# Main Title : Evidence of Coverage:

Content:January 1 – December 31, 2023   
Evidence of Coverage:   
Your Medicare Health Benefits and Services and Prescription Drug Coverage   
as a Member of Blue Medicare EnhancedSM (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 Enhanced, is offered by Blue Cross and Blue Shield of North Carolina (Blue Cross NC). (When this Evidence of Coverage says “we,” “us,” or “our,” it means Blue Cross NC. When it says “plan” or “our plan,” it means Blue Medicare Enhanced.)   
This document is available in languages other than English, in braille, in large print, or other alternate formats. Please call Customer 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 necessary. We will notify affected enrollees about changes at least 30 days in advance.   
This document explains your benefits and rights. Use this document to understand about:   
•Your plan premium and cost sharing;  
•Your medical 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 need further assistance; and,  
•Other protections required by Medicare law.  
Y0079\_10113\_C CMS Approved 09122022 MEENIN H3449-024  
OMB Approval 0938-1051 (Expires February 29, 2024)

# Main Title : Table of Contents

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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 Enhanced, 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 Enhanced.   
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 Enhanced 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 information 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 Internal Revenue Service (IRS) website 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 covered, what you pay as a member   
of the plan, and how to file a complaint if you are not satisfied with a decision or treatment.   
The words “coverage” and “covered services” refer to the medical care and services and the prescription drugs available to you as a member of Blue Medicare Enhanced.  
   
It’s important for you to learn what the plan’s rules are and what services are available to you. We encourage you to set aside some time to look through this Evidence of Coverage document.   
If you are confused, concerned, or just have a question, please contact Customer Service.   
   
   
Section 1.3 Legal information about the Evidence of Coverage   
This Evidence of Coverage is part of our contract with you about how Blue Medicare Enhanced covers your care. Other parts of this contract include your enrollment form, the List of Covered Drugs (Formulary), and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called “riders” or “amendments.”

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

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Chapter 1 Getting started as a member   
The contract is in effect for months in which you are enrolled in Blue Medicare Enhanced   
between January 1, 2023 and December 31, 2023.   
Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of Blue Medicare Enhanced 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 Medicare & Medicaid Services) must approve Blue Medicare Enhanced each year. You can continue each year to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.   
SECTION 2 What makes you eligible to be a plan member?   
Section 2.1 Your eligibility requirements   
You are eligible for membership in our plan as long as:   
•You have both Medicare Part A and Medicare Part B  
•-- and -- you live in our geographic service area (Section 2.2 below describes our servicearea). Incarcerated individuals are not considered living in the geographic service areaeven if they are physically located in it.  
•-- and -- you are a United States citizen or are lawfully present in the United States  
Section 2.2 Here is the plan service area for Blue Medicare Enhanced   
Blue Medicare Enhanced is available only to individuals who live in our plan service area. To   
remain a member of our plan, you must continue to reside in the plan service area. The service   
area is described below.   
Our service area includes these counties in North Carolina:   
Segment 001 (H3449-024-001)   
Alamance  
Buncombe  
Burke  
CatawbaDurham  
Gaston  
GuilfordHaywood  
Orange  
RandolphRockingham  
Rutherford  
Wake

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

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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 Blue Medicare Enhanced   
membership card, you may have to pay the full cost of medical services yourself. Keep your   
Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice   
services, or participate in 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 Enhanced auth orizes use of out-of-network providers.

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

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Chapter 1 Getting started as a member   
SECTION 4 Your monthly costs for Blue Medicare Enhanced   
Your costs may include the following:   
• Plan Premium (Section 4.1)   
• Monthly Medicare Part B Premium (Section 4.2)   
• Optional Supplemental Benefit Premium (Section 4.3)   
• Part D Late Enrollment Penalty (Section 4.4)   
• Income Related Monthly Adjusted Amount (Section 4.5)   
In some situations, your plan premium could be less   
There are programs to help people with limited resources pay for their drugs. These include   
“Extra Help” and State Pharmaceutical Assistance Programs. Chapter 2, Section 7 tells more   
about these programs. If you qualify, enrolling in the program might lower your monthly plan premium.   
If you are already enrolled and getting help from one of these programs, the information about premiums in this Evidence of Coverage may not apply to you. We will send you a separate insert, called the “Evidence of Coverage 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 have this insert, please call Customer Service, and ask for the “LIS Rider.”   
Medicare Part B and Part D premiums differ for people with different incomes. If you have questions about these premiums review your copy of Medicare & You 2023 handbook, the section called “2023 Medicare Costs.” If you need a copy, you can download it from the Medicare website (  
www.medicare.gov ). Or you can order a printed copy by phone at 1-800-  
MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.   
Section 4.1 Plan premium   
As a member of our plan, you pay a monthly plan premium. The tables below show the monthly plan premium amount for each region we serve.   
Segment 001 (H3449-024-001)   
Blue Medicare Enhanced premium is $19 for members in the counties listed below:   
Alamance  
Buncombe  
Burke  
Catawba Durham  
Gaston  
Guilford Haywood  
Orange  
Randolph Rockingham  
Rutherford   
Wake

