# Main Title : Evidence of Coverage

Content:January 1 – December 31, 2023   
Evidence of Coverage:   
Your Medicare Health Benefits and Servi ces and Prescription Drug Coverage   
as a Member of Blue Me dicare Essential PlusSM (HMO-POS)   
This document gives you the details about your Medicare health care and prescription drug   
coverage from January 1 – December 31, 2023. This is an important legal document. Please   
keep it in a safe place.   
For questions about this document, please contact Customer Service at 1-888-310-4110 for   
additional information. (TTY users should   
call 711.) Hours are 8 am to 8 pm daily.   
This plan, Blue Medicare Essentia l Plus, is offered by Blue Cross and Blue Shield of North   
Carolina (Blue Cross NC). (When this Evidence o  
f Coverage says “we,” “us,” or “our,” it means   
Blue Cross NC . When it says “plan” or “our plan ,” it means Blue Medicare Essential Plus .)   
This document is available in la nguages other than English, in br aille, in large print, or other   
alternate formats. Please call Cust  
omer Service for additional information.   
Benefits, premiums, and/or copayments /coinsurance may change on January 1, 2024.   
The formulary, pharmacy network, and/or provider network may change at any time. You will   
receive notice when nec  
essary. We will notify affe cted enrollees about changes at least 30 days   
in advance.   
This document explains your benefits and righ ts. Use this document to understand about:   
• Your plan premium and cost sharing;   
• Your medical and prescription drug benefits;   
• How to file a complaint if you are not satisfied with a service or treatment;   
• How to contact us if you n eed further assistance; and,   
• Other protections required by Medicare law.   
Y0079\_10115\_C CMS Approved 09122022 MEEUIN H3449-023   
OMB Approval 0938-1051 (Expires February 29, 2024)

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# Main Title : CHAPTER 1: Getting started as a member

Content:CHAPTER 1:   
Getting started as a member

# Main Title : SECTION 1 Introduction

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Chapter 1 Getting started as a member   
SECTION 1 Introduction   
Section 1.1 You are enrolled in Blue Medicare Essential Plus, which is a   
Medicare HMO-POS   
You are covered by Medicare, and you have chosen to get your Medicare health care and your   
prescription drug coverage through our plan, Blue Medicare Essential Plus.   
We are required to cover all Part A and Part B services. However, cost sharing and provider   
access in this plan differ from Original Medicare.   
Blue Medicare Essential Plus is a Medicare Advantage HMO Plan (HMO stands for Health   
Maintenance Organization) with a Point-of-Service (POS) option approved by Medicare and   
run by a private company. “Point -of-Service” means you can use providers outside the plan’s   
network for an additional cost. (See Chapter 3, Section 2.4 for inform ation about using the   
Point-of-Service option.)   
Coverage under this Plan qualifies as Qualifying Health Coverage (QHC) and satisfies the   
Patient Protection and Affordable Care Act’ s (ACA) individual shared responsibility   
requirement. Please visit the Inte rnal Revenue Service (IRS) we bsite at: www.irs.gov/affordable-  
care-  
act/individuals-and-  
families for more information.   
Section 1.2 What is the Evidence of Coverage document about?   
This Evidence of Coverage document tells you how to get your medical care and prescription   
drugs. It explains your rights and responsibilities, what is cove red, what you pay as a member   
of the plan, and how to file a complaint if you are not satisfied with a decision or treatment.   
The words “coverage” and “covered services ” refer to the me  
dical care and services and the   
prescription drugs available to you as a member of Blue Medicare Essential Plus.   
It’s important for you to learn what the plan’s rules are and what services are available to you.   
We encourage you to set aside so me time to look through this Evidence of Coverage document.   
If you are confused, concerned, or just have a question, please contact Customer Service.   
Section 1.3 Legal information about the Evidence of Coverage   
This Evidence of Coverage is part of our contract with you about how Blue Medicare Essential   
Plus covers your care. Other parts of this co ntract include your en rollment form, the List of   
Covered Drugs (Formulary) , and any notices you receive fr om us about changes to your   
coverage or conditions that affe ct your coverage. These notices are sometimes calle d “riders” or   
“amendments.”

# Main Title : SECTION 2 What makes you eligible to be a plan member?

Content:7 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 1 Getting started as a member   
The contract is in effect for months in which you are enrolled in Blue Medicare Essential Plus   
between January 1, 2023 and December 31, 2023.   
Each calendar year, Medicare allows us to make ch anges to the plans that we offer. This means   
we can change the costs and benefits of Blue Medicare Essential Plus after December 31, 2023.   
We can also choose to stop offering the plan in your service area, after December 31, 2023.   
Medicare (the Centers for Me dicare & Medicaid Services) mu st approve Blue Medicare   
Essential Plus each year. You can continue each year to get Medicare coverage as a member of   
our plan as long as we choose to continue to of fer the plan and Medicare renews its approval of   
the plan.   
SECTION 2 What makes you eligible to be a plan member?   
Section 2.1 Your eligibility requirements   
You are eligible for membersh ip in our plan as long as:   
• You have both Medicare Part A and Medicare Part B   
• -- and -- you live in our geographi c service area (Section 2.2 be low describes our service   
area). Incarcerated individuals are not considered living in the geographic service area   
even if they are physically located in it.   
• --and -- you are a United States citizen or ar e lawfully present in the United States   
Section 2.2 Here is the plan service area for Blue Medicare Essential Plus   
Blue Medicare Essential Plus is available only to i ndividuals who live in our plan service area.   
To remain a member of our pla n, you must continue to reside in the plan service area. The   
service area is described below.   
Our service area includes these counties in North Carolina:   
Segment 001 (H3449-023-001)   
Alamance   
Buncombe Burke   
Catawba   
Davidson Durham   
Forsyth   
Gaston   
Guilford Haywood   
Irede  
ll   
Mecklenbur g   
Oran ge Randolph   
Rockin g  
ham   
Rutherford   
Wake

# Main Title : SECTION 3 Important membership materials you will receive

Content:9 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 1 Getting started as a member   
SECTION 3 Important membership materials you will receive   
Section 3.1 Your plan membership card   
While you are a member of our plan, you must use your membership card whenever you get   
services covered by this plan and for prescription drugs you ge t at network pharmacies. You   
should also show the provider your Medicaid card, if applicable . Here’s a sample membership   
card to show you what yours will look like:   
FRONT BACK   
DO NOT use your red, white, and blue Medicare car d for covered medical services while you are   
a member of this plan. If you use your Medicare card instead of your Bl ue Medicare Essential   
Plus membership card, you may have to pay the full cost of medical serv ices yourself. Keep your   
Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice   
services, or participate in Medica re approved clinical re search studies also cal led clinical trials.   
If your plan membership card is da maged, lost, or stolen, call Cu stomer Service right away and   
we will send you a new card.   
Section 3.2 Provider Directory   
The Provider Directory lists our network providers and dur able medical equipment suppliers.   
Network providers are the doctors and other health care professionals, medical groups, durable   
medical equipment suppliers, hospi tals, and other health care faci lities that have an agreement   
with us to accept our payment and any pl an cost sharing as payment in full.   
You must use network providers to get your medical care a nd services. If you go elsewhere   
without proper authorization you will have to pa y in full. The only exceptions are emergencies,   
urgently needed services when the network is not available (that is, in situations when it is   
unreasonable or not possible to obtain services in -network), out-of-area dialysis services, and   
cases in which Blue Medicare Essential Plus authorizes use of out-o f-network providers.

# Main Title : SECTION 4 Your monthly costs for Blue Medicare Essential Plus

Content:11 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 1 Getting started as a member   
SECTION 4 Your monthly costs for Blue Medicare Essential Plus   
Your costs may include the following:   
• Plan Premium (Section 4.1)   
• Monthly Medicare Part B Premium (Section 4.2)   
• Optional Supplemental Bene fit Premium (Section 4.3)   
• Part D Late Enrollment Penalty (Section 4.4)   
• Income Related Monthly Adjusted Amount (Section 4.5)   
Section 4.1 Plan premium   
You do not pay a separate monthly plan pr emium for Blue Medicare Essential Plus.   
Section 4.2 Monthly Me dicare Part B Premium   
Many members are required to pay other Medicare premiums   
You must continue paying your Medicare prem iums to remain a member of the plan. This   
includes your premium for Part B. It may also include a prem ium for Part A which affects   
members who aren’t eligible for premium free Part A.   
Section 4.3 Part D Late Enrollment Penalty   
Some members are requir ed to pay a Part D late enrollment penalty . The Part D late enrollment   
penalty is an additional premium th at must be paid for Part D cove rage if at any time after your   
initial enrollment period is over, there is a period of 63 days or more in a row when you did not   
have Part D or other credita ble prescription drug coverage. “Creditable prescription drug   
coverage” is coverage that me ets Medicare’s minimum standards si nce it is expected to pay, on   
average, at least as much as Medicare’s standard prescription drug coverage . The cost of the late   
enrollment penalty depends on how long you went w ithout Part D or other creditable prescription   
drug coverage. You will have to pay this pena lty for as long as you have Part D coverage.   
When you first enroll in Bl ue Medicare Essential Plus , we let you know the amount of the   
penalty. If you do not pay your Part D late enrollment penalty, you could lose your prescription drug   
benefits. You will not have to pay it if:   
• You receive “Extra Help” from Medicare to pay for your prescription drugs.   
• You have gone less than 63 days in a row without cred itable coverage.   
• You have had creditable drug coverage th rough another source such as a former   
employer, union, TRICARE, or Department of Veterans Affairs. Your insurer or your

# Main Title : SECTION 5 More information about your monthly premium

Content:13 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 1 Getting started as a member   
Important: Do not stop paying your Part D late enrollment penalty while you’re waiting for a   
review of the decision about your late enrollme nt penalty. If you do, you could be disenrolled for   
failure to pay your plan premiums.   
Section 4.4 Income Related Monthly Adjustment Amount   
Some members may be required to pay an extr a charge, known as the Part D Income Related   
Monthly Adjustment Amount, also known as IRMAA. The extra char ge is figured out using your   
modified adjusted gross income as reported on yo ur IRS tax return from 2 years ago. If this   
amount is above a certain  
 amount, you’ll pay the standard premium amount and the additional   
IRMAA. For more information on the extra amount you may have to pay based on your income,   
visit https://www.medicare.gov/drug-cove rage-part-d/costs -for-medicare-drug-  
coverage/monthly-prem ium-for-drug-plans  
.   
If you have to pay an extra amount, Social Se curity, not your Medicare plan, will se  
nd you a   
letter telling you what that extra amount will be . The extra amount will be withheld from your   
Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check,   
no matter how you usually pay your plan premium, unless your monthly benefit isn’t enough to   
cover the extra amount owed. If your benefit ch eck isn’t enough to cover the extra amount, you   
will get a bill from Medicare. You must pay the extra amount to the government. It cannot   
be paid with your monthly plan premium. If you do not pay the extra amount, you will be disenrolled from the plan and lose prescription drug coverage.   
If you disagree about paying an extra amount, you can as k Social Security to review the decision.   
To find out more about how to do this, contact Social Security at 1-800-772-1213 (TTY 1-800-  
325-0778).   
SECTION 5 More information about your monthly premium   
Section 5.1 If you pay a Part D late enrollment penalty, there are several   
ways you can pay your penalty   
There are six ways you can pay the penalty. Option 1: Paying by check   
You may decide to pay your Part D late enrollment penalty dire ctly to our plan by check or   
money order. If you choose this option, we w ill send you a monthly invoice. Checks or money   
orders should be made payable to Blue Medicare Essential Plus a nd sent directly to the plan at   
the following address:   
Blue Medicare Essential Plus   
PO Box 580042 Charlotte, NC 28258-0042

# Main Title : SECTION 6 Keeping your plan membership record up to date

Content:15 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 1 Getting started as a member   
If you are having trouble paying your Part D late enrollment pe nalty, if owed, on time, please   
contact Customer Service to see if we can direct you to programs that will help with your costs.   
If we end your membership because you did not pay your Part D late enrollment penalty, if   
owed, you will have health coverage under Origin al Medicare. In addition, you may not be able   
to receive Part D coverage until the following ye ar if you enroll in a new plan during the annual   
enrollment period. (If you go wit hout “creditable” drug coverage for more than 63 days, you may   
have to pay a Part D late enrollment penalty for as long as you ha ve Part D coverage.)   
At the time we end your membership, you may s till owe us for the penalty you have not paid.   
We have the right to pursue co llection of the amount you owe . In the future, if you want to enroll   
again in our plan (or another plan that we offer), you will need to pay the amount you owe before   
you can enroll.   
If you think we have wrongfully ended your membership, you can make a complaint (also called   
a grievance); see Chapter 9 for how to file a co mplaint. If you had an emergency circumstance   
that was out of your control a nd it caused you to not be able to pay your plan Part D late   
enrollment penalty within our grace period, you can make a complaint. For complaints, we will   
review our decision again. Chapter 9, Section 10 of this document tells how to make a complaint,   
or you can call us at 1-888-310- 4110 between 8 am and 8 pm daily. TTY users should call 711.   
You must make your request no later than 60 days after the date your membership ends.   
Section 5.2 Can we change your monthly plan premium during the year?   
No. We are not allowed to change the amount we charge for the plan’s monthly plan premium   
during the y  
ear. If the monthly plan premium changes for next year we will tell you in September   
and the change will take effect on January 1.   
However, in some cases, you may be able to stop paying a late enrollment penalty, if owed, or   
need to start paying a late enrollment penalty. Th is could happen if you be come eligible for the   
“Extra Help” program or if you lose your eligibility for the “E xtra Help” program during the   
year.   
• If you currently pay the Part D late enrollment penalty and become eligible for “Extra   
Help” during the year, you would be able to stop paying your penalty.   
• If you lose Extra Help, you may be subject to the late enrollment penalty if you go 63   
days or more in a row without Part D or ot her creditable prescrip tion drug coverage.   
You can find out more about the “Extra Help” program in Chapter 2, Section 7.   
SECTION 6 Keeping your plan membership record up to date   
Your membership record has information from y our enrollment form, including your address and   
telephone number. It shows your specific plan c overage including your Prima ry Care Provider.

