

2026

Evidence of Coverage

CareFirst BlueCross BlueShield Advantage Salute (PPO)

January 1, 2026 - December 31, 2026

CareFirst BlueCross BlueShield Medicare Advantage is a PPO plan with a Medicare contract. Enrollment in CareFirst BlueCross BlueShield Medicare Advantage depends upon contract renewal.

CareFirst BlueCross BlueShield Medicare Advantage is the business name of CareFirst Advantage PPO, Inc., an independent licensee of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

Y0154_H7379_MA03642IND_C

January 1 – December 31, 2026

Evidence of Coverage for 2026:

Your Medicare Health Benefits and Services as a Member of CareFirst BlueCross BlueShield Advantage Salute PPO

This document gives you the details of your Medicare health care coverage from January 1 – December 31, 2026. **This is an important legal document. Keep it in a safe place.**

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

- Our plan premium and cost sharing
- Our medical benefits
- How to file a complaint if you're not satisfied with a service or treatment
- How to contact us
- Other protections required by Medicare law

For questions about this document, please contact Member Services at 833-536-2001. (TTY users should call 711.) Hours are 8am-8pm EST, 7 days a week October 1 - March 31, and 8am-8pm EST Monday - Friday, April 1 - September 30. This call is free.

This plan, CareFirst BlueCross BlueShield Advantage Salute, is offered by CareFirst Advantage PPO, Inc. CareFirst BlueCross BlueShield Medicare Advantage. (When this *Evidence of Coverage* says "we," "us," or "our," it means CareFirst Advantage PPO, Inc. CareFirst BlueCross BlueShield Medicare Advantage. When it says "plan" or "our plan," it means CareFirst BlueCross BlueShield Advantage Salute.)

This document is available for free in Spanish.

To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back cover of this document). We can give you information in braille, large print, or other alternate formats if you need it.

Per the final rule CMS-4205-F released on April 4, 2024, §§ 422.2267(e)(31)(ii) and 423.2267(e)(33)(ii), plans must provide a Notice of Availability of language assistance services and auxiliary aids and services that at a minimum states that our plan provides language assistance services and appropriate auxiliary aids and services free of charge. Our plan must provide the notice in English and at least the 15 languages most commonly spoken by people with limited English proficiency in the relevant state or states in our plan's service area and must provide the notice in alternate formats for people with disabilities who require auxiliary aids and services to ensure effective communication.

Benefits, premiums, deductibles, and/or copayments/coinsurance may change on January 1, 2027.

Our provider network may change at any time. You'll get notice about any changes that may affect you at least 30 days in advance.

OMB Approval 0938-1051 (Expires: August 31, 2026)

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CHAPTER 1: Get started as a member

SECTION 1 You're a member of CareFirst BlueCross BlueShield Advantage Salute

Section 1.1 You're enrolled in CareFirst BlueCross BlueShield Advantage Salute, which is a Medicare PPO

You're covered by Medicare, and you chose to get your Medicare health care coverage through our plan, CareFirst BlueCross BlueShield Advantage Salute. Our plan covers all Part A and Part B services. However, cost sharing and provider access in this plan are different from Original Medicare.

CareFirst BlueCross BlueShield Advantage Salute is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company. This plan doesn't include Part D drug coverage.

Section 1.2 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how CareFirst BlueCross BlueShield Advantage Salute covers your care. Other parts of this contract include your enrollment form and any notices you get from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called *riders* or *amendments*.

The contract is in effect for the months you're enrolled in CareFirst BlueCross BlueShield Advantage Salute between January 1, 2026 and December 31, 2026.

Medicare allows us to make changes to plans we offer each calendar year. This means we can change the costs and benefits of CareFirst BlueCross BlueShield Advantage Salute after December 31, 2026. We can also choose to stop offering our plan in your service area, after December 31, 2026.

Medicare (the Centers for Medicare & Medicaid Services) must approve CareFirst BlueCross BlueShield Advantage Salute each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue offering our plan and Medicare renews its approval of our plan.

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

You're eligible for membership in our plan as long as you meet all these conditions:

- You have both Medicare Part A and Medicare Part B
- You live in our geographic service area (described in Section 2.2). People who are incarcerated aren't considered to be in the geographic service area even if they're physically located in it.
- You're a United States citizen or are lawfully present in the United States.

Section 2.2 Plan service area for CareFirst BlueCross BlueShield Advantage Salute

CareFirst BlueCross BlueShield Advantage Salute is only available to people who live in our plan service area. To stay a member of our plan, you must continue to live in our plan service area. The service area is described below.

Our service area includes these states: Maryland and Washington D.C.

If you move out of our plan's service area, you can't stay a member of this plan. Call Member Services at 833-536-2001 (TTY users call 711) to see if we have a plan in your new area. When you move, you'll have a Special Enrollment Period to either switch to Original Medicare or enroll in a Medicare health or drug plan in your new location.

If you move or change your mailing address, it's also important to call Social Security. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

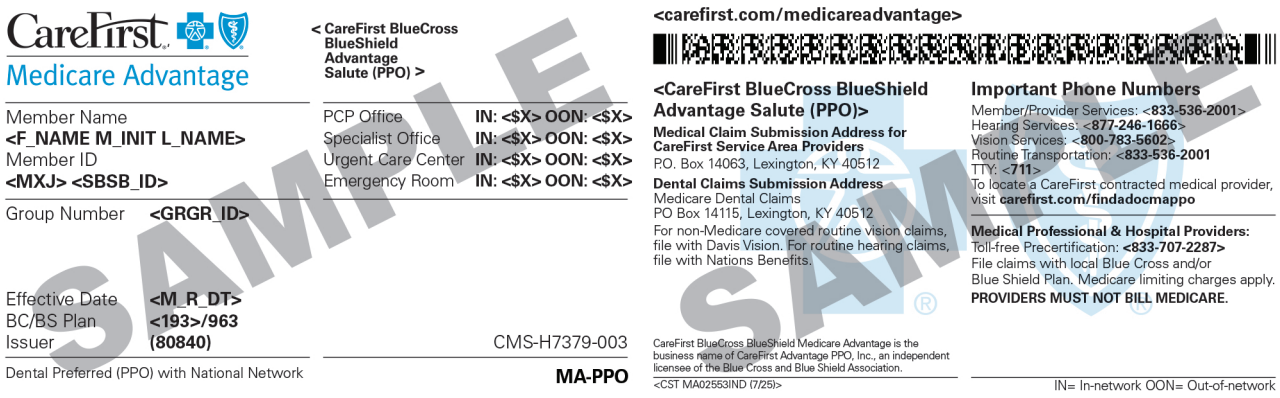
Section 2.3 U.S. citizen or lawful presence

You must be a U.S. citizen or lawfully present in the United States to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify CareFirst BlueCross BlueShield Advantage Salute if you're not eligible to stay a member of our plan on this basis. CareFirst BlueCross BlueShield Advantage Salute must disenroll you if you don't meet this requirement.

SECTION 3 Important membership materials

Section 3.1 Our plan membership card

Use your membership card whenever you get services covered by our plan. You should also show the provider your Medicaid card, if you have one. Sample membership card:


CareFirst Medicare Advantage

< CareFirst BlueCross BlueShield Advantage Salute (PPO) >

Member Name
<F_NAME M_INIT L_NAME>
Member ID
<MXJ> <SBSB_ID>

Group Number **<GRGR_ID>**

Effective Date **<M_R_DT>**
BC/BS Plan **<193>/963**
Issuer **(80840)**

Dental Preferred (PPO) with National Network

PCP Office **IN: <$X> OON: <$X>**
Specialist Office **IN: <$X> OON: <$X>**
Urgent Care Center **IN: <$X> OON: <$X>**
Emergency Room **IN: <$X> OON: <$X>**

CMS-H7379-003

MA-PPO

<carefirst.com/medicareadvantage>

<CareFirst BlueCross BlueShield Advantage Salute (PPO)>
Medical Claim Submission Address for CareFirst Service Area Providers
P.O. Box 14063, Lexington, KY 40512
Dental Claims Submission Address
Medicare Dental Claims
PO Box 14115, Lexington, KY 40512
For non-Medicare covered routine vision claims, file with Davis Vision. For routine hearing claims, file with Nations Benefits.

CareFirst BlueCross BlueShield Medicare Advantage is the business name of CareFirst Advantage PPO, Inc., an independent licensee of the Blue Cross and Blue Shield Association.
<CST MA02553IND (7/25)>

Important Phone Numbers
Member/Provider Services: **<833-536-2001>**
Hearing Services: **<877-246-1666>**
Vision Services: **<800-783-5602>**
Routine Transportation: **<833-536-2001**
TTY: **<711>**
To locate a CareFirst contracted medical provider, visit **carefirst.com/findadocmappo**

Medical Professional & Hospital Providers:
Toll-free Precertification: **<833-707-2287>**
File claims with local Blue Cross and/or Blue Shield Plan. Medicare limiting charges apply.
PROVIDERS MUST NOT BILL MEDICARE.

IN= In-network OON= Out-of-network

SAMPLE

DON'T use your red, white, and blue Medicare card for covered medical services while you're a member of this plan. If you use your Medicare card instead of your CareFirst BlueCross BlueShield Advantage Salute 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 Medicare-approved clinical research studies (also called clinical trials).

If our plan membership card is damaged, lost, or stolen, call Member Services at 833-536-2001 (TTY users call 711) right away and we'll send you a new card.

Section 3.2 Provider Directory

The *Provider Directory* https://www.carefirst.com/medicare-options/medicare-resources/medicare-advantage-plan-resources.html lists our current network providers and durable medical equipment suppliers. **Network providers** are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full.

As a member of our plan, you can choose to get care from out-of-network providers. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and medically necessary. However, if you use an out-of-network provider, your share of the costs for your covered services may be higher. Go to Chapter 3 for more specific information.

If you don't have a *Provider Directory*, you can ask for a copy (electronically or in paper form) from Member Services at 833-536-2001 (TTY users call 711). Requested paper *Provider Directories* will be mailed to you within 3 business days.

SECTION 4 Summary of Important Costs

	Your Costs in 2026
Monthly plan premium* * Your premium can be higher than this amount. Go to Section 4.1 for details.	**$0**
Maximum out-of-pocket amount This is the most you'll pay out-of-pocket for covered Part A and Part B services. (Go to Chapter 4 Section 1 for details.)	**From network providers: $5,900** **From in-network and out-of-network providers combined: $8,950**
Primary care office visits	**$0 copay per visit**
Specialist office visits	**$35 copay per visit**
Inpatient hospital stays	**$335 copay per day for days 1-5, $0 copay per day for days 6-90**

Your costs may include the following:

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

Section 4.1 Plan premium

You don't pay a separate monthly plan premium for CareFirst BlueCross BlueShield Advantage Salute.

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums, check your copy of *Medicare & You 2026* handbook in the section called *2026 Medicare Costs*. Download a copy from the Medicare website (www.Medicare.gov/medicare-and-you) or order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

As a member of this plan, you receive a Part B premium reduction of $100 per month, which is automatically deducted from your full monthly Part B premium. **You must continue paying your Medicare premiums to stay a member of our plan.** This includes your premium for Part B. You may also pay a premium for Part A if you aren't eligible for premium-free Part A.

SECTION 5 More information about your monthly premium

Section 5.1 Our monthly plan premium won't change during the year

We're not allowed to change our plan's monthly plan premium amount during the year. If the monthly plan premium changes for next year, we'll tell you in September and the new premium will take effect on January 1.

SECTION 6 Keep our plan membership record up to date

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

The doctors, hospitals, and other providers in our plan's network **use your membership record to know what services are covered and your cost-sharing amounts**. Because of this, it's very important to you help us keep your information up to date.

If you have any of these changes, let us know:

- Changes to your name, your address, or your phone number
- Changes in any other health coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation, or Medicaid)
- Any liability claims, such as claims from an automobile accident
- If you're admitted to a nursing home
- If you get 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 participate in a clinical research study (**Note:** You're not required to tell our plan about the clinical research studies you intend to participate in, but we encourage you to do so.)

If any of this information changes, let us know by calling Member Services call Member Services at 833-536-2001 (TTY users call 711).

It's also important to contact Social Security if you move or change your mailing address. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

SECTION 7 How other insurance works with our plan

Medicare requires us to collect information about any other medical or drug coverage you have so we can coordinate any other coverage with your benefits under our plan. This is called **Coordination of Benefits**.

Once a year, we'll send you a letter that lists any other medical or drug coverage we know about. Read this information carefully. If it's correct, you don't need to do anything. If the information

isn't correct, or if you have other coverage that is not listed, call Member Services at 833-536-2001 (TTY users call 711). You may need to give our plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

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

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

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

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

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

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

CHAPTER 2:
Phone numbers and resources

SECTION 1 CareFirst BlueCross BlueShield Advantage Salute contacts

For help with claims, billing or member card questions, call or write to CareFirst BlueCross BlueShield Advantage Salute Member Services. We'll be happy to help you.

Member Services – Contact Information	
Call	833-536-2001 Calls to this number are free. 8am-8pm EST, 7 days a week October 1 - March 31, and 8am-8pm EST Monday - Friday, April 1 - September 30 Member Services 833-536-2001 (TTY users call 711) also has free language interpreter services for non-English speakers.
TTY	711 Calls to this number are free. 8am-8pm EST, 7 days a week October 1 - March 31, and 8am-8pm EST Monday - Friday, April 1 - September 30
Fax	844-961-0696
Write	CareFirst BlueCross BlueShield Medicare Advantage Attention: Member Services Department P.O. Box 915 Owings Mills, MD 21117
Website	www.carefirst.com/medicareadvantage

How to ask for a coverage decision or appeal about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. An appeal is a formal way of asking us to review and change a coverage decision. For more information on how to ask for coverage decisions or appeals about your medical care, go to Chapter 7.

Coverage Decisions and Appeals for Medical Care – Contact Information	
Call	833-536-2001 Calls to this number are free. 8am-8pm EST, 7 days a week October 1 - March 31, and 8am-8pm EST Monday - Friday, April 1 - September 30
TTY	711

Coverage Decisions and Appeals for Medical Care – Contact Information	
	Calls to this number are free. 8am-8pm EST, 7 days a week October 1 - March 31, and 8am-8pm EST Monday - Friday, April 1 - September 30
Fax	Medical coverage decisions fax numbers: Inpatient Services: 443-753-2341 Outpatient Services: 443-753-2342 Home Care Services and Durable Medical Equipment: 443-753-2343 Outpatient Therapies--Physical Therapy, Occupational Therapy, and Speech Therapy: 443-753-2346 Behavioral Health and Substance Use: 443-753-2347 Medical Payment Appeals: 443-753-2298 Clinical Expedited Appeals: 410-605-2566
Write	Mail: CareFirst BlueCross BlueShield Preservice Review Department P.O. Box 915 Owings Mills, MD 21117 Email: Inpatient Services: MAInpatient@carefirst.com Outpatient Services: MAOutpatient@carefirst.com Home Care Services and Durable Medical Equipment: MAHC-DME@carefirst.com Outpatient Therapies (Physical Therapy, Occupational Therapy, and Speech Therapy): MAOPAP@carefirst.com Behavioral Health and Substance Use: MABH@carefirst.com
Website	www.carefirst.com/medicareadvantage

How to make a complaint about your medical care

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint doesn't involve coverage or payment disputes. For more information on how to make a complaint about your medical care, go to Chapter 7.

Complaints About Medical Care – Contact Information	
Call	833-536-2001 Calls to this number are free. 8am-8pm EST, 7 days a week October 1 - March 31, and 8am-8pm EST Monday - Friday, April 1 - September 30
TTY	711

Complaints About Medical Care – Contact Information	
	Calls to this number are free. 8am-8pm EST, 7 days a week October 1 - March 31, and 8am-8pm EST Monday - Friday, April 1 - September 30
Fax	443-753-2298
Write	CareFirst BlueCross BlueShield Medicare Advantage Attention: Appeals & Grievances Department P.O. Box 915 Owings Mills, MD 21117
Medicare website	To submit a complaint about CareFirst BlueCross BlueShield Advantage Salute directly to Medicare, go to www.Medicare.gov/my/medicare-complaint .

