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BlueAdvantage!®

Summary of Benefits
BlueAdvantage PPO SapphireSM
BlueAdvantage PPO DiamondSM

Introduction to the Summary of Benefits for BlueAdvantage PPO Sapphire and Diamond January 1, 2008 - December 31, 2008 Anderson, Knox, Loudon and Sevier Counties

Thank you for your interest in BlueAdvantage PPO Sapphire and Diamond. Our plan is offered by BlueCross BlueShield of Tennessee, a Medicare Advantage Preferred Provider Organization (PPO). 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 BlueCross BlueShield of Tennessee 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 health plan, like BlueAdvantage PPO Sapphire or Diamond. You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may be able to join or leave a plan only at certain times. Please call BlueCross BlueShield of Tennessee at the number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY 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 PPO Sapphire and Diamond 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 plans cover and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

Where is BlueAdvantage PPO Sapphire and Diamond Available?

The service area for this plan includes: Anderson, Knox, Loudon, Sevier Counties, TN. You must live in one of these areas to join the plan.

Who is Eligible to Join BlueAdvantage PPO Sapphire and Diamond?

You can join BlueAdvantage PPO Sapphire or Diamond 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 PPO Sapphire or Diamond unless they are members of our organization and have been since their dialysis began.

Can I Choose My Doctors?

BlueAdvantage PPO Sapphire and Diamond have formed a network of doctors, specialists, and hospitals. You can use any doctor who is part of our network. You may also go to doctors outside of our network. The health providers in our network can change at any time. You can ask for a current Provider Directory for an up-to-date list or visit us at www.bcbst-medicare.com. Our customer service number is listed at the end of this introduction.

What Happens IF I Go to a Doctor Who's Not in Your Network?

You can go to doctors, specialists, or hospitals in or out of network. You may have to pay more for the services you receive outside the network, and you may have to follow special rules prior to getting services in and/or out of network. For more information, please call the customer service number at the end of this introduction.

Does My Plan Cover Medicare Part B or Part D Drugs?

BlueAdvantage PPO Sapphire and Diamond do cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

Where Can I Get My Prescriptions If I Join This Plan?

BlueAdvantage PPO Sapphire and Diamond have 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 current Pharmacy Network List or visit us at www.bcbst-medicare.com. Our customer service number is listed at the end of this introduction.

What Is A Prescription Drug Formulary?

BlueAdvantage PPO Sapphire and Diamond use 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 Prescription Drug Plan Costs?

If you qualify for extra help with your Medicare prescription drug plan costs, your premium and costs at the pharmacy will be lower. When you join BlueAdvantage PPO Sapphire or Diamond, Medicare will tell us how much extra help you are getting. Then we will let you know the amount you will pay. If you are not getting this extra help you can see if you qualify by calling 1-800-MEDICARE (1-800-633-4227), TTY users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

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 PPO Sapphire or Diamond, 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.

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 BlueCross BlueShield of Tennessee for more details.

Please call BlueCross BlueShield of Tennessee for more information about this plan. 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 Time

From March 3 to September 30 you may be required to leave a message on weekends and holidays. Calls will be returned the next business day.

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

Prospective members should call (800)-292-5146 for questions related to the Medicare Advantage program. (TTY/TDD (877)-646-6422)

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

Prospective members should call (800)-292-5146 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD (877)-646-6422)

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.

If you have special needs, this document may be available in other formats.

Section 2

Summary of Benefits

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

IMPORTANT INFORMATION

Benefit Category	Original Medicare	BlueAdvantage PPO Sapphire	BlueAdvantage PPO Diamond
1. Premium and Other Important Information	<p>\$96.40 monthly Medicare Part B Premium.</p> <p>\$135 yearly Medicare Part B deductible.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p>	<p>\$0 monthly plan premium in addition to your \$96.40 monthly Medicare Part B premium.</p> <p>In-Network \$5000 out-of-pocket limit. Contact the plan for services that apply.</p> <p>Out-of-Network \$2000 yearly deductible. Contact the plan for services that apply. \$5000 out-of-pocket limit. Contact the plan for services that apply. Unless otherwise noted, out-of-network services not covered.</p> <p>In and Out-of-Network \$10,000 out-of-pocket limit. Contact the plan for services that apply. See page 21 for more information on out-of-pocket limits.</p>	<p>\$99 monthly plan premium in addition to your \$96.40 monthly Medicare Part B premium.</p> <p>In-Network \$2500 out-of-pocket limit. Contact the plan for services that apply.</p> <p>Out-of-Network \$2000 yearly deductible. Contact the plan for services that apply. \$2500 out-of-pocket limit. Contact the plan for services that apply. Unless otherwise noted, out-of-network services not covered.</p> <p>In and Out-of-Network \$5000 out-of-pocket limit. Contact the plan for services that apply. See page 21 for more information on out-of-pocket limits.</p>
2. Doctor and Hospital Choice (For more information, see Emergency - #15 and Urgently Needed Care - #16.)	You may go to any doctor, specialist or hospital that accepts Medicare.	<p>In-Network No referral required for network doctors, specialists, and hospitals. You may have to pay a separate copay for certain doctor office visits.</p>	<p>In-Network No referral required for network doctors, specialists, and hospitals. You may have to pay a separate copay for certain doctor office visits.</p>