# Main Title : SECTION 7 How other insurance works with our plan

Content:16 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 1 Getting started as a member   
The doctors, hospitals, pharmacist s, and other providers in the plan’s network need to have   
correct information about you. These network providers use your membership record to   
know what services and drugs are covered and the cost sharing amounts for you . Because   
of this, it is very importa nt that you help us keep your information up to date.   
Let us know about these changes:   
• Changes to your name, your a ddress, or your phone number   
• Changes in any other health insurance cove rage you have (such as from your employer,   
your spouse’s employer, workers’ compensation, or Medicaid)   
• If you have any liability claims, such as claims from an au tomobile accident   
• If you have been admitted to a nursing home   
• If you receive care in an out-of-area or out -of-network hospital or emergency room   
• If your designated responsible party (such as a caregiver) changes   
• If you are participating in a clinical research study (Note: You are not required to tell   
your plan about the clinical research studies, you intend to participate in, but we   
encourage you to do so)   
If any of this information changes, please le t us know by calling Customer Service. You may   
also change your address on our website www.Medicare.BlueCrossNC.com by registering for   
Blue Connect and clicking on “Profile” and th en the “Contact Preferences Center” tab.   
It is also important to contact Social Security if you move or change your mailing address. You   
can find phone numbers and contact information for Social Security in Chapter 2, Section 5.   
SECTION 7 How other insurance works with our plan   
Other insurance   
Medicare requires that we co llect information from you abou t any other medical or drug   
insurance coverage that you have. That’s because we must coordinate any other coverage you   
have with your benefits unde r our plan. This is called Coordination of Benefits.   
Once each year, we will send you a letter that list s any other medical or drug insurance coverage   
that we know about. Please read over this information carefully. If it is corre ct, you don’t need to   
do anything. If the informat ion is incorrect, or if you have other coverage th at is not listed, please   
call Customer Service. You may need to give your plan member ID number to your other   
insurers (once you have confirme d their identity) so your bills are paid correctly and on time.   
When you have other insurance (like employer group h ealth coverage), th ere are rules set by   
Medicare that decide whether our plan or your other insurance pays first. The insurance that pays   
first is called the “primary payer” and pays up to the limits of its coverage. The one that pays   
second, called the “secondary paye r,” only pays if there are costs left uncovered by the primary

# Main Title : CHAPTER 2: Important phone numbers and resources

Content:CHAPTER 2:   
Important phone numbers   
and resources

# Main Title : SECTION 1 Blue Medicare Essential Plus contacts (how to contact us, including how to reach Customer Service)

Content:19 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 2 Important phone numbers and resources   
SECTION 1 Blue Medicare Essential Plus contacts   
(how to contact us, including how to reach Customer   
Service)   
How to contact our plan’s Customer Service   
For assistance with claims, billing or member card questions, please cal l or write to Blue   
Medicare Essential Plus Customer Service. We will be happy to help you.   
Method Customer Service – Contact Information   
CALL 1-888-310-4110   
Calls to this number are free. Hour s of operation are 8 am to 8 pm   
daily.   
Customer Service also has free language interpreter services available   
for non-English speakers.   
TTY 711   
This number requires special telepho ne equipment and is only for   
people who have difficulties with hearing or speaking.   
Calls to this number are free. Hour s of operation are 8 am to 8 pm   
daily.   
WRITE Blue Medicare Essential Plus   
PO Box 17509 Winston-Salem, NC 27116-7509   
WEBSITE www.Medicare.BlueCrossNC.com

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

Content:24 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 2 Important phone numbers and resources   
SECTION 2 Medicare   
(how to get help and information directly from the Federal   
Medicare program)   
Medicare is the Federal health insurance progra m for people 65 years of age or older, some   
people under age 65 with disabilities, and peopl e with End-Stage Renal Disease (permanent   
kidney failure requiri ng dialysis or a ki dney transplant).   
The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services   
(sometimes called “CMS”). This agency cont racts with Medicare Advantage organizations   
including us.   
Method Medicare – Contact Information   
CALL 1-800-MEDICARE, or 1-800-633-4227   
Calls to this number are free.   
24 hours a day, 7 days a week.   
TTY 1-877-486-2048 This number requires special telepho ne equipment and is only for   
people who have difficulties with hearing or speaking.   
Calls to this number are free.   
WEBSITE www.medicare.gov   
This is the official government website for Medicare. It gives you up-  
to-date information about Medicare and current Medicare issues. It   
also has information about hos pitals, nursing homes, physicians,   
home health agencies, and dialysis facilities. It includes documents   
you can print directly from your computer. You can also find   
Medicare contacts in your state.   
The Medicare website also has de tailed information about your   
Medicare e  
ligibility and enrollment options with the fo llowing tools:   
• Medicare E  
ligibility Tool: Provides Medicare eligibility   
status information.   
• Medicare   
Plan Finder: Provides personalized information   
about available Medicare prescription drug plans, Medicare   
health plans, and Medigap (M edicare Supplement Insurance)   
policies in your area. These tools provide an estimate of what   
your out-of-pocket costs might be in different Medicare plans.

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

Content:26 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 2 Important phone numbers and resources   
SECTION 3 State Health Insu rance Assistance Program   
(free help, information, and answers to your questions   
about Medicare)   
The State Health Insurance Assistance Program (SHIP) is a government program with trained   
counselors in every state. In North Carolina, the SHIP is called Seni ors' Health Insurance   
Information Program (SHIIP).   
SHIIP is independent (not connected with a ny insurance company or health plan) state   
program that gets money from the Federal government to give free local health insurance   
counseling to people with Medicare. SHIIP counselors can help you understand your Medi care rights, help y ou make complaints   
about your medical care or treatment, and help you straighten out problems with your   
Medicare bills. SHIIP counselors can also help you with Medicare questions or problems and   
help you understand your Medicare plan choices and answer ques tions about switching plans.   
METHOD TO ACCESS SHIP and OTHER RESOURCES:   
• Visit www.medicare.gov   
• Click on “ Talk to Someone” in the middle of the homepage   
• You now have the following options   
• Option #1: You can have a live chat with a 1-800   
MEDICARE representative   
• Option #2: You can select your STATE from the dropdown   
menu and click GO. This will take you to a page with phone   
numbers and resources specific to your state .   
Method Seniors' Health Insura nce Information Program (SHIIP)   
(North Carolina SHIP ) – Contact Information   
CALL 1-855-408-1212   
WRITE NC Department of Insurance Seniors’ Health Insurance Information Program (SHIIP) 1201 Mail Service Center Raleigh, NC 27699-1201   
ncshiip@ncdoi.gov   
WEBSITE www.ncdoi.com/SHIIP

# Main Title : SECTION 4 Quality Improvement Organization

Content:27 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 2 Important phone numbers and resources   
SECTION 4 Quality Improvement Organization   
There is a designated Quality Improvement Orga nization for serving Medi care beneficiaries in   
each state. For North Carolina, the Quality Improvement Organization is called KEPRO.   
KEPRO has a group of doctors and other health care professionals who are paid by Medicare   
to check on and help improve the quality of care for people with Me dicare. KEPRO is an   
independent organization. It is not connected with our plan.   
You should contact KEPRO in any of these situations:   
• You have a complaint about the quality of care you have received.   
• You think coverage for your hospi tal stay is ending too soon.   
• You think coverage for your home health care, skilled nur sing facility care, or   
Comprehensive Outpatient Rehabilitation Faci lity (CORF) services are ending too soon.   
Method KEPRO (North Caroli na's Quality Improvement   
Organization ) – Contact Information   
CALL 1-888-317-0751   
Hours of operation are 9 am to 5 pm, Monday through Friday and 11   
am to 3 pm weekends and holidays.   
TTY 711 This number requires special telepho ne equipment and is only for   
people who have difficulties with hearing or speaking.   
WRITE 5201 W. Kennedy Blvd.   
Suite 900 Tampa, FL 33609   
QIOCommunications@kepro.com   
WEBSITE www.keproqio.com

# Main Title : SECTION 5 Social Security

Content:28 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 2 Important phone numbers and resources   
SECTION 5 Social Security   
Social Security is responsible for determ ining eligibility and handling enrollment for   
Medicare. U.S. citizens and lawf ul permanent residents who are 65 or older, or who have a   
disability or End-Stage Renal Disease and meet certain conditi ons, are eligible for Medicare.   
If you are already getting Social Security checks, enrollment into Medi care is automatic. If   
you are not getting Social Security checks, you have to enroll in Medicare. To apply for   
Medicare, you can call Social Security or visit your local Social Security office.   
Social Security is also responsible for determining who has to pay an extra amount for their   
Part D drug coverage because they have a hi gher income. If you got a letter from Social   
Security telling you that you have to pay th e extra amount and have questions about the   
amount or if your income went down because of a life-changing event, you can call Social   
Security to ask for reconsideration.   
If you move or change your mailing address, it is important that you contact Social Security to   
let them know.   
Method Social Security – Contact Information   
CALL 1-800-772-1213   
Calls to this number are free.   
Available 8:00 am to 7:00 pm, Monday through Friday. You can use Social Security  
’s auto mated telephone services to get   
recorded information and conduct some business 24 hours a day.   
TTY 1-800-325-0778   
This number requires special telepho ne equipment and is only for   
people who have difficulties with hearing or speaking.   
Calls to this number are free.   
Available 8:00 am to 7:00 pm, Monday through Fr  
iday.   
WEBSITE www.ssa.gov

# Main Title : SECTION 6 Medicaid

Content:29 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 2 Important phone numbers and resources   
SECTION 6 Medicaid   
Medicaid is a joint Federal and state government program that helps wi th medical costs for   
certain people with limited incomes and resour ces. Some people with Medicare are also   
eligible for Medicaid.   
The programs offered through Medi caid help people with Medicare pay their Medicare costs,   
such as their Medicare premiums. Thes e “Medicare Savings Programs” include:   
• Qualified Medicare Beneficiary (QMB): Helps pay Medicare Part A and Part B   
premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some   
people with QMB are also eligible fo r full Medicaid benefits (QMB+).)   
• Specified Low-Income Medicare Beneficiary (SLMB): Helps pay Part B premiums. (Some people with SLMB are also eligib le for full Medicaid benefits (SLMB+).)   
• Qualifying Individual (QI): Helps pay Part B premiums.   
• Qualified Disabled & Working Individuals (QDWI): Helps pay Part A premiums.   
To find out more about Medica id and its programs, contact North Carolina Department of   
Health and Human Services.   
Method   
North Carolina Department of Health and Human  
Services – Contact Information   
CALL 1-800-662-7030   
Hours of operation are 8 am to 5 pm, Monday through Friday,   
excluding state holidays.   
TTY 711   
This number requires special tele phone equipment and is only   
for people who have difficulties with hearing or speaking.   
WRITE 2001 Mail Service Center   
Raleigh, NC 27699-2000   
WEBSITE www.ncdhhs.gov

# Main Title : SECTION 7 Information about programs to help people pay for their prescription drugs

Content:30 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 2 Important phone numbers and resources   
SECTION 7 Information about progr ams to help people pay for   
their prescription drugs   
The Medicare.gov website (https://www.medicare.gov/ drug-coverage-part-d/costs-for-medicare-  
drug-coverage/costs-in-the-covera ge-gap/5-ways  
-to-get-help-with -prescription-costs) provides   
information on how to lower your prescription drug costs. For pe ople with limited incomes, there   
are also other programs to assist, described below.   
Medicare’s “Extra Help” Program   
Medicare provides “Extra Help” to pay prescr iption drug costs for peop le who have limited   
income and resources. Resources include your savings and stoc ks, but not your home or car. If   
you qualify, you get help paying for any Medicare drug plan’s monthly premium, yearly   
deductible, and prescription copayments. This “E xtra Help” also counts toward your out-of-  
pocket costs.   
If you automatically qualify for “Extra Help” Medi care will mail you a letter. You will not have   
to apply. If you do not automatically qualify, 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:   
•   
 1-800-MEDICARE (1-800-633-4227). TTY us ers should call 1-877-486-2048, 24 hours   
a day/7 days a week;   
• The Social Security Office at 1-800-772-1213, between 8 am to 7 pm, Monday through   
Friday. TTY users should call 1-800-325-0778 (applications); or   
• Your State Medicaid Office (a pplications) (See Section 6 of this chapter for contact   
information).   
If you believe you have qualified for “Extra He lp” and you believe that you are paying an   
incorrect cost sharing amount when you get your prescription at a pharmacy, our plan has a   
process for you to either reque st assistance in obtaining evidence of your proper copayment   
level, or, if you already have the eviden ce, to provide this evidence to us.   
• For urgent situations, you may ask your pha rmacist to charge th e Low-Income Subsidy   
(LIS) copayment at the time you get your prescription. The pharmacist will call   
Customer Service and state that he/she has evidence of your LIS eligibility. If possible,   
the pharmacist can fax the documentation to our Enrollment Depa rtment at 1-336-659-  
2957. If the pharmacist is not able to send a fax, he/she can attest to the Customer   
Service Professional that you have the proper documentation. In that case, you will need   
to mail a copy of the docume ntation to our office at:   
Blue Medicare Essential Plus   
Attn: Enrollment PO Box 17168 Winston-Salem, NC 27116-7168

# Main Title : SECTION 9 Do you have “group insurance” or other health insurance from an employer?

Content:34 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 2 Important phone numbers and resources   
SECTION 8 How to contact the Railroad Retirement Board   
The Railroad Retirement Board is an independent Federal agency that administers   
comprehensive benefit programs for the nation’ s railroad workers and their families.   
If you receive your Medicare through the Railroad Retirement Board, it is important that you let   
them know if you move or change your mailing address. If you have questions regarding your   
benefits from the Railroad Retirement Board, contact the agency.   
Method Railroad Retirement Board – Contact Information   
CALL 1-877-772-5772   
Calls to this number are free.   
If you press “0,” you may speak with an RRB representative   
from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday.   
If you press “1”, you may access the automated RRB   
HelpLine and recorded inform ation 24 hours a day, including   
weekends and holidays.   
TTY 1-312-751-4701 This number requires special tele phone equipment and is only   
for people who have difficulties with hearing or speaking.   
Calls to this number a  
re not free.   
WEBSITE rrb.gov   
SECTION 9 Do you have “group in surance” or other health   
insurance from an employer?   
If you (or your spouse) get benefits from your (or your spouse’s) employe r or retiree group as   
part of this plan, you may call the employer/union benefits administrator or Customer Service if   
you have any questions. You can ask about your (o r your spouse’s) employer or retiree health   
benefits, premiums, or the enro llment period. (Phone numbers fo r Customer Service are printed   
on the back cover of this document.) You may also call 1-800-MEDICARE (1-800-633-4227;   
TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan .   
If you have other prescription drug coverage through your (or your spouse’s) employer or   
retiree group, please co  
ntact that group’s benefits administrator. The benefits administrator   
can help you determine how your current prescr iption drug coverage will work with our plan.

# Main Title : CHAPTER 3: Using the plan for your medical services

Content:CHAPTER 3:   
Using the plan   
for your medical services

# Main Title : SECTION 1 Things to know about getting your medical care covered as a member of our plan

Content:36 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 3 Using the plan for your medical services   
SECTION 1 Things to know about getting your medical care   
covered as a member of our plan   
This chapter explains what you need to know a bout using the plan to get your medical care   
covered. It gives definitions of terms and explains the rules you will need to follow to get the   
medical treatments, services, equipment, pres cription drugs, and other medical care that are   
covered by the plan.   
For the details on what medical care is cove red by our plan and how much you pay when you   
get this care, use the benefits chart in the next chapter, Chapter 4 ( Medical Benefits Chart, what   
is covered and what you pay).   
Section 1.1 What are “network providers” and “covered services”?   
• “Providers” are doctors and other health care pr ofessionals licensed by the state to   
provide medical services and care. The term “providers” also include s hospitals and other   
health care facilities.   
• “Network providers” are the doctors and other hea lth care professionals, medical   
groups, hospitals, and other health care facilities that have an agreement with us to accept   
our payment and your cost sharing amount as payment in full. We have arranged for   
these providers to deliver covered services to members in our plan. The providers in our   
network bill us directly fo r care they give you. When you see a network provider, you   
pay only your share of the cost for their services.   
• “Covered services” include all the medical care, health care services, supplies,   
equipment, and Prescription Dr ugs that are covered by our pl an. Your covered services   
for medical care are listed in the benefits ch art in Chapter 4. Your covered services for   
prescription drugs are discussed in Chapter 5.   
Section 1.2 Basic rules for getting y our medical care covered by the plan   
As a Medicare health plan, Blue Medicare Esse ntial Plus must cover all services covered by   
Original Medicare and must follow Original Medicare’s coverage rules. Blue Medicare Essential Plus will genera lly cover your medical care as long as:   
• The care you receive is included in th e plan’s Medical Benefits Chart (this chart is in   
Chapter 4 of this document).   
• The care you receive is considered medically necessary . “Medically necessary” means   
that the services, supp lies, equipment, or drugs are needed for the prevention, diagnosis,   
or treatment of your medical condition and meet accepted st andards of medical practice.   
• You have a network primary care provi der (a PCP) who is providing and   
overseeing your care. As a member of our plan, you must choose a network PCP (for   
more information about this, see Section 2.1 in this chapter).