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

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Chapter 1 Getting started as a member   
SECTION 5 More information about your monthly premium   
Section 5.1 There are several ways you can pay your plan premium   
There are six ways you can pay your plan premium.   
Option 1: Paying by check   
You may decide to pay your premium directly to our plan by check or money order. If you   
choose this option, we will send you a monthly invoice. Checks or money orders should be   
made payable to Blue Medicare Enhanced and sent directly to the plan at the following address:   
Blue Medicare Enhanced   
PO Box 580042   
Charlotte, NC 28258-0042   
You may also bring a check or money order (not cash) to the plan in person at 5660 University Parkway, Winston-Salem, NC 27105, Monday through Friday from 8 am to 5 pm: or, at 1965 Ivy Creek Boulevard, Durham, NC 27707, Monday through Friday from 8 am to 5 pm. Please write your member number the check or money order and include the bottom of your invoice with the payment. Your premium payment is due the 1st day of each month.   
Option 2: Paying online   
If you choose to receive a monthly invoice, you can pay online using your bank account and routing number or credit card via our member portal, Blue Connect, by visiting   
www.Medicare.BlueCrossNC.com . You must register for a member account or log in to use this   
feature. If you choose this option, you will need to log in to Blue Connect to pay each invoice   
you receive.   
Option 3: Paying by automatic bank withdrawal after you have enrolled in the plan   
You may have your premium automatically withdrawn from your bank account after you are a member of the plan. You can change to this method of payment by filling out the information on the back of your invoice, or you can print an Authorization for Automatic Bank Draft form at   
www.Medicare.BlueCrossNC.com . If you need more information about starting automatic bank   
withdrawal, you may call Customer Service. Your premium is due the 1st day of each month. The automatic bank draft deduction will be made from your bank account on the 5th business   
day of each month. If you do not have enough money in your bank account, we may try up to two times and your bank may charge service fees.   
Option 4: Paying by phone   
If you choose to receive a monthly invoice, you can pay by calling our toll-free automated pay-by-phone number at 1-844-395-4535. You can use your bank account and routing number

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

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Chapter 1 Getting started as a member   
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 year. If the monthly plan premium changes for next year we will tell you in September   
and the change will take effect on January 1.   
However, in some cases the part of the premium that you have to pay can change during the year. This happens if you become eligible for the “Extra Help” program or if you lose your eligibility for the “Extra Help” program during the year. If a member qualifies for “Extra Help” with their prescription drug costs, the “Extra Help” program will pay part of the member’s monthly plan premium. A member who loses their eligibility during the year will need to start paying their full monthly premium. 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 your enrollment form, including your address and telephone number. It shows your specific plan coverage including your Primary Care Provider.   
The doctors, hospitals, pharmacists, 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 important that you help us keep your information up to date.   
Let us know about these changes:   
• Changes to your name, your address, or your phone number   
• Changes in any other health insurance coverage you have (such as from your employer,   
your spouse’s employer, workers’ compensation, or Medicaid)   
• If you have any liability claims, such as claims from an automobile accident   
• If you have been admitted to a nursing home   
• If you receive care in an out-of-area or out-of-network hospital or emergency room   
• If your designated responsible party (such as a caregiver) changes   
• If you are participating in a clinical research study (Note: You are not required to tell   
your plan about the clinical research studies, you intend to participate in, but we encourage you to do so)

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

Content:18 2023 Evidence of Coverage for Blue Medicare Enhanced   
Chapter 1 Getting started as a member   
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 othe  
r 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   
coverage. The secondary payer may not pay all of the uncovered costs. If you have other   
insurance, tell your doctor , hospital, and pharmacy.   
These rules apply for employer or union group health plan coverage:   
• If you have retiree coverage , Medicare pays first.   
• If your group health plan coverage is based on your or a family member’s current   
employment, who pays first depends on your  
 age, the number of people employed by   
your employer, and whether you have Medicare based on age, disab ility, or End-Stage   
Renal Disease (ESRD):   
o If you’re under 65 and disabled and you or your family member is still working,   
your group health plan pays first if the em  
ployer has 100 or more employees or at   
least one employer in a mult iple employer plan that ha s more than 100 employees.   
o If you’re over 65 and you or your spouse is still working, your group health plan   
pays first if the employer has 20 or more   
employees or at leas t one employer in a   
multiple employer plan that has more than 20 employees.   
• If you have Medicare because of ESRD, your group health plan will pay first for the first   
30 months after you become eligible for Medicare.