How to ask us to pay our share of the cost for medical care you got

If you got a bill or paid for services (like a provider bill) you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill, go to Chapter 5 for more information.

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to Chapter 7 for more information.

Payment Requests – Contact Information	
Call	833-536-2001 8am-8pm EST, 7 days a week October 1st - March 31st, and 8am-8pm Monday - Friday, April 1st - September 30th Calls to this number are free.
TTY	711 Calls to this number are free. 8am-8pm EST, 7 days a week October 1 - March 31, and 8am-8pm EST Monday - Friday, April 1 - September 30
Fax	855-215-6947
Write	CareFirst BlueCross BlueShield Medicare Advantage Attention: Member Claims Reimbursement P.O. Box 915 Owings Mills, MD 21117
Website	www.carefirst.com/medicareadvantage

SECTION 2 Get help from Medicare

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

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (CMS). This agency contracts with Medicare Advantage organizations including our plan.

Medicare – Contact Information	
Call	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
Chat Live	Chat live at www.Medicare.gov/talk-to-someone.
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044
Website	www.Medicare.gov • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly “Wellness” visits). • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers. You can also visit www.Medicare.gov to tell Medicare about any complaints you have about CareFirst BlueCross BlueShield Advantage Salute: **To submit a complaint to Medicare,** go to www.Medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

SECTION 3 State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. Here is a list of the State Health Insurance Assistance Programs in each state we serve:

- In Maryland, the SHIP is called the State Health Insurance Assistance Program.
- In Washington, D.C., the SHIP is called the Health Insurance Counseling Project.

The State Health Insurance Assistance Program is an independent state program (not connected with any insurance company or health plan) that gets money from the federal government to give free local health insurance counseling to people with Medicare.

State Health Insurance Assistance Program counselors can help you understand your Medicare rights, make complaints about your medical care or treatment, and straighten out problems, with your Medicare bills. State Health Insurance Assistance Program counselors can also help you with Medicare questions or problems, help you understand your Medicare plan choices, and answer questions about switching plans.

State Health Insurance Assistance Program (Maryland SHIP) Contact Information	
Call	410-767-1100 or 800-243-3425
TTY	711
Write	State Health Insurance Assistance Program Maryland Department of Aging 36 S Charles Street, 12th Floor Baltimore, MD 21201
Website	https://aging.maryland.gov/Pages/state-health-insurance-program.aspx

Health Insurance Counseling Project (Washington D.C. SHIP) Contact Information	
Call	202-727-8370
TTY	711
Write	Health Insurance Counseling Project D.C. Department of Aging 250 E Street SW Washington, DC 20024
Website	https://dacl.dc.gov/service/health-insurance-counseling

SECTION 4 Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state. For Maryland and Washington D.C., the Quality Improvement Organization is called Commence Health.

Commence Health has a group of doctors and other health care professionals paid by Medicare to check on and help improve the quality of care for people with Medicare. Commence Health is an independent organization. It's not connected with our plan.

Contact Commence Health in any of these situations:

- You have a complaint about the quality of care you got. Examples of quality-of-care concerns include getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

Commence Health (Maryland & Washington D.C.'s Quality Improvement Organization) – Contact Information	
Call	888-396-4646 Monday-Friday, 9am-5pm (local time), Saturday, Sunday and Holidays, 10am-4pm (local time). 24-hour voicemail service is available.
TTY	711
Write	Commence Health BFCC-QIO 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701
Website	www.livantaqio.com

SECTION 5 Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment.

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

Social Security– Contact Information	
Call	1-800-772-1213 Calls to this number are free. Available 8 am to 7 pm, Monday through Friday.

Social Security– Contact Information	
	Use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8 am to 7 pm, Monday through Friday.
Website	www.ssa.gov

SECTION 6 Medicaid

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid offers programs to help people with Medicare pay their Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualifying Individual (QI):** Helps pay Part B premiums
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums

To find out more about Medicaid and Medicare Savings Programs, contact Maryland Medical Assistance or DC Medicaid.

Maryland Medical Assistance – Contact Information	
Call	410-767-6500 or 877-463-3464 Monday-Friday 8:30am-5pm
TTY	800-735-2258
Write	Maryland Department of Health 201 West Preston Street Baltimore, MD 21201
Website	https://mmcp.health.maryland.gov

DC Medicaid – Contact Information	
Call	202-671-4200 Monday-Friday 8:15am-4:45pm
TTY	711
Write	Washington D.C. Department of Human Services 64 New York Ave, NE, 6th Floor Washington, DC 20002
Website	https://dc.gov/service/medicaid

SECTION 7 Railroad Retirement Board (RRB)

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 get Medicare through the Railroad Retirement Board, let them know if you move or change your mailing address. For questions about your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board (RRB) – Contact Information	
Call	1-877-772-5772 Calls to this number are free. Press "0" to speak with an RRB representative from 9 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9 am to 12 pm on Wednesday. Press "1" to access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number aren't free.
Website	rrb.gov/

SECTION 8 If you have group insurance or other health insurance from an employer

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner's) employer or retiree group as part of this plan, call the employer/union benefits administrator or Member Services at 833-536-2001 (TTY users call 711) with any questions. You

can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Member Services are printed on the back cover of this document.) You can call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2048.

CHAPTER 3:
Using our plan for your medical services

SECTION 1 How to get medical care as a member of our plan

This chapter explains what you need to know about using our plan to get your medical care covered. For details on what medical care our plan covers and how much you pay when you get care, go to the Medical Benefits Chart in Chapter 4.

Section 1.1 Network providers and covered services

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

Section 1.2 Basic rules for getting your medical care to be covered by our plan

As a Medicare health plan, CareFirst BlueCross BlueShield Advantage Salute must cover all services covered by Original Medicare and follow Original Medicare's coverage rules.

CareFirst BlueCross BlueShield Advantage Salute will generally cover your medical care as long as:

- **The care you get is included in our plan's Medical Benefits Chart** in Chapter 4.
- **The care you get is considered medically necessary**. Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You get your care from a provider who is eligible to provide services under Original Medicare.** As a member of our plan, you can get care from either a network provider or an out-of-network provider (go to Section 2 for more information).

- The providers in our network are listed in the *Provider Directory* https://www.carefirst.com/medicare-options/medicare-resources/medicare-advantage-plan-resources.html.
- If you use an out-of-network provider, your share of the costs for your covered services may be higher.
- While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we can't pay a provider who is not eligible to participate in Medicare. If you go to a provider who is not eligible to participate in Medicare, you'll be responsible for the full cost of the services you receive. Check with your provider before getting services to confirm that they're eligible to participate in Medicare.

SECTION 2 Use network and out-of-network providers to get medical care

Section 2.1 You may choose a Primary 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 Primary Care Provider. A PCP can help manage your overall health care and can assist with coordinating services with other healthcare providers. A PCP is not responsible for obtaining authorization for the services provided by a specialist when authorization is required. Authorization is the responsibility of the specialist or other provider. Your PCP can either be a network provider or an out-of-network provider.

How to choose a PCP

Check the provider directory for providers in your area that are accepting new patients and reach out to them to schedule an appointment.

How to change your PCP

You can change your PCP for any reason, at any time. It’s also possible that your PCP might leave our plan’s network of providers, and you’d need to choose a new PCP.

Section 2.2 How to get care from specialists and other network providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. For example:

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

You do not need a referral from a PCP to visit a specialist or other providers.

Prior authorization may be needed for certain services (please see Chapter 4 for information on which services require prior authorization). Authorization can be obtained from the plan. You

or your provider, including a non-contracted provider, can ask the plan before a service is furnished whether the plan will cover it. You or your provider can request that this determination be in writing. This process is called an advanced determination. If we say we will not cover your services, you, or your provider, have the right to appeal our decision not to cover your care. Chapter 7 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made.

Note: It is important to know in advance what Medicare will or will not cover. Be sure to ask your provider if a service is covered. Providers should let you know when something is not covered and give you a written notice, or tell you verbally, when Medicare does not cover the service.

When a specialist or another network provider leaves our plan

We may make changes to the hospitals, doctors and specialists (providers) in our plan's network during the year. If your doctor or specialist leaves our plan, you have these rights and protections:

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.
- We'll notify you that your provider is leaving our plan so that you have time to choose a new provider.
  - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past 3 years.
  - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past 3 months.
- We'll help you choose a new qualified in-network provider for continued care.
- If you're undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- When an in-network provider or benefit is unavailable or inadequate to meet your medical needs, we'll arrange for any medically necessary covered benefit outside of our provider network at in-network cost sharing. Prior authorization from the plan is needed.
- If you find out your doctor or specialist is leaving our plan, please contact us so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider or that your care isn't being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality-of-care grievance to our plan, or both (go to Chapter 7.).

Section 2.3 How to get care from out-of-network providers

As a member of our plan, you can choose to get care from out-of-network providers. However, providers that don't contract with us are under no obligation to treat you, except in emergency situations. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and are medically necessary. However, **if you use an out-of-network provider, your share of the costs for your covered services may be higher.** Here are more important things to know about using out-of-network providers:

- You can get your care from an out-of-network provider, however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we can't pay a provider who isn't eligible to participate in Medicare. If you get care from a provider who isn't eligible to participate in Medicare, you'll be responsible for the full cost of the services you receive. Check with your provider before getting services to confirm that they're eligible to participate in Medicare.
- You don't need a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers, ask for a pre-visit coverage decision to confirm that the services you get are covered and are medically necessary. (Go to Chapter 7, Section 4 for information about asking for coverage decisions.) This is important because:
  - Without a pre-visit coverage decision, and if our plan later determines that the services aren't covered or were not medically necessary, our plan may deny coverage and you'll be responsible for the entire cost. If we say we won't cover the services you got, you have the right to appeal our decision not to cover your care (go to Chapter 7 to learn how to make an appeal.)
- It's best to ask an out-of-network provider to bill our plan first. But, if you've already paid for the covered services, we'll reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill that you think we should pay, you can send it to us for payment (go to Chapter 5).
- If you're using an out-of-network provider for emergency care, urgently needed services, or out-of-area dialysis, you may not have to pay a higher cost-sharing amount (go to Section 3).

SECTION 3 How to get services in an emergency, disaster, or urgent need for care

Section 3.1 Get care if you have a medical emergency

A **medical emergency** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent your loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The

medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You don't need to get approval or a referral first from your PCP. You don't need to use a network doctor. You can get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they're not part of our network. We also cover emergency services outside the United States and its territories.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Please contact Member Services at 833-536-2001 8am-8pm EST, 7 days a week October 1 - March 31, and 8am-8pm EST Monday - Friday, April 1 - September 30 (TTY users should call 711). This information is also listed on the back of your CareFirst BlueCross BlueShield Advantage Salute medical identification card and on the back cover of this Evidence of Coverage booklet.

Covered services in a medical emergency

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

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

After the emergency is over, you're entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. Your follow-up care will be covered by our plan.

If you get your follow-up care from out-of-network providers, you'll pay the higher out-of-network cost sharing.

What if it wasn’t a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn’t a medical emergency after all. If it turns out that it wasn't an emergency, as long as you reasonably thought your health was in serious danger, we'll cover your care.

However, after the doctor says it wasn’t an emergency, the amount of cost sharing that you pay will depend on whether you get the care from network providers or out-of-network providers. If you get the care from network providers, your share of the costs will usually be lower than if you get the care from out-of-network providers.

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

A service that requires immediate medical attention (but isn't an emergency) is an urgently needed service if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

You can receive urgent care through urgent care centers or through telehealth and online options. Your *Provider Directory* includes a list of urgent care centers that are within the network. You can also take advantage of remote options such as Additional Telehealth Services (see the Medical Benefits Chart in Chapter 4 for more information).

Urgently needed services are covered worldwide.

Only benefits rendered in an urgent care setting are covered. If you are admitted, inpatient benefits related to your urgent care visit are not covered by the plan.

If you have an emergency service outside the U.S. and its territories, you will be responsible for payment at the time services are rendered. You may then submit your claims and proof of payment for reimbursement consideration (minus any applicable member cost sharing). Transportation and repatriation are not covered.

For more information please see Chapter 5 (Section 1).

Our plan covers worldwide emergency services outside the United States under the following circumstances.

- The care is needed to treat, evaluate, or stabilize an emergency medical condition; or
- Services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care.

Only benefits rendered in an emergency room setting are covered. If you are admitted, inpatient benefits related to your emergency are not covered by the plan.

If you have an emergency service outside the U.S. and its territories, you will be responsible for payment at the time services are rendered. You may then submit your claims and proof of payment for reimbursement consideration (minus any applicable member cost sharing). Transportation and repatriation are not covered.

For more information please see Chapter 5 (Section 1).

Section 3.3 Get care during a disaster

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

Visit www.carefirst.com/medicareadvantage for information on how to get needed care during a disaster.

If you can't use a network provider during a disaster, our plan will allow you to get care from out-of-network providers at in-network cost sharing.

SECTION 4 What if you're billed directly for the full cost of covered services?

If you have paid more than our plan cost sharing for covered services, or if you got a bill for the full cost of covered medical services, you can ask us to pay our share of the cost of covered services. Go to Chapter 5 for information about what to do.

Section 4.1 If services aren't covered by our plan, you must pay the full cost

CareFirst BlueCross BlueShield Advantage Salute covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4. If you get services that aren't covered by our plan, you're responsible 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 use up your benefit for that type of covered service. Any amounts you pay after the benefit has been exhausted will not count toward the out-of-pocket maximum.

SECTION 5 Medical services in a clinical research study?

Section 5.1 What is a clinical research study

A clinical research study (also called a *clinical trial*) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically ask for volunteers to participate in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for covered services you get as part of the study. If you tell us you're in a qualified clinical trial, you're only responsible for the in-network cost sharing for the services in that trial. If you paid more—for example, if you already paid the Original Medicare cost-sharing amount—we'll reimburse the difference between what you paid and the in-network cost sharing. You'll need to provide documentation to show us how much you paid.

If you want to participate in any Medicare-approved clinical research study, you don't need to tell us or get approval from us. The providers that deliver your care as part of the clinical research study don't need to be part of our plan's network. (This doesn't apply to covered benefits that require a clinical trial or registry to assess the benefit, including certain benefits requiring

coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.)

While you don't need our plan's permission to be in a clinical research study, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

If you participate in a study not approved by Medicare, you'll be responsible for paying all costs for your participation in the study.

Section 5.2 Who pays for services in a clinical research study

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

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

After Medicare pays its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you'll pay the same amount for the services you get as part of the study as you would if you got these services from our plan. However, you must submit documentation showing how much cost sharing you paid. Go to Chapter 5 for more information on submitting requests for payments.

Example of cost sharing in a clinical trial: Let's say you have a lab test that costs $100 as part of the research study. Your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan. In this case, Original Medicare would pay $80 for the test, and you would pay the $20 copay required under Original Medicare. You would then notify our plan that you got a qualified clinical trial service and submit documentation (like a provider bill) to our plan. Our plan would then directly pay you $10. This makes your net payment for the test $10, the same amount you'd pay under our plan's benefits.

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

- Generally, Medicare won't pay for the new item or service the study is testing unless Medicare would cover the item or service even if you weren't in a study.
- Items or services provided only to collect data and not used in your direct health care. For example, Medicare won't pay for monthly CT scans done as part of a study if your medical condition would normally require only one CT scan.
- Items and services provided by the research sponsors free-of-charge for people in the trial.

Get more information about joining a clinical research study

Get more information about joining a clinical research study in the Medicare publication *Medicare and Clinical Research Studies,* available at www.Medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

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

Section 6.1 A religious non-medical health care institution

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we'll instead cover 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 How to get care from a religious non-medical health care institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you're conscientiously opposed to getting medical treatment that is **non-excepted**.

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

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

- The facility providing the care must be certified by Medicare.
- Our plan only covers *non-religious* aspects of care.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
  - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
  - – *and* – you must get approval in advance from our plan before you're admitted to the facility, or your stay won't be covered.

Medicare Inpatient Hospital and Skilled Nursing Facility Care coverage limits apply. Please refer to the Medical Benefits Chart in Chapter 4 for more details.