INPATIENT CARE

Benefit Category	Original Medicare	BlueAdvantage PPO Sapphire	BlueAdvantage PPO Diamond
<p>3. Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)</p>	<p>For each benefit period: Days 1 - 60: \$1,024 deductible</p> <p>Days 61 - 90: \$256 per day</p> <p>Days 91 - 150: \$512 per lifetime reserve day</p> <p>Please call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.</p> <p>Lifetime reserve days can only be used once.</p> <p>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.</p>	<p>In-Network For Medicare-covered hospital stays:</p> <p>Days 1 - 7: \$175 copay per day</p> <p>Days 8 - 90: \$0 copay per day</p> <p>\$0 copay for additional hospital days</p> <p>No limit to the number of days covered by the plan each benefit period.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>Out-of-Network 20% of the cost for each hospital stay.</p>	<p>In-Network \$0 copay</p> <p>No limit to the number of days covered by the plan each benefit period.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>Out-of-Network 20% of the cost for each hospital stay.</p>

INPATIENT CARE Continued

Benefit Category	Original Medicare	BlueAdvantage PPO Sapphire	BlueAdvantage PPO Diamond
4. Inpatient Mental Health Care	<p>Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care" above)</p> <p>190 day limit in a Psychiatric Hospital</p>	<p>In-Network For hospital stays:</p> <p>Days 1 - 7: \$175 copay per day Days 8 - 9t0: \$0 copay per day</p> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>Out-of-Network 20% of the cost for each hospital stay.</p>	<p>In-Network \$0 copay</p> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p> <p>Out-of-Network 20% of the cost for each hospital stay.</p>
5. Skilled Nursing Facility (in a Medicare-certified skilled nursing facility)	<p>For each benefit period after at least a 3-day covered hospital stay:</p> <p>Days 1 - 20 \$0 per day Days 21 - 100 \$128 per day</p> <p>100 days for each benefit period.</p> <p>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.</p>	<p>Prior authorization is required.</p> <p>In-Network For SNF stays:</p> <p>Days 1 - 20: \$0 copay per day Days 21 - 100: \$150 copay per day</p> <p>100 days covered for each benefit period</p> <p>No prior hospital stay is required.</p> <p>Out-of-Network 20% of the cost for SNF benefits.</p>	<p>Prior authorization is required.</p> <p>In-Network For SNF stays:</p> <p>Days 1 - 100: \$0 copay per day</p> <p>100 days covered for each benefit period</p> <p>No prior hospital stay is required.</p> <p>Out-of-Network 20% of the cost for SNF benefits.</p>

OUTPATIENT CARE

Benefit Category	Original Medicare	BlueAdvantage PPO Sapphire	BlueAdvantage PPO Diamond
6. Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	\$0 copay.	Authorization rules may apply. In-Network \$0 copay for Medicare-covered home health visits. Out-of-Network 20% for home health visits.	Authorization rules may apply. In-Network \$0 copay for Medicare-covered home health visits. Out-of-Network 20% for home health visits.
7. Hospice	You pay part of the cost for outpatient drugs and inpatient respite care.	In-Network You must get care from a Medicare-certified hospice.	In-Network You must get care from a Medicare-certified hospice.
8. Doctor Office Visits	20% coinsurance	See "Routine Physical Exams," for more information. In-Network \$20 copay for each primary care doctor visit for Medicare-covered benefits. \$40 copay for each specialist visit for Medicare-covered benefits. Out-of-Network 20% for each primary care doctor visit. 20% for each specialist visit. See page 21 for more information on doctor office visits.	See "Routine Physical Exams," for more information. In-Network \$10 copay for each primary care doctor visit for Medicare-covered benefits. \$10 copay for each specialist visit for Medicare-covered benefits. Out-of-Network 20% for each primary care doctor visit. 20% for each specialist visit. See page 21 for more information on doctor office visits.
9. Chiropractic Services	20% coinsurance Routine care not covered 20% coinsurance for manual manipulation of the spine to correct subluxation if you get it from a chiropractor or other qualified provider.	In-Network \$40 copay for Medicare-covered visits. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part. Out-of-Network 20% of the cost for chiropractic benefits.	In-Network \$10 copay for Medicare-covered visits. Medicare-covered chiropractic visits are for manual manipulation of the spine to correct a displacement or misalignment of a joint or body part. Out-of-Network 20% of the cost for chiropractic benefits.

OUTPATIENT CARE Continued

Benefit Category	Original Medicare	BlueAdvantage PPO Sapphire	BlueAdvantage PPO Diamond
10. Podiatry Services	<p>20% coinsurance</p> <p>Routine care not covered.</p> <p>20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p>	<p>In-Network \$40 copay for each Medicare-covered visit.</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p> <p>Out-of-Network 20% of the cost for podiatry benefits.</p>	<p>In-Network \$10 copay for each Medicare-covered visit.</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p> <p>Out-of-Network 20% of the cost for podiatry benefits.</p>
11. Outpatient Mental Health Care	<p>50% coinsurance for most outpatient mental health services.</p>	<p>In-Network \$40 copay for each Medicare-covered individual or group therapy visit.</p> <p>Out-of-Network 20% of the cost for Mental Health benefits.</p> <p>20% of the cost for Mental Health benefits with a psychiatrist.</p>	<p>In-Network \$10 copay for each Medicare-covered individual or group therapy visit.</p> <p>Out-of-Network 20% of the cost for Mental Health benefits.</p> <p>20% of the cost for Mental Health benefits with a psychiatrist.</p>
12. Outpatient Substance Abuse	<p>Care 20% coinsurance</p>	<p>In-Network \$40 copay for Medicare-covered individual or group visits.</p> <p>Out-of-Network 20% of the cost for outpatient substance abuse benefits.</p>	<p>In-Network \$10 copay for Medicare-covered individual or group visits.</p> <p>Out-of-Network 20% of the cost for outpatient substance abuse benefits.</p>
13. Outpatient Services/Surgery	<p>20% coinsurance for the doctor</p> <p>20% of outpatient facility</p>	<p>Authorization rules may apply.</p> <p>In-Network \$250 copay for each Medicare-covered ambulatory surgical center visit.</p> <p>\$250 copay for each Medicare-covered outpatient hospital facility visit.</p> <p>Out-of-Network 20% of the cost for ambulatory surgical center benefits.</p> <p>20% of the cost for outpatient hospital facility benefits.</p>	<p>Authorization rules may apply.</p> <p>In-Network \$0 copay for each Medicare-covered ambulatory surgical center visit.</p> <p>\$0 copay for each Medicare-covered outpatient hospital facility visit.</p> <p>Out-of-Network 20% of the cost for ambulatory surgical center benefits.</p> <p>20% of the cost for outpatient hospital facility benefits.</p>