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

Content:CHAPTER 2:   
Important phone numbers   
and resources

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

Content:21 2023 Evidence of Coverage for Blue Medicare Enhanced   
Chapter 2 Important phone numbers and resources   
SECTION 1 Blue Medicare Enhanced 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 Enhanced Customer Service. We will be happy to help you.   
Method Customer Service – Contact Information   
C  
ALL 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 Enhanced   
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:26 2023 Evidence of Coverage for Blue Medicare Enhanced   
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 “CM  
S”). 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 in  
formation 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   
Medica  
re eligibility and enrollment options with the fo llowing tools:   
• Medicare Eligibility Tool: Provides Medicare eligibility   
status information.   
• Medicare Plan Finder: Provides personalized information   
about available Medicare prescr  
iption 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:28 2023 Evidence of Coverage for Blue Medicare Enhanced   
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 tr  
eatment, 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   
o Option #1: You can have a live chat with a 1-800   
MEDICARE representative   
o Option #2: You can select your STATE from the dropdown   
menu and click GO. This will take y  
ou 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:29 2023 Evidence of Coverage for Blue Medicare Enhanced   
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:30 2023 Evidence of Coverage for Blue Medicare Enhanced   
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 kno  
w.   
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 conduc  
t 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 Friday.   
WEBSITE www.ssa.gov

# Main Title : SECTION 6 Medicaid

Content:31 2023 Evidence of Coverage for Blue Medicare Enhanced   
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 P  
rograms” 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 als  
o 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 b   
enefits (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 S  
ervice 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:32 2023 Evidence of Coverage for Blue Medicare Enhanced   
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 the Low Income Subsidy   
(LIS) copay  
ment 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 Enhanced   
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:36 2023 Evidence of Coverage for Blue Medicare Enhanced   
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 y  
our 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 are 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 contact 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 carecovered as a member of our plan

Content:38 2023 Evidence of Coverage for Blue Medicare Enhanced   
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 th  
is 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 med  
ical 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 your medical care covered by the plan   
As a Medicare health plan, Blue Medicare Enhan ced must cover all servi ces covered by Original   
Medica  
re and must follow Original Medicare’s coverage rules.   
Blue Medicare Enhanced will generally 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 yourmedical care

Content:39 2023 Evidence of Coverage for Blue Medicare Enhanced   
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:   
o The plan covers emergency care or urgent ly needed services that you get from an   
out-of-network provider. For more info  
rmation about this, and to see what   
emergency or urgently needed services means, see Section 3 in this chapter.   
o 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, y  
ou 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.   
o 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.   
o 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:42 2023 Evidence of Coverage for Blue Medicare Enhanced   
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 fu  
rnish 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 th  
at 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:Section 5.1 What is a “clinical research study”? 45 2023 Evidence of Coverage for Blue Medicare Enhanced   
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 f  
ull 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 Enhanced covers all medically necessary services as listed in the Medical   
Benefits Chart in Chapter 4 of this document.   
If you receive services not covered by our plan or   
services obtained out-of-network and were not authorized, you are 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”?   
A clinical research study (also called a “clinical trial”) is a way that doctors and scientists test   
new types of medical care, like how well a new 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 con  
tact 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:47 2023 Evidence of Coverage for Blue Medicare Enhanced   
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   
Institu  
tion  
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” medical care or treatment is any medical care or treatment that is   
voluntary  
 and not required by any federal, state, or local law.   
• “Excepted” medical treatment is medical care or 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:48 2023 Evidence of Coverage for Blue Medicare Enhanced   
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:   
o You must have a medical condition that would allow you to receive covered   
servic  
es for inpatient hospital care or skilled nursing facility care.   
o– and – you must get approval in advance from our plan before you are admitted   
to the facility, or your stay will no  
t 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   
months. As a member of Blue Medicare Enhanced, however, you   
usually will not acquire ownership of rented DME items no matter how many copayments you   
make for the item while a member of our plan, even if you made up to 12 consecutive payments   
for the DME item under Original Medicare before you joined our plan. Under certain limited   
circumstances, we will transfer ownership of the DME item to you. Call Customer Service for   
more information.   
What happens to payments you made for durable medical equipment if you   
switch to  
 Original Medicare?   
If you did not acquire ownership of the DME item while in our plan, you will have to make 13   
new consecutive payments after you switch to O  
riginal Medicare in order to own the item. The   
payments made while enrolled in your plan do not count.   
Example 1: You made 12 or fewe r consecutive payments for the item 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 fewe r consecutive payments for the item 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 coveredservices