# Main Title : SECTION 2 Use providers in the plan’s network to get your medical care

Content:37 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 3 Using the plan for your medical services   
• You must receive your care from a network provider (for more information about   
this, see Section 2 in this chapter). In most cases, car e you receive from an out-of-  
network provider (a provider who is not part of our plan’s networ k) will not be covered.   
This means that you will have to pay the provider in full for th e services furnished. Here   
are three exceptions:   
• The plan covers emergency care or urgent ly needed services that you get from an   
out-of-network provider. For more information about this, and to see what   
emergency or urgently needed services means, see Section 3 in this chapter.   
• If you need medical care that Medicare requ ires our plan to cover but there are no   
specialists in our network that provide this care, you can get this care from an out-  
of-network provider at the same cost sharing you normally pay in-network.   
Authorization must be obtained from the plan prior to seeking care. In this situation,   
you will pay the same as you would pay if you got the care from a network   
provider. For information a bout getting approval to see an out-of-network doctor,   
see Section 2.4 in this chapter.   
• The plan covers kidney dial ysis services that you get at a Medicare-certified   
dialysis facility when you are tempor arily outside the plan’s service area or when   
your provider for this service is temporar ily unavailable or inaccessible. The cost   
sharing you pay the plan for dialysis can ne ver exceed the cost sharing in Original   
Medicare. If you are outside the plan’s service area and obtain the dialysis from a   
provider that is outside the plan’s network, your cost sharing cannot exceed the cost   
sharing you pay in-network. However, if you r usual in-network pr ovider for dialysis   
is temporarily unavailable and you choose to obtain services inside the service area   
from a provider outside the plan’s network th e cost sharing for the dialysis may be   
higher.   
• While you are a member of our Point of Service (POS) plan, you may use either network providers or out-of-network provide rs for covered routine dental services.   
Please see Section 2.3 in this chapter.   
SECTION 2 Use providers in the plan’s network to get your   
medical care   
Section 2.1 You must choose a Primar y Care Provider (PCP) to provide  
and oversee your medical care   
What is a “PCP” and what does the PCP do for you?   
• A PCP is a plan provider you choose to provi de your routine or basic medical care.   
•   
 You may choose your PCP from among the following PCP-designa ted providers: a   
physician specializing in Family Practice, Genera l Practice, Internal Medicine, Geriatrics,   
Pediatrics, or other physician speciali st listed in the PCP section of the Provider   
Directory ; a nurse practitioner (where availabl e); or a physician assistant (where   
available).

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

Content:40 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 3 Using the plan for your medical services   
What if a specialist or another network provider leaves our plan?   
We may make changes to the hospita ls, doctors, and specialists (providers) that are part of your   
plan during the year. If your doc tor or specialist leaves your pl an you have certain rights and   
protections that are summarized below:   
• Even though our network of providers may change during the year, Medicare requires   
that we furnish you with uninterrupted access to qualified doctors and specialists.   
• We will make a good faith effort to provide you with at l east 30 days’ notice that your   
provider is leaving our plan so that you have time to select a new provider.   
• We will assist you in selecting a new qualified provider to co ntinue managing your health   
care needs.   
• If you are undergoing medical treatment, you have the right to request, and we will work   
with you to ensure that the medically n ecessary treatment you are receiving is not   
interrupted.   
• If our network does not have a qualified specia list for a plan-covere d service, we must   
cover that service at in-network cost shari ng. Prior authorization fro m the plan is needed.   
• If you find out your doctor or specialist is leav ing your plan, please contact us so we can   
assist you in finding a new provi der to manage your care.   
• If you believe we have not furnished you with a qualified provider to replace your   
previous provider or that your care is not being appropriately managed, you have the   
right to file a quality of care complaint to the QIO, a quality of care grievance to the plan,   
or both. Please see Chapter 9.   
Section 2.4 How to get care from out-of-network providers   
As a member of our plan, you can choose to receive care from out-of- network providers for   
covered routine dental services only. For more information, se e “Non-Medicare-Covered Dental   
Services” in Chapter 4.   
You, your PCP or network specialis t may contact the plan to reque st prior author ization for you   
to obtain specialized services fr om a provider that is not ava ilable in network by calling the   
number listed on the back of your card. Members are entitled to receive services from out-of-network providers for emergency or out of   
area urgently needed services. In addition, we cover dialysis services for ESRD members who   
have traveled outside the plan’s service area and are not able to access contracted ESRD   
providers.   
SECTION 3 How to get services when you have an emergency or   
urgent need for care or during a disaster   
Section 3.1 Getting care if you have a medical emergency   
What is a “medical emergency” a nd what should you do if you have one?

# Main Title : SECTION 5 How are your medical services covered when you are in a “clinical research study”?

Content:43 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 3 Using the plan for your medical services   
during a disaster, you may be able to fill your prescription drugs at an out-of-network pharmacy.   
Please see Chapter 5, Section 2.5 for more information.   
SECTION 4 What if you are billed directly for the full cost of your   
covered services?   
Section 4.1 You can ask us to pay our share of the cost of covered   
services   
If you have paid more than your plan cost sharing for covered services, or if you have received a   
bill for the full cost of covered medical services, go to Chapter 7 ( Asking us to pay our share of a   
bill you have received for covered medical services or drugs ) for information a bout what to do.   
Section 4.2 If services are not covered by our plan, you must pay the full   
cost   
Blue Medicare Essential Plus c overs all medically necessary serv ices as listed in the Medical   
Benefits Chart in Chapter 4 of this document. If you receive services not covered by our plan or   
services obtained out-of-network and were not aut horized, you are responsi ble for paying the full   
cost of services.   
For covered services that have a benefit limitation, you also pay the full cost of any services you   
get after you have used up your benef it for that type of covered service. Costs incurred once the   
benefit limit has been reached do not count towards the out-of-pocket maximum.   
SECTION 5 How are your medical services covered when you are   
in a “clinical research study”?   
Section 5.1 What is a “clinical research study”?   
A clinical research s  
tudy (also called a “clinical tr  
ial”) is a way that doctors and scientists test   
new types of medical care, like how well a new ca ncer drug works. Certain clinical research   
studies are approved by Medicare . Clinical research studies approved by Medicare typically   
request volunteers to pa rticipate in the study.   
Once Medicare approves the study, and you express interest, someone who works on the study   
will contact you to explain more about the study a nd see if you meet the requirements set by the   
scientists who are running the study. You can participate in the study as long as you meet the   
requirements for the study, and you have a full understanding and acceptance of what is involved   
if you participate in the study.   
If you participate in a Medicare-app roved study, Original Medicare pays most of the costs for the   
covered services you receive as pa rt of the study. If you tell us that you are in a qualified clinical

# Main Title : SECTION 6 Rules for getting care in a “religious non-medical health care institution”

Content:45 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 3 Using the plan for your medical services   
When you are part of a clinical research study, neither Medicare nor our plan will pay for any   
of the following :   
• Generally, Medicare will not pay for the new item or serv ice that the study is testing   
unless Medicare would cover the ite m or service even if you were not in a study.   
• Items or services provided only to collect da ta, and not used in your direct health care.   
For example, Medicare would not pay for mont hly CT scans done as part of the study if   
your medical condition would normally require only one CT scan.   
Do you want to know more?   
You can get more information about joining a c linical research study by visiting the Medicare   
website to read or download the publication “Med icare and Clinical Research Studies.” (The   
publication is available at: www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-  
Studies.pdf.)   
You can also call 1-800-MEDICA RE (1-800-633-4227), 24 hours a day, 7 days a   
week. TTY users shou ld call 1-877-486-2048.   
SECTION 6 Rules for getting care in a “religious non-medical   
health care institution”   
Section 6.1 What is a religious n on-medical health care institution?   
A religious non-medical health care institution is a facility that provides care for a condition that   
would ordinarily be treated in a hospital or ski lled nursing facility. If getting care in a hospital or   
a skilled nursing facility is against a member’s religious beliefs, we will instead provide   
coverage for care in a religious non-medical health care institution. This benefit is provided only   
for Part A inpatient services (non- medical health care services).   
Section 6.2 Receiving Care from a Re ligious Non-Medical Health Care   
Institution   
To get care from a religious non-medical health care institution, you must sign a legal document   
that says you are conscientiously opposed to getting medical trea tment that is “non-excepted.”   
• “Non-excepted” med  
ical care o  
r treatment is any medical care or treatment that is   
voluntary and not required by any federal, state, or local law.   
• “Excepted” medical treatment is medical care or treatme nt that you get that is not   
voluntary or is required under federal, state, or local law.   
To be covered by our plan, the care you get from a religious non-medical he alth care institution   
must meet the following conditions:   
• The facility providing the care must be certified by Medicare.   
• Our plan’s coverage of servic es you receive is limited to non-religious aspects of care.

# Main Title : SECTION 7 Rules for ownership of durable medical equipment

Content:46 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 3 Using the plan for your medical services   
• If you get services from this in stitution that are provided to you in a facility, the   
following conditions apply:   
• You must have a medical condition that would allow you to receive covered   
services for inpatient hospital ca  
re or skilled nursing facility care.   
• – and – you must get approval in advance from our plan before you are admitted   
to the facility, or your stay will not be covered.   
Inpatient hospital, Skilled Nursing Facility, in-hom e (home health) coverage limits apply. Please   
see benefits chart in Chapter 4.   
SECTION 7 Rules for ownership of durable medical equipment   
Section 7.1 Will you own the durable medical equipment after making a   
certain number of payments under our plan?   
Durable medical equipment (D ME) includes items such as oxygen equipment and supplies,   
wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating   
devices, IV infusion pumps, nebulizers, and hospita l beds ordered by a provider for use in the   
home. The member always owns ce rtain items, such as prosthetic s. In this section, we discuss   
other types of DME that you must rent.   
In Original Medicare, people w ho rent certain types of DME own the equipment after paying   
copayments for the item for 13 mo nths. As a member of Blue Me dicare Essential Plus, however,   
you usually will not acquire ownership of rented DME items no matter how many copayments   
you make for the item while a me mber of our plan, even if you made up to 12 consecutive   
payments for the DME item under Original Medicare before you joined ou r plan. Under certain   
limited circumstances, we will transfer owners hip of the DME item to you. Call Customer   
Service for more information.   
What happens to payments you made for durable medical equipment if you   
switch to Original Medicare?   
If you did not acquire ownership of the DME item while in our plan, you will have to make 13   
new consecutive payments after you switch to Or iginal Medicare in order to own the item. The   
payments made while enrolled in your plan do not count.   
Example 1: You made 12 or fewer consecutive payments for the it em in Original Medicare and   
then joined our plan. The payment you made in Original Medicare do not count. You will have   
to make 13 payments to our plan before owning the item .   
Example 2: You made 12 or fewer consecutive payments for the it em in Original Medicare and   
then joined our plan. You were in our plan but did not obtain ow nership while in our plan. You   
then go back to Original Medicare. You will have to make 13 consecutive new payments to own

# Main Title : CHAPTER 4: Medical Benefits Chart (what is covered and what you pay)

Content:CHAPTER 4:   
Medical Benefits Chart   
(what is covered and   
what you pay)

# Main Title : SECTION 1 Understanding your out-of-pocket costs for covered services

Content:50 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 4 Medical Benefits Char t (what is covered and what you pay)   
SECTION 1 Understanding your out-of-pocket costs for covered   
services   
This chapter provides a Medical Benefits Chart that lists your covered services and shows how   
much you will pay for each covered service as a member of Blue Medicare Essential Plus. Later   
in this chapter, you can find information about me dical services that ar e not covered. Additional   
Part D limitations and exclusions can be found in Addendum A.   
Section 1.1 Types of out-of-pocket co sts you may pay for your covered   
services   
To understand the payment informat ion we give you in this chapter, you need to know about the   
types of out-of-pocket costs you ma y pay for your covered services.   
• A “copayment” is the fixed amount you pay each time you receive certain medical   
services. You pay a copayment at the time you get the medical service. (The Medical   
Benefits Chart in Section 2 tell s you more about your copayments.)   
• “Coinsurance” is the percentage you pay of the to tal cost of certai n medical services.   
You pay a coinsurance at the time you get the medical servic e. (The Medical Benefits   
Chart in Section 2 tells you more about your coinsurance.)   
The cost of the service, on which member copa yment/coinsurance is based, is on the Medicare   
allowable amount for covered services.   
Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB)   
program should never pay deductible s, copayments, or coinsurance. Be sure to show your proof   
of Medicaid or QMB eligibility to your provider, if applicable.   
Section 1.2 What is the most you wi ll pay for Medicare Part A and Part B   
covered medical services?   
Because you are enrolled in a Medicare Advantage Plan, there is a limit on the total amount you   
have to pay out-of-pocket each year for in-net work medical services that are covered under   
Medicare Part A and Part B. This limit is called the maximum out-of-p ocket (MOOP) amount for   
medical services. For calendar year 2023 this amount is:   
Segment 001 (H3449-023-001)   
Blue Medicare Essential Plus maximum out-o f-pocket is $3,950 for me mbers in the counties   
listed below:   
Alamance   
Buncombe Burke Catawba Davidson Durham   
Forsyth   
Gaston   
Guilford Haywood   
Irede  
ll   
Mecklenbur g   
Oran ge Randolph   
Rockin g  
ham   
Rutherford   
Wake

# Main Title : SECTION 2 Use the Medical Benefits Chart to find out what is covered and how much you will pay

Content:53 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 4 Medical Benefits Char t (what is covered and what you pay)   
SECTION 2 Use the Medical Benefits Chart to find out what is   
covered and how much you will pay   
Section 2.1 Your medical benefits and costs as a member of the plan   
The Medical Benefits Chart on the following pages lists the services Blue Medicare Essential   
Plus covers and what you pay out-of-pocket for e ach service. Part D pr escription drug coverage   
is in Chapter 5. The services listed in the Me dical Benefits Chart ar e covered only when the   
following coverage requirements are met:   
• Your Medicare covered services must be pr ovided according to the coverage guidelines   
established by Medicare.   
• Your services (including medical care, se rvices, supplies, equi pment, and Part B   
prescription drugs) must be medically necessary. “Medic ally necessary” means that the   
services, supplies, or drugs are needed for th e prevention, diagnosis, or treatment of your   
medical condition and meet accepted standards of medical practice.   
• You receive your care from a ne twork provider. In most ca ses, care you receive from an   
out-of-network provider will not be covered, un less it is emergent or urgent care or   
unless your plan or a network provider has given you a referral. This means that you will   
have to pay the provider in fu ll for the services furnished.   
• You have a primary care provi der (a PCP) who is providi ng and overseeing your care.   
• Some of the services listed in th e Medical Benefits Chart are covered only if your doctor   
or other network provider gets approval in advance (sometimes called “prior   
authorization”) from us. Covered services that need appr oval in advance are marked in   
the Medical Benefits Chart in bold. In addition, the followin g services not listed in the   
Benefits Chart require prior authorization:   
Medically Necessary Cosmetic Procedures (o r those potentially cosmetic), such as   
but not limited to:   
Abdominoplasty Blepharoplasty Breast Reduction   
Investigational Procedures (or those potentially investigational)   
Nonparticipating Providers and Services   
Surgery   
Refractive Surgical Procedures   
Sacral Neurostimulators   
Spinal Neurostimulators