OUTPATIENT CARE Continued

Benefit Category	Original Medicare	BlueAdvantage PPO Sapphire	BlueAdvantage PPO Diamond
<p>14. Ambulance Services (medically necessary ambulance services)</p>	<p>20% coinsurance</p>	<p>In-Network \$200 copay for Medicare-covered ambulance benefits.</p> <p>Out-of-Network 20% of the cost for ambulance benefits.</p>	<p>In-Network \$100 copay for Medicare-covered ambulance benefits.</p> <p>Out-of-Network 20% of the cost for ambulance benefits.</p>
<p>15. Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)</p>	<p>20% coinsurance for the doctor</p> <p>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.</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p>In-Network \$50 for Medicare-covered emergency room visits.</p> <p>Out-of-Network Worldwide coverage.</p> <p>In and Out-of-Network If you are admitted to the hospital within 3-day(s) for the same condition, you pay \$0 for the emergency room visit</p> <p>See page 21 for more information on Worldwide coverage.</p>	<p>In-Network \$50 for Medicare-covered emergency room visits.</p> <p>Out-of-Network Worldwide coverage.</p> <p>In and Out-of-Network If you are admitted to the hospital within 3-day(s) for the same condition, you pay \$0 for the emergency room visit</p> <p>See page 21 for more information on Worldwide coverage.</p>
<p>16. Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)</p>	<p>20% coinsurance, or a set copay</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p>\$40 for Medicare-covered urgently needed care visits.</p> <p>If you are admitted to the hospital within 3-day(s) for the same condition, \$0 for the urgent-care visit.</p>	<p>\$10 for Medicare-covered urgently needed care visits.</p> <p>If you are admitted to the hospital within 3-day(s) for the same condition, \$0 for the urgent-care visit.</p>

OUTPATIENT MEDICAL SERVICES AND SUPPLIES

Benefit Category	Original Medicare	BlueAdvantage PPO Sapphire	BlueAdvantage PPO Diamond
<p>17. Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)</p>	20% coinsurance	<p>Authorization rules may apply.</p> <p>In-Network \$40 copay for Medicare-covered Occupational Therapy visits.</p> <p>\$40 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.</p> <p>Out-of-Network 20% of the cost for Occupational Therapy benefits.</p> <p>20% of the cost for Physical and/or Speech/Language Therapy visits.</p>	<p>Authorization rules may apply.</p> <p>In-Network \$10 copay for Medicare-covered Occupational Therapy visits.</p> <p>\$10 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.</p> <p>Out-of-Network 20% of the cost for Occupational Therapy benefits.</p> <p>20% of the cost for Physical and/or Speech/Language Therapy visits.</p>
<p>18. Durable Medical Equipment (includes wheelchairs, oxygen, etc.)</p>	20% coinsurance	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items.</p> <p>Out-of-Network 20% of the cost for durable medical equipment.</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items.</p> <p>Out-of-Network 20% of the cost for durable medical equipment.</p>
<p>19. Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)</p>	20% coinsurance	<p>In-Network 20% of the cost for Medicare-covered items.</p> <p>Out-of-Network 20% of the cost for prosthetic devices.</p>	<p>In-Network 20% of the cost for Medicare-covered items.</p> <p>Out-of-Network 20% of the cost for prosthetic devices.</p>

OUTPATIENT MEDICAL SERVICES AND SUPPLIES Continued

Benefit Category	Original Medicare	BlueAdvantage PPO Sapphire	BlueAdvantage PPO Diamond
<p>20. Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies</p> <p>(includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)</p>	<p>20% coinsurance</p>	<p>In-Network \$0 copay for Diabetes self-monitoring training.</p> <p>\$0 copay for Nutrition Therapy for Diabetes.</p> <p>\$0 copay for Diabetes supplies.</p> <p>Out-of-Network 20% of the cost for Diabetes self-monitoring training.</p> <p>20% of the cost for Nutrition Therapy for Diabetes.</p> <p>20% of the cost for Diabetes supplies.</p> <p>See page 21 for more information on Diabetes Monitoring and Testing Supplies.</p>	<p>In-Network \$0 copay for Diabetes self-monitoring training.</p> <p>\$0 copay for Nutrition Therapy for Diabetes.</p> <p>\$0 copay for Diabetes supplies.</p> <p>Out-of-Network 20% of the cost for Diabetes self-monitoring training.</p> <p>20% of the cost for Nutrition Therapy for Diabetes.</p> <p>20% of the cost for Diabetes supplies.</p> <p>See page 21 for more information on Diabetes Monitoring and Testing Supplies.</p>
<p>21. Diagnostic Tests, X-Rays, and Lab Services</p>	<p>20% coinsurance for diagnostic tests and x-rays</p> <p>\$0 copay for Medicare-covered lab services</p> <p>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.</p>	<p>In-Network \$0 copay for Medicare-covered:</p> <ul style="list-style-type: none"> - lab services - diagnostic procedures and tests - X-rays. - diagnostic radiology services (not including X-rays) - therapeutic radiology services <p>Out-of-Network 20% of the cost for diagnostic procedures, tests, and lab services.</p> <p>20% of the cost for therapeutic radiology services</p> <p>20% of the cost for diagnostic radiology services</p> <p>See page 21 for more information on diagnostic tests, x-rays and lab services.</p>	<p>In-Network \$0 copay for Medicare-covered:</p> <ul style="list-style-type: none"> - lab services - diagnostic procedures and tests - X-rays. - diagnostic radiology services (not including X-rays) - therapeutic radiology services <p>Out-of-Network 20% of the cost for diagnostic procedures, tests, and lab services.</p> <p>20% of the cost for therapeutic radiology services</p> <p>20% of the cost for diagnostic radiology services</p> <p>See page 21 for more information on diagnostic tests, x-rays and lab services.</p>