Content:52 2023 Evidence of Coverage for Blue Medicare Enhanced   
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 covere d service as a member of Blue Medicare Enhanced. Later in   
this chapter, you can find information about medical services that are 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-pock  
et 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 $3,700.   
The amounts you pay for copayments and coinsura nce for in-network covered services count   
toward this maximum out-of-  
pocket amount. (The amounts you pay for your plan premiums and   
for your Part D prescription drugs do not count toward your maximum out-of-pocket amount. In   
addition, amounts you pay for some services do not count toward your ma ximum out-of-pocket   
amount. These services are marked with an asterisk in the Medical Benefits Chart.) If you reach   
the maximum out-of-pocket amount of $3,700, you will not have to pay any out-of-pocket costs   
for the rest of the year for in -network covered Part A and Part B services. However, you must   
continue to pay your plan premium and the Medicare Part B premium (unless your Part B   
premium is paid for you by Medica id or another third party).

# 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 Enhanced   
Chapter 4 Medical Benefits Chart (what is covered and what you pay)   
Section 1.3 Our plan does not allow providers to “balance bill” you   
As a member of Blue Medicare Enhanced, an important protection for you is that you only have   
to pay your cost sharing amount when you get services covered by our plan. Providers may not add additional separate charges, called “balance billing.” This protection applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don’t pay certain provider charges.   
Here is how this protection works.   
• If your cost sharing is a copayment (a set amount of dollars, for example, $15.00), then you pay only that amount for any covered services from a network provider.   
• If your cost sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:   
o If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan’s reimbursement rate (as   
determined in the contract between the provider and the plan).   
o If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the   
Medicare payment rate for participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral or for emergencies or urgently needed services.)   
o If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral, or for emergencies or urgently needed services.)   
• If you believe a provider has “balance billed” you, call Customer Service.   
SECTION 2 Use the Medical Benefits Chart to find out what is   
covered and how much you will pay   
Section 2.1 Your medical benefits and costs as a member of the plan   
The Medical Benefits Chart on the following pages lists the services Blue Medicare Enhanced   
covers and what you pay out-of-pocket for each service. Part D prescription drug coverage is in   
Chapter 5. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

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

Content:2023 Evidence of Coverage for Blue Medicare Enhanced 105   
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 o  
r for improvement of the   
functioning of a malformed body member.   
• Covered for all stages of reconstruction for   
a breast after a   
mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.   
Custodial care   
Custodial care is personal   
care that 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 bath  
ing or dressing. √

# 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:2023 Evidence of Coverage for Blue Medicare Enhanced 110   
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”

Content:2023 Evidence of Coverage for Blue Medicare Enhanced 113   
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 co  
vered drug a nd 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 par  
ticipate 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 no  
rmal 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 lis  
t 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:2023 Evidence of Coverage for Blue Medicare Enhanced 115   
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 mo  
st 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 usually means that you or your provider will have   
to take extra steps in o  
rder 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 v  
ersion 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?

Content:2023 Evidence of Coverage for Blue Medicare Enhanced 116   
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 wa  
nt to take is not covered.   
• The drug is covered, but there are extra 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 reas  
ons 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 some 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?

Content:2023 Evidence of Coverage for Blue Medicare Enhanced 121   
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 are taking (except for market withdrawal, a generic drug replacing a brand name 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 prescription 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 information about appealing a decision, go to Chapter 9.)   
Here are three general rules about drugs that Medicare 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 outside the United States or its territories.   
• Our plan usually cannot cover off-label use. “Off-label use” is any use of the drug other   
than those indicated on a drug’s label as approved by the Food and Drug Administration.   
• Coverage for “off-label use” 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