# Main Title : SECTION 3 What services are not covered by the plan?

Content:104 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 4 Medical Benefits Char t (what is covered and what you pay)   
SECTION 3 What services are not covered by the plan?   
Section 3.1 Services we do not cover (exclusions)   
This section tells you what services are “exclude d” from Medicare coverage and therefore, are   
not covered by this plan.   
The chart below lists services and items that ei ther are not covered under any condition or are   
covered only under specific conditions. If you get services that are excl uded (not covered), you must pa y for them yourself except under   
the specific conditions listed below. Even if you receive the excluded services at an emergency   
facility, the excluded services are still not cove red and our plan will not pay for them. The only   
exception: is if the service is a ppealed and decided: upon appeal to be a medical service that we   
should have paid for or covered because of your specific situation. (F or information about   
appealing a decision we have ma de to not cover a medical serv ice, go to Chapter 9, Section 5.3   
in this document.)   
Services not covered by   
Medicare Not covered under any condition Covered only under specific   
conditions   
Acupuncture Available for people with chronic low back pain under certain circumstances.   
Cosmetic surgery or procedures • Covered in cases of an accidental injury or for improv  
ement of the   
functioning of a malformed body member.   
• Covered for all stages of reconstruction for a breast after a   
mastectomy, as well as f  
or the   
unaffected breast to produce a symmetrical appearance.   
Custodial care   
Custodial care is personal   
care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathin g or dressin  
g. √

# Main Title : CHAPTER 5: Using the plan’s coverage for Part D prescription drugs

Content:CHAPTER 5:   
Using the plan’s coverage   
for Part D prescription drugs

# Main Title : SECTION 2 Fill your prescription at a network pharmacy or through the plan’s mail-order service

Content:109 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 5 Using the plan’s coverage for Part D prescription drugs   
SECTION 1 Introduction   
This chapter explains rules for using your coverage for Part D drugs . Please see Chapter 4 for   
Medicare Part B drug benefits and hospice drug benefits.   
Section 1.1 Basic rules for the plan’s Part D drug coverage   
The plan will generally cover your drugs as long as you follow these basic rules:   
• You must have a provider (a doc tor, dentist, or other prescr iber) write you a prescription   
which must be valid under applicable state law.   
• Your prescriber must not be on Medi care’s Exclusion or Preclusion Lists.   
• You generally must use a network pharmacy to fill your prescription. (See Section 2, Fill   
your prescriptions at a network pharmacy or through the plan’s mail-order service. )   
• Your drug must be on the plan’s List of Covered Drugs (Formulary) (we call it the “Drug   
List” for short). (See Section 3, Your drugs need to be on the plan’s “Drug List .”)   
• Your drug must be used for a medically accepted indication. A “medically accepted   
indication” is a use of the drug that is either approved by the Food and Drug   
Administration or supported by certain re ference books. (See S ection 3 for more   
information about a medical ly accepted indication.)   
SECTION 2 Fill your prescription at a network pharmacy or   
through the plan’s mail-order service   
Section 2.1 Use a network pharmacy   
In most cases, your prescriptions are covered only if they are filled at the plan’s network   
pharmacies. (See Section 2.5 for information abou t when we would cover prescriptions filled   
at out-of-network pharmacies.)   
A network pharmacy is a pharmacy that has a contract with the plan to provide your covered   
prescription drugs. The term “covered drugs” means all of the Part D prescription drugs that are   
on the plan’s Drug List.   
Section 2.2 Network pharmacies   
How do you find a network pharmacy in your area?   
To find a network pharmacy, you can look in your Pharmacy Directory , visit our website   
www.BlueCrossNC.com/find-a-drug-or-pharmac y, and/or call Customer Service.

# Main Title : SECTION 3 Your drugs need to be on the plan’s “Drug List”

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Chapter 5 Using the plan’s coverage for Part D prescription drugs   
• Any network chain pharmacy that participates in our network with in North Carolina is   
also considered in-network outside of No rth Carolina. So you may visit these stores   
nationwide, and your prescriptions will be c overed at the in-netwo rk benefit level;   
• You are in an emergency situation and re quire access to a covered Part D drug, for   
instance when you are in an outpatient hospital setting;   
• You are traveling outside of the service area; you a) run out of the covered drug(s) or b)   
become ill and need a covered drug and cannot access a network pharmacy;   
• You cannot obtain a covered drug in a timely manner within th e service area, because, for   
example, there is no network pharmacy within a reasonable driving dist ance that provides   
24-hour service;   
• You reside in a long term care facility and th e contracted long term care pharmacy does   
not participate in the plan ’s pharmacy network; or   
• You must fill a prescription for a covered dr ug, and that particular drug is not regularly   
stocked at accessible network retail or ma il-order pharmacies (for example, an orphan   
drug or other specialty pharmaceutical that is typically shipped directly from   
manufacturers or special vendors).   
How do you ask for reimbursement from the plan?   
If you must use an out-of-network pharmacy, you w ill generally have to pay the full cost (rather   
than your normal cost share) at the time you f ill your prescription. You ca n ask us to reimburse   
you for our share of the cost. (C hapter 7, Section 2.1 explains how to ask the plan to pay you   
back.)   
SECTION 3 Your drugs need to be on the plan’s “Drug List”   
Section 3.1 The “Drug List” tells which Part D drugs are covered   
The plan has a “ List of Covered Drugs (Formulary).” In this Evidence of Coverage , we call it   
the “Drug List” for short.   
The drugs on this list are selected by the plan w ith the help of a team of doctors and pharmacists.   
The list meets Medicare’s requirements and has been approved by Medicare.   
The drugs on the Drug List are only those covered under Medicare Part D. We will generally cover a drug on the plan’s Drug List as long as you follow the other coverage   
rules explained in this chapter and the use of the drug is a medically accepted indication. A   
“medically accepted indication” is a use of the drug that is either :   
• Approved by the Food and Drug Administr ation. (That is, the Food and Drug   
Administration has approved the drug for the diagnosis or condition for which it is being   
prescribed.)

# Main Title : SECTION 4 There are restrictions on coverage for some drugs

Content:114 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 5 Using the plan’s coverage for Part D prescription drugs   
Section 3.3 How can you find out if a specific drug is on the Drug List?   
You have three ways to find out:   
1. Check the most recent Drug List we provided electronically.   
2. Visit the plan’s website www.Medicare.BlueCrossNC.com. The Drug List on the   
website is always the most current.   
3. Call Customer Service to find out if a partic ular drug is on the plan’s Drug List or   
to ask for a copy of the list.   
SECTION 4 There are restrictions on coverage for some drugs   
Section 4.1 Why do some drugs have restrictions?   
For certain prescription drugs, special rules restri ct how and when the plan covers them. A team   
of doctors and pharmacists developed these ru les to encourage you and your provider to use   
drugs in the most effective ways.   
To find out if any of these restrictions apply to a drug you take or want to take, check the Drug   
List. If a safe, lower-cost drug wi ll work just as well medically as a higher-cost dr ug, the plan’s   
rules are designed to encourage you and your pr ovider to use that lower-cost option.   
Please note that sometimes a drug may appear more than once on our drug list. This is because   
the same drugs can differ based on the strengt h, amount, or form of th e drug prescribed by your   
health care provider, and different restrictions or cost sharing may apply to the different versions   
of the drug (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus   
liquid).   
Section 4.2 What kinds of restrictions?   
The sections below tell you more about the type s of restrictions we us e for certain drugs.   
If there is a restriction for your drug, it usua lly means that you or your provider will have   
to take extra steps in order for us to cover the drug. Contact Customer Se rvice to learn what   
you or your provider would need to do to get coverage for the dr ug. If you want us to waive the   
restriction for you, you will need to use the coverage decision process and ask us to make an   
exception. We may or may not agree to waive the restriction for you. (See Chapter 9.)   
Restricting brand name drugs wh en a generic version is available   
Generally, a “generic” drug works the same as a brand name drug a nd usually costs less. In most   
cases, when a generic version of a brand name drug is available, our network pharmacies   
will provide you the generic version instead of the brand name drug. However, if your   
provider has told us the medical reason that neither the generic dr ug nor other covered drugs that

# Main Title : SECTION 5 What if one of your drugs is not covered in the way you’d like it to be covered?

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Chapter 5 Using the plan’s coverage for Part D prescription drugs   
treat the same condition will work for you, then we will cover the brand name drug. (Your share   
of the cost may be greate r for the brand name drug th an for the generic drug.)   
Getting plan approval in advance   
For certain drugs, you or your provider need to get a pproval from the plan before we will agree to   
cover the drug for you. This is called “ prior authorization.” This is put in place to ensure   
medication safety and help guide appropriate use of certain drugs. If you do not get this approval,   
your drug might not be covered by the plan.   
Trying a different drug first   
This requirement encourages you to try less costly but usually just as effective drugs before the   
plan covers another drug. For example, if Dr ug A and Drug B treat the same medical condition,   
the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then   
cover Drug B. This requirement to tr y a different drug first is called “ step therapy.”   
Quantity limits For certain drugs, we limit how much of a drug you can get each time you fill your prescription.   
For example, if it is normally considered safe to take only one pill per day for a certain drug, we   
may limit coverage for your prescription to no more than one pill per day.   
SECTION 5 What if one of your drugs is not covered in the way   
you’d like it to be covered?   
Section 5.1 There are things you can do if your drug is not covered in the   
way you’d like it to be covered   
There are situations where there is a prescrip tion drug you are currently taking, or one that you   
and your provider thinks you s hould be taking, that is not on our formulary or is on our   
formulary with restrictions. For example:   
•   
 The drug might not be covered at all. Or ma ybe a generic version of the drug is covered   
but the brand name version you want to take is not covered.   
•   
 The drug is covered, but there are ex  
tra rules or restrictions on coverage for that drug as   
explained in Section 4.   
• The drug is covered, but it is in a cost shar ing tier that makes your cost sharing more   
expensive than you think it should be.   
There are things you can do if your drug is not covered in the way that you’d like it to be   
covered.   
• If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn   
what you can do.

# Main Title : SECTION 6 What if your coverage changes for one of your drugs?

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Chapter 5 Using the plan’s coverage for Part D prescription drugs   
Service to ask for a list of covered drugs that treat the same medical condition. This list can help   
your provider find a covered drug that might work for you.   
You can ask for an exception   
You and your provider can ask the pl an to make an exception in the cost sharing tier for the drug   
so that you pay less for it. If your provider says that you have medical reasons that justify asking   
us for an exception, your pr ovider can help you request an exception to the rule.   
If you and your provider want to ask for an exception, Ch apter 9, Section 6.4 tells what to do . It   
explains the procedures and dead lines that have been set by Medi care to make sure your request   
is handled promptly and fairly. Drugs in our Specialty Tier are not eligible for this type of exception. We do not lower the cost   
sharing amount for drugs in this tier.   
SECTION 6 What if your coverage changes for one of your   
drugs?   
Section 6.1 The Drug List can change during the year   
Most of the changes in drug coverage happen at the beginning of each year (January 1).   
However, during the year, the plan can make so me changes to the Drug List. For example, the   
plan might:   
• Add or remove drugs from the Drug List.   
• Move a drug to a higher or lower cost sharing tier .   
• Add or remove a restriction on coverage for a drug .   
• Replace a brand name drug with a generic drug.   
We must follow Medicare requirements befo re we change the plan’s Drug List.   
Section 6.2 What happens if coverag e changes for a drug you are taking?   
Information on changes to drug coverage   
When changes to the Drug List occur, we post in formation on our website about those changes.   
We also update our online Drug Li st on a regularly scheduled ba sis. Below we point out the   
times that you would get direct notice if changes are made to a drug that you are taking.   
Changes to your drug coverage that aff ect you during the current plan year   
• A new generic drug replaces a brand name dr ug on the Drug List (or we change the   
cost sharing tier or add new restriction s to the brand name drug or both)

# Main Title : SECTION 7 What types of drugs are not covered by the plan?

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Chapter 5 Using the plan’s coverage for Part D prescription drugs   
changes will likely affect you starting January 1 of the next plan year if you stay in the same   
plan.   
In general, changes that will not affect you during the current plan year are:   
• We move your drug into a higher cost sharing tier.   
• We put a new restriction on the use of your drug.   
• We remove your drug from the Drug List.   
If any of these changes happen for a drug you ar e taking (except for ma rket withdrawal, a   
generic drug replacing a brand na me drug, or other change noted in the sections above), then the   
change won’t affect your use or what you pay as your share of the cost until January 1 of the next   
year. Until that date, you probably won’t see any increase in your payments or any added   
restrictions to your use of the drug.   
We will not tell you about these types of changes directly during the current plan year. You will   
need to check the Drug List for the next plan year (when the list is available during the open   
enrollment period) to see if there are any changes to the drugs you are taking that will impact you   
during the next plan year.   
SECTION 7 What types of drugs are not covered by the plan?   
Section 7.1 Types of drugs we do not cover   
This section tells you what kinds of prescrip tion drugs are “excluded.” This means Medicare   
does not pay for these drugs.   
If you get drugs that are excluded, you must pay for them yourself (except for certain excluded   
drugs covered under our enhanced drug coverage). If you appeal and the requested drug is found   
not to be excluded under Part D, we will pay for or cover it. (For inform ation about appealing a   
decision, go to Chapter 9.) Here are three general rules about drugs that Me dicare drug plans will not cover under Part D:   
• Our plan’s Part D drug coverage cannot cover a drug that would be covered under   
Medicare Part A or Part B.   
• Our plan cannot cover a drug purchased outsi de the United States or its territories.   
• Our plan usually cannot cover off-label use. “O ff-label use” is any use of the drug other   
than those indicated on a dr ug’s label as approved by the Food and Drug Administration.   
• Coverage for “off-label us e” is allowed only when the use is supported by certain   
references, such as the American Hospital Formulary Service Drug Information and the   
DRUGDEX Information System.