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 You won't own some durable medical equipment after making a certain number of payments under our plan

Durable medical equipment (DME) includes items like oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for members to use in the home. The member always owns some DME items, like prosthetics. Other types of DME you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. **As a member of CareFirst BlueCross BlueShield Advantage Salute you won't get ownership of rented DME items no matter how many copayments you make for the item while a member of our plan.** You won't get ownership even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan.

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

If you didn't get ownership of the DME item while in our plan, you'll have to make 13 new consecutive payments after you switch to Original Medicare to own the DME item. The payments you made while enrolled in our plan don't count toward these 13 payments.

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare don't count.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You didn't get ownership of the item while in our plan. You then go back to Original Medicare. You'll have to make 13 consecutive new payments to own the item once you rejoin Original Medicare. Any payments you already made (whether to our plan or to Original Medicare) don't count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage CareFirst BlueCross BlueShield Advantage Salute will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

If you leave CareFirst BlueCross BlueShield Advantage Salute or no longer medically require oxygen equipment, the oxygen equipment must be returned.

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

Original Medicare requires an oxygen supplier to provide you services for 5 years. During the first 36 months, you rent the equipment. For the remaining 24 months, the supplier provides the equipment and maintenance (you're still responsible for the copayment for oxygen). After 5 years, you can choose to stay with the same company or go to another company. At this point, the 5-year cycle starts over again, even if you stay with the same company, and you're again required to pay copayments for the first 36 months. If you join or leave our plan, the 5-year cycle starts over.

CHAPTER 4:
Medical Benefits Chart (what's covered and what you pay)

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

The Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of CareFirst BlueCross BlueShield Advantage Salute. This section also gives information about medical services that aren't covered. It also explains limits on certain services.

Section 1.1 Out-of-pocket costs you may pay for covered services

Types of out-of-pocket costs you may pay for covered services include:

- **Copayment:** 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 tells you more about your copayments.)
- **Coinsurance:** the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program don't pay deductibles, copayments or coinsurance. If you're in one of these programs, be sure to show your proof of Medicaid or QMB eligibility to your provider.

Section 1.2 What's the most you'll pay for Medicare Part A and Part B covered medical services?

Under our plan, there are 2 different limits on what you pay out-of-pocket for covered medical services:

- Your **in-network maximum out-of-pocket amount (MOOP)** is $5,900. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from network providers. The amounts you pay for deductibles, copayments, and coinsurance for covered services from network providers count toward this in-network maximum out-of-pocket amount. (The amounts you pay for plan premiums and services from out-of-network providers don't count toward your in-network maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your in-network maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart.) If you pay $5,900 for covered Part A and Part B services from network providers, you won't have any out-of-pocket costs for the rest of the year when you see our network providers. However, you must continue to pay our plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).
- Your **combined maximum out-of-pocket amount** is $8,950. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from both in-network and out-of-network providers. The amounts you pay for deductibles, copayments, and coinsurance for covered services count toward this combined maximum out-of-pocket amount. (The amounts you pay for our plan premiums don't count toward your combined maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your combined maximum out-of-pocket amount. These services are marked in the Medical Benefits Chart. If you pay $8,950 for covered services, you'll have 100% coverage and won't have any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Providers aren't allowed to balance bill you

As a member of CareFirst BlueCross BlueShield Advantage Salute, you have an important protection because you only have to pay your cost-sharing amount when you get services covered by our plan. Providers can't bill you for 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's a dispute and we don't pay certain provider charges.

Here's how this protection from balance billing 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. You'll generally have higher copayments when you get care from out-of-network providers.
- If your cost sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:

- If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (this is set in the contract between the provider and our plan).
- If you get 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.
- If you get the covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.

- If you think a provider has balance billed you, call Member Services at 833-536-2001 (TTY users call 711).

SECTION 2 The Medical Benefits Chart shows your medical benefits and costs

The Medical Benefits Chart on the next pages lists the services CareFirst BlueCross BlueShield Advantage Salute covers and what you pay out of pocket for each service. The services listed in the Medical Benefits Chart are covered only when these requirements are met:

- Your Medicare-covered services must be provided according to Medicare coverage guidelines.
- Your services (including medical care, services, supplies, equipment, and Part B drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan may not require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- Some of the services listed in the Medical Benefits Chart are covered as in-network services *only* if your doctor or other network provider gets approval in advance (sometimes called prior authorization).
  - Covered services that need approval in advance to be covered as in-network services are marked in italics in the Medical Benefits Chart.
  - You never need approval in advance for out-of-network services from out-of-network providers.
  - While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.

Other important things to know about our coverage:

- For benefits where your cost sharing is a coinsurance percentage, the amount you pay depends on what type of provider you get the services from:

  - If you get the covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (as determined in the contract between the provider and our plan).
  - If you get 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.
  - If you get the covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You 2026* handbook. View it online at www.Medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.)
- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you're also treated or monitored for an existing medical condition during the visit when you get the preventive service, a copayment will apply for the care you got for the existing medical condition.
- If Medicare adds coverage for any new services during 2026, either Medicare or our plan will cover those services.

Special Supplemental Benefits for the Chronically Ill: Important Benefit Information for Enrollees with Chronic Conditions.

If you are diagnosed with the following chronic condition(s) identified below and meet certain criteria, you may be eligible for special supplemental benefits for the chronically ill.

- Chronic alcohol use disorder and other substance use disorders (SUDs),
- Autoimmune disorders,
- Cancer,
- Cardiovascular disorders,
- Chronic heart failure,
- Dementia,
- Diabetes mellitus,
- Overweight, obesity, and metabolic syndrome,
- Chronic gastrointestinal disease,
- Chronic kidney disease (CKD),
- Severe hematologic disorders,
- HIV/AIDS,
- Chronic lung disorders,
- Chronic and disabling mental health conditions,
- Neurological disorders,
- Stroke,

- Post-organ transplantation,
- Immunodeficiency and Immunosuppressive disorders,
- Conditions associated with cognitive impairment,
- Conditions with functional challenges,
- Chronic conditions that impair vision, vision, hearing (deafness), taste, touch, and smell,
- Conditions that require continued therapy services in order for individuals to maintain or retain functioning,
- Chronically underweight

Members must attest to having one or more of the chronic conditions listed above and the plan may choose to confirm the diagnosis via claims review.

- For more detail, go to the Special Supplemental Benefits for the Chronically Ill row in the Medical Benefits Chart below.
- Contact us to find out exactly which benefits you may be eligible for.

 **This apple shows preventive services in the Medical Benefits Chart.**

Medical Benefits Chart

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
 **Abdominal aortic aneurysm screening** A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer;	$0 copay at a PCP office or $35 copay at a Specialist office for each Medicare-covered acupuncture visit. $20 copay for any additional	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
• nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy. An additional 8 sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. **Provider Requirements:** Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27. Our plan also covers routine acupuncture beyond chronic low back pain.	acupuncture services beyond Medicare-covered services (12 visits per calendar year). Non-Medicare covered / routine services do not count toward your maximum out-of-pocket (MOOP).	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	*Prior authorization may be required for non-emergent services.* $240 copay for each Medicare-covered one-way ambulance ground trip. 20% for each Medicare-covered air ambulance trip. This copay is not waived if you are admitted to a hospital.	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.
Annual Physical Exam The plan covers a routine physical exam, in addition to the annual wellness visit, once a year. This exam includes a detailed medical/family history and the performance of a detailed head to toe assessment with hands-on examination of all the body systems. Additional services include, as appropriate, follow-up orders or referrals to other practitioners, lab tests, clinical screenings, EKG, recommendations for preventive screenings, vaccination(s), and counseling about healthy behaviors.	$0 copay for an annual physical exam (1 per calendar year).	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.
 **Annual wellness visit** If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.	50% coinsurance for all services out-of-network You pay these amounts until you reach the

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Note: Your first annual wellness visit can't take place within 12 months of your *Welcome to Medicare* preventive visit. However, you don't need to have had a *Welcome to Medicare* visit to be covered for annual wellness visits after you've had Part B for 12 months.		out-of-pocket maximum.
Bone mass measurement For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women aged 40 and older • Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for covered screening mammograms.	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	$10 copay for each Medicare-covered cardiac or intensive cardiac rehabilitation visit.	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.
Cardiovascular disease screening tests Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you're at high risk of cervical or vaginal cancer or you're of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.
Chiropractic services Covered services include: • Manual manipulation of the spine to correct subluxation • Our plan also covers routine chiropractic services beyond manual manipulation of the spine to correct subluxation	*Prior authorization may be required for Medicare-covered chiropractic services only.* $10 copay for each Medicare-covered chiropractic visit.	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
	$10 copay for any additional chiropractic service beyond Medicare-covered services (12 visits per calendar year). Non-Medicare covered / routine services do not count toward your maximum out-of-pocket (MOOP).	
Chronic pain management and treatment services Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning.	Cost sharing for this service will vary depending on individual services provided under the course of treatment. Please consult the Medical Benefits Chart for cost-sharing amounts. These services will most likely be provided through a PCP or Specialist and your cost sharing would be: $0 copay for each Medicare-covered Primary Care Provider visit or	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
	each telehealth visit. $35 copay for each Medicare-covered Specialist visit.	
 **Colorectal cancer screening** The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 years and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed.	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam and there is no coinsurance, copayment, or deductible in our plan. $0 copay for each Medicare-covered barium enema.	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
• Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare-covered non-invasive stool-based colorectal cancer screening test returns a positive result. • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.		
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions	*Clinical review may be required for non-preventive dental services.* $40 copay for Medicare-covered comprehensive dental services. Non-Medicare covered / routine ser-	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. In addition, we cover Preventive and Comprehensive dental services. For more information on the additional dental coverage provided by the plan, please see the chart following this Medical Benefits Chart.	vices do not count toward your maximum out-of-pocket (MOOP). **Preventive Services:** Cleanings: $0 copay per service Oral Exams: $0 copay per service X-rays: $0 copay per service Fluoride Treatment: $0 copay per service **Additional Comprehensive Services:** Our plan also covers additional comprehensive dental services, up to a benefit maximum amount of $1,000 per calendar year. Extractions - $40 to $100 Adjunct General Services - $15 to $30 Endodontics - $100 to $200	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
	Periodontics - $50 to $300 Restorative - $15 to $400 Implant Services- $70 to $500 Prosthodontics, Removable - $30 to $700 Prosthodontics, Fixed - $40 to $400 Oral and Maxillofacial Surgery - $40 to $100 Adjunctive General Services - $15 to $30 For information on the preventive and comprehensive dental coverage please see the chart after the Medical Benefits Chart.	
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of these risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • For people with diabetes who have severe diabetic foot disease: one pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts, or one pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions. True Metrix and Accu-Chek products are preferred at network pharmacies. For other blood glucose	$0 copay for Medicare-covered diabetic supplies. 15% coinsurance for Medicare-covered therapeutic shoes and inserts. $0 copay for each Medicare-covered diabetes self-management training.	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
meter or test strip products, please contact your DME supplier. We may apply quantity limits for certain Part B diabetic supplies. If the request exceeds the quantity limits, a review may be required.		
Durable medical equipment (DME) and related supplies (For a definition of durable medical equipment, go to Chapter 10 and Chapter 3, Section 7.) Covered items include, but aren't limited to, wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at www.carefirst.com/medicareadvantage.	*Prior authorization may be required and is the responsibility of the provider or supplier.* Your cost sharing for Medicare oxygen equipment coverage is 15% coinsurance for Medicare-covered items. every month. Your cost sharing will not change after being enrolled for 36 months. If prior to enrolling in CareFirst BlueCross BlueShield Advantage Salute you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in CareFirst BlueCross BlueShield Advantage Salute	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
	is a 15% coinsurance for Medicare-covered items.	
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse. Cost sharing for necessary emergency services you get out-of-network is the same as when you get these services furnished in-network. Emergency care is covered worldwide. Only benefits rendered in an emergency room setting are covered. If you are admitted, inpatient benefits related to your emergency are not covered by the plan. If you have an emergency service outside the U.S. and its territories, you will be responsible for payment at the time services are rendered. You may then submit your claims and proof of payment for reimbursement consideration (minus any applicable member cost sharing). Transportation and repatriation are not covered.	$110 copay for each Medicare-covered emergency room visit. Copay is waived if you are admitted to the hospital within 24 hours for the same condition. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital in order to pay the in-network cost-sharing amount for the part of your stay after you are stabilized. If you stay at the out-of-network hospital, your stay will be covered but you will pay the out-of-network cost-sharing amount for the part of your stay after you are stabilized. **Worldwide Emergency Coverage:** ***Worldwide Emergency benefits do NOT count toward your maximum out-of-pocket (MOOP).*** $0 copay for each worldwide emergency room visit. $50,000 (USD) combined limit per year for emergency and urgent care services provided outside the U.S. and its territories.	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
For more information please see Chapter 5 (Section 1).		
Fitness benefit (SilverSneakers) **SilverSneakers® Membership** SilverSneakers can help you live a healthier, more active life through fitness and social connection. You are covered for a fitness benefit through SilverSneakers at participating locations[1] where you can take classes[2] and use exercise equipment and other amenities, at no additional cost to you. Enroll in as many locations as you like, at any time. You also have access to instructors who lead specially designed group exercise online classes, seven days a week with SilverSneakers LIVE. Additionally, SilverSneakers Community gives you options to get active outside of traditional gyms at recreation centers, parks and other neighborhood locations. SilverSneakers also connects you to a support network and online resources through SilverSneakers On-Demand videos and the SilverSneakers GO mobile app. Activate your free online account at SilverSneakers.com to view your SilverSneakers Member ID number and explore everything SilverSneakers has to offer. For additional questions, go to SilverSneakers.com or call 1-888-423-4632 (TTY: 711) Monday through Friday, 8 a.m. to 8 p.m. ET. **Always talk with your doctor before starting an exercise program.** [1]Participating locations ("PL") are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL. Inclusion of specific	$0 copay for all listed services. Benefit is covered through plan contracted vendor only.	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
PLs is not guaranteed and PL participation may differ by health plan. [2]Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location. SilverSneakers is a registered trademark of Tivity Health, Inc. © 2025 Tivity Health, Inc. All rights reserved.		
Health and wellness education programs Our health and wellness programs are designed to enrich the health and quality of life of members. These programs are focused on improving health outcomes, including chronic conditions. Our plan covers: - Access to CareFirst's Health Library (https://www.carefirst.com/wellness) with helpful information about health management and wellness, as well as links to exclusive CareFirst resources. - In Home Assessment - A targeted annual assessment to complete a comprehensive evaluation of your health status in the convenience of your home with an advanced clinician. This evaluation will be shared with your PCP to help initiate proactive care services to help manage your health throughout the year. Receive assistance to review and support any immediate health needs you may have, research and help take full advantage of navigating Health Plan Benefits. For more information please contact 1-800-558-9922 (TTY: 711).	$0 copay for all listed services.	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Hearing services Diagnostic hearing and balance evaluations performed by your PCP *OR* provider to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. In addition to Medicare-covered benefits, we also cover the following through NationsHearing: • Routine hearing exams: one exam every year • Hearing aids: two hearing aids every year • Hearing aid fitting evaluations: one hearing aid fitting/evaluation every year • Routine hearing exam and hearing aids are covered through a vendor and also provides the following services: • Sixty (60)-day money-back guarantee • Three (3) follow up appointments within one year of fitting date • Sixty (60)-batteries per year per hearing aid • 3-year manufacturer's warranty • 1-time replacement coverage for lost, stolen or damaged hearing aid • First set of ear mold(s), when needed Our plan has contracted with NationsHearing to provide your non-Medicare-covered hearing services. You must obtain your hearing aids from a NationsHearing provider. Please contact NationsHearing by phone at (877) 246-1666 (TTY: 711) for more information or to schedule an appointment.	$30 copay for each Medicare-covered exam to diagnose and treat hearing and balance issues. $0 copay for a routine hearing exam (once per calendar year). Hearing Aids: $0 copay per entry hearing aid $175 copay per basic hearing aid $475 copay per prime hearing aid $775 copay per preferred hearing aid $1,075 copay per advanced hearing aid $1,475 copay per premium hearing aid Non-Medicare covered / routine services do not count toward your maximum out-of-pocket (MOOP). Benefit is covered through plan contracted vendor only $0 copay for a fitting and evaluation for a	50% coinsurance for Medicare-covered exam to diagnose and treat hearing and balance issues.