PREVENTIVE SERVICES

Benefit Category	Original Medicare	BlueAdvantage PPO Sapphire	BlueAdvantage PPO Diamond
<p>22. Bone Mass Measurement</p> <p>(for people with Medicare who are at risk)</p>	<p>20% coinsurance</p> <p>Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.</p>	<p>In-Network \$0 copay</p> <p>Out-of-Network 20% of the cost.</p>	<p>In-Network \$0 copay</p> <p>Out-of-Network 20% of the cost.</p>
<p>23. Colorectal Screening Exams</p> <p>(for people with Medicare age 50 and older)</p>	<p>20% coinsurance</p> <p>Covered when you are high risk or when you are age 50 and older.</p>	<p>In-Network \$0 copay for Medicare-covered colorectal screenings.</p> <p>Out-of-Network 20% of the cost for colorectal screenings.</p>	<p>In-Network \$0 copay for Medicare-covered colorectal screenings.</p> <p>Out-of-Network 20% of the cost for colorectal screenings.</p>
<p>24. Immunizations</p> <p>(Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine)</p>	<p>\$0 copay for Flu and Pneumonia vaccines</p> <p>20% coinsurance for Hepatitis B vaccine</p> <p>You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.</p>	<p>In-Network \$0 copay for Flu and Pneumonia vaccines.</p> <p>\$0 copay for Hepatitis B vaccine.</p> <p>No referral needed for Flu and pneumonia vaccines.</p> <p>No referral needed for other immunizations.</p> <p>Out-of-Network 20% of the cost for immunizations.</p>	<p>In-Network \$0 copay for Flu and Pneumonia vaccines.</p> <p>\$0 copay for Hepatitis B vaccine.</p> <p>No referral needed for Flu and pneumonia vaccines.</p> <p>No referral needed for other immunizations.</p> <p>Out-of-Network 20% of the cost for immunizations.</p>
<p>25. Mammograms (Annual Screening)</p> <p>(for women with Medicare age 40 and older)</p>	<p>20% coinsurance</p> <p>No referral needed.</p> <p>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.</p>	<p>In-Network \$0 copay for Medicare-covered screening mammograms.</p> <p>Out-of-Network 20% of the cost for screening mammograms.</p>	<p>In-Network \$0 copay for Medicare-covered screening mammograms.</p> <p>Out-of-Network 20% of the cost for screening mammograms.</p>
<p>26. Pap Smears and Pelvic Exams</p> <p>(for women with Medicare)</p>	<p>\$0 copay for Pap smears</p> <p>Covered once every 2 years. Covered once a year for women with Medicare at high risk.</p> <p>20% coinsurance for Pelvic Exams</p>	<p>In-Network \$0 copay for pap smears and pelvic exams.</p> <p>Out-of-Network 20% of the cost for pap smears and pelvic exams.</p>	<p>In-Network \$0 copay for pap smears and pelvic exams.</p> <p>Out-of-Network 20% of the cost for pap smears and pelvic exams.</p>

PREVENTIVE SERVICES Continued

Benefit Category	Original Medicare	BlueAdvantage PPO Sapphire	BlueAdvantage PPO Diamond
<p>27. Prostate Cancer Screening Exams (for men with Medicare age 50 and older)</p>	<p>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.</p>	<p>In-Network \$0 copay for Medicare-covered prostate cancer screening.</p> <p>Out-of-Network 20% of the cost for prostate cancer screening.</p>	<p>In-Network \$0 copay for Medicare-covered prostate cancer screening.</p> <p>Out-of-Network 20% of the cost for prostate cancer screening.</p>
<p>28. ESRD</p>	<p>20% coinsurance for dialysis</p>	<p>In-Network \$20 copay for in and out-of-area dialysis \$0 copay for Nutrition Therapy for Renal Disease</p> <p>Out-of-Network 20% of the cost for Renal Disease. 20% of the cost for Nutrition Therapy.</p>	<p>In-Network \$10 copay for in and out-of-area dialysis \$0 copay for Nutrition Therapy for Renal Disease</p> <p>Out-of-Network 20% of the cost for Renal Disease. 20% of the cost for Nutrition Therapy.</p>

