manage their condition. • **Ratings of health plan responsiveness and care.** Includes ratings of member satisfactions with the plan. • **Health Plan member complaints, appeals, and choosing to leave the health plan.** Includes how often members have made complaints against the plan and how often members choose to leave the plan. • **Health plan telephone customer service.** Includes how well the plan handles member calls.

BlueCross BlueShield of Tennessee - H5884

Medicare Prescription Drug Plan Ratings

The Medicare Program rates how well Medicare Prescription Drug Plans perform in different categories (for example, customer service, drug pricing, patient safety). The information provided below is a summary rating of our plan's overall performance. This information is available to help you make the best choice. If you would like to get additional information on our plan's performance please contact us at 800-292-5146 (toll-free) or 877-664-6422 (TTY/TDD) for prospective members, 800-841-7434 (toll-free) or 888-423-9490 (TTY/TDD) for current members, or you may visit www.medicare.gov.

Below is a summary of how our plan rated in quality and performance.

The number of stars shows how well our plan performs.

★★★★★	means excellent
★★★★	means very good
★★★	means good
★★	means fair
★	means poor

BlueCross BlueShield of Tennessee - H5884	
Summary Rating of Prescription Drug Plan Quality	★★★★ 4 stars
	This summary rating gives an **overall score** on the drug plan's quality and performance on **19 different topics in 4 categories:**: • Drug plan customer service: Includes how well the drug plan handles calls and makes decisions about member appeals. • Drug plan member complaints, members who choose to leave, and Medicare audit findings: Includes how often members complain about the drug plan and how often members choose to leave the drug plan. • Member experience with drug plan: Includes member satisfaction information. • Drug pricing and patient safety: Includes how well the drug plan prices prescriptions and provides accurate pricing information on the Medicare website. Includes information on how often members with certain medical conditions get prescription drugs that are considered safer and clinically recommended for their condition. This information is gathered from several different sources, including results from Medicare's regular monitoring activities, reviews of billing and other information that plans submit to Medicare, and Medicare's member surveys.

2011 BlueAdvantage PFFS℠
Enrollment Request Form
Gold Option

Unfold the enrollment request form and print clearly with a black ball point pen.

- **Press hard enough so that your writing appears on the yellow copy.**
- **Be sure to complete all required fields and answer all questions.**
- **Sign and date the third page of the enrollment form.**
- **Remove the yellow copy and keep it for your records.**
- **Mail the enrollment request form in the envelope provided. Or to the address below:**

Attention: Community Programs 3G
BlueCross BlueShield of Tennessee
1 Cameron Hill Circle, Suite 0006
Chattanooga, Tennessee 37402-0006

Fax Number: 423-591-9344
1-888-832-9613

of Tennessee
plans for better health. plans for a better life.®

A health plan with a Medicare contract.

2011 BlueAdvantage PFFS Enrollment Request Form

To Enroll in BlueAdvantage PFFS, Please Provide the Following Information

Please check the plan you want to enroll in: ❑ BlueAdvantage PFFS **Gold**

LAST Name	FIRST Name	Middle Initial	❑ Mr. ❑ Mrs. ❑ Ms.
Birth Date __ __/__ __/__ __ __ __ (M M / D D / Y Y Y Y)	Sex ❑ M ❑ F	Home Phone Number ( )	Alternate Phone Number ( )

Permanent Residence Street Address (P.O. Box is not allowed):

City	County	State	ZIP
Mailing Address (Only if different from permanent residence address)	City	State	ZIP
Emergency Contact (optional)	Phone No.: ( )	Relationship to You:	

E-mail Address (optional)

Please Provide Your Medicare Insurance Information

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card;

-OR-

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

  You must have Medicare Part A and Part B to join a Medicare Advantage plan such as BlueAdvantage PFFS.

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name: _____

Medicare Claim Number **Sex** _____

__ __ __ - __ __ - __ __ __ __ ___

Is Entitled To	**Effective Date**
HOSPITAL (Part A)	_____
MEDICAL (Part B)	_____

Paying Your Plan Premium

You can pay your monthly plan premium by mail or Electronic Funds Transfer (EFT), each month. You can also choose to pay your premium by automatic deduction from your Social Security benefit check each month.