# Main Title : SECTION 8 Filling a prescription

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Chapter 5 Using the plan’s coverage for Part D prescription drugs   
In addition, by law, the following categories of dr ugs are not covered by Me dicare drug plans:   
(Our plan covers certain drugs listed below through our enha nced drug coverage, for which you   
may be charged an additional premium. More information is provided below.)   
• Non-prescription drugs (also ca lled over-the-counter drugs)   
• Drugs used to promote fertility   
• Drugs used for the relief of cough or cold symptoms   
• Drugs used for cosmetic purposes or to promote hair growth   
• Prescription vitamins and min eral products, except prenat al vitamins and fluoride   
preparations   
• Drugs used for the treatment of sexual or erectile dysfunction   
• Drugs used for treatment of anorex ia, weight loss, or weight gain   
• Outpatient drugs for which the manufacturer seeks to require that associated tests or   
monitoring services be purcha sed exclusively from the ma nufacturer as a condition of   
sale   
We offer additional coverage of some prescription drugs (enhanced drug coverage) not normally covered in a Medicare prescription drug plan. Our plan covers a sexua l dysfunction medication.   
For more details on tier placement and limits, pl ease refer to the formulary. The amount you pay   
for these drugs does not count towards qualifying you for the Catastrophic Coverage Stage. (The   
Catastrophic Coverage Stage is described in Chapter 6, Section 7 of this document.)   
In addition, if you are receiving “Extra Help” to pay for your prescrip tions, the “Extra Help”   
program will not pay for the drugs not normally covered. However, if you have drug coverage   
through Medicaid, your stat e Medicaid program may cover some prescription drugs not normally   
covered in a Medicare drug plan. Please contact your state Medica id program to determine what   
drug coverage may be available to you. (You can find phone numbers and contact information   
for Medicaid in Chapter 2, Section 6.)   
SECTION 8 Filling a prescription   
Section 8.1 Provide your membership information   
To fill your prescription, pr ovide your plan membership in formation, which can be found on   
your membership card, at the network pha rmacy you choose. The network pharmacy will   
automatically bill the plan for our share of your drug cost. You will need to pay the pharmacy   
your share of the cost when you pick up your prescription.

# Main Title : SECTION 9 Part D drug coverage in special situations

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Chapter 5 Using the plan’s coverage for Part D prescription drugs   
Section 8.2 What if you don’t have your membership information with   
you?   
If you don’t have your plan member ship information with you when you fill your prescription,   
you or the pharmacy can call the plan to get the necessary information.   
If the pharmacy is no t able to get the n ecessary information, you may have to pay the full cost   
of the prescription when you pick it up . (You can then ask us to reimburse you for our share.   
See Chapter 7, Section 2.1 for information about how to ask the plan for reimbursement.)   
SECTION 9 Part D drug coverage in special situations   
Section 9.1 What if you’re in a hospi tal or a skilled nu rsing facility for a  
stay that is covered by the plan?   
If you are admitted to a ho spital or to a skilled nursing facil ity for a stay covered by the plan, we   
will generally cover the cost of your prescrip tion drugs during your stay. Once you leave the   
hospital or skilled nursing facility, the plan wi ll cover your prescripti on drugs as long as the   
drugs meet all of our rules for cove rage described in this Chapter.   
Section 9.2 What if you’re a reside nt in a long-term care (LTC  
) facility?   
Usually, a long-term care (LTC) f acility (such as a nursing home) has its own pharmacy or uses a   
pharmacy that supplies drugs for a ll of its residents. If you are a resident of a LTC facility, you   
may get your prescription drugs through the facility’s phar macy or the one it us es, as long as it is   
part of our network.   
Check your Pharmacy Directory to find out if your LTC facility’s pharmacy or th e one it uses is   
part of our network. If it isn’t, or if you need more informatio n or assistance, please contact   
Customer Service. If you are in a LTC facility, we must ensure that you are able to routinely   
receive your Part D benefits thr ough our network of LTC pharmacies.   
What if you’re a resident in a long-term care (LTC) facili ty and need a drug that is   
not on our Drug List or is restricted in some way   
Refer to Section 5.2 about a temporary or emergency supply.   
Section 9.3 What if you’re also getti ng drug coverage from an employer or   
retiree group plan?   
If you currently have other prescription drug cove rage through your (or your spouse’s) employer   
or retiree group, please contact that group’s benefits administrator. He or she can help you   
determine how your current prescription drug coverage will work with our plan.

# Main Title : SECTION 10 Programs on drug safety and managing medications

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Chapter 5 Using the plan’s coverage for Part D prescription drugs   
In general, if you have employee or retiree group coverage, the drug coverage you get from us   
will be secondary to your group coverage. That means your group coverage would pay first.   
Special note about ‘creditable coverage’:   
Each year your employer or retiree group should send you a notice that tell s if your prescription   
drug coverage for the next cal endar year is “creditable.”   
If the coverage from the group plan is “creditable ,” it means that the plan has drug coverage that   
is expected to pay, on average, at least as much as Medicare’s standard prescription drug   
coverage.   
Keep this notice about creditable coverage because you may need it later. If you enroll in a   
Medicare plan that includes Pa rt D drug coverage, you may need these notices to show that you   
have maintained creditable coverage. If you didn’t get the cred itable coverage notice, request a   
copy from your employer or retiree plan’s bene fits administrator or the employer or union.   
Section 9.4 What if you’re in Medicare-certified hospice?   
Hospice and our plan do not cover the same drug at the same time . If you are enrolled in   
Medicare hospice and require ce rtain drugs (e.g., anti-nausea, laxative, pain medication or   
antianxiety drugs) that are not covered by your hospice because it is unrelated to your terminal   
illness and related conditions, our plan must rece ive notification from either the prescriber or   
your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent   
delays in receiving these drugs that should be covered by our pl an, ask your hospice provider or   
prescriber to provide notification befo re your prescription is filled.   
In the event you either revoke your hospice elec tion or are discharged from hospice our plan   
should cover your drugs as explained in this do cument. To prevent any delays at a pharmacy   
when your Medicare hospice benefit ends, bring documentation to the pharmacy to verify your   
revocation or discharge.   
SECTION 10 Programs on drug safety and managing medications   
Section 10.1 Programs to help members use drugs safely   
We conduct drug use reviews for our members to help make sure that they are getting safe and   
appropriate care.   
We do a review each time you fill a prescription. We also review our records on a regular basis.   
During these reviews, we look for potential problems such as:   
• Possible medicat ion errors

# Main Title : CHAPTER 6: What you pay for your Part D prescription drugs

Content:CHAPTER 6:   
What you pay for your   
Part D prescription drugs

# Main Title : SECTION 1 Introduction

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Chapter 6 What you pay for your Part D prescription drugs   
Are you currently getting help to pay for your drugs?   
If you are in a program that helps pay for your drugs, some information in this Evidence of   
Coverage about the costs for Part D prescription drugs may not apply to you. We sent   
you a separate insert, called the “Evidence of Co verage Rider for People Who Get Extra Help   
Paying for Prescription Drugs” (also known as the “Low Income Subsidy Rider” or the “LIS   
Rider”), which tells you about your drug coverage. If you don’t ha ve this insert, please call   
Customer Service, and ask for the “LIS Rider.”   
SECTION 1 Introduction   
Section 1.1 Use this chapter together with other materials that explain   
your drug coverage   
This chapter focuses on what you pay for Part D prescription drugs. To keep things simple, we   
use “drug” in this chapter to mean a Part D pr escription drug. As explained in Chapter 5, not all   
drugs are Part D drugs – some drugs are covered under Medicare Part A or Part B and other   
drugs are excluded from Medi care coverage by law.   
To understand the payment information, you need to know what drugs are covered, where to fill   
your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5,   
Sections 1 through 4 explain these:   
Section 1.2 Types of out-of-pocket costs you may pay for covered drugs   
There are different types of out-o f-pocket costs for Part D drugs. The amount that you pay for a   
drug is called “cost sharing,” and there ar e three ways you may be asked to pay.   
• The “deductible” is the amount you pay for drugs before our plan be gins to pay its share.   
• “Copayment” is a fixed amount you pay each time you fill a prescription.   
• “Coinsurance” is a percentage of the total cost you pay each time you fill a prescription.   
Section 1.3 How Medicare calcula tes your out-of-pocket costs   
Medicare has rules about what counts and what does not count toward your out -of-pocket costs.   
Here are the rules we must follow to keep track of your out -of-pocket costs.

# Main Title : SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in

Content:130 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 6 What you pay for your Part D prescription drugs   
SECTION 2 What you pay for a drug depends on which “drug   
payment stage” you are in when you get the drug   
Section 2.1 What are the drug payment stages for Blue Medicare Essential   
Plus members?   
There are four “drug payment stages” for your prescription drug coverage under Blue Medicare   
Essential Plus. How much you pay depends on what stage you are in when you get a prescription   
filled or refilled. Details of each stage are in Sections 4 through 7 of this chapter. The stages are:   
Stage 1: Yearly Deductible Stage   
Stage 2: Initial Coverage Stage Stage 3: Coverage Gap Stage   
Stage 4: Catastrophic Coverage Stage   
Important Message About What You Pay for Insulin - You won’t pay more than $35 for a   
one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier   
it’s on, even if you haven’t paid your deductible.   
SECTION 3 We send you reports that explain payments for your   
drugs and which payment stage you are in   
Section 3.1 We send you a monthly summary called the Part D Explanation   
of Benefits (the “Part D EOB”)   
Our plan keeps track of the costs of your prescripti on drugs and the payments you have made   
when you get your prescriptions filled or refill ed at the pharmacy. This way, we can tell you   
when you have moved from one drug payment stage to the next. In particul ar, there are two types   
of costs we keep track of:   
• We keep track of how much you have paid. This is called your “ out-of-pocket” cost.   
• We keep track of your “ total drug costs .” This is the amount you pay out-of-pocket,   
or others pay on your behalf plus the amount paid by the plan.   
If you have had one or more pres criptions filled through the plan during the previous month, we   
will send you a Part D Explanation of Benefits (“Part D EOB”). The Part D EOB includes:   
• Information for that month . This report gives the payment details about the   
prescriptions you have filled during the previous month. It shows the total drug costs,   
what the plan paid, and what you and others on your behalf paid.   
• Totals for the year since January 1. This is called “year-to-da te” information. It shows   
the total drug costs and total payments for your drugs since the year began.

# Main Title : SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs, and you pay your share

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Chapter 6 What you pay for your Part D prescription drugs   
SECTION 4 During the Deductible Stage, you pay the full cost of your   
Tier 4 and 5 drugs   
The Deductible Stage is the first payment stage for your drug coverage. You will pay a yearly   
deductible of $150 on Tier 4 and 5 drugs. You must pay the full cost of your Tier 4 and 5   
drugs until you reach the plan’s deductible amount. For all other drugs, you will not have to pay   
any deductible.   
• The “full cost” is usually lower than the normal full price of the drug, since our plan has   
negotiated lower costs for most drugs at network pharmacies.   
Once you have paid $150 for your Tier 4 and 5 dr ugs, you leave the Deductible Stage and move   
on to the Initial Coverage Stage.   
SECTION 5 During the Initial Co verage Stage, the plan pays its   
share of your drug costs, and you pay your share   
Section 5.1 What you pay for a dr ug depends on the drug and where you   
fill your prescription   
During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription   
drugs, and you pay your share (you r copayment or coinsu rance amount). Your share of the cost   
will vary depending on the drug and where you fill your prescription.   
The plan has six cost sharing tiers   
Every drug on the plan’s Drug List is in one of six cost sharing tiers. In general, the higher the   
cost sharing tier number, the hi gher your cost for the drug:   
• Cost sharing Tier 1: Preferred Generic Drugs   
• Cost sharing Tier 2: Generic Drugs   
• Cost sharing Tier 3: Preferred Brand Drugs and some Generic Drugs   
• Cost sharing Tier 4: Non-Preferred Drugs   
• Cost sharing Tier 5: Specialt y Drugs (highest drug tier)   
• Cost sharing Tier 6: Select Care Drug s (lowest drug tier; a limited number of   
Generic Drugs for high blood pressure, diabet es, high cholesterol, osteoporosis, and   
rheumatoid arthritis for which we offer a low or no copayment)   
To find out which cost shari ng tier your drug is in, look it up in the plan’s Drug List.

# Main Title : SECTION 6 Costs in the Coverage Gap Stage

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Chapter 6 What you pay for your Part D prescription drugs   
Section 5.5 You stay in the Initial Coverage Stage until your total drug   
costs for the year reach $4,660   
You stay in the Initial Coverage Stage until th e total amount for the pr escription drugs you have   
filled reaches the $4,660 limit for the Init ial Coverage Stage .   
We offer additional coverage on some prescription drugs that are not normally covered in a   
Medicare Prescription Drug Plan. Payments made for these drugs will not count towards your   
initial coverage limit or total out-of-pocket costs.   
The Part D EOB that you receive will help you k eep track of how much you, the plan, and any   
third parties, have spent on your behalf dur ing the year. Many people do not reach the $4,660   
limit in a year.   
We will let you know if you reach this $4,660 amount . If you do reach this amount, you will   
leave the Initial Coverage Stag e and move on to the Coverage Gap Stage. See Section 1.3 on   
how Medicare calculates your out-of-pocket costs.   
SECTION 6 Costs in the Coverage Gap Stage   
When you are in the Coverage Gap Stage, th e Medicare Coverage Gap Discount Program   
provides manufacturer discounts on brand name drugs. You pay 25% of the negotiated price and   
a portion of the dispensing fee for brand name drugs. Both th e amount you pay, and the amount   
discounted by the manufacturer count toward you r out-of-pocket costs as if you had paid them   
and move you through the coverage gap.   
You also receive some coverage for generic drugs. You pay a $0 copayment for a 30-day supply   
of Tier 6 Select Care Drugs at a preferred re tail or preferred mail-o rder pharmacy and a $3   
copayment for a 30-day supply at a standard retail or standard mail-order pharmacy. You pay   
25% of the cost for all other c overed generic drugs and the plan pays the rest. Only the amount   
you pay counts and moves you through the coverage gap. You continue paying these costs until your ye arly out-of-pocket payments reach a maximum   
amount that Medicare has set. Once you reach this amount $7,400, you leave the Coverage Gap   
Stage and move to the Catastrophic Coverage Stage.   
Medicare has rules about what counts and what does not count toward your out -of-pocket costs.   
Blue Medicare Essential Plus o ffers additional gap coverage fo r insulins. During the Coverage   
Gap stage, your out-of-pocket costs for insulins will be a $35 copayment for a one-month supply.   
To find out which drugs are insulins, revi ew the most recent Drug List we provided   
electronically. All insulins on our Drug List are included in th e program. If you have questions   
about the Drug List, you can also call Customer Service (phone numbers for Customer Service   
are printed on the back cover of this booklet).

# Main Title : SECTION 8 Part D Vaccines. What you pay for depends on how and where you get them

Content:138 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 6 What you pay for your Part D prescription drugs   
SECTION 7 During the Catastrophic Coverage Stage, the plan   
pays most of the cost for your drugs   
You enter the Catastrophic C overage Stage when your out-of- pocket costs have reached the   
$7,400 limit for the calendar year . Once you are in the Catastr ophic Coverage Stage, you will   
stay in this payment stage until the end of the calendar year.   
During this stage, the plan will pay most of the cost for your drugs. You will pay:   
• Your share of the cost for a covered drug will be either coinsurance or a copayment,   
whichever is the larger amount:   
• –either – coinsurance of 5% of the cost of the drug   
• –or – $4.15 for a generic drug or a drug that is treated like a generic   
and $10.35 for all other drugs.   
SECTION 8 Part D Vaccines. Wh at you pay for depends on how   
and where you get them   
Important Message About What You Pay for Vaccines - Our plan covers most Part D   
vaccines at no cost to you, even if you haven’t pa id your deductible. Call Customer Service for   
more information.   
There are two parts to our cove rage of Part D vaccinations:   
• The first part of cove rage is the cost of the vaccine medication itself .   
• The second part of covera ge is for the cost of giving you the vaccine. (This is sometimes   
called the “administration” of the vaccine.)   
Your costs for a Part D vaccination depend on three things:   
1. The type of vaccine (what you are being vaccinated for).   
• Some vaccines are considered medical benefits. (See the Medical Benefits Chart   
(what is covered and what you pay) in Chapter 4).   
• Other vaccines are considered Part D drugs. You can find these v accines listed in the   
plan’s List of Covered Drugs (Formulary).   
2. Where you get the vaccine.   
• The vaccine itself may be dispensed by a pharmacy or provided by the doctor’s   
office.   
3. Who gives you the vaccine.