Content:2023 Evidence of Coverage for Blue Medicare Enhanced 122   
Chapter 5 Using the plan’s coverage for Part D prescription drugs   
In addition, by law, the following categories of drugs are not covered by Medicare drug plans:   
(Our plan covers certain drugs listed below through our enhanced drug coverage, for which you may be charged an additional premium. More information is provided below.)   
•Non-prescription drugs (also called 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 mineral products, except prenatal vitamins and fluoridepreparations  
•Drugs used for the treatment of sexual or erectile dysfunction  
•Drugs used for treatment of anorexia, weight loss, or weight gain  
•Outpatient drugs for which the manufacturer seeks to require that associated tests ormonitoring services be purchased exclusively from the manufacturer as a condition ofsale  
We offer additional coverage of some prescription drugs (enhanced drug coverage) not normally covered in a Medicare prescription drug plan. Our plan covers a sexual dysfunction medication. For more details on tier placement and limits, please 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 prescriptions, the “Extra Help” program will not pay for the drugs not normally covered. However, if you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid 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, provide your plan membership information, which can be found on your membership card, at the network pharmacy 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

Content:2023 Evidence of Coverage for Blue Medicare Enhanced 123   
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 nursing 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

Content:2023 Evidence of Coverage for Blue Medicare Enhanced 124   
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 tells if your prescription drug coverage for the next calendar 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 Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn’t get the creditable coverage notice, request a copy from your employer or retiree plan’s benefits 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 certain 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 receive 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 plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.   
In the event you either revoke your hospice election or are discharged from hospice our plan   
should cover your drugs as explained in this document. 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 medication 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

Content:2023 Evidence of Coverage for Blue Medicare Enhanced 128   
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:2023 Evidence of Coverage for Blue Medicare Enhanced 131   
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   
Enhanced members?   
There are four “drug payment stages” for your prescription drug coverage under Blue Medicare   
Enhanced. 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.   
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 prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, 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 prescriptions 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 theprescriptions 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.

# 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 There is no deductible for Blue Medicare Enhanced   
Section 4.1 You do not pay a deductible for your Part D drugs   
There is no deductible for Blue Medicare Enhanced. You begin in the Initial Coverage Stage   
when you fill your first prescription of the year. See Section 5 for information about your coverage in the Initial Coverage Stage.   
SECTION 5 During the Initial Coverage Stage, the plan pays its   
share of your drug costs, and you pay your share   
Section 5.1 What you pay for a drug 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 (your copayment or coinsurance 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 higher 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: Specialty Drugs (highest drug tier)   
• Cost sharing Tier 6: Select Care Drugs (lowest drug tier; a limited number of Generic Drugs for high blood pressure, diabetes, high cholesterol, osteoporosis, and rheumatoid arthritis for which we offer a low or no copayment)   
To find out which cost sharing tier your drug is in, look it up in the plan’s Drug List.   
Your pharmacy choices   
How much you pay for a drug depends on whether you get the drug from:   
• A network retail pharmacy that offers standard cost sharing. Costs may be less at   
pharmacies that offer preferred cost sharing.   
• A network retail pharmacy that offers preferred cost sharing.

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

Content:2023 Evidence of Coverage for Blue Medicare Enhanced 138   
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 the total amount for the prescription drugs you have   
filled reaches the $4,660 limit for the Initial 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 keep track of how much you, the plan, and any third parties, have spent on your behalf during 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 Stage 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, the 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 the amount you pay, and the amount discounted by the manufacturer count toward your 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 retail or preferred mail-order pharmacy and a $1 copayment for a 30-day supply at a standard retail or standard mail-order pharmacy. You pay 25% of the cost for all other covered 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 yearly 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 Enhanced offers additional gap coverage for 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, review the most recent Drug List we provided electronically. All insulins on our Drug List are included in the 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:2023 Evidence of Coverage for Blue Medicare Enhanced 139   
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 Coverage Stage when your out-of-pocket costs have reached the   
$7,400 limit for the calendar year. Once you are in the Catastrophic 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:  
o–either – coinsurance of 5% of the cost of the drug  
o–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. What 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. Call Member Service for more information.   
There are two parts to our coverage of Part D vaccinations:   
•The first part of coverage is the cost of the vaccine medication itself.  
•The second part of coverage is for the cost of giving you the vaccine. (This is sometimescalled 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 vaccines listed in theplan’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.  
•A pharmacist may give the vaccine in the pharmacy, or another provider may give it  
in the doctor’s office.