People with limited incomes may qualify for extra help to pay for their prescription drug costs. If you qualify, Medicare could pay for 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and co-insurance. Additionally, those who qualify won't have a coverage gap or a late enrollment penalty. Many people qualify for these savings and don't even know it. For more information about this extra help, contact your local Social Security office, or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You can also apply for extra help online at www.socialsecurity.gov/prescriptionhelp.

If you qualify for extra help with your Medicare prescription drug coverage costs, Medicare will pay all or part of your plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount that Medicare doesn't cover.

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

❑ Get a bill

❑ Electronic funds transfer (EFT) from your bank account each month.
Please complete and attach the enclosed authorization form.

❑ Automatic deduction from your monthly Social Security benefit check.
(The Social Security deduction may take two or more months to begin. In most cases, the first deduction from your Social Security benefit check will include all premiums due from your enrollment effective date up to the point withholding begins.)

Please Read and Answer These Important Questions

1. Do you have End Stage Renal Disease (ESRD)? ❑ Yes ❑ No

   If you answered "Yes" to this question and you don't need regular dialysis any more, or have had a successful kidney transplant, **please attach a note or records** from your doctor showing you don't need dialysis or have had a successful kidney transplant.

2. Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits, or State pharmaceutical assistance programs.

   Will you have other prescription drug coverage in addition to BlueAdvantage PFFS? ❑ Yes ❑ No

   If "Yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Name of Other Coverage	ID # for this Coverage	Group # for this Coverage

3. Do you or your spouse work? ❑ Yes ❑ No

Please check the box below if you prefer that we send you information in CD format.

❑ **Computer CD with Large Print**

Please contact BlueAdvantage PFFS at 1-800-841-7434 (TTY users should call TTY: 1-888-423-9490) if you need information in another format than what is listed above.

Our office hours are 8 a.m. to 9 p.m. Eastern Time, 7 days a week. From March 2 to September 30, you may be required to leave a message on holidays and weekends. Calls will be returned the next business day.

STOP Please Read This Important Information

BlueAdvantage PFFS, a Medicare Advantage Private Fee-for-Service plan, works differently than a Medicare supplement plan as well as other Medicare Advantage plans. Your doctor or hospital isn't required to agree to accept our plan's terms and conditions and may choose not to treat you, except in emergencies. You should verify that your provider(s) will accept BlueAdvantage PFFS before each visit. Providers can find the plan's terms and conditions on our Web site at *www.bcbst.com/providers/BenefitHighlights.shtml*.

Once BlueAdvantage PFFS has your enrollment form, you will get a call from a plan representative. This call is to make sure that you understand how a Private Fee-for-Service plan works and to confirm your intent to enroll in BlueAdvantage PFFS. If BlueAdvantage PFFS isn't able to reach you by telephone, then you will get a letter by mail that contains similar information.

If you currently have health coverage from an employer or union, joining BlueAdvantage PFFS could affect your employer or union health benefits. If you have health coverage from an employer or union, joining BlueAdvantage PFFS may change how your current coverage works. You or your dependents could lose your other health or drug coverage completely and not get it back if you join BlueAdvantage PFFS. Read the communications your employer or union sends you. If you have questions, visit their Web site, or contact the office listed in their communications. If there is no information on whom to contact, your benefits administrator or the office that answers questions about your coverage can help.

Please Read and Sign Below

By completing this enrollment application, I agree to the following:

BlueAdvantage PFFS is a Medicare Private Fee-For-Service plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I understand that this plan is a Medicare Advantage Private-Fee-for-Service plan and I can be in only one Medicare health plan at a time. I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or Medicare prescription drug plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (Example: Annual Enrollment Period from November 15 – December 31 of every year), or under certain special circumstances.

As a Medicare Private Fee-for-Service plan, BlueAdvantage PFFS works differently than a Medicare supplement plan as well as other Medicare Advantage plans. BlueAdvantage PFFS pays instead of Medicare, and I will be responsible for the amounts that BlueAdvantage PFFS doesn't cover, such as copayments and coinsurances. Original Medicare won't pay for my health care while I am enrolled in BlueAdvantage PFFS.

Before seeing a provider, I should verify that the provider will accept BlueAdvantage PFFS. I understand that my health care providers have the right to choose whether to accept BlueAdvantage PFFS's payment terms and conditions every time I see them. I understand that if my provider doesn't accept BlueAdvantage PFFS, I will need to find another provider that will.