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
	hearing aid visit (once per calendar year). Benefit is covered through plan contracted vendor only.	
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months If you are pregnant, we cover: • Up to 3 screening exams during a pregnancy	There's no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.
Home health agency care Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but aren't limited to: • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	*Prior authorization may be required and is the responsibility of the provider.* $0 copay for Medicare-covered home health visits.	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but aren't limited to: • Professional services, including nursing services, furnished in accordance with our plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier	*Prior authorization may be required and is the responsibility of the provider or supplier.* $35 copay for each Medicare-covered Specialist visit.	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.
Hospice care You're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not CareFirst BlueCross BlueShield Advantage Salute.	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
• Short-term respite care • Home care When you're admitted to a hospice, you have the right to stay in our plan; if you stay in our plan you must continue to pay plan premiums. **For hospice services and for services that are covered by Medicare Part A or B that are related to your terminal prognosis:** Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You'll be billed Original Medicare cost sharing. **For services that are covered by Medicare Part A or B not related to your terminal prognosis:** If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B that aren't related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (like if there's a requirement to get prior authorization). • If you get the covered services from a network provider and follow plan rules for getting service, you pay only our plan cost-sharing amount for in-network services • If you get the covered services from an out-of-network provider, you pay the cost sharing under Original Medicare **For services covered by CareFirst BlueCross BlueShield Advantage Salute but not covered by Medicare Part A or B:** CareFirst BlueCross		

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
BlueShield Advantage Salute will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our plan cost-sharing amount for these services. **Note:** If you need non-hospice care (care that's not related to your terminal prognosis), you should contact us to arrange the services.		
Immunizations Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you're at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you're at risk and they meet Medicare Part B coverage rules	There is no coinsurance, copayment, or deductible for the pneumonia, flu/ influenza, Hepatitis B, and COVID-19 vaccines.	
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. Covered services include but aren't limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units)	*Prior authorization may be required and is the responsibility of the provider.* For each Medicare-covered inpatient hospital stay: $335 per day for days 1-5, $0 copay per day for days 6-90 For each Medicare-covered	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
• Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If CareFirst BlueCross BlueShield Advantage Salute provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion. All CareFirst Medicare Advantage plans provide coverage for travel and lodging related organ transplant for eligible members with an approved prior authorization for a covered Medicare organ transplant provided at a distant location. The benefit period for a covered transplant begins five days prior to the transplant and extends	hospital stay, you are required to pay the applicable cost sharing, starting with Day 1 each time you are admitted. Cost sharing does not apply on day of discharge.	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
through the patient's transplant episode of care (not to exceed one year from the date of the transplant). Travel and lodging expenses are covered for the recipient (exclusive of inpatient hospital admission) and companion, subject to eligibility of the recipient and an approved prior authorization. The combined total maximum reimbursement allowed for travel and lodging per transplant episode of care is $5,000 a year. Lodging expenses are limited up to $150 per day, which applies to the combined $5,000 annual maximum. Please refer to the Reimbursement Policy for Transplant Services for more information. • Blood - including storage and administration. Coverage of whole blood and packed red cells starts with the first pint of blood you need. All other components of blood are covered beginning with the first pint. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you're not sure if you're an inpatient or an outpatient, ask the hospital staff. Get more information in the Medicare fact sheet *Medicare Hospital Benefits*. This fact sheet is available at https://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital.	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.
Inpatient services in a psychiatric hospital • Covered services include mental health care services that require a hospital stay.	*Prior authorization may be required and is the responsibility of the provider.*	50% coinsurance for all services out-of-network You pay these amounts until you

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
• Medicare limits covered inpatient mental health services provided in a psychiatric hospital to a maximum of 190 days. These 190 days are referred to as a "lifetime limit." • The 190-day lifetime limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital. • Our plan covers 90 days of inpatient mental health care services per admission. We also cover 60 extra days over your lifetime. These are called "lifetime reserve days." If you need more than 90 days of inpatient mental health care, you may use your lifetime reserve days. Once these lifetime reserve days have all been used, your coverage for inpatient mental health care will be limited to 90 days per admission.	For each Medicare-covered inpatient psychiatric hospital stay: $245 copay per days 1-5, $0 copay days 6-90	reach the out-of-pocket maximum.
Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay If you've used up your inpatient benefits or if the inpatient stay is not reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you get while you're in the hospital or the skilled nursing facility (SNF). Covered services include, but aren't limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts, and other devices used to reduce fractures and dislocations	*Prior authorization may be required and is the responsibility of the provider.* You pay the applicable cost sharing for services as though they were provided on an outpatient basis. Please refer to the applicable benefit in the Medical Benefits Chart of this Evidence of Coverage.	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
• Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy		
 **Medical nutrition therapy** This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.
 **Medicare Diabetes Prevention Program (MDPP)** **MDPP services are covered for eligible people under all Medicare health plans.**	There is no coinsurance, copayment, or deductible for the MDPP benefit.	50% coinsurance for all services out-of-network You pay these amounts until you reach the

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.		out-of-pocket maximum.
Medicare Part B drugs **These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include:** • Drugs that usually aren't self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan • The Alzheimer's drug, Leqembi®, (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment • Clotting factors you give yourself by injection if you have hemophilia	*Prior authorization may be required and is the responsibility of the provider.* 0-20% coinsurance for Medicare-covered Part B chemotherapy drugs. 0-20% coinsurance for Medicare-covered Part B other drugs and insulin. Insulin cost sharing is subject to a cap of $35 for one-month's supply Medicare Part B drugs may be subject to step	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
• Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Keep in mind, Medicare drug coverage (Part D) covers immunosuppressive drugs if Part B doesn't cover them • Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug • Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. • Oral anti-nausea drugs: Medicare covers oral antinausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B	therapy requirements.	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
• Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv®, and the oral medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa, Mircera®, or Methoxy polyethylene glycol-epoetin beta) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: https://www.carefirst.com/medicare-options/compare-medicare-plans/medicare-part-b-prescription-drugs.html. We also cover some vaccines under our Part B drug benefit.		
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Opioid treatment program services: Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	$40 copay for each opioid treatment program service.	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but aren't limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Diagnostic non-laboratory tests such as CT scans, MRIs, vEKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem.	*Prior authorization may be required for non-routine tests and services.* $50 copay for each Medicare-covered diagnostic procedure or test. $0 copay for each Medicare-covered lab service (per day per facility). $200 copay for each Medicare-covered diagnostic radiological service. $0 copay	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
• Other outpatient diagnostic tests	for diagnostic mammograms $50 copay for each Medicare-covered nuclear medicine service. 20% coinsurance for each Medicare-covered therapeutic radiological service. $20 copay for each Medicare-covered X-ray service. $0 copay for Medicare-covered blood services. 15% coinsurance of the total cost for Medicare-covered prosthetic and orthotic devices and medical supplies related to prosthetics, splints, and other devices.	
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria	*Prior authorization may be required and is the responsibility of the provider.*	50% coinsurance for all services out-of-network You pay these amounts until you reach the

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, you should ask the hospital staff. Get more information in the Medicare fact sheet *Medicare Hospital Benefits.* This fact sheet is available at https://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	$250 copay for each Medicare-covered outpatient hospital observation.	out-of-pocket maximum.
Outpatient hospital services We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but aren't limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital	*Prior authorization may be required and is the responsibility of the provider.* $250 copay for each Medicare-covered outpatient hospital facility visit. copay for select outpatient hospital services. $200 copay for each Medicare-covered	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
• Medical supplies such as splints and casts • Certain drugs and biologicals you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff.	Ambulatory Surgical Center visit. copay for select services received at an Ambulatory Surgical Center. To see the cost-sharing amounts you will pay, refer to other sections of the Medical Benefits Chart for services that could apply in an outpatient hospital setting, such as: • Partial hospitalization • Emergency care • Medicare Part B prescription drugs • Durable Medical Equipment	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
	• Outpatient diagnostic tests, therapeutic services and supplies, including lab and x-ray Outpatient surgery	
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.	$10 copay for each Medicare-covered individual therapy visit with any type of mental health professional. $0 copay for telehealth visit. $10 copay for each Medicare-covered group therapy visit with any type of mental health professional. $0 copay for each telehealth visit.	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.
Outpatient rehabilitation services Covered services include physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	*Prior authorization may be required and is the responsibility of the provider.* $35 copay for each Medicare-covered occupational therapy, physical therapy, or speech	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
	language therapy visit.	
Outpatient substance use disorder services Outpatient substance abuse services include various levels of care, to include: • Office-based outpatient treatment • Intensive outpatient programs (IOP) • Partial hospitalization programs (PHP) • Residential treatment • Inpatient care, including detoxification. All levels of care may include individual and/or group counseling and medication-assisted treatments.	$40 copay for each Medicare-covered individual outpatient substance abuse treatment visit. $20 copay for each Medicare-covered group outpatient substance abuse treatment visit.	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.	*Prior authorization may be required and is the responsibility of the provider.* $250 copay for each Medicare-covered outpatient hospital facility visit. $200 copay for each Medicare-covered Ambulatory Surgical Center visit.	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.
Over the counter items (OTC) An allowance towards mail-order over the counter (OTC) products, a wide selection of drugs, supplies, and self-care products, available without a prescription. Examples of OTC items	Members will receive a $40 quarterly allowance for any mail order over-the-counter (OTC) purchases through our vendor.	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
include but are not limited to: adhesive or elastic bandages, antihistamines, analgesics, decongestants, anti-inflammatories, antiseptics, sleep aids, supplements, incontinence supplies, compression hosiery, toothpaste, denture adhesives, denture cleaners, and gum stimulators. The OTC catalog contains a complete listing of all plan-covered OTC drugs, supplies, and self-care products and the price of each item. Available products and brands may change throughout the year and are subject to availability. Quantity limits apply to select items. Please go to the plan website to access the catalog and order items.		
Partial hospitalization services and Intensive outpatient services *Partial hospitalization* is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. *Intensive outpatient service* is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a federally qualified health center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.	*Prior authorization may be required and is the responsibility of the provider.* $20 copay for each Medicare-covered partial hospitalization or intensive outpatient services.	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically necessary medical care or surgery services you get in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP *OR* specialist, if your doctor orders it to see if you need medical treatment • Certain additional telehealth services, including those for: Primary Care Provider, Specialist, Mental Health Care (individual or group), and Mental Health Care with a Psychologist (individual or group), and urgently needed services. Services will only be provided via telehealth when deemed clinically appropriate by the network provider rendering the service. ◦ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. ◦ We offer the following means of telehealth: ▪ Interactive video visits for professional services when care can be provided in this format as determined by an in or out-of-network provider. • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare	$0 copay for each Medicare-covered Primary Care Provider visit or each telehealth visit. $35 copay for each Medicare-covered Specialist visit or each telehealth visit. $10 copay for each Medicare-covered individual therapy visit with any type of mental health professional. $0 copay for telehealth visit. $10 copay for each Medicare-covered group therapy visit with any type of mental health professional. $0 copay for each telehealth visit. $25 copay for each Medicare-covered urgent care visit in-person. $0 virtual urgent care visit.	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network

• Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home
• Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location
• Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location
• Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if:
  • You have an in-person visit within 6 months prior to your first telehealth visit
  • You have an in-person visit every 12 months while getting these telehealth services
  • Exceptions can be made to the above for certain circumstances
• Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers
• Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**:
  • You're not a new patient **and**
  • The check-in isn't related to an office visit in the past 7 days **and**
  • The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment
• Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**:
  • You're not a new patient **and**
  • The evaluation isn't related to an office visit in the past 7 days **and**		

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
• The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion by another network provider prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)		
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs In additional to Medicare-covered podiatry services above, we also offer: • Non-Medicare routine podiatry care for members with any medical condition affecting the lower limbs	$10 copay for each Medicare-covered podiatry visit. $10 copay for any additional podiatry service beyond Medicare-covered services (12 visits per calendar year combined in-and out-of-network). Non-medicare (routine services) do not count towards your maximum out-of-pocket (MOOP).	50% coinsurance for all services out-of-network 12 visits per calendar year combined in and out-of-network. You pay these amounts until you reach the out-of-pocket maximum.

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug. • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to 8 HIV screenings every 12 months. A one-time hepatitis B virus screening.	There is no coinsurance, copayment, or deductible for the PrEP benefit.	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.
Prostate cancer screening exams For men aged 50 and older, covered services include the following – once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for an annual PSA test $0 copay for each Medicare-covered digital rectal exam.	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.
Prosthetic and orthotic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include but aren't limited to testing, fitting, or training in the	*Prior authorization may be required and is the responsibility of the provider or supplier.* 15% coinsurance of the total cost for Medicare-covered	50% coinsurance for all services out-of-network You pay these amounts until you reach the

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
use of prosthetic and orthotic devices; as well as colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to *Vision Care* later in this table for more detail.	prosthetic and orthotic devices and medical supplies related to prosthetics, splints, and other devices.	out-of-pocket maximum.
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	$10 copay for each Medicare-covered pulmonary rehabilitation service.	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified people, a LDCT is covered every 12 months.	There is no coinsurance, copayment, or deductible for the Medicare covered counseling and	50% coinsurance for all services out-of-network You pay these amounts until you

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Eligible members are people age 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who get an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the members must get an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	shared decision-making visit or for the LDCT.	reach the out-of-pocket maximum.
Screening for Hepatitis C Virus infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. If you were born between 1945-1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus.	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to 6 sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3 or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you're admitted as an inpatient to a hospital for special care)	$0 copay for Medicare-covered kidney disease education services. 20% coinsurance for each Medicare-covered renal dialysis visit.	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, please go to **Medicare Part B drugs** in this table.		
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, go to Chapter 12. Skilled nursing facilities are sometimes called SNFs.) We cover up to 100 days per benefit period of skilled nursing inpatient services in a skilled nursing facility in accord with Medicare guidelines. A prior hospital stay is not required. Covered services include but aren't limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy and speech therapy • Drugs administered to you as part of our plan of care (this includes substances that are naturally present in the body, such as blood clotting factors.)	*Prior authorization may be required and is the responsibility of the provider.* For each Medicare-covered Skilled Nursing Facility stay: $0 copay per day for days 1 to 20, $200 copay per day for days 21 to 100 A benefit period begins the day you go into a skilled nursing facility. The benefit period ends when you haven't received any skilled care in a SNF for 60	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
• Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you get SNF care from network facilities. Under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital	days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods. Cost sharing applies to day of discharge.	
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: • Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • Are competent and alert during counseling	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
• A qualified physician or other Medicare-recognized practitioner provides counseling We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.)		
Special Supplemental Benefits for the Chronically Ill Members that are diagnosed with certain qualifying conditions (see list below) can use all or a portion of the $75 monthly allowance toward groceries (ex. beverages, frozen food, non-perishable/perishable foods, vitamins, dietary supplements, diabetes health and wellness nutrition, or weight management), utilities (please note some utility companies will not allow a partial payment, please check with your company before using the card) or rent (please note some rental companies or landlords may not accept payment through the healthcare prepaid card, full or partial. There will be a reimbursement process in place to provide assistance, however a receipt of payment will be required) through a healthcare prepaid card provided by the plan when you join the plan. The qualifying conditions are: Chronic alcohol use disorder and other substance use disorders (SUDs), Autoimmune disorders, Cancer, Cardiovascular disorders, Chronic heart failure,	$75 monthly allowance applies through plan approved vendor only.	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Dementia, Diabetes mellitus, Overweight, obesity, and metabolic syndrome, Chronic gastrointestinal disease, Chronic kidney disease (CKD), Severe hematologic disorders, HIV/AIDS, Chronic lung disorders, Chronic and disabling mental health conditions, Neurologic disorders, Stroke, Post-organ transplantation, Immunodeficiency and Immunosuppressive disorders, Conditions associated with cognitive impairment, Conditions with functional challenges, Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell, Conditions that require continued therapy services in order for individuals to maintain or retain functioning,		