# 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

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 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 care or a prescription drug, you may need to pay the full cost.   
Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In these cases, you can ask our plan to pay you back (paying you back is often called “reimbursing” you). It is your right to be paid back by our plan whenever you’ve paid more than your share of the cost for medical services 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 your share of cost sharing as discussed in the document. First try to resolve the bill with the provider. If that does not work, send the bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly. If we decide not to pay it, we will notify the provider. You should never pay more than plan-allowed cost sharing. If this provider is contracted, you still have the right to treatment.   
Here are examples of situations in which you may need to ask our plan to pay you back or to pay   
a bill you have received:   
1. When you’ve received emergency or urgently needed medical care   
from a provider who is not in our plan’s network   
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 legally required to provide emergency care. If you accidentally pay the entire amount yourself at the time you receive the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.   
• You may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.   
o If the provider is owed anything, we will pay the provider directly.   
o If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.   
2. When a network provider sends you a bill you think you should not pay   
Network providers should always bill the plan directly, and ask you only for your share of the cost. But sometimes they make mistakes, and ask you to pay more than your share.   
• You only have to pay your cost sharing amount when you get covered services. We do   
not allow providers to add additional separate charges, called “balance billing.” This

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

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covered medical services or drugs 144  
   
 • 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 about or don’t think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.   
• Save your receipt and send a copy to us when you ask us to pay you back. In some   
situations, we may need to get more information 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. This means that if we deny your request for payment, you can appeal 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 any payment you have made. It’s a good idea to make a copy of your bill and receipts for your records. You must submit your claim to us within 12 months 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 help us process the information faster. The   
following information is needed to process any reimbursement 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 the form from our website   
www.Medicare.BlueCrossNC.com/medicare/forms-library or call Customer Service and   
ask for the form.   
Mail your request for payment together with any bills or paid receipts to us at these addresses:   
   
For Medical Claims:   
Blue Medicare Enhanced   
Attn: Medical Claims   
PO Box 17509   
Winston-Salem, NC 27116-7509 For Prescription Drug Claims:   
   
Blue Medicare Enhanced   
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

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covered medical services or drugs 145  
   
 SECTION 3 We will consider your request for payment and say   
yes or no   
Section 3.1 We check to see whether we should cover the service 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 you 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 the 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 appeal 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 mistake in turning down your request for payment or the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 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

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Chapter 8 Your rights and responsibilities 147  
   
 SECTION 1 Our plan must honor your rights and cultural   
sensitivities as a member of the plan   
Section 1.1 We must provide information in a way that works for you and   
consistent with your cultural sensitivities (in languages other   
than English, in braille, in large print, or other alternate formats, etc.)   
Your plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how a plan may meet these accessibility requirements include, but are not limited to: provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.   
Our plan has free interpreter services available to answer questions from non-English speaking members. Some documents may be available in the top 15 languages spoken in our state. We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan’s benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Customer Service.   
Our plan is required to give female enrollees the option of direct access to a women’s health   
specialist within the network for women’s routine and preventive health care services.   
If providers in the plan’s network for a specialty are not available, it is the plan’s responsibility   
to locate specialty providers outside the network who will provide you with the necessary care. In this case, you will only pay in-network cost sharing. If you find yourself in a situation where there are no specialists in the plan’s network that cover a service you need, call the plan for information on where to go to obtain this service at in-network cost sharing.   
If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, seeing a women’s health specialists 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-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.   
Section 1.2 We must ensure that you get timely access to your covered   
services and drugs   
You have the right to choose a primary care provider (PCP) in the plan’s network to provide and arrange for your covered services. 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

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 o You can visit the Medicare website to read or download the publication   
“Medicare Rights & Protections.” (The publication is available at:   
www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf .)   
o 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.   
o Chapters 3 and 4 give the details about your medical services.   
o Chapters 5 and 6 give the details about your Part D prescription drug coverage.   
• If you have any other health insurance coverage 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 providers that you are enrolled in our plan.   
Show your plan membership card whenever 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.   
o 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.   
o Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.   
o If you have any questions, be sure to ask and get an answer you can understand.   
• Be considerate. We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor’s office, hospitals, and other offices.   
• Pay what you owe. As a plan member, you are responsible for these payments:   
o You must pay your plan premiums.   
o You must continue to pay a premium for your Medicare Part B to remain a member of the plan.

# 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

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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 processes for handling problems and concerns:   
• For some problems, you need to use the process for coverage decisions and appeals.   
• For other problems, you need to use the process for making complaints; also called   
grievances.   
Both of these processes have been approved by Medicare. Each process has a set of rules,   
procedures, and deadlines that must be followed by us and by you.   
The guide in Section 3 will help you identify the right process to use and what you should do.   
Section 1.2 What about the legal terms?   
There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand. To make things easier, this chapter:   
• Uses simpler words in place of certain legal terms. For example, this chapter generally says, “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “organization determination,” or “coverage determination” or “at-risk determination,” and “independent review organization” instead of “Independent Review Entity.”   
• It also uses abbreviations as little as possible.   
However, it can be helpful – and sometimes quite important – for you to know the correct legal terms. Knowing which terms to use will help you communicate more accurately to get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.   
SECTION 2 Where to get more information and personalized   
assistance   
We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. Therefore, you should always reach out to customer service for help. But in some situations, you may also want help or guidance from someone who is not connected with us. Below are two entities that can assist you.