PART D PRESCRIPTION DRUGS

Benefit Category	Original Medicare	BlueAdvantage PPO Sapphire	BlueAdvantage PPO Diamond
29. Prescription Drugs	<p>Most drugs not covered. (You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan.)</p>	<p>Drugs Covered under Medicare Part D</p> <p>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.</p> <p>Different out-of-pocket costs may apply for people who - have limited incomes,</p> <ul style="list-style-type: none"> - live in long term care facilities, or - have access to Indian/Tribal/Urban (Indian Health Service). <p>The plan offers national in-network prescription coverage. This means that you will pay the same 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).</p> <p>Total yearly drug costs are the total drug costs paid by both you and the plan.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Your provider must get prior authorization from BlueAdvantage PPO Sapphire for certain drugs.</p> <p>If the actual cost of a drug is less than the normal copay amount for that drug, you will pay the actual cost, not the higher copay amount.</p> <p>You may have to pay more than your copay if you choose to use a higher cost drug when a lower cost drug is available.</p>	<p>Drugs Covered under Medicare Part D</p> <p>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.</p> <p>Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> - have limited incomes, - live in long term care facilities, or - have access to Indian/Tribal/Urban (Indian Health Service). <p>The plan offers national in-network prescription coverage. This means that you will pay the same 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).</p> <p>Total yearly drug costs are the total drug costs paid by both you and the plan.</p> <p>The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Your provider must get prior authorization from BlueAdvantage PPO Diamond for certain drugs.</p> <p>If the actual cost of a drug is less than the normal copay amount for that drug, you will pay the actual cost, not the higher copay amount.</p> <p>You may have to pay more than your copay if you choose to use a higher cost drug when a lower cost drug is available.</p>

PART D PRESCRIPTION DRUGS Continued

Benefit Category	Original Medicare	BlueAdvantage PPO Sapphire	BlueAdvantage PPO Diamond
		<p>In-Network \$0 deductible.</p> <p>Initial Coverage You pay the following until total yearly drug costs reach \$2510:</p> <p>Retail Pharmacy</p> <p>Tier 1</p> <ul style="list-style-type: none"> - \$5 copay for a one-month (30-day) supply of drugs - \$15 copay for a three-month (90-day) supply of drugs <p>Tier 2</p> <ul style="list-style-type: none"> - \$35 copay for a one-month (30-day) supply of drugs - \$105 copay for a three-month (90-day) supply of drugs <p>Tier 3</p> <ul style="list-style-type: none"> - \$60 copay for a one-month (30-day) supply of drugs - \$180 copay for a three-month (90-day) supply of drugs <p>Tier 4</p> <ul style="list-style-type: none"> - 33% coinsurance for a one-month (30-day) supply of drugs - 33% coinsurance for a three-month (90-day) supply of drugs <p>Long Term Care Pharmacy</p> <p>Tier 1</p> <ul style="list-style-type: none"> - \$5 copay for a one-month (31-day) supply of drugs <p>Tier 2</p> <ul style="list-style-type: none"> - \$35 copay for a one-month (31-day) supply of drugs <p>Tier 3</p> <ul style="list-style-type: none"> - \$60 copay for a one-month (31-day) supply of drugs <p>Tier 4</p> <ul style="list-style-type: none"> - 33% coinsurance for a one-month (31-day) supply of drugs 	<p>In-Network \$0 deductible.</p> <p>Initial Coverage You pay the following until total yearly drug costs reach \$2510:</p> <p>Retail Pharmacy</p> <p>Tier 1</p> <ul style="list-style-type: none"> - \$5 copay for a one-month (30-day) supply of drugs - \$15 copay for a three-month (90-day) supply of drugs <p>Tier 2</p> <ul style="list-style-type: none"> - \$35 copay for a one-month (30-day) supply of drugs - \$105 copay for a three-month (90-day) supply of drugs <p>Tier 3</p> <ul style="list-style-type: none"> - \$60 copay for a one-month (30-day) supply of drugs - \$180 copay for a three-month (90-day) supply of drugs <p>Tier 4</p> <ul style="list-style-type: none"> - 33% coinsurance for a one-month (30-day) supply of drugs - 33% coinsurance for a three-month (90-day) supply of drugs <p>Long Term Care Pharmacy</p> <p>Tier 1</p> <ul style="list-style-type: none"> - \$5 copay for a one-month (31-day) supply of drugs <p>Tier 2</p> <ul style="list-style-type: none"> - \$35 copay for a one-month (31-day) supply of drugs <p>Tier 3</p> <ul style="list-style-type: none"> - \$60 copay for a one-month (31-day) supply of drugs <p>Tier 4</p> <ul style="list-style-type: none"> - 33% coinsurance for a one-month (31-day) supply of drugs

PART D PRESCRIPTION DRUGS Continued

Benefit Category	Original Medicare	BlueAdvantage PPO Sapphire	BlueAdvantage PPO Diamond
		<p>Mail Order</p> <p>Tier 1</p> <ul style="list-style-type: none"> - \$5 copay for a one-month (30-day) supply of drugs - \$15 copay for a three-month (90-day) supply of drugs <p>Tier 2</p> <ul style="list-style-type: none"> - \$35 copay for a one-month (30-day) supply of drugs - \$105 copay for a three-month (90-day) supply of drugs <p>Tier 3</p> <ul style="list-style-type: none"> - \$60 copay for a one-month (30-day) supply of drugs - \$180 copay for a three-month (90-day) supply of drugs <p>Tier 4</p> <ul style="list-style-type: none"> - 33% coinsurance for a one-month (30-day) supply of drugs - 33% coinsurance for a three-month (90-day) supply of drugs <p>Coverage Gap After your total yearly drug costs reach \$2510, you pay 100% until your yearly out-of-pocket drug costs reach \$4050.</p> <p>Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4050, you pay the greater of:</p> <ul style="list-style-type: none"> - \$2.25 copay for generic (including brand drugs treated as generic) and \$5.60 copay for all other drugs, or - 5% coinsurance. 	<p>Mail Order</p> <p>Tier 1</p> <ul style="list-style-type: none"> - \$5 copay for a one-month (30-day) supply of drugs - \$15 copay for a three-month (90-day) supply of drugs <p>Tier 2</p> <ul style="list-style-type: none"> - \$35 copay for a one-month (30-day) supply of drugs - \$105 copay for a three-month (90-day) supply of drugs <p>Tier 3</p> <ul style="list-style-type: none"> - \$60 copay for a one-month (30-day) supply of drugs - \$180 copay for a three-month (90-day) supply of drugs <p>Tier 4</p> <ul style="list-style-type: none"> - 33% coinsurance for a one-month (30-day) supply of drugs - 33% coinsurance for a three-month (90-day) supply of drugs <p>Coverage Gap After your total yearly drug costs reach \$2510, you pay 100% until your yearly out-of-pocket drug costs reach \$4050.</p> <p>Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$ 4050, you pay the greater of:</p> <ul style="list-style-type: none"> - \$2.25 copay for generic (including brand drugs treated as generic) and \$5.60 copay for all other drugs, or - 5% coinsurance.