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Chronically underweight The healthcare prepaid card can be used at participating grocery stores that accept Visa or MasterCard, or to pay utility companies, rental agencies or landlords directly. Members must activate the card by calling 844-479-6334 (TTY: 711) and will also need to attest to a qualifying condition. Once this is completed, it will take 48 hours (business days) for the funds to be available on the card. Qualifying members will receive a replacement card annually for no additional charge. There is no monthly or annual rollover for this benefit. Please contact Member Services at 1-844-479-6334 (TTY: 711) for more information.		
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD). Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms and who are trained in exercise therapy for PAD	$10 copay for each Medicare-covered supervised exercise therapy visit.	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
• Be under the direct supervision of a physician, physician assistant, or nurse practitioner/ clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.		
Transportation (Non-Emergency) Covered services include: One-way trips directly to and from any health-related location every calendar year via taxi, van, or other approved type of transportation. This benefit is only valid for health- related purposes. Routine transportation is provided to the member, and when necessary, due to the health status of the member, one (1) escort. The transportation benefit can only be used for appointments and pharmacy visits directly related to the member. Transportation cannot be used for anyone other than the member. We are not responsible for any lost items, injuries, etc. during the transportation service. Members are required to provide three (3) business days (Monday-Friday, excluding holidays) advance notice to arrange for transportation. Members should call 833-536-2001 (TTY Users: 711) 8 a.m. to 8 p.m., local time, 7 days a week from October 1 through March 31 and 8 a.m. to 8 p.m., local time, Monday through Friday from April 1 through September 30.	$0 copay for 24 one-way trips directly to and from any health-related location every calendar year via taxi, van, or other approved type of transportation. This benefit is only covered through our vendor.	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
Cancellations or changes must be made at least two (2) hours prior to the scheduled trip, or it will be deducted from the number of trips remaining.		
Urgently needed services A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or, even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable. Urgently needed services are covered worldwide. Only benefits rendered in an urgent care setting are covered. If you are admitted, inpatient benefits related to your urgent care visit are not covered by the plan. If you have an emergency service outside the U.S. and its territories, you will be responsible for payment at the time services are rendered. You may then submit your claims and proof of payment for reimbursement consideration (minus any applicable member cost sharing). Transportation and repatriation are not covered. For more information please see Chapter 5 (Section 1).	$25 copay for each Medicare-covered urgent care visit in-person. $0 virtual urgent care visit. Copay is waived if you are admitted to the hospital within 48 hours for the same condition. **Worldwide Urgently Needed Services:** ***Worldwide Urgently needed services do NOT count toward your maximum out-of-pocket (MOOP).*** $0 copay for each worldwide urgent care visit. $50,000 (USD) combined limit per year for emergency and urgent care services provided outside the U.S. and its territories.	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
 **Vision care** Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. • For people who are at high risk for glaucoma, we cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older and Hispanic Americans who are 65 or older. • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. If you have 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery. We also cover through Davis Vision: • Diabetic eye exam • Routine eye exam • Additional eyewear that includes prescription lenses and one pair of eyeglass frames or contact lenses. For more details about the routine vision coverage and allowances, please contact Davis Vision 1-888-573-2990 (TTY: 711).	$30 copay for each Medicare-covered eye exam to diagnose and treat diseases and conditions of the eye. $0 copay for one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery. $0 copay for each Medicare-covered glaucoma screening visit. $0 copay for each diabetic eye exam (one per calendar year). The vision benefit cannot be combined with any provider-offered discounts or promotions. Insurance must be used at time of sale for benefits to apply. $0 copay for a routine eye exam (includes dilation & refraction), once every calendar year.	50% coinsurance for all services out-of-network $200 maximum for all eyewear. You pay these amounts until you reach the out-of-pocket maximum.

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
	Additional Eyewear Coverage: Eyewear (Frames and Lenses): - Select frames purchased from Davis Vision's exclusive collection will be covered in full through our vendor. - $200 allowance for any other frames annually. - Single Vision, Bifocal, Trifocal, and Lenticular lenses have a $10 copay for each type of lenses annually. Contacts (Medical and Elective): - If contact lenses are medically necessary they will be covered in full through Davis Vision, . - $250 allowance for elective contact lenses annually. - Contact lens evaluation and fitting is a maximum reimbursement of $60.	

Covered Service	What you pay when you get these services In-Network	What you pay when you get these services Out-of-Network
	Non-Medicare covered / routine services do not count toward your maximum-out-of-pocket (MOOP).	
Welcome to Medicare preventive visit Our plan covers the one-time *Welcome to Medicare* preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the *Welcome to Medicare* preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you want to schedule your *Welcome to Medicare* preventive visit.	There is no coinsurance, copayment, or deductible for the *Welcome to Medicare* preventive visit.	50% coinsurance for all services out-of-network You pay these amounts until you reach the out-of-pocket maximum.

Preventive and Enhanced Comprehensive Dental Coverage Chart

You have additional preventive and comprehensive dental coverage beyond Medicare-covered services. See the table below for a full overview of covered services, frequencies, and cost-sharing amounts.

For any questions about dental benefits, please contact Member Services.

Note: Prior authorization may be required for some services. Services from non-participating dentists are not covered unless authorized by the plan or for dental emergencies. In other cases, members will be responsible for any out-of-network services.

The American Dental Association (ADA) may periodically change the current dental terminology (CDT) codes or definitions listed in the ADA publications. If such changes result in different CDT codes being used by participating dentists to describe the covered dental services listed below, the coverage and patient responsibility will not change.

CODE	**INN/ONN**	
Plan Type	**Medicare Advantage PPO**	
Plan Name	**CareFirst BlueCross BlueShield Advantage Salute (PPO)**	
Plan Features	Includes Comprehensive Dental Coverage	All Comprehensive services are subject to $1000 maximum plan coverage
Individual Deductible:	$0	
Network:	In and Out-of-Network coverage available	

	Preventive Dental Services	**Frequency**	**Cost-Sharing In-Network**	**Cost-Sharing Out-of-Network**
	Oral Exams (16b1)			
D0120	PERIODIC ORAL EXAMINATION—ESTABLISHED PATIENT	Twice per year	$0	50% coinsurance
D0140	LIMITED ORAL EVALUATION—PROBLEM FOCUSED Also covered with D9995 as a teledenstistry modifier	Once a day per provider	$0	50% coinsurance
D0150	COMPREHENSIVE ORAL EVALUATION—NEW OR ESTABLISHED PATIENT	Once per three years per provider	$0	50% coinsurance
D0160	DETAILED AND EXTENSIVE ORAL EVALUATION—PROBLEM FOCUSED, BY REPORT	Once a day per provider	$0	50% coinsurance
D0180	COMPREHENSIVE PERIODONTAL EVALUATION—NEW OR ESTABLISHED PATIENT	Once per three years per provider	$0	50% coinsurance
D0190	Screening of a patient; a screening, including state or federally mandated screenings, to determine an individual's need to be seen by dentist for diagnosis Only covered with D9995 as a teledenstistry modifier	Once per date of service	$0	50% coinsurance
	Dental X-Rays (16b2)			
D0210	INTRAORAL—COMPLETE SERIES OF RADIOGRAPHIC IMAGES	Once every three years	$0	50% coinsurance
D0220	INTRAORAL—PERIAPICAL FIRST RADIOGRAPHIC IMAGE	Once per provider per day	$0	50% coinsurance

	Preventive Dental Services	**Frequency**	**Cost-Sharing In-Network**	**Cost-Sharing Out-of-Network**
D0230	INTRAORAL—PERIAPICAL EACH ADDITIONAL RADIOGRAPHIC IMAGE	Up to six a day	$0	50% coinsurance
D0270	BITEWING—SINGLE RADIOGRAPHIC IMAGE	One bitewing set a year	$0	50% coinsurance
D0272	BITEWINGS—TWO RADIOGRAPHIC IMAGES		$0	50% coinsurance
D0273	BITEWINGS—THREE RADIOGRAPHIC IMAGES		$0	50% coinsurance
D0274	BITEWINGS—FOUR RADIOGRAPHIC IMAGES		$0	50% coinsurance
D0277	VERTICAL BITEWINGS—7 TO 8 RADIOGRAPHIC IMAGES	Once every three years	$0	50% coinsurance
D0330	PANORAMIC RADIOGRAPHIC IMAGE	Once every three years	$0	50% coinsurance
	Prophylaxis (16b4)			
D1110	PROPHYLAXIS—ADULT	Twice per year	$0	50% coinsurance
	Fluoride Treatment (16b5)			
D1206	TOPICAL APPLICATION OF FLUORIDE VARNISH	Only one of the codes twice a year	$0	50% coinsurance
D1208	TOPICAL APPLICATION OF FLUORIDE—EXCLUDING VARNISH		$0	50% coinsurance
	Comprehensive Dental (16c)			
	Annual Maximum (applies to comprehensive dental ONLY)	**$1000 Annual Plan Maximum:**		
	Comprehensive Dental Services	**Frequency**	**Cost-Sharing In-Network**	**Cost-Sharing Out-of-Network**
	Restorative Services (16c1)			
D2140	AMALGAM—ONE SURFACE, PRIMARY OR PERMANENT	One surface per 12 months	$30.00	50% coinsurance
D2150	AMALGAM—TWO SURFACES, PRIMARY OR PERMANENT	One surface per 12 months	$40.00	50% coinsurance
D2160	AMALGAM—THREE SURFACES, PRIMARY OR PERMANENT	One surface per 12 months	$50.00	50% coinsurance
D2161	AMALGAM—FOUR OR MORE SURFACES, PRIMARY OR PERMANENT	One surface per 12 months	$60.00	50% coinsurance

	Comprehensive Dental Services	Frequency	Cost-Sharing In-Network	Cost-Sharing Out-of-Network
D2330	RESIN-BASED COMPOSITE—ONE SURFACE, ANTERIOR	One surface per 12 months	$30.00	50% coinsurance
D2331	RESIN-BASED COMPOSITE—TWO SURFACES, ANTERIOR	One surface per 12 months	$40.00	50% coinsurance
D2332	RESIN-BASED COMPOSITE—THREE SURFACES, ANTERIOR	One surface per 12 months	$50.00	50% coinsurance
D2335	RESIN-BASED COMPOSITE—FOUR OR MORE SURFACES OR INVOLVING INCISAL ANGLE (ANTERIOR)	One surface per 12 months	$60.00	50% coinsurance
D2391	RESIN-BASED COMPOSITE—ONE SURFACE, POSTERIOR	One surface per 12 months	$30.00	50% coinsurance
D2392	RESIN-BASED COMPOSITE—TWO SURFACES, POSTERIOR	One surface per 12 months	$40.00	50% coinsurance
D2393	RESIN-BASED COMPOSITE—THREE SURFACES, POSTERIOR	One surface per 12 months	$50.00	50% coinsurance
D2394	RESIN-BASED COMPOSITE—FOUR OR MORE SURFACES, POSTERIOR	One surface per 12 months	$60.00	50% coinsurance
D2542	ONLAY—METALLIC—TWO SURFACES	Once per tooth every 5 years	$200.00	50% coinsurance
D2543	ONLAY—METALLIC—THREE SURFACES	Once per tooth every 5 years	$200.00	50% coinsurance
D2544	ONLAY—METALLIC—FOUR OR MORE SURFACES	Once per tooth every 5 years	$300.00	50% coinsurance
D2642	ONLAY—PORCELAIN/CERAMIC—TWO SURFACES	Once per tooth every 5 years	$200.00	50% coinsurance
D2643	ONLAY—PORCELAIN/ CERAMIC—THREE SURFACES	Once per tooth every 5 years	$300.00	50% coinsurance
D2644	ONLAY—PORCELAIN/CERAMIC—FOUR OR MORE SURFACES	Once per tooth every 5 years	$300.00	50% coinsurance
D2662	ONLAY—RESIN-BASED COMPOSITE—TWO SURFACES	Once per tooth every 5 years	$200.00	50% coinsurance
D2663	ONLAY—RESIN-BASED COMPOSITE—THREE SURFACES	Once per tooth every 5 years	$300.00	50% coinsurance
D2664	ONLAY—RESIN-BASED COMPOSITE—FOUR OR MORE SURFACES	Once per tooth every 5 years	$300.00	50% coinsurance

	Comprehensive Dental Services	Frequency	Cost-Sharing In-Network	Cost-Sharing Out-of-Network
D2721	CROWN—RESIN WITH PREDOMINANTLY BASE METAL	Once per tooth every 5 years	$400.00	50% coinsurance
D2740	CROWN—PORCELAIN/CERAMIC	Once per tooth every 5 years	$400.00	50% coinsurance
D2751	CROWN—PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	Once per tooth every 5 years	$400.00	50% coinsurance
D2753	CROWN—PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS	Once per tooth every 5 years	$400.00	50% coinsurance
D2781	CROWN—3/4 CAST PREDOMINATELY BASE METAL	Once per tooth every 5 years	$400.00	50% coinsurance
D2783	CROWN—3/4 PORCELAIN/CERAMIC	Once per tooth every 5 years	$400.00	50% coinsurance
D2790	CROWN—FULL CAST HIGH NOBLE METAL	Once per tooth every 5 years	$400.00	50% coinsurance
D2791	CROWN—FULL CAST PREDOMINANTLY BASE	Once per tooth every 5 years	$400.00	50% coinsurance
D2792	CROWN—FULL CAST NOBLE METAL	Once per tooth every 5 years	$400.00	50% coinsurance
D2794	CROWN—TITANIUM AND TITANIUM ALLOYS	Once per tooth every 5 years	$400.00	50% coinsurance
D2910	RE-CEMENT OR RE-BOND INLAY, ONLAY, VENEER OR PARTIAL COVERAGE RESTORATION	Once every 12 months	$20.00	50% coinsurance
D2915	RE-CEMENT OR RE-BOND INDIRECTLY FABRICATED OR PREFABRICATED POST AND CORE	Once every 12 months	$20.00	50% coinsurance
D2920	RE-CEMENT OR RE-BOND CROWN	Once every 12 months	$20.00	50% coinsurance
D2940	PROTECTIVE RESTORATION	Once per tooth per year	$20.00	50% coinsurance
D2950	CORE BUILDUP, INCLUDING ANY PINS WHEN REQUIRED	Once per tooth every 5 years	$60.00	50% coinsurance
D2951	PIN RETENTION—PER TOOTH, IN ADDITION TO RESTORATION	As needed	$15.00	50% coinsurance
D2952	POST AND CORE IN ADDITION TO CROWN, INDIRECTLY FABRICATED	Once per tooth every 5 years	$100.00	50% coinsurance

	Comprehensive Dental Services	Frequency	Cost-Sharing In-Network	Cost-Sharing Out-of-Network
D2954	PREFABRICATED POST AND CORE IN ADDITION TO CROWN	Once per tooth every 5 years	$60.00	50% coinsurance
	Implant Services (16c6)			
D6013	SURGICAL PLACEMENT OF MINI IMPLANT	Once every 5 years	$200.00	50% coinsurance
D6056	PREFABRICATED ABUTMENT—INCLUDES MODIFICATION AND PLACEMENT	Once every 5 years	$300.00	50% coinsurance
D6057	CUSTOM FABRICATED ABUTMENT—INCLUDES PLACEMENT	Once every 5 years	$300.00	50% coinsurance
D6058	ABUTMENT SUPPORTED PORCELAIN/ CERAMIC CROWN	Once every 5 years	$400.00	50% coinsurance
D6059	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (HIGH NOBLE METAL)	Once every 5 years	$400.00	50% coinsurance
D6060	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINANTLY BASE METAL)	Once every 5 years	$400.00	50% coinsurance
D6061	ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (NOBLE METAL)	Once every 5 years	$400.00	50% coinsurance
D6062	ABUTMENT SUPPORTED CAST METAL CROWN (HIGH NOBLE METAL)	Once every 5 years	$400.00	50% coinsurance
D6063	ABUTMENT SUPPORTED CAST METAL CROWN (PREDOMINANTLY BASE METAL)	Once every 5 years	$400.00	50% coinsurance
D6064	ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL)	Once every 5 years	$400.00	50% coinsurance
D6065	IMPLANT SUPORTED PORCELAIN/ CERAMIC CROWN	Once every 5 years	$400.00	50% coinsurance
D6066	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	Once every 5 years	$400.00	50% coinsurance
D6067	IMPLANT SUPPORTED CROWN - HIGH NOBLE ALLOYS	Once every 5 years	$400.00	50% coinsurance
D6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	Once every 5 years	$400.00	50% coinsurance