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

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complaints)  
   
 State Health Insurance Assistance Program (SHIP)   
Each state has a government program with trained counselors. The program is not connected   
with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.   
The services of SHIP counselors are free. You will find phone numbers and website URLs in Chapter 2, Section 3 of this document.   
Medicare   
You can also contact Medicare to get help. To contact Medicare:   
• You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.   
• You can also visit the Medicare website ( www.medicare.gov ).   
SECTION 3 To deal with your problem, which process should you  
use?   
If you have a problem or concern, you only need to read the parts of this chapter that apply to   
your situation. The guide that follows will help.   
   
Is your problem or concern about your benefits or coverage?   
This includes problems about whether medical care or prescription 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

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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 decisions 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, including payment. This is the process you use for   
issues such as whether something is covered or not and the way in which something is covered.   
Asking for coverage decisions prior to receiving services   
A coverage decision is a decision we make about your benefits and 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 specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you. In limited circumstances a request for a coverage decision will be dismissed, which means we won’t review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn’t legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.   
We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide a service 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 who made the original decision.   
When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we were properly following the rules. When we have completed the review, we give you our decision. In limited circumstances a

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

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Chapter 9 What to do if you have a problem or complaint (coverage decisions, appeals,   
complaints)  
   
 o While we can accept an appeal request without the form, we cannot begin or   
complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.   
• You also have the right to hire a lawyer. You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, you are not required to hire a lawyer to ask for any kind of coverage decision or appeal a decision.   
Section 4.3 Which section of this chapter gives the details for your   
situation?   
There are four different situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:   
• Section 5 of this chapter: “Your medical care: How to ask for a coverage decision or make an appeal”   
• Section 6 of this chapter: “Your Part D prescription drugs: How to ask for a coverage decision or make an appeal”   
• Section 7 of this chapter: “How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon”   
• Section 8 of this chapter: “How to ask us to keep covering certain medical services if you   
think your coverage is ending too soon” (Applies only to these services: home health   
care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)   
If you’re not sure which section you should be using, please call Customer Service. You can also get help or information from government organizations such as your SHIP.   
SECTION 5 Your medical care: How to ask for a coverage   
decision or make an appeal of a coverage decision   
Section 5.1 This section tells what to do if you have problems getting   
coverage for medical care or if you want us to pay you back for our share of the cost of your care   
This section is about your benefits for medical care and services. These benefits 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 prescription drugs. In some

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

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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 requ  
ire 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 g  
ive 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 and 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. S  
ection 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

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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 illness 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 hosp  
ital. 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

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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. Th  
e 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

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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 ab  
le 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 rev  
iew 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.   
o 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.   
o 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 .   
o 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:2023 Evidence of Coverage for Blue Medicare Enhanced 192   
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 related   
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   
confiden  
tial information?   
Disrespect, poor customer service, or other negative behaviors • Has someone been rude or disrespectful to you?   
• Are you unhappy with our Customer Service?   
• Do you feel you are being 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 Service or other staff at the plan?   
o Examples include waiting too long on the phone, in   
the waiting or exam roo  
m, 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?

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Chapter 10 Ending your membership in the plan  
   
 SECTION 1 Introduction to ending your membership in our plan   
Ending your membership in Blue Medicare Enhanced may be voluntary (your own choice) or   
involuntary (not your own choice):   
• You might leave our plan because you have decided that you want to leave. Sections 2 and 3 provide information on ending your membership voluntarily.   
• There are also limited situations where we are required to end your membership. Section 5 tells you about situations when we must end your membership.   
If you are leaving our plan, our plan must continue to provide your medical care and 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 membership 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”). During this time, review your health and drug coverage and decide about coverage 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 new 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 prescription drug plan.   
• Original Medicare without a separate Medicare prescription drug plan.   
o 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?

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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 because of a special situation, you can choose to change both your Medicare health coverage and 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 separate 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 late enrollment penalty if you join a Medicare drug plan later.   
Your membership will usually end on the first day of the month after your request to change your plan is received.   
If you receive “Extra Help” from Medicare 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 should 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

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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 from Blue Medicare Enhanced 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 Enhanced when your new plan’s coverage begins.   
• Original Medicare without a separate Medicare prescription drug plan.   
o • 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 Enhanced when your coverage in Original Medicare begins.   
   