PART D PRESCRIPTION DRUGS Continued

Benefit Category	Original Medicare	BlueAdvantage PPO Sapphire	BlueAdvantage PPO Diamond
		<p>Out-of-Network 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 pay more than the copay if you get your drugs at an out-of-network pharmacy.</p> <p>Out-of-Network Initial Coverage You pay the following until total yearly drug costs reach \$2510:</p> <p>Tier 1 - \$5 copay for a one-month (30-day) supply of drugs</p> <p>Tier 2 - \$35 copay for a one-month (30-day) supply of drugs</p> <p>Tier 3 - \$60 copay for a one-month (30-day) supply of drugs</p> <p>Tier 4 - 33% coinsurance for a one-month (30-day) supply of drugs</p> <p>Out-of-Network Coverage Gap After your total yearly drug costs reach \$2510, you pay 100% until your yearly out-of-pocket drug costs reach \$4050.</p> <p>Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4050, you pay the greater of:</p> <ul style="list-style-type: none"> - \$2.25 copay for generic (including brand drugs treated as generic) and \$5.60 copay for all other drugs, or - 5% coinsurance. <p>See page 22 for more information on prescription drugs</p>	<p>Out-of-Network 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 pay more than the copay if you get your drugs at an out-of-network pharmacy.</p> <p>Out-of-Network Initial Coverage You pay the following until total yearly drug costs reach \$2510:</p> <p>Tier 1 - \$5 copay for a one-month (30-day) supply of drugs</p> <p>Tier 2 - \$35 copay for a one-month (30-day) supply of drugs</p> <p>Tier 3 - \$60 copay for a one-month (30-day) supply of drugs</p> <p>Tier 4 - 33% coinsurance for a one-month (30-day) supply of drugs</p> <p>Out-of-Network Coverage Gap After your total yearly drug costs reach \$2510, you pay 100% until your yearly out-of-pocket drug costs reach \$4050.</p> <p>Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4050, you pay the greater of:</p> <ul style="list-style-type: none"> - \$2.25 copay for generic (including brand drugs treated as generic) and \$5.60 copay for all other drugs, or - 5% coinsurance. <p>See page 22 for more information on prescription drugs</p>

MISCELLANEOUS SERVICES

Benefit Category	Original Medicare	BlueAdvantage PPO Sapphire	BlueAdvantage PPO Diamond
30. Dental Services	Preventive dental services (such as cleaning) not covered.	<p>In-Network \$0 copay for Medicare-covered dental benefits</p> <p>In general, preventive dental benefits (such as cleaning) not covered</p>	<p>In-Network \$0 copay for Medicare-covered dental benefits</p> <p>\$0 copay for the following preventive dental benefits:</p> <ul style="list-style-type: none"> - oral exams - cleanings - fluoride treatments - dental x-rays <p>Out-of-Network 0% of the cost for preventive dental benefits.</p> <p>In and Out-of-Network \$100 limit for dental benefits every year. This limit applies to both in-network and out-of-network benefits.</p> <p>Contact the plan for availability of additional in-network and out-of-network comprehensive dental benefits.</p>
31. Hearing Services	<p>Routine hearing exams and hearing aids not covered.</p> <p>20% coinsurance for diagnostic hearing exams.</p>	<p>In-Network In general, routine hearing exams and hearing aids not covered.</p> <ul style="list-style-type: none"> - \$40 copay for diagnostic hearing exams <p>Out-of-Network 20% of the cost for hearing exams.</p>	<p>In-Network \$0 copay for hearing aids.</p> <ul style="list-style-type: none"> - \$10 copay for diagnostic hearing exams - \$10 copay for up to 1 routine hearing test(s) every two years - \$10 copay for up to 1 hearing aid fitting evaluation(s) every two years <p>\$200 limit for routine hearing aids every two years.</p> <p>Out-of-Network 20% of the cost for hearing exams.</p>