# Main Title : CHAPTER 7: Asking us to pay our share of a bill you have received for covered medical services or drugs

Content:CHAPTER 7:   
Asking us to pay our share of a bill   
you have received for covered   
medical services or drugs

# Main Title : SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered services or drugs

Content:141 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 7 Asking us to pay our share of a bill you have received for   
covered medical services or drugs   
SECTION 1 Situations in which you should ask us to pay our   
share of the cost of your covered services or drugs   
Sometimes when you get medical ca re or a prescription drug, you may need to pay the full cost.   
Other times, you may find that you have paid mo re than you expected un der the coverage rules   
of the plan. In these cases, you can ask our plan to pay you back (paying you back is often called   
“reimbursing” you). It is your righ t to be paid back by our plan whenever you’ve paid more than   
your share of the cost for medical services or drugs that are covered by our plan. There may be   
deadlines that you must meet to get paid back. Please see Section 2 of this chapter.   
There may also be times when you get a bill from a provider for the full cost of medical care   
you have received or possibly for more than you r share of cost shari ng as discussed in the   
document. First try to resolve the bill with the provider. If that does not work, send the bill to   
us instead of paying it. We will look at the bill and decide whether the services should be   
covered. If we decide they should be covered, we will pay the provider directly. If we decide   
not to pay it, we will notify the provider. You should never pay more than plan-allowed cost   
sharing. If this provider is contracted, you still have the right to treatment.   
Here are examples of situations in which you may need to ask our plan to pay you back or to pay   
a bill you have received:   
1. When you’ve received emergency or urgently needed medical care   
from a provider who is not in our plan’s network   
You can receive emergency or urgently needed services from any provider, whether or not   
the provider is a part of our network. In these cases,   
• You are only responsible for paying your share of the cost for emergency or urgently   
needed services. Emergency providers are le gally required to provide emergency care.   
If you accidentally pay the entire amount yourse lf at the time you r eceive the care, ask   
us to pay you back for our share of the co st. Send us the bill, along with documentation   
of any payments you have made.   
• You may get a bill from the provider asking for payment that you th ink you do not owe.   
Send us this bill, along with documentation of any payments you have already made.   
• If the provider is owed anything, we will pay the provider directly.   
• If you have already paid more than your sh are of the cost of the service, we will   
determine how much you owed and pay you back for our share of the cost.   
2. When a network provider sends y ou a bill you think you should not pay   
Network providers should always bill the pl an directly, and ask you only for your share of   
the cost. But sometimes they make mistakes , and ask you to pay more than your share.   
• You only have to pay your cost sharing am ount when you get covered services. We do   
not allow providers to add additional separate charges, called “balance billing.” This

# Main Title : SECTION 2 How to ask us to pay you back or to pay a bill you have received

Content:143 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 7 Asking us to pay our share of a bill you have received for   
covered medical services or drugs   
• For example, the drug may not be on the plan’s List of Covered Drugs (Formulary) ; or   
it could have a requirement or restriction that you didn’t know a bout or don’t think   
should apply to you. If you decide to get th e drug immediately, you may need to pay   
the full cost for it.   
• Save your receipt and send a copy to us wh en you ask us to pay you back. In some   
situations, we may need to get more inform ation from your doctor in order to pay you   
back for our share of the cost.   
All of the examples above are types of coverage decisions. Th is means that if we deny your   
request for payment, you can appe al our decision. Chapter 9 of this document has information   
about how to make an appeal.   
SECTION 2 How to ask us to pay you back or to pay a bill you   
have received   
You may request us to pay you back by sending us a request in writing. If you send a request in   
writing, send your bill and documentation of an y payment you have made. It’s a good idea to   
make a copy of your bill and receipts for your records. You must submit your claim to us   
within 12 months for medical services, or 3 years for Part D drugs , of the date you received   
the service, item, or drug.   
To make sure you are giving us all the information we need to make a decision, you can fill out   
our claim form to make your request for payment.   
• You don’t have to use the form, but it will he lp us process the information faster. The   
following information is needed to process any reimbur sement request.   
Member name   
Member ID number (found on your ID card)   
Date of service Description of the services Provider name and address Paid in full receipt   
• Either download a copy of th e form from our website   
www.Medicare.BlueCrossNC.com/medicare/forms -library or call Customer Service and   
ask for the form.   
Mail you  
r request for pa  
yment together with any bills or paid receipts to us at these addresses:   
For Medical Claims:   
Blue Medicare Essential Plus   
Attn: Medic  
al Claims   
PO Box 17509 Winston-Salem, NC 27116-7509 For Prescription Drug Claims:   
Blue Medicare Essential Plus   
Attn: Prescription Drug Claims   
PO Box 17509   
Winston-Salem, NC 27116-7509

# Main Title : SECTION 3 We will consider your request for payment and say yes or no

Content:144 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 7 Asking us to pay our share of a bill you have received for   
covered medical services or drugs   
SECTION 3 We will consider y our request for payment and say   
yes or no   
Section 3.1 We check to see whether we should cover the service or drug  
and how much we owe   
When we receive your request for payment, we will let you know if we need any additional   
information from you. Otherwise, we will consider your request and make a coverage decision.   
• If we decide that the medical care or drug is covered and yo u followed all the rules, we   
will pay for our share of the cost. If you have already paid for the service or drug, we will   
mail your reimbursement of our share of th e cost to you. If you have not paid for the   
service or drug yet, we will mail the payment directly to the provider.   
• If we decide that the medical care or drug is not covered, or you did not follow all the   
rules, we will not pay for our share of the cost. We will send you a letter explaining the   
reasons why we are not sending the payment and your right to app eal that decision.   
Section 3.2 If we tell you that we will not pay for all or part of the medical   
care or drug, you can make an appeal   
If you think we have made a mist ake in turning down your request for payment or the amount we   
are paying, you can make an appeal . If you make an appeal, it mean s you are asking us to change   
the decision we made when we turned down your request for payment. Th e appeals process is a   
formal process with detailed procedures and impor tant deadlines. For the details on how to make   
this appeal, go to Chapte r 9 of this document.

# Main Title : CHAPTER 8: Your rights and responsibilities

Content:CHAPTER 8:   
Your rights and responsibilities

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

Content:146 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 8 Your rights and responsibilities   
SECTION 1 Our plan must honor your rights and cultural   
sensitivities as a memb er of the plan   
Section 1.1 We must provide informati on in a way that works for you and   
consistent with your cultural sensitivities (in languages other   
than English, in braille, in large print, or other alternate   
formats, etc.)   
Your plan is required to ensure that all services, both clinical and non-clinical, are provided in a   
culturally competent manner and are accessible to all enrollees, including those with limited   
English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and   
ethnic backgrounds. Examples of how a plan ma y meet these accessibility requirements include,   
but are not limited to: provision of translator services, interpreter services, teletypewriters, or   
TTY (text telephone or teletypewriter phone) connection.   
Our plan has free interpreter services availabl e to answer questions from non-English speaking   
members. Some documents may be available in th e top 15 languages spoken in our state. We can   
also give you information in braille, in large pr int, or other alternate formats at no cost if you   
need it. We are required to give you information about the plan’s benefits in a format that is   
accessible and appropriate for you. To get inform ation from us in a way that works for you,   
please call Customer Service. Our plan is required to give female enrollees the option of direct access to a women’s health   
specialist within the network for women’s r outine and preventive he alth care services.   
If providers in the plan’s network for a specialty ar e not available, it is th e plan’s responsibility   
to locate specialty providers outside the netw ork who will provide you with the necessary care.   
In this case, you will only pay in-network cost sh aring. If you find yourself in a situation where   
there are no specialists in the plan’s network that cover a se rvice you need, call the plan for   
information on where to go to obtain this service at in-network cost sharing.   
If you have any trouble getting in formation from our plan in a fo rmat that is accessible and   
appropriate for you, seeing a women’s health specia lists or finding a network specialist, please   
call to file a grievance with the plan at 1-888-310-4110 (TTY 711) , 8 am to 8 pm daily. You may   
also file a complaint with Medicare by calling 1-800-ME DICARE (1-800-633-4227) or directly   
with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.   
Section 1.2 We must ensure that you get timely access to your covered   
services and drugs   
You have the right to choose a pr imary care provider (PCP) in the plan’s network to provide and   
arrange for your covered se rvices. We do not require you to get referrals to go to network   
providers.

# Main Title : SECTION 2 You have some responsibilities as a member of the plan

Content:151 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 8 Your rights and responsibilities   
• You can visit the Medicare website to read or download the publication   
“Medicare Rights & Protections.” (T he publication is available at:   
www.medicare.gov/Pubs/pdf/11534-Medic are-Rights-and-Protections.pdf.)   
• Or, you can call 1-800-MEDICARE (1- 800-633-4227), 24 hours a day, 7 days a   
week (TTY 1-877-486-2048).   
SECTION 2 You have some responsibilities as a member of the   
plan   
Things you need to do as a member of the plan are listed below. If you have any questions,   
please call Customer Service.   
• Get familiar with your covered drugs and the rules you must follow to get these   
covered drugs. Use this Evidence of Coverage to learn what is covered for you and the   
rules you need to follow to get your covered drugs.   
• Chapters 3 and 4 give the details about your medical services.   
• Chapters 5 and 6 give the details abou t your Part D prescr iption drug coverage.   
• If you have any other health insurance cov erage or prescription drug coverage in   
addition to our plan, you are required to tell us. Chapter 1 tells you about coordinating   
these benefits.   
• Tell your doctor and other health care provid ers that you are enrolled in our plan.   
Show your plan membership card whenev er you get your medical care or Part D   
prescription drugs.   
• Help your doctors and other providers help you by giving them information, asking   
questions, and following through on your care.   
• To help get the best care, tell your doctors and other health providers about your   
health problems. Follow the treatment plans and instructions that you and your   
doctors agree upon.   
• Make sure your doctors know all of the drugs you are taking, including over-the-  
counter drugs, vitamins, and supplements.   
• If you have any questions, be sure to as k and get an answer you can understand.   
• Be considerate. We expect all our members to respect the rights of other patients. We   
also expect you to act in a way that help s the smooth running of your doctor’s office,   
hospitals, and other offices.   
• Pay what you owe. As a plan member, you are re sponsible for these payments:   
• You must continue to pay a premium for your Medicare Part B to remain a   
member of the plan.   
• For most of your medical services or drugs covered by the plan, you must pay   
your share of the cost when you get the service or drug.

# Main Title : CHAPTER 9: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Content:CHAPTER 9:   
What to do if you have a problem   
or complaint (coverage decisions,   
appeals, complaints)

# Main Title : SECTION 2 Where to get more information and personalized assistance

Content:154 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals,  
complaints)   
SECTION 1 Introduction   
Section 1.1 What to do if you have a problem or concern   
This chapter explains two types of pro cesses for handling problems and concerns:   
• For some problems, you need to use the process for coverage decisions and appeals.   
• For other problems, you need to use the process for making complaints; also called   
grievances.   
Both of these processes have been approved by Medicare. Each process has a set of rules,   
procedures, and deadlines that must be followed by us and by you.   
The guide in Section 3 will help you identify th e right process to use and what you should do.   
Section 1.2 What about the legal terms?   
There are legal terms for some of the rules, proc edures, and types of dead lines explained in this   
chapter. Many of these terms ar e unfamiliar to most people and can be hard to understand. To   
make things easier, this chapter:   
• Uses simpler words in place of certain legal terms. For example, this chapter generally   
says, “making a complaint” rather than “fi ling a grievance,” “covera ge decision” rather   
than “organization determination,” or “coverage determina tion” or “at-risk   
determination,” and “independe nt review organization” inst ead of “Independent Review   
Entity.”   
• It also uses abbreviations as little as possible.   
However, it can be helpful – a nd sometimes quite important – for you to know the correct legal   
terms. Knowing which terms to use will help you communicate more accurately to get the right help or information for your s ituation. To help you know which terms to use, we include legal   
terms when we give the details for handling specific types of situations.   
SECTION 2 Where to get more information and personalized    
assistance   
We are always available to help you. Even if you have a compla int about our treatment of you,   
we are obligated to honor your right to complai n. Therefore, you should always reach out to   
customer service for help. But in some situations, you may also want help or guidance from   
someone who is not connected with us. Be low are two entities th at can assist you.

# Main Title : SECTION 3 To deal with your problem, which process should you use?

Content:155 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals,  
complaints)   
State Health Insurance Assistance Program (SHIP)   
Each state has a government program with trai ned counselors. The program is not connected   
with us or with any insurance company or health plan. The couns elors at this program can help   
you understand which process you should use to ha ndle a problem you are having. They can also   
answer your questions, give you more inform ation, and offer guida nce on what to do.   
The services of SHIP counsel ors are free. You will find phone numbers and website URLs in   
Chapter 2, Section 3 of this document.   
Medicare   
You can also contact Medicare to get help. To contact Medicare:   
• You can call 1-800-MEDICARE (1-800-633- 4227), 24 hours a day, 7 days a week.   
TTY users should call 1-877-486-2048.   
• You can also visit the Medicare website (www.medicare.gov).   
SECTION 3 To deal with your problem, which process should you   
use?   
If you have a problem or concern, yo u only need to read the parts of this chapter that apply to   
your situation. The guide that follows will help.   
Is your problem or concern about your benefits or coverage? This includes problems about whet her medical care or prescrip tion drugs are covered or not,   
the way they are covered, and problems related to payment for medical care or prescription   
drugs.   
Yes.   
Go on to the next section of this chapter, Section 4, “A guide to the basics of   
coverage decisions and appeals.”   
No.   
Skip ahead to Section 10 at the end of this chapter: “How to make a complaint   
about quality of care, waiting times, customer service or other concerns.”