SECTION 4 Until your membership 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 prescription 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 Enhanced must end your membership in the plan in certain situations

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Chapter 10 Ending your membership in the plan  
   
 SECTION 5 Blue Medicare Enhanced must end your membership   
in the plan in certain situations   
Section 5.1 When must we end your membership in the plan?   
Blue Medicare Enhanced must end your membership 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.   
o If you move or take a long trip, call Customer Service to find out if the place you are moving or traveling to is in our plan’s area.   
• If you 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 information about other insurance you have that provides   
prescription drug coverage.   
• If you intentionally give us incorrect information when you are enrolling in our plan and   
that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)   
• If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)   
• If you let someone else use your membership card to get medical care. (We cannot make   
you leave our plan for this reason unless we get permission from Medicare first.)   
o If we end your membership because of this reason, Medicare may have your case   
investigated by the Inspector General.   
• If you do not pay the plan premiums for two calendar months following the premium due date.   
o We must notify you in writing that you have two calendar months following the premium due date to pay the plan premium before we end your membership.   
• 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.

# Main Title : CHAPTER 11: Legal notices

Content:CHAPTER 11:   
Legal notices

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

Content:2023 Evidence of Coverage for Blue Medicare Enhanced 204   
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 affect your rights and responsibilities even if the laws are not included or explained in this document.   
SECTION 2 Notice about nondiscrimination   
We don’t discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.  
 All organizations that provide Medicare Advantage plans, like our plan, must obey Federal   
laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, 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 have concerns about discrimination or unfair treatment, please   
call the Department of Health and Human Services’ Office for Civil Rights at 1-800-368-1019   
(TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services’ Office for Civil Rights at   
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 responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Blue Medicare Enhanced, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

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

Content:2023 Evidence of Coverage for Blue Medicare Enhanced 205   
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 people whose primary language is not English. Please contact the Customer Service 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 lingüísticos gratuitos para 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 important information about what drugs the plan covers. The plan cannot cover drugs that are not considered 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 Service to request a hard copy.   
SECTION 6 Notice about Blue Cross 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 independent corporation operating 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 Carolina. Blue Cross NC is not contracting as an agent of the Blue Cross and Blue Shield Association. You hereby acknowledge and agree that you have not entered into this policy based upon representations by any person other than Blue Cross NC and that no person, entity or organization other than Blue Cross NC shall be held accountable or liable to you for any obligations to you created under 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 for independent, locally operated Blue Cross and/or Blue Shield Plans (Licensees). Neither the Association nor any one of the independent Blue Cross and Blue Shield Licensees are accountable or liable for the actions or inactions of another Blue Cross and Blue Shield Licensee.

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

Content:2023 Evidence of Coverage for Blue Medicare Enhanced 206   
Chapter 11 Legal notices   
   
 SECTION 7 Third Party Liability (Subrogation Right)   
Subrogation means that the plan is allowed to recover the amount of medical benefits the plan   
paid as a result of an illness 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 liable, and you later obtain recovery, 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 damages that include repayment for medical and medically related expenses incurred for your benefit, you must provide timely written notice to us of the pending or potential claim by writing to Customer Service at the address for the plan listed in Section 1 of Chapter 2 of this Evidence of Coverage. Additionally, you must, at the plan's request, give us any information we may need and sign any documents that may be required to assist in recovering the amount of benefits paid and do nothing to prejudice plan's subrogation rights. We may, at our option, take such action as may be appropriate and necessary to preserve our rights under this third party liability/subrogation provision, including the right to intervene in any lawsuit you have commenced with a third party. 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 plan. For this purpose, the definition of prompt will be 120 days after the earlier of the following: 1) the date a claim is filed with 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 Cancer 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 breast to produce a symmetrical appearance; and   
3. Prostheses and physical complications of mastectomy, including lymphedemas, in a   
manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter.   
Contact Customer Service for more information.

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

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Chapter 11 Legal notices   
   
 SECTION 9 Incentives   
Blue Medicare Enhanced requires that providers and staff make decisions about care based on   
medical necessity and the existence 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 health care. You may (for personal or religious reasons) refuse to accept the procedures or treatments recommended by your network provider. Or, you may request treatment that a network 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 includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave, 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 obtained in these instances. You can request a determination 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 organization. You cannot assign any benefit or the right to receive payment due under our plan to any person, corporation or other organization 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 “Medicare 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 and presented to Blue Cross NC for payment in accordance with the rules of the Medicare Advantage Program policies then in effect.

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

Content:2023 Evidence of Coverage for Blue Medicare Enhanced 208   
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 member  
s. 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, w  
e 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 sta  
te 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