MISCELLANEOUS SERVICES

Benefit Category	Original Medicare	BlueAdvantage PPO Sapphire	BlueAdvantage PPO Diamond
32. Vision Services	<p>20% coinsurance for diagnosis and treatment of diseases and conditions of the eye.</p> <p>Routine eye exams and glasses not covered.</p> <p>Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>Annual glaucoma screenings covered for people at risk.</p>	<p>In-Network Non-Medicare-covered eye exams and glasses not covered. \$0 copay for</p> <ul style="list-style-type: none"> - one pair of eyeglasses or contact lenses after each cataract surgery - \$40 copay for exams to diagnose and treat diseases and conditions of the eye. <p>Out-of-Network 20% of the cost for eye exams.</p>	<p>In-Network \$0 copay for</p> <ul style="list-style-type: none"> - one pair of eyeglasses or contact lenses after each cataract surgery - glasses - contacts - lenses - frames - \$10 copay for exams to diagnose and treat diseases and conditions of the eye. - \$10 copay for up to 1 routine eye exam(s) every year <p>\$100 limit for eye wear every year.</p> <p>Out-of-Network 20% of the cost for eye exams.</p>
33. Physical Exams	<p>20% coinsurance for one exam within the first 6 months of your new Medicare Part B coverage</p> <p>When you get Medicare Part B, you can get a one time physical exam within the first 6 months of your new Part B coverage. The coverage does not include lab tests.</p>	<p>In-Network \$0 copay for routine exams. Limited to 1 exam(s) every year.</p> <p>Out-of-Network 20% of the cost for routine exams.</p>	<p>In-Network \$0 copay for routine exams. Limited to 1 exam(s) every year.</p> <p>Out-of-Network 20% of the cost for routine exams.</p>
Health/Wellness Education	Not covered.	<p>In-Network This plan covers health/wellness education benefits.</p> <ul style="list-style-type: none"> - Written health education materials, including Newsletters - Other Wellness Benefits 	<p>In-Network This plan covers health/wellness education benefits.</p> <ul style="list-style-type: none"> - Written health education materials, including Newsletters - Other Wellness Benefits
Transportation (Routine)	Not covered.	<p>In-Network \$0 copay for each one-way trip to a plan-approved location.</p> <p>Out-of-Network 20% of the cost for transportation. See page 23 for more information on transportation.</p>	<p>In-Network \$0 copay for each one-way trip to a plan-approved location.</p> <p>Out-of-Network 20% of the cost for transportation. See page 23 for more information on transportation.</p>

Section 3

Summary of Benefits

Unless noted, all of the information in this section applies to both options (Sapphire and Diamond).

BlueAdvantage PPO Plans Feature Annual Out-of-Pocket Maximums

Once your out-of-pocket expenses for most Medicare-covered services exceeds your plan's out-of-pocket amount in a calendar year, you will no longer be required to pay any copays for those services for the remainder of that year. For PPO Sapphire the out-of-pocket maximum is \$5,000 for in-network expenses and \$10,000 for in and out-of-network expenses. For BlueAdvantage PPO Diamond the out-of-pocket maximum is \$2,500 for in-network expenses and \$5,000 for in and out-of-network expenses. Most of your expenses will apply toward this out-of-pocket maximum. Expenses that do not apply include: plan premiums, expenses for Medicare-covered diabetic supplies health expenses incurred during foreign travel and prescription drug expenses including copays.

Primary Care Doctor Office Visits

A primary care doctor office visit is defined as primary care delivered by a doctor, nurse practitioner or physician's assistant in any of these types of medical offices: family practice, general practice, internal medicine, gynecology or gerontology.

Worldwide Coverage for Urgently Needed Care and Emergency Care

Unlike the Original Medicare plan, you can receive coverage for health care services received while traveling outside of the country. Your coverage is subject to an annual deductible of \$250. Once your deductible has been met, you pay 20 percent of the cost of any services that would have been covered by Medicare. There is an annual payment limit of \$25,000. Coverage is good for 60 days of foreign travel.

Diabetes Monitoring and Testing Supplies

Some diabetic monitoring and testing supplies fall under Medicare Part B coverage and some fall under Medicare Part D coverage. BlueAdvantage PPO Sapphire and Diamond plans cover Medicare Part B approved items at 100 percent. Items that are covered under Medicare Part D are subject to your prescription drug copays and benefits.

Medicare Part B Items include insulin pumps and blood glucose self-testing equipment. Examples: glucose monitors, glucose control solutions, test strips, lancets and lancet devices.

Medicare Part D Items include diabetic supplies for administering insulin. Examples: alcohol swabs, needles, syringes, gauze, insulin inhalers and insulin.

Diagnostic Tests, X-rays and Lab Services

You may be required to pay an office visit if these services are provided during a doctor's office visit.

Prescription Drug Coverage

Coverage Phase	What You Pay
<p>Phase 1: Initial Coverage \$0-\$2,510</p> <p>Total drug costs including what you and the plan pay.</p>	<p>For a 30-day at a retail or mail order network pharmacy you pay:</p> <ul style="list-style-type: none"> - \$5 for Tier 1 drugs - \$35 for Tier 2 drugs - \$60 for Tier 3 drugs - 33% for Tier 4 drugs <p>For a 90-day supply at a retail network pharmacy you pay:</p> <ul style="list-style-type: none"> - \$15 for Tier 1 drugs - \$105 for Tier 2 drugs - \$180 for Tier 3 drugs - 33% for Tier 4 drugs
<p>Phase 2: Coverage Gap \$2,510 in Total Expenses to \$4,050 in Your Out-of-Pocket Expenses</p> <p>Your out-of-pocket expenses include the copays you paid during Phase 1 and your 100 percent expenses during this phase.</p>	<p>You pay 100 percent of your prescription drug expenses. However, you receive BlueCross BlueShield of Tennessee's discount when you continue to use network pharmacies.</p>
<p>Phase 3: Catastrophic Coverage When Your Out-of-Pocket Expenses Exceed \$4,050</p>	<p>For a 30-day supply at a retail network pharmacy you pay the greater of:</p> <ul style="list-style-type: none"> - \$2.25 for Tier 1 drugs and \$5.60 for all other drugs - OR - 5 percent coinsurance

Each Option Uses a Different Formulary (List of Covered Drugs)

- BlueAdvantage PPO Sapphire Formulary covers approximately 3,700 Medicare Part D covered drugs. This option covers fewer drugs than the Diamond option.
- BlueAdvantage PPO Diamond Formulary covers all Medicare Part D covered drugs. This option covers more drugs than Sapphire.

These benefits only apply to drugs on the formulary. If you take any drugs that are not listed, you will be responsible for 100 percent of the cost of those drugs. These drugs will not apply to your Medicare Part D out-of-pocket expenses.

To see if your drugs are covered, please call BlueCross BlueShield of Tennessee or visit our Web site at www.bcbst-medicare.com.