	Comprehensive Dental Services	Frequency	Cost-Sharing In-Network	Cost-Sharing Out-of-Network
D6076	IMPLANT SUPPORTED RETAINER FOR FPD - PORCELAIN FUSED TO HIGH NOBLE ALLOYS	Once every 5 years	$400.00	50% coinsurance
D6077	IMPLANT SUPPORTED RETAINER FOR METAL FPD - HIGH NOBLE ALLOYS	Once every 5 years	$400.00	50% coinsurance
D6082	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE ALLOYS	Once every 5 years	$400.00	50% coinsurance
D6083	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO NOBLE ALLOYS	Once every 5 years	$400.00	50% coinsurance
D6084	IMPLANT SUPPORTED CROWN - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS	Once every 5 years	$400.00	50% coinsurance
D6086	IMPLANT SUPPORTED CROWN - PREDOMINATELY BASE ALLOYS	Once every 5 years	$400.00	50% coinsurance
D6087	IMPLANT SUPPORTED CROWN - NOBLE ALLOYS	Once every 5 years	$400.00	50% coinsurance
D6088	IMPLANT SUPPORTED CROWN - TITANIUM AND TITANIUM ALLOYS	Once every 5 years	$400.00	50% coinsurance
D6094	ABUTMENT SUPPORTED CROWN TITANIUM AND TITANIUM ALLOYS	Once every 5 years	$400.00	50% coinsurance
D6097	ABUTMENT SUPPORTED CROWN - PORCELAIN FUSED TO TITANIUM OR TITANIUM ALLOYS	Once every 5 years	$400.00	50% coinsurance
D6098	IMPLANT SUPPORTED RETAINER - PORCELAIN FUSED TO PREDOMINANTLY BASE ALLOYS	Once every 5 years	$400.00	50% coinsurance
D6099	IMPLANT SUPPORTED RETAINER FOR FPD - PORCELAIN FUSED TO NOBLE ALLOYS	Once every 5 years	$400.00	50% coinsurance
D6100	IMPLANT REMOVAL, BY REPORT	As needed	$500.00	50% coinsurance
D6101	DEBRIDEMENT OF A PERI-IMPLANT DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT, AND SURFACE CLEANING OF THE EXPOSED IMPLANT SURFACES, INCLUDING FLAP ENTRY AND CLOSURE	Once every 12 months	$150.00	50% coinsurance

	Comprehensive Dental Services	Frequency	Cost-Sharing In-Network	Cost-Sharing Out-of-Network
D6102	DEBRIDEMENT AND OSSEOUS CONTOURING OF A PERI-IMPLANT DEFECT OR DEFECTS SURROUNDING A SINGLE IMPLANT AND INCLUDES SURFACE CLEANING OF THE EXPOSED IMPLANT SURFACES, INCLUDING FLAP ENTRY AND CLOSURE	Once every 12 months	$150.00	50% coinsurance
D6120	IMPLANT SUPPORTED RETAINER - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS	Once every 5 years	$400.00	50% coinsurance
D6121	IMPLANT SUPPORTED RETAINER FOR METAL FPD - PREDOMINANTLY BASE ALLOYS	Once every 5 years	$400.00	50% coinsurance
D6122	IMPLANT SUPPORTED RETAINER FOR METAL FPD - NOBLE ALLOYS	Once every 5 years	$400.00	50% coinsurance
D6123	IMPLANT SUPPORTED RETAINER FOR METAL FPD - TITANIUM AND TITANIUM ALLOYS	Once every 5 years	$400.00	50% coinsurance
D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY REPORT	Once every 5 years	$70.00	50% coinsurance
D6195	ABUTMENT SUPPORTED RETAINER - PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS	Once every 5 years	$400.00	50% coinsurance
	Endodontics (16c2)			
D3310	ENDODONTIC THERAPY, ANTERIOR TOOTH (EXCLUDING FINAL RESTORATION)	Once per tooth per lifetime	$200.00	50% coinsurance
D3320	ENDODONTIC THERAPY, PREMOLAR TOOTH (EXCLUDING FINAL RESTORATION)	Once per tooth per lifetime	$200.00	50% coinsurance
D3330	ENDODONTIC THERAPY, MOLAR (EXCLUDING FINAL RESTORATION)	Once per tooth per lifetime	$200.00	50% coinsurance
D3346	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - ANTERIOR	Once per tooth per lifetime	$200.00	50% coinsurance
D3347	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - PREMOLAR	Once per tooth per lifetime	$200.00	50% coinsurance
D3348	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - MOLAR	Once per tooth per lifetime	$200.00	50% coinsurance

	Comprehensive Dental Services	Frequency	Cost-Sharing In-Network	Cost-Sharing Out-of-Network
D3410	APICOECTOMY—ANTERIOR	Once per tooth per lifetime	$200.00	50% coinsurance
D3421	APICOECTOMY—PREMOLAR (FIRST ROOT)	Once per tooth per lifetime	$200.00	50% coinsurance
D3425	APICOECTOMY—MOLAR (FIRST ROOT)	Once per tooth per lifetime	$200.00	50% coinsurance
D3426	APICOECTOMY (EACH ADDITIONAL ROOT)	Once per tooth per lifetime	$100.00	50% coinsurance
D3430	RETROGRADE FILLING—PER ROOT	As needed	$100.00	50% coinsurance
D3450	ROOT AMPUTATION—PER ROOT	As needed	$100.00	50% coinsurance
	Periodontics (16c3)			
D4341	PERIODONTAL SCALING AND ROOT PLANING—FOUR OR MORE TEETH PER QUADRANT	Once every 24 months	$50.00	50% coinsurance
D4342	PERIODONTAL SCALING AND ROOT PLANING—ONE TO THREE TEETH PER QUADRANT	Once every 24 months	$50.00	50% coinsurance
D4346	SCALING IN PRESENCE OF GENERALIZED MODERATE OR SEVERE GINGIVAL INFLAMMATION—FULL MOUTH, AFTER ORAL EVALUATION	Once every 24 months	$50.00	50% coinsurance
D4355	FULL MOUTH DEBRIDEMENT TO ENABLE A COMPREHENSIVE ORAL EVALUATION AND DIAGNOSIS ON A SUBSEQUENT VISIT	Once every 36 months	$60.00	50% coinsurance
D4910	PERIODONTAL MAINTENANCE	Twice per year	$50.00	50% coinsurance
D4210	GINGIVECTOMY OR GINGIVOPLASTY—FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	Once every 5 years	$200.00	50% coinsurance
D4211	GINGIVECTOMY OR GINGIVOPLASTY—ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	Once every 5 years	$100.00	50% coinsurance
D4212	GINGIVECTOMY OR GINGIVOPLASTY TO ALLOW ACCESS FOR RESTORATIVE PROCEDURE, PER TOOTH	Once every 5 years	$100.00	50% coinsurance

	Comprehensive Dental Services	Frequency	Cost-Sharing In-Network	Cost-Sharing Out-of-Network
D4240	GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANING— FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	Once every 5 years	$100.00	50% coinsurance
D4241	GINGIVAL FLAP PROCEDURE, INCLUDING ROOT PLANING— ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	Once every 5 years	$100.00	50% coinsurance
D4260	OSSEOUS SURGERY (INCLUDING ELEVATION OF FULL THICKNESS FLAP ENTRY AND CLOSURE)—FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	Once every 5 years	$300.00	50% coinsurance
D4261	OSSEOUS SURGERY (INCLUDING ELEVATION OF FULL THICKNESS FLAP ENTRY AND CLOSURE)—ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT	Once every 5 years	$300.00	50% coinsurance
D4263	BONE REPLACEMENT GRAFT—RETAINED NATURAL TOOTH—FIRST SITE IN QUADRANT	Once every 5 years	$200.00	50% coinsurance
D4264	BONE REPLACEMENT GRAFT—RETAINED NATURAL TOOTH—EACH ADDITIONAL SITE IN QUADRANT	Once every 5 years	$100.00	50% coinsurance
	Prosthodontics, Removable (16c4)			
D5110	COMPLETE DENTURE—MAXILLARY	Once every 5 years	$400.00	50% coinsurance
D5120	COMPLETE DENTURE—MANDIBULAR	Once every 5 years	$400.00	50% coinsurance
D5130	IMMEDIATE DENTURE—MAXILLARY	Once every 5 years	$400.00	50% coinsurance
D5140	IMMEDIATE DENTURE—MANDIBULAR	Once every 5 years	$400.00	50% coinsurance
D5211	MAXILLARY PARTIAL DENTURE—RESIN BASE (INCLUDING RETENTIVE /	Once every 5 years	$400.00	50% coinsurance

	Comprehensive Dental Services	Frequency	Cost-Sharing In-Network	Cost-Sharing Out-of-Network
	CLASPING MATERIALS, RESTS AND TEETH)			
D5212	MANDIBULAR PARTIAL DENTURE—RESIN BASE (INCLUDING RETENTIVE / CLASPING MATERIALS, RESTS AND TEETH)	Once every 5 years	$400.00	50% coinsurance
D5213	MAXILLARY PARTIAL DENTURE—CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE / CLASPING MATERIALS, RESTS AND TEETH)	Once every 5 years	$400.00	50% coinsurance
D5214	MANDIBULAR PARTIAL DENTURE—CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE / CLASPING MATERIALS, RESTS AND TEETH)	Once every 5 years	$400.00	50% coinsurance
D5221	IMMEDIATE MAXILLARY PARTIAL DENTURE—RESIN BASE (INCLUDING RETENTIVE / CLASPING MATERIALS, RESTS AND TEETH)	Once every 5 years	$400.00	50% coinsurance
D5222	IMMEDIATE MANDIBULAR PARTIAL DENTURE—RESIN BASE (INCLUDING RETENTIVE / CLASPING MATERIALS, RESTS AND TEETH)	Once every 5 years	$400.00	50% coinsurance
D5223	IMMEDIATE MAXILLARY PARTIAL DENTURE—CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE / CLASPING MATERIALS, RESTS AND TEETH)	Once every 5 years	$400.00	50% coinsurance
D5224	IMMEDIATE MANDIBULAR PARTIAL DENTURE—CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING RETENTIVE / CLASPING MATERIALS, RESTS AND TEETH)	Once every 5 years	$400.00	50% coinsurance
D5225	MAXILLARY PARTIAL DENTURE—FLEXIBLE BASE (INCLUDING ANY CLASPS, RESTS AND TEETH)	Once every 5 years	$400.00	50% coinsurance

	Comprehensive Dental Services	Frequency	Cost-Sharing In-Network	Cost-Sharing Out-of-Network
D5226	MANDIBULAR PARTIAL DENTURE—FLEXIBLE BASE (INCLUDING ANY CLASPS, RESTS AND TEETH)	Once every 5 years	$400.00	50% coinsurance
D5282	REMOVABLE UNILATERAL PARTIAL DENTURE—ONE PIECE CAST METAL (INCLUDING CLASPS AND TEETH), MAXILLARY	Once every 5 years	$200.00	50% coinsurance
D5283	REMOVABLE UNILATERAL PARTIAL DENTURE—ONE PIECE CAST METAL (INCLUDING CLASPS AND TEETH), MANDIBULAR	Once every 5 years	$200.00	50% coinsurance
D5410	ADJUST COMPLETE DENTURE—MAXILLARY	Once every 12 months per arch	$30.00	50% coinsurance
D5411	ADJUST COMPLETE DENTURE—MANDIBULAR	Once every 12 months per arch	$30.00	50% coinsurance
D5421	ADJUST PARTIAL DENTURE—MAXILLARY	Once every 12 months per arch	$30.00	50% coinsurance
D5422	ADJUST PARTIAL DENTURE—MANDIBULAR	Once every 12 months per arch	$30.00	50% coinsurance
D5511	REPAIR BROKEN COMPLETE DENTURE BASE, MANDIBULAR	Once every 12 months per arch	$50.00	50% coinsurance
D5512	REPAIR BROKEN COMPLETE DENTURE BASE, MAXILLARY	Once every 12 months per arch	$50.00	50% coinsurance
D5611	REPAIR RESIN PARTIAL DENTURE BASE, MANDIBULAR	Once every 12 months per arch	$50.00	50% coinsurance
D5612	REPAIR RESIN PARTIAL DENTURE BASE, MAXILLARY	Once every 12 months per arch	$50.00	50% coinsurance
D5621	REPAIR CAST PARTIAL FRAMEWORK, MANDIBULAR	Once every 12 months per arch	$50.00	50% coinsurance
D5622	REPAIR CAST PARTIAL FRAMEWORK, MAXILLARY	Once every 12 months per arch	$50.00	50% coinsurance
D5630	REPAIR OR REPLACE BROKEN RETENTIVE/CLASPING MATERIALS—PER TOOTH	Once every 12 months per arch	$50.00	50% coinsurance
D5640	REPLACE BROKEN TEETH—PER TOOTH	Once every 12 months per arch	$50.00	50% coinsurance
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	Once every 12 months per arch	$50.00	50% coinsurance

	Comprehensive Dental Services	Frequency	Cost-Sharing In-Network	Cost-Sharing Out-of-Network
D5660	ADD CLASP TO EXISTING PARTIAL DENTURE—PER TOOTH	Once every 12 months per arch	$50.00	50% coinsurance
D5710	REBASE COMPLETE MAXILLARY DENTURE	Once every 36 months	$60.00	50% coinsurance
D5711	REBASE COMPLETE MANDIBULAR DENTURE	Once every 36 months	$60.00	50% coinsurance
D5720	REBASE MAXILLARY PARTIAL DENTURE	Once every 36 months	$60.00	50% coinsurance
D5721	REBASE MANDIBULAR PARTIAL DENTURE	Once every 36 months	$60.00	50% coinsurance
D5730	RELINE COMPLETE MAXILLARY DENTURE (CHAIRSIDE)	Once every 36 months	$60.00	50% coinsurance
D5731	RELINE COMPLETE MANDIBULAR DENTURE (CHAIRSIDE)	Once every 36 months	$60.00	50% coinsurance
D5740	RELINE MAXILLARY PARTIAL DENTURE (CHAIRSIDE)	Once every 36 months	$60.00	50% coinsurance
D5741	RELINE MANDIBULAR PARTIAL DENTURE (CHAIRSIDE)	Once every 36 months	$60.00	50% coinsurance
D5750	RELINE COMPLETE MAXILLARY DENTURE (LABORATORY)	Once every 36 months	$60.00	50% coinsurance
D5751	RELINE COMPLETE MANDIBULAR DENTURE (LABORATORY)	Once every 36 months	$60.00	50% coinsurance
D5760	RELINE MAXILLARY PARTIAL DENTURE (LABORATORY)	Once every 36 months	$60.00	50% coinsurance
D5761	RELINE MANDIBULAR PARTIAL DENTURE (LABORATORY)	Once every 36 months	$60.00	50% coinsurance
D5850	TISSUE CONDITIONING, MAXILLARY	Once every 12 months	$60.00	50% coinsurance
D5851	TISSUE CONDITIONING, MANDIBULAR	Once every 12 months	$60.00	50% coinsurance
D5863	OVERDENTURE—COMPLETE MAXILLARY	Once every 5 years	$700.00	50% coinsurance
D5864	OVERDENTURE—PARTIAL MAXILLARY	Once every 5 years	$700.00	50% coinsurance
D5865	OVERDENTURE—COMPLETE MANDIBULAR	Once every 5 years	$700.00	50% coinsurance