BlueAdvantage PFFS serves a specific service area. If I move out of the area that BlueAdvantage PFFS serves, I need to notify BlueAdvantage PFFS so I can disenroll and find a new plan in my new area. Once I am a member of BlueAdvantage PFFS, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from BlueAdvantage PFFS when I get it to know which rules I must follow to get coverage with this Private Fee-for-Service plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with BlueAdvantage PFFS, he/she may be paid based on my enrollment in BlueAdvantage PFFS.

Release of Information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that BlueAdvantage PFFS will release my information including my prescription drug event data to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by BlueAdvantage PFFS or by Medicare.

Signature	**Today's Date**

If you are the authorized representative, you must sign above and provide the following information:

Name: _____

Address: _____

Phone Number: ( ) _____- _____ Relationship to Enrollee: _____

Attestation of Eligibility for an Enrollment Period

Typically, you may enroll in a Medicare Advantage plan during the annual enrollment period between November 15 and December 31 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period.

Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ❑ I am making my annual enrollment period election (Nov. 15 - Dec. 31).
- ❑ I am new to Medicare.
- ❑ I recently moved outside of the service area for my current plan or I recently moved and this plan is a new option for me.

  I moved on (insert date): _____.
- ❑ I have both Medicare and Medicaid or my state helps pay for my Medicare premiums.
- ❑ I get extra help paying for Medicare prescription drug coverage.

- ❑ I no longer qualify for extra help paying for my Medicare prescription drugs.

  I stopped receiving extra help on (insert date): _____

- ❑ I am moving into, live in or recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility).

  I moved/will move into/out of the facility on (insert date): _____.

- ❑ I recently left a PACE program on (insert date): _____.

- ❑ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's).

  I lost my drug coverage on (insert date): _____.

- ❑ I am leaving employer or union coverage on (insert date) :_____.

- ❑ I belong to a pharmacy assistance program provided by my state.

- ❑ I recently returned to the United States after living permanently outside of the U.S.

  I returned to the U.S. on (insert date): _____.

- ❑ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.

- ❑ None of these statements applies to me.*

Please contact BlueAdvantage PFFS at 1-800-292-5146 (TTY users should call 1-877-664-6422) to see if you are eligible to enroll. We are open 8 a.m. to 9 p.m. Eastern Time, 7 days a week. From March 2 to September 30, you may be required to leave a message on weekends and holidays. Calls will be returned the next business day.

Office Use Only

Name of staff member/agent/broker (if assisted in enrollment): _____

Plan ID #:_____ Effective Date of Coverage: _____

ICEP/IEP: _____ AEP: _____ SEP (type): _____ Not Eligible: _____

Licensed Agent Use Only

I certify that I have truly and accurately recorded on this application the information supplied by the applicant.

Licensed Agent:_____ Agent ID #_____ Date Received:_____

Agent Signature:_____

SOA: ❑ Yes ❑ No

If "Yes," attach form or enter Reference #: _____

BlueAdvantage Automatic Bank Draft Authorization

Save Time, Money and Avoid Worry

Now you can pay your BlueCross BlueShield of Tennessee premiums without writing a check. You can just authorize your financial institution to pay your premiums automatically through your bank account. These easy ways to pay your BlueCross BlueShield of Tennessee premiums have big advantages for you.

Save Time

You won't have to write checks. Your financial institution automatically deducts or credits your premiums from your bank account and you receive a record of payment on your bank statement.

Save Money

You will save postage costs by letting your financial institution handle the payment of your premiums.

Avoid Worry

You won't have to worry about missing a payment, losing your bill, or being away from home when the bill comes. Your financial institution handles the payments for you.

Questions You May Have About the Automatic Bank Draft System

- **What type of bank account qualifies for the Automatic Bank Draft System?**
  Any type of account that permits checks or drafts to withdraw funds. It should be a checking account at a bank or a savings and loans institution.

- **What if someone else pays my BlueCross BlueShield of Tennessee premiums?**
  The person who makes your payment can use the Automatic Bank Draft system by completing the Bank Draft Authorization form on the next page.

- **What if I change banks?**
  Simply complete a new authorization form to continue the Automatic Bank Draft withdrawal at your financial institution. Just let us know about the change, and we will send you a new authorization form.