Things You and Your Doctor Need to Consider When Choosing a Tier 4 Drug

For a few Tier 4 drugs, you may be required to try lower tier alternatives before these drugs are covered. This requirement will be noted in your plan's formulary and it only applies to a few of the drugs in this tier. If the lower tier drugs do not work for you, your doctor can submit an authorization request for the Tier 4 drug.

Transportation Benefit

If you are traveling more than 150 miles from home and become hospitalized, you can receive the following assistance:

- Air medical transportation to a hospital close to your home.
- Transportation for your traveling companion.
- In the event of your death, transportation of remains to funeral facility near your home.

In-network services must be provided by AirMed International.

Care Management

When you need care, our staff of registered nurses will be there to help coordinate the care that is right for you with your health care providers. Through education, care planning and follow-up phone calls from your care management nurse, you and your family will be able to better manage your health care.

Medical Grievances and Appeals Processes

What is a Grievance?

If you have a problem with any of our medical or prescription drug policies and procedures, you may file a grievance. You cannot be dropped from the plan for making a complaint.

What is an Appeal?

If we deny a claim, service or coverage for a prescription drug, we will explain why. If you disagree with our decision regarding the handling of your claim or a denial of a service or prescription drug, you have the right to file an appeal. Your claim will be reviewed again. If we cannot overturn the decision, your appeal will be reviewed by an independent organization that works for Medicare.

Appointing a Representative to Act on Your Behalf

You may assign someone such as a relative, friend, advocate, an attorney or any physician to act as your representative and file an appeal for you. A representative may:

- Obtain information about the enrollee's claim to the extent consistent with current Federal and state law;
- Submit evidence;
- Make statements of fact and law; and
- Make any request, or give or receive any notice about the appeal proceedings.

Both you and your representative must sign, date and complete the Appointment of Representative form found on our Web site. If you want to assign a representative to ask for an appeal for you, this signed form must be filed with your appeal. Unless you decide you no longer want to have a representative, the form will be good for one year after the date you and your representative sign the form. If future appeals are filed during this time, your representative must file a photocopy of the signed representative form for each appeal. If your physician agrees to act as your representative and files an appeal for you, you cannot be charged by your physician for filing the appeal.

How to File a Medical Grievance or Appeal

Call Customer Service to file or check on the status of a medical grievance or appeal
1-800-841-7434
Hearing impaired TTY/TDD: 1-888-423-9490
8 a.m. to 9 p.m. Eastern Time, 7 days a week

From March 3 to September 30, you may be required to leave a message on weekends and holidays. Calls will be returned the next business day.

To file a medical grievance or appeal in writing please visit www.bcbst-medicare.com and print the appropriate form. Complete, sign and mail the form to:

BlueCross BlueShield of Tennessee
Attn: BlueAdvantage Operations Appeals/Grievance coordinator
P.O. Box 180205
Chattanooga, TN 37402

Or fax to: (423) 296-5498

More Detailed Information is Available

This information is a brief overview of the BlueAdvantage PPO medical grievance and appeals processes. More details are provided in your Evidence of Coverage.

Pharmacy Grievances, Coverage Determinations and Appeals

What is a grievance?

A grievance is any complaint other than one that involves a coverage determination. You would file a grievance if you have any type of problem with BlueAdvantage PPO or one of our network pharmacies that does not relate to coverage for a prescription drug. You may file a grievance with us either orally or in writing no later than 60 days after the event or incident that precipitates the grievance. We will respond to your grievance within 30 days after receiving your request.

What is a coverage determination?

A coverage determination is a decision whether or not we provide or pay for a Part D drug and what your share of the cost is for the drug. Coverage determinations also include exception requests. These will be reviewed within 72 hours of receiving all the information required to review your request.

What is an appeal?

An appeal is the review of an unfavorable coverage determination. You would file an appeal if you want us to reconsider and change a decision we have made about what Part D prescription drug benefits are covered for you or what we will pay for a prescription drug. You must request an appeal within 60 days from the date of the notice of the coverage determination. Appeals are reviewed and determinations returned within 7 days upon receiving all necessary information.

What if I need my request expedited?

If you or your health care provider believe that waiting for a decision under the standard time frame may place your life, health, or ability to regain maximum function in serious jeopardy, an expedited appeal may be requested. Once all necessary information is received, your request will be reviewed and a determination sent to you and all necessary parties within 24 hours.

How to submit a grievance, coverage determination or appeal

The first step to filing grievance, appeal, or seeking a coverage determination is to call Member Services.

1-800-841-7434

Hearing impaired TTY/TDD: 1-888-423-9490

Sunday through Saturday, 8 a.m. to 9 p.m. Eastern Time

From March 3 to September 30 you may be required to leave a message on weekends and holidays. Calls will be returned the next business day.

To file a pharmacy grievance in writing please visit www.bcbst-medicare.com and print the appropriate form. Complete, sign and mail the form to:

BlueCross BlueShield of Tennessee

Attn: BlueAdvantage Operations Grievance Coordinator

P.O. Box 180205

Chattanooga, TN 37402

Or fax to: (423) 296-5498

To file a pharmacy appeal in writing, please visit www.bcbst-medicare.com and print the appropriate form. Complete, sign and mail the form to:

Preferred Care Services, Inc.

Attn: Pharmacy Review

P.O. Box 12485

Birmingham, AL 35202-2485

Or fax to (205) 220-9575

More Detailed Information is Available

This information is a brief overview of the BlueAdvantage PPO pharmacy grievance, coverage determination and appeals processes. More details are provided in your Evidence of Coverage.



A health plan with a Medicare contract.
This document is available in alternative formats.

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