# Main Title : SECTION 4 A guide to the basics of coverage decisions and appeals

Content:156 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals,  
complaints)   
COVERAGE DECISIONS AND APPEALS   
SECTION 4 A guide to the basics of coverage decisions and    
appeals   
Section 4.1 Asking for coverage deci sions and making appeals: the big   
picture   
Coverage decisions and appeals deal with problems related to your benefits and coverage for   
medical services and prescription drugs, includ ing payment. This is the process you use for   
issues such as whether somethi ng is covered or not and the way in which something is covered.   
Asking for coverage decisions prior to receiving services   
A coverage decision is a decision we make about your benefits a nd coverage or about the amount   
we will pay for your medical services or drugs. For example, your plan network doctor makes a   
(favorable) coverage decision for you whenever you receive medical care from him or her or if   
your network doctor refers you to a medical specia list. You or your doctor can also contact us   
and ask for a coverage decision if your doctor is unsure whether we will cover a particular   
medical service or refuse s to provide medical care you think that you need. In other words, if you   
want to know if we will cover a medical service before you receive it, you can ask us to make a   
coverage decision for you. In limited circumstan ces a request for a coverage decision will be   
dismissed, which means we won’ t review the request. Examples of when a request will be   
dismissed include if the request is incomplete, if someone makes the request on your behalf but   
isn’t legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a   
request for a coverage decision, we will send a notice explaining why the request was dismissed   
and how to ask for a review of the dismissal.   
We are making a coverage decision for you whenever we decide what is covered for you and   
how much we pay. In some cases, we might deci de a service or drug is not covered or is no   
longer covered by Medicare for you. If you disagree with this coverage decision, you can make   
an appeal.   
Making an appeal   
If we make a coverage decision, whether before or after a service is received, and you are not   
satisfied, you can “appeal” the decision. An appeal is a formal way of asking us to review and   
change a coverage decision we have made. Under certain circumstances, which we discuss later,   
you can request an expedited or “fast appeal” of a coverage decision. Your appeal is handled by   
different reviewers than those w ho made the original decision.   
When you appeal a decision for the first time, this is called a Level 1 app eal. In this appeal, we   
review the coverage decision we made to check to see if we were properly following the rules.   
When we have completed the review, we give you our decision. In limited circumstances a

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

Content:158 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals,  
complaints)   
• While we can accept an appeal request without the form, we cannot begin or   
complete our review until we receive it. If we do not receive the form within 44   
calendar days after receiving your appeal request (our deadline for making a   
decision on your appeal), your appeal request will be dismissed. If this happens,   
we will send you a written notice explai ning your right to ask the independent   
review organization to review our decision to dismiss your appeal.   
• You also have the right to hire a lawyer. You may contact your own lawyer, or get the   
name of a lawyer from your local bar associa tion or other referral service. There are also   
groups that will give you free legal services if you qualify. However, you are not   
required to hire a lawyer to ask for any kind of coverage decision or appeal a decision.   
Section 4.3 Which section of this chapter gives the details for your   
situation?   
There are four different situa tions that involve coverage decisions and appeals. Since each   
situation has different rules and d eadlines, we give the details for each one in a separate section:   
• Section 5 of this chapter: “Your medical care: How to ask for a coverage decision or make an appeal”   
• Section 6 of this chapter: “Your Part D prescr iption drugs: How to ask for a coverage   
decision or make an appeal”   
• Section 7 of this chapter: “How to ask us to c over a longer inpatient hospital stay if you   
think the doctor is di scharging you too soon”   
• Section 8 of this chapter: “How to ask us to k eep covering certain medi cal services if you   
think your coverage is ending too soon” ( Applies only to these services: home health   
care, skilled nursing facility care, and Comprehensive Outpat ient Rehabilitation Facility   
(CORF) services)   
If you’re not sure which section you should be using, please call Cu stomer Service. You can also   
get help or information from governme nt organizations such as your SHIP.   
SECTION 5 Your medical care: How to ask for a coverage    
decision or make an appeal of a coverage decision   
Section 5.1 This section tells what to do if you have problems getting   
coverage for medical care or if you want us to pay you back   
for our share of the cost of your care   
This section is about your benefits for medical care and services. These benefi ts are described in   
Chapter 4 of this document: Medical Benefits Chart (what is covered and what you pay ). To   
keep things simple, we generally refer to “medical care coverage” or “medical care” which includes medical items and services as well as Medicare Part B prescr iption drugs. In some

# Main Title : SECTION 6 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

Content:166 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals,  
complaints)   
• We must give you our answer within 60 calenda r days after we receive your appeal. If   
you are asking us to pay you back for medical care you have already received and paid   
for, you are not allowed to ask for a fast appeal.   
• If the independent review organization deci des we should pay, we must send you or the   
provider the payment within 30 calendar days. If the answer to your appeal is yes at any   
stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.   
SECTION 6 Your Part D prescription drugs: How to ask for a   
coverage decision or make an appeal   
Section 6.1 This section tells you what to do if you have problems getting   
a Part D drug or you want us to pay you back for a Part D drug   
Your benefits include coverage for many prescription drugs. To be covered, the drug must be   
used for a medically accepted indication. (See Ch apter 5 for more inform ation about a medically   
accepted indication.) For details about Part D drug s, rules, restrictions, and costs please see   
Chapters 5 and 6. This section is about your Part D drugs only. To keep things simple, we   
generally say “drug” in the rest of this section, instead of repea ting “covered outpatient   
prescription drug” or “Part D drug” every time. We also use the term “drug list” instead of “List   
of Covered Drugs” or “Formulary.”   
• If you do not know if a drug is covered or if you meet the rules, you can ask us. Some   
drugs require that you get approval from us before we will cover it.   
• If your pharmacy tells you that your prescription cannot be filled as written, the   
pharmacy will give you a written notice expl aining how to contact us to ask for a   
coverage decision.   
Part D coverage decisions and appeals   
Legal Term   
An initial coverage decision about your Part D drugs is called a “coverage determination.”   
A coverage decision is a decision we make about your benefits a nd coverage or about the amount   
we will pay for your drugs. This section tells what you can do if you are in any of the following situations:   
• Asking to cover a Part D drug that is not on the plan’s List of Covered Drugs . Ask for an   
exception. Section 6.2   
• Asking to waive a restriction on the plan’s coverage for a drug (such as limits on the amount of the drug you can get). Ask for an exception. Section 6.2

# Main Title : SECTION 7 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

Content:175 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals,  
complaints)   
What if the review organization says no to your appeal?   
If this organization says no to part or all of your appeal, it means they agree with our decision   
not to approve your request (or part of your requ est). (This is called “upho lding the decision.” It   
is also called “turning down your appeal.”). In this case, the independe nt review organization   
will send you a letter:   
• Explaining its decision.   
• Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you   
are requesting meets a certain minimum. If th e dollar value of the drug coverage you are   
requesting is too low, you cannot make anothe r appeal and the decision at Level 2 is   
final.   
• Telling you the dollar value that must be in disp ute to continue with the appeals process.   
Step 4: If your case meets the requireme nts, you choose whether you want to   
take your appeal further.   
• There are three additional levels in the appeal s process after Level 2 (for a total of five   
levels of appeal).   
• If you want to go on to a Level 3 appeal the de tails on how to do this are in the written   
notice you get after your Level 2 appeal decision.   
• The Level 3 appeal is handled by an Administr ative Law Judge or attorney adjudicator.   
Section 9 in this chapter tell s more about Levels 3, 4, and 5 of the appeals process.   
SECTION 7 How to ask us to cover a longer inpatient hospital    
stay if you think the doctor is discharging you too   
soon   
When you are admitted to a hospital, you have the right to get all of your covered hospital   
services that are necessary to diagnos e and treat your il lness or injury.   
During your covered hospital stay, your doctor and the hospital staf f will be working with you to   
prepare for the day when you will leave the hospital. They will help arrange for care you may need after you leave.   
• The day you leave the hospital is called your “ discharge date .”   
• When your discharge date is decided, your doctor or the hospital staff will tell you.   
• If you think you are being asked to leave the hospital too s oon, you can ask for a longer   
hospital stay, and your reque st will be considered.

# Main Title : SECTION 8 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Content:182 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals,  
complaints)   
Step 3: If the independent review or ganization turns down your appeal, you   
choose whether you want to take your appeal further.   
• There are three additional levels in the appeal s process after Level 2 (for a total of five   
levels of appeal). If reviewers say no to your Level 2 appeal, you decide whether to   
accept their decision or go on to Level 3 appeal.   
• Section 9 in this chapter te lls more about Levels 3, 4, a nd 5 of the appeals process.   
SECTION 8 How to ask us to keep covering certain medical    
services if you think your coverage is ending too   
soon   
Section 8.1 This section is only about three services:   
Home health care, skilled nursing facility care, and   
Comprehensive Outpatient Rehabilitation Facility (CORF) services   
When you are getting home health services, skilled nursing care, or rehabilitation care   
(Comprehensive Outpatient Rehabilitation Facility) , you have the right to keep getting your   
covered services for that type of care for as long as the care is needed to diagnose and treat your   
illness or injury.   
When we decide it is time to stop covering any of the three type s of care for you, we are required   
to tell you in advance. When your coverage for that care ends, we will stop paying our share of   
the cost for your care. If you think we are ending the c overage of your care too soon, you can appeal our decision.   
This section tells you how to ask for an appeal.   
Section 8.2 We will tell you in advan ce when your coverage will be ending   
Legal Term   
“Notice of Medicare Non-Coverage.” It tells you how you can request a “fast-track   
appeal.” Requesting a fast-track appeal is a formal , legal way to request a change to our   
coverage decision about wh en to stop your care.   
1. You receive a notice in writing at least two days before our plan is going to stop   
covering your care. The notice tells you:   
• The date when we will stop covering the care for you.

# Main Title : SECTION 9 Taking your appeal to Level 3 and beyond

Content:188 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals,  
complaints)   
Step 3: If the independent review organization says no to your appeal, you   
choose whether you want to take your appeal further.   
• There are three additional levels of appeal after Level 2, for a total of five levels of   
appeal. If you want to go on to a Level 3 appe al, the details on how to do this are in the   
written notice you get after your Level 2 appeal decision.   
• A Level 3 appeal is reviewed by an Administr ative Law Judge or attorney adjudicator.   
Section 9 in this chapter te lls more about Levels 3, 4, a nd 5 of the appeals process.   
SECTION 9 Taking your appeal to Level 3 and beyond   
Section 9.1 Appeal Levels 3, 4 a nd 5 for Medical Service Requests   
This section may be appropriate for you if you have made a Level 1 appeal and a Level 2 appeal, and both of your appeals have been turned down.   
If the dollar value of the item or medical service you have ap pealed meets certain minimum   
levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the   
minimum level, you cannot appeal any further. Th e written response you receive to your Level 2   
appeal will explain how to make a Level 3 appeal.   
For most situations that involve appeals, the last thr ee levels of appeal wo rk in much the same   
way. Here is who handles the review of your appeal at each of these levels.   
Level 3 appeal An Administrative Law Judge or an attorney adjudicator who works for   
the Federal government will review your appeal a nd give you an answer.   
• If the Administrative Law Judge or attorney adjudicator says yes to your appeal,   
the appeals process may or may not be over. Unlike a decision at a Level 2 appeal, we   
have the right to appeal a Level 3 decision that is favorable to you. If we decide to appeal,   
it will go to a Level 4 appeal.   
• If we decide not to appeal, we must authorize or provide you with the service   
within 60 calendar days af ter receiving the Administrative Law Judge’s or   
attorney adjudicator’s decision.   
• If we decide to appeal the decision, we will send you a copy of the Level 4 appeal   
request with any accompanying documents. We may wait for the Level 4 appeal   
decision before authorizing or providing the service in dispute.   
• If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process may or may not be over .   
• If you decide to accept this decision that turns down your appeal, the appeals   
process is over.

# Main Title : SECTION 10 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Content:191 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals,  
complaints)   
MAKING COMPLAINTS   
SECTION 10 How to make a complaint about quality of care,    
waiting times, customer service, or other concerns   
Section 10.1 What kinds of problems are handled by the complaint   
process?   
The complaint process is only used for certain types of problems . This includes pr oblems re  
lated   
to quality of care, waiting times , and the customer service. Here are examples of the kinds of   
problems handled by the complaint process.   
Complaint Example   
Quality of  
 your medical   
care • Are you unhappy with the quality of the care you have   
received (including care in the hospital)?   
Respecting your privacy • Did someone not respect your right to privacy or share   
confidential information  
?   
Disrespect, poor custom  
er   
service, or other negative behaviors • Has someone been rude or disrespectful to you?   
• Are you unhappy with our Customer Service?   
• Do you feel you are being enc ouraged to leave the plan?   
Waiting times • Are you having trouble gett ing an appointment, or   
waiting too long to get it?   
• Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our   
Customer Se  
rvice or other staff at the plan?   
• Examples include waiting too long on the phone, in   
the waiting or exam room, or getting a prescription.   
Cleanliness •   
 Are you unhappy with the cleanliness or condition of a   
clinic, hospital, or doctor’s office?   
Information you get from us • Did we fail to give you a required notice?   
• Is our written informatio n hard to understand?

# Main Title : CHAPTER 10: Ending your membership in the plan

Content:CHAPTER 10:   
Ending your membership in the plan

# Main Title : SECTION 2 When can you end your membership in our plan?

Content:196 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 10 Ending your membership in the plan   
SECTION 1 Introduction to ending yo ur membership in our plan   
Ending your membership in Blue Medicare Essential Plus may be voluntary (your own choice)   
or involuntary (not your own choice):   
• You might leave our plan because you have decided that you want to leave. Sections 2   
and 3 provide information on endi ng your membership voluntarily.   
• There are also limited situations where we are required to end your membership. Section   
5 tells you about situations when we must end your membership.   
If you are leaving our plan, our plan must continue to provide your medical ca re and prescription   
drugs and you will continue to pay your share of the cost until your membership ends.   
SECTION 2 When can you end your membership in our plan?   
Section 2.1 You can end your memb ership during the Annual Enrollment   
Period   
You can end your membership in our plan during the Annual Enrollment Period (also known   
as the “Annual Open Enrollment Period”). Du ring this time, review your health and drug   
coverage and decide about c overage for the upcoming year.   
• The Annual Enrollment Period is from October 15 to December 7 .   
• Choose to keep your current coverage or make changes to your coverage for the   
upcoming year. If you decide to change to a ne w plan, you can choose any of the   
following types of plans:   
• Another Medicare health plan with or without prescription drug coverage.   
• Original Medicare with a separate Medicare pr escription drug plan.   
• Original Medicare without a separate Medicare prescription drug plan.   
• If you choose this option, Medicare may enroll you in a drug plan,   
unless you have opted out of automatic enrollment.   
Note: If you disenroll from Medicare prescription drug coverage and go without   
creditable prescription drug coverage for 63 or more days in a row, you may have   
to pay a Part D late enrollment penalty if you join a Medicare drug plan later.   
• Your membership will end in our plan when your new plan’s coverage begins on   
January 1.

# Main Title : SECTION 3 How do you end your membership in our plan?

Content:198 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 10 Ending your membership in the plan   
To find out if you are eligible for a Special Enrollment Period , please call Medicare at 1-800-  
MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.   
If you are eligible to end your membership becau se of a special situation, you can choose to   
change both your Medicare health coverage a nd prescription drug coverage. You can choose:   
• Another Medicare health plan with or without prescription drug coverage.   
• Original Medicare with a separate Medicare prescription drug plan.   
• – or – Original Medicare without a se parate Medicare prescription drug plan.   
Note: If you disenroll from Medicare prescription drug coverage and go without   
creditable prescription drug coverage for a continuous period of 63 days or more, you   
may have to pay a Part D la te enrollment penalty if you join a Medicare drug plan   
later.   
Your membership will usually end on the first day of the month af ter your request to change   
your plan is received.   
If you receive “Extra Help” from Medic are to pay for your prescription drugs: If you   
switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan,   
Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment   
Section 2.4 Where can you get more information about when you can end   
your membership?   
If you have any questions about ending your membership you can:   
• Call Customer Service .   
• You can find the information in the Medicare & You 2023 handbook.   
• Contact Medicare at 1-800-MEDICARE (1-800-633- 4227), 24 hours a day, 7 days a   
week. TTY users shou ld call 1-877-486-2048.   
SECTION 3 How do you end your membership in our plan?   
The table below explains how you should end your membership in our plan.