	Comprehensive Dental Services	Frequency	Cost-Sharing In-Network	Cost-Sharing Out-of-Network
D5866	OVERDENTURE—PARTIAL MANDIBULAR	Once every 5 years	$700.00	50% coinsurance
D5875	MODIFICATION OF REMOVABLE PROSTHESIS FOLLOWING IMPLANT SURGERY	Once every 12 months per arch	$60.00	50% coinsurance
	Prosthodontics, Fixed (16c7)			
D6210	PONTIC—CAST HIGH NOBLE METAL	Once every 5 years	$400.00	50% coinsurance
D6211	PONTIC—CAST PREDOMINANTLY BASE METAL	Once every 5 years	$400.00	50% coinsurance
D6212	PONTIC—CAST NOBLE METAL	Once every 5 years	$400.00	50% coinsurance
D6214	PONTIC—TITANIUM AND TITANIUM ALLOYS	Once every 5 years	$400.00	50% coinsurance
D6240	PONTIC—PORCELAIN FUSED TO HIGH NOBLE METAL	Once every 5 years	$400.00	50% coinsurance
D6241	PONTIC—PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	Once every 5 years	$400.00	50% coinsurance
D6242	PONTIC—PORCELAIN FUSED TO NOBLE METAL	Once every 5 years	$400.00	50% coinsurance
D6243	PONTIC—PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS	Once every 5 years	$400.00	50% coinsurance
D6245	PONTIC—PORCELAIN/CERAMIC	Once every 5 years	$400.00	50% coinsurance
D6250	PONTIC—RESIN WITH HIGH NOBLE METAL	Once every 5 years	$400.00	50% coinsurance
D6251	PONTIC—RESIN WITH PREDOMINANTLY BASE METAL	Once every 5 years	$400.00	50% coinsurance
D6252	PONTIC—RESIN WITH NOBLE METAL	Once every 5 years	$400.00	50% coinsurance
D6750	RETAINER CROWN—PORCELAIN FUSED TO HIGH NOBLE METAL	Once every 5 years	$400.00	50% coinsurance
D6751	RETAINER CROWN—PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	Once every 5 years	$400.00	50% coinsurance
D6752	RETAINER CROWN—PORCELAIN FUSED TO NOBLE METAL	Once every 5 years	$400.00	50% coinsurance

	Comprehensive Dental Services	Frequency	Cost-Sharing In-Network	Cost-Sharing Out-of-Network
D6753	RETAINER CROWN—PORCELAIN FUSED TO TITANIUM AND TITANIUM ALLOYS	Once every 5 years	$400.00	50% coinsurance
D6780	RETAINER CROWN—3/4 CAST HIGH NOBLE METAL	Once every 5 years	$400.00	50% coinsurance
D6781	RETAINER CROWN—3/4 CAST PREDOMINANTLY BASED METAL	Once every 5 years	$400.00	50% coinsurance
D6782	RETAINER CROWN—3/4 CAST NOBLE METAL	Once every 5 years	$400.00	50% coinsurance
D6783	RETAINER CROWN—3/4 PORCELAIN/ CERAMIC	Once every 5 years	$400.00	50% coinsurance
D6790	RETAINER CROWN—FULL CAST HIGH NOBLE METAL	Once every 5 years	$400.00	50% coinsurance
D6791	RETAINER CROWN—FULL CAST PREDOMINANTLY BASE METAL	Once every 5 years	$400.00	50% coinsurance
D6792	RETAINER CROWN—FULL CAST NOBLE METAL	Once every 5 years	$400.00	50% coinsurance
D6794	RETAINER CROWN—TITANIUM AND TITANIUM ALLOYS	Once every 5 years	$400.00	50% coinsurance
D6930	RE-CEMENT OR RE-BOND FIXED PARTIAL DENTURE	Once every 12 months	$40.00	50% coinsurance
	Oral and Maxillofacaial Surgery (16c8)			
D7210	EXTRACTION, ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/ OR SECTIONING OF TOOTH, AND EXCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED	Once per tooth per lifetime	$100.00	50% coinsurance
D7220	REMOVAL OF IMPACTED TOOTH—SOFT TISSUE	Once per tooth per lifetime	$100.00	50% coinsurance
D7230	REMOVAL OF IMPACTED TOOTH—PARTIALLY BONY	Once per tooth per lifetime	$100.00	50% coinsurance
D7240	REMOVAL OF IMPACTED TOOTH—COMPLETELY BONY	Once per tooth per lifetime	$100.00	50% coinsurance
D7241	REMOVAL OF IMPACTED TOOTH—COMPLETELY BONY, WITH UNUSUAL SURGICAL COMPLICATIONS	Once per tooth per lifetime	$100.00	50% coinsurance

	Comprehensive Dental Services	Frequency	Cost-Sharing In-Network	Cost-Sharing Out-of-Network
D7250	REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)	Once per tooth per lifetime	$100.00	50% coinsurance
D7111	EXTRACTION, CORONAL REMNANTS—PRIMARY TOOTH	Once per tooth per lifetime	$40.00	50% coinsurance
D7140	EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL)	Once per tooth per lifetime	$50.00	50% coinsurance
D7280	EXPOSURE OF AN UNERUPTED TOOTH	Once per tooth per lifetime	$100.00	50% coinsurance
D9222	DEEP SEDATION/GENERAL ANESTHESIA— FIRST 15 MINUTES	As needed	$60.00	50% coinsurance
D9223	DEEP SEDATION/GENERAL ANESTHESIA— EACH SUBSEQUENT 15 MINUTE INCREMENT	As needed	$60.00	50% coinsurance
	Adjunctive General Services (16c10)			
D9910	APPLICATION OF DESENSITIZING MEDICAMENT	Twice per year	$15.00	50% coinsurance
D1354	INTERIM CARIES ARRESTING MEDICAMENT APPLICATION—PER TOOTH	One application per surface per lifetime	$15.00	50% coinsurance
D9110	PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN, MINOR PROCEDURE	No limit - available as needed	$30.00	50% coinsurance

Section 2.1 Get care using our plan's optional visitor/traveler benefit

If you do not permanently move, but you are continuously away from our plan's service area for more than six months, we usually must disenroll you from our plan. However, we offer a visitor/traveler Program which will include Blue Medicare Advantage PPO network coverage of all Part A, Part B, and Supplemental benefits offered by your plan outside your service area in 48 states and 2 territories: Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin and West Virginia. For some of the states listed, MA PPO networks are only available in portions of the state. This will allow you to remain enrolled when you are outside of our service area for less than 12 months. Under our visitor/traveler program you may receive all plan covered services at in-network cost sharing. Please contact the plan for assistance in locating a provider when using the visitor/traveler

benefit. If you are in the visitor/traveler area, you can stay enrolled in our plan for up to 12 months. If you have not returned to the plan's service area within 12 months, you will be disenrolled from the plan.

Call 1-800-810-Blue to find a Blue Medicare Advantage PPO provider. Members who see Medicare Advantage PPO providers in any geographic area where the Visitor/Travel Program is offered will pay the same cost sharing level (in-network cost sharing) they would pay if they received covered benefits from in-network providers in their service area.

SECTION 3 Services that aren't covered by our plan (exclusions)

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

The chart below lists services and items that either aren't covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you get the excluded services at an emergency facility, the excluded services are still not covered, and our plan won't pay for them. The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we made to not cover a medical service, go to Chapter 7, Section 5.3 in this document.)

Services not covered by Medicare	Covered only under specific conditions
Cosmetic surgery or procedures	Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance
Custodial care Custodial care is personal care that doesn't require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing	Not covered under any condition

Services not covered by Medicare	Covered only under specific conditions
Experimental medical and surgical procedures, equipment, and medications Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community	May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (Go to Chapter 3, Section 5 for more information on clinical research studies)
Fees charged for care by your immediate relatives or members of your household	Not covered under any condition
Full-time nursing care in your home	Not covered under any condition
Home-delivered meals	Not covered under any condition
Homemaker services include basic household help, including light housekeeping or light meal preparation.	Not covered under any condition
Naturopath services (uses natural or alternative treatments)	Not covered under any condition
Orthopedic shoes or supportive devices for the feet	Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with, diabetic foot disease
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	Not covered under any condition
Private room in a hospital	Covered only when medically necessary
Reversal of sterilization procedures and or non-prescription contraceptive supplies	Not covered under any condition
Services considered not reasonable and necessary, according to Original Medicare standards	Not covered under any condition

CHAPTER 5:
Asking us to pay our share of a bill for covered medical services

SECTION 1 Situations when you should ask us to pay our share for covered services

Sometimes when you get medical care, you may need to pay the full cost. Other times, you may pay more than you expected under the coverage rules of our plan, or you may get a bill from a provider. In these cases, you can ask our plan to pay you back (reimburse you). It's your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services covered by our plan. There may be deadlines that you must meet to get paid back. Go to 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 got or for more than your share of cost sharing. First, try to resolve the bill with the provider. If that doesn't work, send the bill to us instead of paying it. We'll look at the bill and decide whether the services should be covered. If we decide they should be covered, we'll pay the provider directly. If we decide not to pay it, we'll 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.

Examples of situations in which you may need to ask our plan to pay you back or to pay a bill you got:

1. **When you got medical care from a provider who isn't in our plan's network**

   When you get care from a provider who is not part of our network, you're only responsible for paying your share of the cost. (Your share of the cost may be higher for an out-of-network provider than for a network provider.) Ask the provider to bill our plan for our share of the cost.

   - Emergency providers are legally required to provide emergency care. You're only responsible for paying your share of the cost for emergency or urgently needed services. If you pay the entire amount yourself at the time you get 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 made.
   - You may get a bill from the provider asking for payment that you think you don't owe. Send us this bill, along with documentation of any payments you have already made.
     - If the provider is owed anything, we'll pay the provider directly.

- If you have already paid more than your share of the cost of the service, we'll determine how much you owed and pay you back for our share of the cost.

- While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we can't pay a provider who is not eligible to participate in Medicare. If the provider is not eligible to participate in Medicare, you'll be responsible for the full cost of the services you got.

2. When a network provider sends you a bill you think you shouldn't pay

Network providers should always bill our 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 don't allow providers to add additional separate charges, called *balance billing*. This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there's a dispute and we don't pay certain provider charges.
- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We'll contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under our plan.

3. If you're retroactively enrolled in our plan

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

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

When you send us a request for payment, we'll review your request and decide whether the service or drug should be covered. This is called making a **coverage decision**. If we decide it should be covered, we'll pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 7 has information about how to make an appeal.

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

You can ask us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records. **You must submit your claim to us within one (1) year** of the date you received the service or item. To make sure you are giving us all the

information we need to make a decision, you must fill out our claim form to make your request for payment.

- Download a copy of the form from our website (www.carefirst.com/medicareadvantage) or call Member Services at 833-536-2001 (TTY users call711) and ask for the form.

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

CareFirst BlueCross BlueShield Medicare Advantage
Attention: Member Claims Reimbursement
P.O. Box 915
Owings Mills, MD 21117

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

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

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

Section 3.1 If we tell you we won't pay for all or part of the medical care, you can make an appeal

If you think we have made a mistake in turning down your request for payment or the amount we're paying, you can make an appeal. If you make an appeal, it means you're 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 details on how to make this appeal, go to Chapter 7.

CHAPTER 6:
Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities

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, braille, large print, or other alternate formats, etc.) Debemos brindar información de una manera que sea apropiada para usted (en otros idiomas además del inglés, en letra grande o en formatos alternativos, etc.)

Our 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 our plan may meet these accessibility requirements include, but aren't limited to, provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you materials in braille, in large print, or other alternate formats at no cost if you need it. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Member Services at 833-536-2001 (TTY users call 711).

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 our plan's network for a specialty aren't available, it's our plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you'll only pay in-network cost sharing. If you find yourself in a situation where there are no specialists in our plan's network that cover a service you need, call the plan for information on where to go to get 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 specialist or finding a network specialist, call to file a grievance with Customer Service at 833-536-2001 (TTY users should call 711). You can 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.

Su plan tiene la obligación de garantizar que todos los servicios, tanto clínicos como no clínicos, se presten de manera competente desde el punto de vista cultural y que sean accesibles para todos los afiliados, incluidos aquellos que tienen un dominio limitado del inglés, una capacidad limitada de lectura, una incapacidad auditiva o un origen cultural y étnico distinto. Algunos

ejemplos de cómo un plan puede cumplir estos requisitos de accesibilidad son, entre otros: la prestación de servicios de traductor, servicios de intérprete, teletipos o conexión TTY (teléfono de texto o teletipo).

Nuestro plan cuenta con servicios gratuitos de interpretación para responder a las preguntas de los afiliados que no hablan inglés. También podemos proporcionarle información en sistema braille, letras grandes u otros formatos alternativos sin costo alguno si lo necesita. Debemos brindarle información sobre los beneficios del plan en un formato que sea accesible y apropiado para usted. Para que le brindemos información de una manera que funcione para usted, llame a Servicios para Miembros.

Nuestro plan tiene la obligación de ofrecer a las mujeres inscritas la opción de acceso directo a un especialista en atención médica para la mujer dentro de la red para los servicios de atención médica preventiva y de rutina para la mujer.

Si los proveedores de la red del plan para una especialidad no están disponibles, es responsabilidad del plan encontrar proveedores especializados fuera de la red que le proporcionen la atención necesaria. En este caso, solo pagará la distribución de costos dentro de la red. Si se encuentra en una situación en la que no hay especialistas en la red del plan que cubran un servicio que usted necesita, llame al plan para que le informen sobre dónde acudir para obtener ese servicio con la distribución de costos dentro de la red.

Si tiene problemas para obtener información de nuestro plan en un formato que sea accesible y apropiado para usted, llame para presentar un reclamo al Servicio al Cliente al 833-536-2001 (Los usuarios de TTY deben llamar 711. También puede presentar un reclamo ante Medicare llamando al 1-800-MEDICARE (1-800-633-4227) o directamente en la Oficina de Derechos Civiles al 1-800-368-1019 o TTY 1-800-537-7697.

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

You have the right to choose a provider for your care.

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

If you think you aren’t getting your medical care within a reasonable amount of time, Chapter 7, Section 9 tells what you can do.

Section 1.3 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your personal health information includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.

- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a *Notice of Privacy Practice*, that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

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

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

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

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

If you have questions or concerns about the privacy of your personal health information, call Member Services at 833-536-2001 (TTY users call 711).

Notice of Privacy Practices

This notice describes how medical and financial 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 and financial information is important to us.

This notice applies to members of fully-insured groups and individual policyholders only. If you are a member of a self-insured group, while we continue to safeguard your personal information with the same safety mechanisms, you will get a *Notice of Privacy Practices* from your group health plan. If you are unsure if you are a fully insured or self-insured member, please contact your group administrator. This notice applies to the privacy practices of CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst BlueChoice, Inc., FirstCare, Inc. (CareFirst), CareFirst Advantage, Inc. and CareFirst Advantage PPO, Inc. We may share your financial and protected health information (oral, written or electronic) as well as the protected

health information of others on your insurance policy as needed for payment or health care operations purposes.

Uses & disclosures of medical information

Our legal duty

This notice describes our privacy practices, which include how we may use, disclose (share or give out), collect, handle and protect our members' protected health information. We are required by certain federal and state laws to maintain the privacy of your protected health information. We also are required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice took effect October 1, 2016 and is intended to amend the notice of CareFirst privacy practices with an effective date of April 14, 2003.

We reserve the right to change our privacy practices and the terms of this notice at any time, as long as law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including protected health information we created or received before we made the changes. If we make a significant change in our privacy practices, we will change this notice and post the new notice on our website, **www.carefirst.com**, and provide the revised notice or information about the changes and how to get the revised notice in our next annual mailing to our health plan subscribers.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

We maintain physical, electronic and procedural safeguards in accordance with federal and state standards to protect your health information. All of our associates receive training on these standards at the time they are hired and thereafter receive annual refresher training. Access to your protected health information is restricted to appropriate business purposes and requires pass codes to access our computer systems and badges to access our facilities. Associates who violate our standards are subject to disciplinary actions.

Primary uses and disclosures of protected health information

We use and disclose protected health information about you for payment and health care operations. The federal health care privacy regulations ("HIPAA Privacy Rule") generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, applicable state or federal privacy laws might impose a privacy standard under which we will be required to operate. For example, we will follow more stringent state privacy laws that relate to uses and disclosures of the protected health information concerning

HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing and reproductive rights. In addition to these state law requirements, we also may use or disclose your protected health information for health benefits administration purposes (such as claims

and enrollment processing, care management and wellness offerings, claims payment, and fraud detection and prevention efforts), for our business operations (including for quality measurement and enhancement and benefit improvement and development) and in the following situations:

Payment: We may use and disclose your protected health information for all activities that are included within the definition of "payment" as written in the HIPAA Privacy Rule. For example, we might use and disclose your protected health information to pay claims for services provided to you by doctors, hospitals, pharmacies and others that are covered by your health plan. We also may use your information to determine your eligibility for benefits, coordinate benefits, examine medical necessity, obtain premiums and issue explanations of benefits to the person who subscribes to the health plan in which you participate.