- **What if I want to cancel the Automatic Bank Draft service?**
  Just give us a written notice and we will convert your payment method to bill you directly. To avoid a disruption in service, please send your request at least two weeks before your premium is due.

How To Sign Up for Automatic Bank Draft

1. Fill out the attached bank draft authorization form completely.
2. Attach the authorization to the BlueCross BlueShield of Tennessee health application.
3. Attach a voided check to confirm bank information.
4. If payment is to be withdrawn from an account other than yours, the person making your BlueCross BlueShield of Tennessee payments should follow steps above.
5. Until your bank draft begins, you will receive a bill and you will need to pay your premiums by check.

of Tennessee
plans for better health. plans for a better life.™

****Confidential** Complete This Form Only for Automatic Bank Draft Payment**

Subscriber Name: _____

Subscriber ID Number: _____

Name of Bank: _____

Bank Routing Number: _____

Bank Account Number: _____

Name on Bank Account: _____

Subscriber's Address: _____

City: _____ State: _____ ZIP: _____

Daytime Phone Number: (____) _____ e-mail: _____

I authorize BlueCross BlueShield of Tennessee to charge the bank account listed above for payment of health insurance premiums related to the subscriber ID/policy identified on this form. Premiums charged to my bank account will be in the amount shown on the health insurance policy. I understand that this amount may change, but that the subscriber will be notified in writing 30 days prior to such changes. **This authorization is valid until I provide written notice of cancellation to BlueCross BlueShield of Tennessee.**

Subscriber Signature: _____ Date: _____
Signature(s) of Bank Depositor (Sign Exactly as Name Appears on Bank Records)

We must have your completed form 30 days in advance of your premium due date. We will send you confirmation to let you know when your Bank Draft payment will take effect. **If you are billed before your bank draft payment goes into effect, please return payment as requested.**

Please fax all correspondence about Automatic bank draft payments to 423-535-1308, 7 days a week. (TTY/TDD users may call 1-888-423-9490 or mail to:

BlueCross BlueShield of Tennessee
1 Cameron Hill Circle – Suite 0033
Chattanooga, TN 37402-9983

A health plan with a Medicare Contract.
www.bcbst-medicare.com

FROM _____

_____

_____

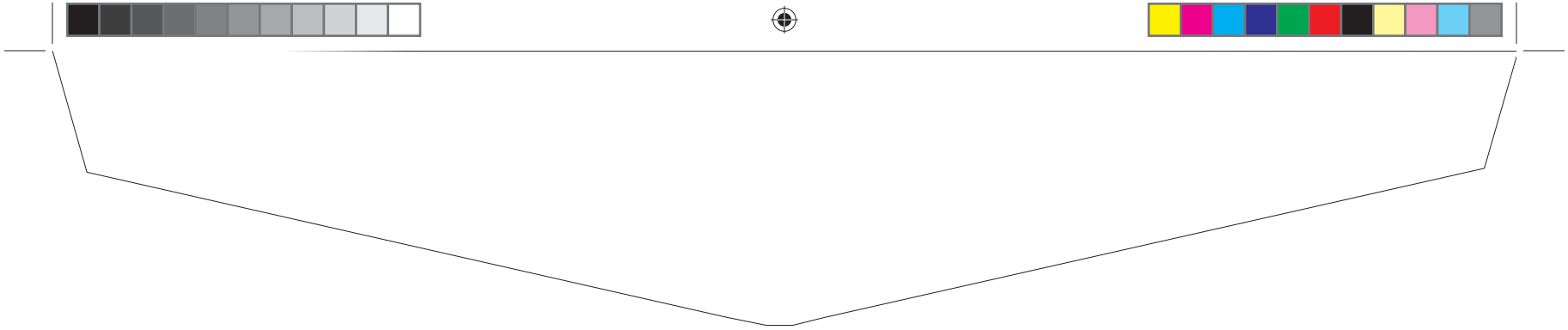
NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL

FIRST-CLASS MAIL PERMIT NO. 692 CHATTANOOGA TN

POSTAGE WILL BE PAID BY ADDRESSEE

ATTN: COMMUNITY ROGRAMS 3G
BLUECROSS BLUESHIELD OF TENNESSEE
1 CAMERON HILL CIRCLE, STE 0006
CHATTANOOGA TN 37402-9826



Did you remember to complete, sign and date your application form?

H5884-BA-21 (08.10)