# Main Title : SECTION 4 Until your membership ends, you must keep getting your medical services and drugs through our plan

Content:199 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 10 Ending your membership in the plan   
If you would like to switch from   
our plan to: This is what you should do:  
• Another Medicare health plan. • Enroll in the new Medicare health plan. You will automatically be disenrolled fro  
m Blue   
Medicare Essential Plus when your new plan’s coverage begins.   
• Original Medicare with a separate   
Medicare prescription drug plan. • Enroll in the new Medicare prescription drug plan.   
You will automatically be disenrolled from Blue Medicare Essential Plus when your new plan’s coverage begins.   
• Original Medicare without a   
separate Medicare prescription drug plan.   
• • Send us a written request to disenroll.   
Contact Customer Service if you need more information on how to do this.   
• You can also contact Medicare, at 1-800-  
MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled.   
TTY users should call 1-877-486-2048.   
• You will be disenrolled from Blue Medicare Essential Plus when your coverage in Original   
Medicare begins.   
SECTION 4 Until your membersh ip ends, you must keep getting   
your medical services and drugs through our plan   
Until your membership ends and your new Medicare coverage begins, you must continue to get your medical care and prescrip tion drugs through our plan.   
• Continue to use our network providers to receive medical care.   
• Continue to use our network pharmacies or mail-order to get your prescriptions   
filled.   
• If you are hospitalized on the day that your membership ends, your hospital stay   
will be covered by our plan until you are discharged (even if you are discharged after   
your new health coverage begins).

# Main Title : SECTION 5 Blue Medicare Essential Plus must end your membership in the plan in certain situations

Content:200 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 10 Ending your membership in the plan   
SECTION 5 Blue Medicare Essen tial Plus must end your   
membership in the plan in certain situations   
Section 5.1 When must we end your membership in the plan?   
Blue Medicare Essential Plus must end your memb ership in the plan if any of the following   
happen:   
• If you no longer have Medicare Part A and Part B.   
• If you move out of our service area.   
• If you are away from our service area for more than six months.   
• If you move or take a long trip, call Custom er Service to find out if the place you   
are moving or traveling to is in our plan’s area.   
• If you become incarcerated (go to prison).   
• If you are no longer a United States citizen or lawfully present in the United States.   
• If you lie or withhold inform ation about other insuran ce you have that provides   
prescription drug coverage.   
• If you intentionally give us in correct information when you ar e enrolling in our plan and   
that information affects your el igibility for our plan. (We can not make you leave our plan   
for this reason unless we get pe rmission from Medicare first.)   
• If you continuously behave in a way that is di sruptive and makes it difficult for us to   
provide medical care for you a nd other members of our pla n. (We cannot make you leave   
our plan for this reason unless we get permission from Medicare first.)   
• If you let someone else use your membership card to get me dical care. (We cannot make   
you leave our plan for this reason unless we get permi ssion from Medicare first.)   
• If we end your membership because of this reason, Medicare may have your case   
investigated by the Inspector General.   
• If you are required to pay the extra Part D amount because of your income and you do not   
pay it, Medicare will disenroll you from our plan and you will lose prescription drug   
coverage.   
Where can you get more information?   
If you have questions or would like more info rmation on when we can end your membership,   
call Customer Service.

# Main Title : CHAPTER 11: Legal notices

Content:CHAPTER 11:   
Legal notices

# Main Title : SECTION 3 Notice about Medicare Secondary Payer subrogation rights

Content:203 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 11 Legal notices   
SECTION 1 Notice about governing law   
The principal law that applies to this Evidence of Coverage document is Title XVIII of the Social   
Security Act and the regulations created under the Social Security Act by the Centers for   
Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under   
certain circumstances, the laws of the state you live in. This may affe ct your rights and   
responsibilities even if the laws are not included or e xplained in this document.   
SECTION 2 Notice about nondiscrimination   
We don’t discriminate based on race, ethnicity, national orig in, color, religion, sex, gender, age,   
sexual orientation, mental or physical disabilit y, health status, claims experience, medical   
history, genetic information, evid ence of insurability, or geographic location within the service   
area. All organizations that provide Medicare Advantage plans, like our plan, must obey Federal   
laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation   
Act of 1973, the Age Discriminati on Act of 1975, the Amer icans with Disabilities Act, Section   
1557 of the Affordable Care Act, and all other laws that apply to organizations that get Federal   
funding, and any other laws and rules that apply for any other reason.   
If you want more information or ha ve concerns about discriminati on or unfair tr eatment, please   
call the Department of Health and Human Services’ Office for Civil Rights at 1-800-368-1019   
(TTY 1-800-537-7697) or your local Office for Civil Right s. You can also review information   
from the Department of Health and Huma n Services’ Office for Civil Rights at   
https://www.hhs.gov/ocr/index.   
If you have a disability and need help with access to care, please call us at Customer Service. If   
you have a complaint, such as a problem with wheelchair access, Customer Service can help.   
SECTION 3 Notice about Medicare Secondary Payer subrogation   
rights   
We have the right and responsibilit y to collect for covered Medicare services for which Medicare   
is not the primary payer. According to CM S regulations at 42 CFR sections 422.108 and   
423.462, Blue Medicare Essential Plus, as a Medi care Advantage Organiza tion, will exercise the   
same rights of recovery that the Secretary exercises under CMS regulations in subparts B   
through D of part 411 of 42 CFR and the rules esta blished in this section supersede any State   
laws.

# Main Title : SECTION 6 Notice about Blue Cross and Blue Shield of North Carolina (Blue Cross NC)

Content:204 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 11 Legal notices   
SECTION 4 Nondiscrimination and Accessibility Notice   
Blue Cross and Blue Shield of North Carolina (Blue Cross NC) provides free aids to service   
people with disabilities as well as free language services for pe ople whose primary language is   
not English. Please contact the Customer Servi ce number on the back of your ID card for   
assistance.   
Blue Cross and Blue Shield of North Carolina (Blue Cross NC) proporciona asistencia gratuita a   
las personas con discapacidades, así como servicios li ngüísticos gratuitos pa ra las personas cuyo   
idioma principal no es el inglés. Comuníquese con el número para servicio al cliente que aparece   
en el reverso de su tarjeta del seguro para obtener ayuda.   
SECTION 5 Notice about the plan formulary   
The plan formulary contains impor tant information about what drugs the plan covers. The plan   
cannot cover drugs that are not c onsidered to be Part B or Part D drugs as defined by law.   
Certain categories of drugs were specifically excluded by Congress from being covered as Part D   
drugs. The formulary can be found on our website at www.medicare.BlueCrossNC.com. You may also call Customer Serv ice to request a hard copy.   
SECTION 6 Notice about Blue Cro ss and Blue Shield of North   
Carolina (Blue Cross NC)   
This Evidence of Coverage is a contract between you and Blue Cross and Blue Shield of North   
Carolina (Blue Cross NC), which is an indepe ndent corporation operati ng under a license from   
the Blue Cross and Blue Shield Association, an association of independent Blue Cross and/or   
Blue Shield plans, permitting Blue Cross NC to use the Blue Cross and Blue Shield service marks in the state of North Caroli na. Blue Cross NC is not contra cting as an agent of the Blue   
Cross and Blue Shield Association. You he reby acknowledge and agree that you have not   
entered into this policy based upon representation s by any person other than Blue Cross NC and   
that no person, entity or organi zation other than Blue Cross NC shall be held accountable or   
liable to you for any obligations to you created u nder this policy. This paragraph does not create   
any additional obligations whatsoever on the part of Blue Cross NC other than those obligations   
created under other provisions of this agreement or under applicable law.   
The Blue Cross and Blue Shield Association is a trade association fo r independent, locally   
operated Blue Cross and/or Blue Shield Plans (L icensees). Neither the Association nor any one   
of the independent Blue Cross a nd Blue Shield Licensees are accountable or liable for the actions   
or inactions of another Blue Cr oss and Blue Shield Licensee.

# Main Title : SECTION 8 The Women’s Health and Cancer Rights Act (WHCRA) of 1998

Content:205 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 11 Legal notices   
SECTION 7 Third Party Liability (Subrogation Right)   
Subrogation means that the plan is allowed to re cover the amount of medi cal benefits the plan   
paid as a result of an illne ss or injury to you, which was caused by someone else. If we pay   
benefits for medical or dental expenses you incur as a result of any act of a third party for which   
the third party is or may be lia ble, and you later obtain recover y, you are obligated to reimburse   
us for the benefits paid in accordance with 42 C.F.R. § 422.108. Nothing herein shall limit our   
right to recovery from another source that may otherwise exist at law. If you make a claim   
against a third party for damage s that include repayment for medical and medically related   
expenses incurred for your benef it, you must provide timely writt en notice to us of the pending   
or potential claim by writing to Cust omer Service at the address for th e plan listed in Section 1 of   
Chapter 2 of this Evidence of Coverage. Additio nally, you must, at the plan's request, give us   
any information we may need and sign any docum ents that may be required to assist in   
recovering the amount of benefits paid and do noth ing to prejudice plan's subrogation rights. We   
may, at our option, take such action as may be appropriate and nece ssary to preserve our rights   
under this third party liability/subrogation provi sion, including the right to intervene in any   
lawsuit you have commenced with a third part y. If you have a claim against another person,   
your plan will deny payment of all medical bills pending settlement of the claim against the other   
person. If there is not a prompt settlement, your plan will conditionally pay the medical bills and require that you reimburse the pla n. For this purpose, the definiti on of prompt will be 120 days   
after the earlier of the following: 1) the date a claim is filed w ith the third party or the third   
party's insurer or a lien is filed against a potential liability settlement; or 2) the date the service   
was furnished or, in the case of inpatient hospital services, the date of discharge.   
SECTION 8 The Women’s Health and Cancer Rights Act (WHCRA)    
of 1998   
As required by the Women’s Health and Can cer Rights Act (WHCRA) of 1998, this plan   
provides coverage for:   
1. All stages of reconstruction of the breast on which the mastectomy has been performed;   
2. Surgery and reconstruction of the other brea st to produce a symmetr ical appearance; and   
3. Prostheses and physical complications of mastectomy, including lymphedemas, in a   
manner determined in consulta tion with the attending physician and the patient. Such   
coverage may be subject to annual deductib les and coinsurance provisions as may be   
deemed appropriate and are cons istent with those establishe d for other benefits under the   
plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollmen t and annually thereafter.   
Contact Customer Service for more information.

# Main Title : SECTION 12 Out-of-Area Services

Content:206 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 11 Legal notices   
SECTION 9 Incentives   
Blue Medicare Essential Plus requires that provi ders and staff make deci sions about care based   
on medical necessity and the existe nce of coverage at the time of service. We do not provide any   
incentives to encourage denial of care or denial of claims. You can be confident that your   
doctors are free to investigate and consider appropriate treatment protocols free from any   
influence from your plan.   
SECTION 10 Disagreement with the network provider’s    
recommended treatment or receiving services that    
are non-covered by Blue Cross NC   
When you enroll in our plan, you agree that your PCP and other network providers are   
responsible for determining the treatment that is appropriate and medically necessary for your   
care. You have the right to participate fully in decisions about your he alth care. You may (for   
personal or religious reasons) refuse to accept the procedures or treatments recommended by   
your network provider. Or, you ma y request treatment that a ne twork provider judges to be   
incompatible with generally accepted professional standards of medical care. You have the right   
to refuse the treatment advice of the network provider. This incl udes the right to leave a hospital   
or other medical facility, even if your doctor advises you not to l eave, and the right to stop taking   
your medication. If you refuse treatment, you accept responsibility for what happens as a result   
of your refusing treatment.   
You also have the right to seek care that is not covered by our plan. However, we will have no   
obligation to pay for any care ob tained in these instances. You can request a de termination of   
coverage directly from us using the process described in Chapter 9, Section 5.2 of this book.   
SECTION 11 Notice about assignment of benefits   
Assignment means the transfer of your rights to the benefits provided by our plan to another   
person, corporation, or organiza tion. You cannot assign any benefi t or the right to receive   
payment due under our plan to any person, corporat ion or other organizati on without our written   
consent. Any assignment by you will be void.   
SECTION 12 Out-of-Area Services   
Blue Cross NC has relationships with other Blue Cross and/or Blue Shield Licensees (“Host   
Blues”) referred to generally as the “M edicare Advantage Program.” When you access   
healthcare services outside the geographic area Blue Cross NC serves, the claim for those   
services will be processed through the Medicare Advantage Program an d presented to Blue   
Cross NC for payment in accordance with the ru les of the Medicare Advantage Program policies   
then in effect.

# Main Title : SECTION 13 Notice of Privacy Practices of Blue Cross NC

Content:207 2023 Evidence of Coverage for Blue Medicare Essential Plus   
Chapter 11 Legal notices   
SECTION 13 Notice of Privacy Practices of Blue Cross NC   
THIS NOTICE DESCRIBES HOW MEDICA L INFORMATION ABOUT YOU MAY BE   
USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS   
INFORMATION.   
PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL   
INFORMATION IS IMPORTANT TO US.   
Our Responsibilities   
We are committed to protecting the privacy of the medical in formation and other personal   
information we keep regarding our members. We call this information Protected Health   
Information or “PHI” throughout this notice. We are required by law to maintain the privacy of   
your Protected Health Informa tion. We are also required to gi ve you this notice about our   
privacy practices, our legal duties, and your rights concerning your PHI. We must follow the   
privacy practices that are described in this notice while it is in effect. This notice is effective as   
of July 1, 2013 and will remain in pl ace until we replace it.   
We reserve the right to change this notice and ou r privacy practices at any time, provided such   
changes are permitted by applicable law. We also reserve the right to make the changes in our   
privacy practices and the new notice effective for all PHI that we already have about you as well   
as for PHI that we may receive in the future. Be fore we make a material change in our privacy   
practices, we will update this notice and send the ne w notice to our health plan subscribers at the   
time of the change or as required by applicable law.   
You may request a copy of this notice by calling the customer service number on the back of   
your identification card. You may also obtain a copy from our Web site,   
www.Medicare.BlueCrossNC.com. For more info rmation or questions about our privacy   
practices, please contact the Pr ivacy Official by writing to P. O. Box 2291, Durham, NC 27702.   
How We Use and Disclose Your Protected Health Information   
We may use and disclose your PHI as permit ted by federal and stat e privacy laws and   
regulations, including the fede ral health care privacy regu lations known as “HIPAA.” If an   
applicable state privacy law is more protective of your health in formation or is more stringent   
than HIPAA, we will follow the state law. Fo r example, some state laws have stricter   
requirements about disclosing information about certain conditions or treatment for certain   
conditions such as HIV, AIDS, mental healt h, substance abuse/chemic al dependency, genetic   
testing or reproductive rights.   
If you cease to be a member, we will no longer disclose your PHI, except as permitted or   
required by law.

# Main Title : CHAPTER 12: Definitions of important words

Content:CHAPTER 12:   
Definitions of important words