Health care operations: We may use and disclose your protected health information for all activities that are included within the definition of "health care operations" as defined in the HIPAA Privacy Rule. For example, we may use and disclose your protected health information to determine our premiums for your health plan, conduct quality assessment and improvement activities, engage in care coordination or case management, and manage our business.

Business associates: In connection with our payment and health care operations activities, we contract with individuals and entities (called "business associates") to perform various functions on our behalf or to provide certain types of services (such as member service support, utilization management, subrogation or pharmacy benefit management). We may share your contact information and phone number including your mobile number with our business associates. To perform these functions or to provide the services, our business associates will receive, create, maintain, use or disclose protected health information, but only after we require the business associates to agree in writing to contract terms designed to appropriately safeguard your information.

Other covered entities: We may use or disclose your protected health information to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with certain aspects of their health care operations. For example, we may disclose your protected health information to a health care provider when needed by the provider to render treatment to you, and we might disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing.

Other possible uses and disclosures of protected health information

The following is a description of other possible ways in which we may (and are permitted to) use and/or disclose your protected health information:

To you or with your authorization: We must disclose your protected health information to you, as described in the Individual Rights section of this notice. You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose not listed in this notice. If you give us an authorization, you may revoke it in writing

at any time. Your revocation will not affect any use or disclosures that we made as permitted by your authorization while it was in effect. To the extent (if any) that we maintain or receive psychotherapy notes about you, most disclosures of these notes require your authorization. Also, to the extent (if any) that we use or disclose your information for our fundraising practices, we will provide you with the ability to opt out of future fundraising communications. In addition, most (but not all) uses and disclosures of medical information for marketing purposes, and disclosures that constitute a sale of protected health information, require your authorization. Without your written authorization, we may not use or disclose your protected health information for any reason except those described in this notice.

Disclosures to the Secretary of the U.S. Department of Health and Human Services: We are required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services (DHHS) when the Secretary is investigating or determining our compliance with the federal Privacy Regulations.

To plan sponsors: Where permitted by law, we may disclose your protected health information to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions.

For example, a plan sponsor may contact us seeking information to evaluate future changes to your benefit plan. We also may disclose summary health information (this type of information is defined in the HIPAA Privacy Rule) about the enrollees in your group health plan to the plan sponsor to obtain premium bids for the health insurance coverage offered through your group health plan or to decide whether to modify, amend or terminate your group health plan.

To family and friends: If you agree (or if you are unavailable to agree), such as in a medical emergency situation, we may disclose your protected health information to a family member, friend or other person to the extent necessary to help with your health care or with payment of your health care.

Underwriting: We might receive your protected health information for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits. We will not use or disclose protected health information that is genetic information of an individual for such purposes. We will not use or further disclose this protected health information received under these circumstances for any other purpose, except as required by law, unless and until you enter into a contract of health insurance or health benefits with us.

Health oversight activities: We might disclose your protected health information to a health oversight agency for activities authorized by law, such as: audits, investigations, inspections, licensure or disciplinary actions, or civil, administrative or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system, (ii) government benefit programs, (iii) other government regulatory programs and (iv) compliance with civil rights laws.

Abuse or neglect: We may disclose your protected health information to appropriate authorities if we reasonably believe that you might be a possible victim of abuse, neglect, domestic violence or other crimes.

To prevent a serious threat to health or safety: Consistent with certain federal and state laws, we may disclose your protected health information if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Coroners, medical examiners, funeral directors and organ donation: We may disclose protected health information to a coroner or medical examiner for purposes of identifying you after you die, determining your cause of death or for the coroner or medical examiner to perform other duties authorized by law. We also might disclose, as authorized by law, information to funeral directors so that they may carry out their duties on your behalf. Further, we might disclose protected health information to organizations that handle organ, eye or tissue donation and transplantation.

Research: We may disclose your protected health information to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information and (2) approved the research.

Inmates: If you are an inmate of a correctional institution, we may disclose your protected health information to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to you, (2) your health and safety and the health and safety of others or (3) the safety and security of the correctional institution. ***Workers' compensation:*** We may disclose your protected health information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

Public health and safety: We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety or the health or safety of others.

Required by law: We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to DHHS upon their request for purposes of determining whether we are in compliance with federal privacy laws.

Legal process and proceedings: We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.

Law enforcement: We may disclose to a law enforcement official limited protected health information of a suspect, fugitive, material witness, crime victim or missing person. We might disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Military and national security: We may disclose to military authorities the protected health information of Armed Forces personnel under certain circumstances. We might disclose to federal officials protected health information required for lawful counterintelligence, intelligence and other national security activities.

Other uses and disclosures of your protected health information: Other uses and disclosures of your protected health information that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of protected health information. However, the revocation will not be effective for information that we already have used or disclosed in reliance on your authorization.

Individual rights

Access: You have the right to look at or get copies of the protected health information contained in a designated record set, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot reasonably do so. You must make a request in writing to obtain access to your protected health information. You may request the information be as an electronic copy in certain circumstance, if you make the request in writing. You also may request access by sending a letter to the address at the end of this notice. If you request copies, we might charge you a reasonable fee for each page and postage if you want the copies mailed to you. If you request an alternative format, we might charge a cost-based fee for providing your protected health information in that format. If you prefer, we will prepare a summary or an explanation of your protected health information, but we might charge a fee to do so.

We may deny your request to inspect and copy your protected health information in certain limited circumstances. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable. If you are denied access to your information and the denial is subject to review, you may request that the denial be reviewed. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same person who denied your initial request.

Disclosure accounting: You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes other than treatment, payment, health care operations and certain other activities. We will provide you with the date on which we made the disclosure, the name of the person or entity to which we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure and certain other information. Your request may be for disclosures made up to six years before the date of your request.

You may request an accounting by submitting your request in writing using the information listed at the end of this notice. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction requests: You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency) until or unless we receive a written request from you to terminate

the restriction. Any agreement that we might make to a request for additional restrictions must be in writing and signed by a person authorized to make such an agreement on our behalf. We

will not be liable for uses and disclosures made outside of the requested restriction unless our agreement to restrict is in writing. We are permitted to end our agreement to the requested restriction by notifying you in writing.

You may request a restriction by writing to us using the information listed at the end of this notice. In your request tell us: (1) the information of which you want to limit our use and disclosure and (2) how you want to limit our use

and/or disclosure of the information. You may also use the information listed at the end of this notice to send a written request to terminate an agreed upon restriction.

Confidential communication: If you believe that a disclosure of all or part of your protected health information may endanger you, you have the right to request that we communicate with you in confidence about your protected health information. This means that you may request that we send you information by alternative means, or to an alternate location. We may accommodate your request if it is reasonable, specifies the alternative means or alternate location, and specifies how payment issues (premiums and claims) will be handled. You may request a confidential communication by writing to us using the information listed at the end of this notice.

Amendment: You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic notice: Even if you agree to receive this notice on our Website or by electronic mail (email), you are entitled to receive a paper copy as well. Please contact us using the information listed at the end of this notice to obtain this notice in written form. If the email transmission has failed, and CareFirst is aware of the failure, then we will provide a paper copy of the notice to you.

Breach Notification: In the event of breach of your unsecured health information, we will provide you notification of such a breach as required by law or where we otherwise deem appropriate.

Collection of Personal Financial Information & Uses and disclosures of financial information

We may collect personal financial information about you from many sources, including:

Information you provide on enrollment applications or other forms, such as your name, address, social security number, salary, age and gender.

Information about your relationship with CareFirst, our affiliates and others, such as your policy coverage, premiums and claims payment history.

Information as described above that we obtain from any of our affiliates.

Information we receive about you from other sources such as your employer, your provider, your broker and other third parties.

Information we receive about you when you log on to our Website. We have the capability through the use of "cookies" to track certain information, such as finding out if members have previously visited the CareFirst Website or to track the amount of time visitors spend on the Website. These cookies do not collect personally identifiable information and we do not combine information collected through cookies with other personal financial information to determine the identity of visitors to its Website. We will not disclose cookies to third parties.

How your information is used

We use the information we collect about you in connection with underwriting or administration of an insurance policy or claim or for other purposes allowed by law. At no time do we disclose your financial information to anyone outside of CareFirst unless we have proper authorization from you, or we are permitted or required to do so by law. We maintain physical, electronic and procedural safeguards in accordance with federal and state standards that protect

your information. In addition, we limit access to your financial information to those CareFirst employees, business partners, providers, benefit plan administrators, brokers, consultants and agents who need to know this information to conduct CareFirst business or to provide products or services to you.

Disclosure of your financial information

In order to protect your privacy, third parties that are either affiliated or nonaffiliated with CareFirst are also subject to strict privacy laws. Affiliated entities are companies that are part of the CareFirst corporate family and include health maintenance organizations (HMOs), third party administrators, health insurers, long term care insurers and

insurance agencies. In some situations, related to our insurance transactions involving you, we will disclose your personal financial information to a non-affiliated third party that helps us to provide services to or for you.

When we disclose information to these third parties, we require them to agree to protect your financial information and to use it only for its intended purpose, and to comply with all relevant laws.

Changes in our privacy policy

CareFirst periodically reviews its policies and reserves the right to change them. If we change the substance of our privacy policy, we will continue our commitment to keep your financial information secure — it is our highest priority. Even if you are no longer a CareFirst customer, our privacy policy will continue to apply to your records.

Questions and complaints

Information on CareFirst privacy practices

You may request a copy of our notices at any time. If you want more information about our privacy practices, if you would like additional copies of this notice, or have questions or

concerns, please call the Member Services number on your ID card or contact the CareFirst Privacy Office using the information below.

Filing a complaint

If you are concerned that we might have violated your privacy rights, or you disagree with a decision we made about your individual rights, you may use the contact information listed at the end of this notice to complain to us. You also may submit a written complaint to DHHS. We will provide you with the contact information for DHHS upon request.

We support your right to protect the privacy of your protected health and financial information. We will not retaliate in any way if you choose to file a complaint with us or with DHHS.

Contact Information:

CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. Privacy Office CT 10-03

10455 Mill Run Circle, Owings Mills, MD 21117

Phone: 800-853-9236

Fax: 410-505-6692

Email: privacy.office@carefirst.com

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst BlueCross BlueShield Medicare Advantage is the business name of CareFirst Advantage, Inc. and CareFirst Advantage PPO, Inc. CareFirst BlueCross BlueShield Community Health Plan District of Columbia is the business name of Trusted Health Plan (District of Columbia), Inc. In the District of Columbia and Maryland, CareFirst MedPlus is the business name of First Care, Inc. In Virginia, CareFirst MedPlus is the business name of First Care, Inc. of Maryland (used in VA by: First Care, Inc.). CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst Advantage, Inc. and CareFirst Advantage PPO, Inc. Trusted Health Plan (District of Columbia), Inc., CareFirst BlueChoice, Inc., First Care, Inc., and The Dental Network, Inc. are independent licensees of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

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

As a member of CareFirst BlueCross BlueShield Advantage Salute, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, call Member Services at 833-536-2001 (TTY users call 711):

- **Information about our plan**. This includes, for example, information about our plan's financial condition.

- **Information about our network providers.** You have the right to get information about the qualifications of the providers in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services.
- **Information about why something is not covered and what you can do about it.** Chapter 7 provides information on asking for a written explanation on why a medical service isn't covered or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 You have the right to know your treatment options and participate in decisions about your care

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

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

- **To know about all your choices.** You have the right to be told about all treatment options recommended for your condition, no matter what they cost or whether they're covered by our plan.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no.**" You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. If you refuse treatment, you accept full responsibility for what happens to your body as a result.

You have the right to give instructions about what's to be done if you can't make medical decisions for yourself

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

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

Legal documents you can use to give your directions in advance of these situations are called **advance directives**. Documents like a **living will** and **power of attorney for health care** are examples of advance directives.

How to set up an advance directive to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill out the form and sign it**. No matter of where you get this form, it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people.** Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

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

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

If your instructions aren't followed

If you sign an advance directive and you believe that a doctor or hospital didn't follow the instructions in it, you can file a complaint with the Office of the Attorney General.

If you reside in Maryland, contact:

Maryland Attorney General

Health Decisions Policy Division

300 W. Preston Street,

3rd Floor,

Baltimore, MD 21201

If you reside in Washington D.C., contact:

Office of the Attorney General for the District of Columbia

400 Sixth Street, NW,

Washington, DC 20001

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

If you have any problems, concerns, or complaints and need to ask for coverage, or make an appeal, Chapter 7 of this document tells what you can do. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we're required to treat you fairly**.

Section 1.7 If you believe you're being treated unfairly, or your rights aren't being respected

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

If you believe you've been treated unfairly or your rights haven't been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you're having from these places:

- **Call Member Services at** 833-536-2001 **(TTY users call** 833-536-2001**)**
- **Call your local SHIP** at 410-767-1100 or 800-243-3425 (Maryland) or 202-727-8370 (Washington D.C.)
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

Section 1.8 How to get more information about your rights

Get more information about your rights from these places:

- **Call Member Services at** 833-536-2001 **(TTY users call** 833-536-2001**)**
- **Call your local SHIP at** 410-767-1100 or 800-243-3425 (Maryland) or 202-727-8370 Washington D.C.
- **Contact Medicare**
  - Visit www.Medicare.gov to read the publication *Medicare Rights & Protections* (available at https://www.medicare.gov/publications/11534-medicare-rights-and-protections.pdf)
  - Call 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048).

SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, call Member Services at 833-536-2001 (TTY users call 711).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* to learn what's covered and the rules you need to follow to get covered services.
  - Chapters 3 and 4 give details about medical services.
- **If you have any other health coverage in addition to our plan, or separate drug coverage, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show our plan membership card whenever you get your medical care.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions you and your doctors agree on.
  - Make sure your doctors know all of the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect 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're responsible for these payments:
  - You must continue to pay your Medicare Part B premiums to stay a member of our plan.
  - For some of your medical services covered by our plan, you must pay your share of the cost when you get the service.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you**.**
- **If you move *outside* of our plan service area, you can't stay a member of our plan.**
- **If you move, tell Social Security (or the Railroad Retirement Board).**

CHAPTER 7: If you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 What to do if you have a problem or concern

This chapter explains 2 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 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 information in this chapter will help you identify the right process to use and what to do.

Section 1.1 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. To make things easier, this chapter uses more familiar words in place of some legal terms.

However, it's sometimes important to know the correct legal terms. To help you know which terms to use will help you communicate more accurately to get the right help or information, we include these legal terms when we give the details for handling specific situations.

SECTION 2 Where to get more information and personalized help

We're 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. You should always call Member Services at 833-536-2001 (TTY users call 711) for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help are:

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're having. They can also answer 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 for help:

- Call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.
- Visit www.Medicare.gov

SECTION 3 Which process to use for your problem

Is your problem or concern about your benefits or coverage?

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

Yes.

Go to **Section 4, A guide to coverage decisions and appeals.**

No.

Go to **Section 9 How to make a complaint about quality of care, waiting times, customer service or other concerns.**

COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to coverage decisions and appeals

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

Asking for coverage decisions before you get services

If you want to know if we'll cover a medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical care. For example, if our plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either you or your network doctor can show that you got a

standard denial notice for this medical specialist, or the *Evidence of Coverage* makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we'll cover a particular medical service or refuses to provide medical care you think you need.

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'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we might decide medical care isn't covered or is no longer covered 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 you get a benefit, and you aren't satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we made. Under certain circumstances, you can ask for 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 properly followed the rules. When we complete the review, we give you our decision.

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

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

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

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

Section 4.1 Get help when asking for a coverage decision or making an appeal

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

- **Call Member Services at 833-536-2001 (TTY users call 711)**
- **Get free help** from your State Health Insurance Assistance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call Member Services at 833-536-2001 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.)
  - For medical care or Part B drugs, your doctor can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
- **You can ask someone to act on your behalf.** You can name another person to act for you as your *representative* to ask for a coverage decision or make an appeal.
  - If you want a friend, relative, or another person to be your representative, call Member Services at 833-536-2001 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.carefirst.com/medicareadvantage.) This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.
  - We can accept an appeal request from a representative without the form, but we can't begin or complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll 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 can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.2 Rules and deadlines for your different situations

There are 3 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give the details for each one of these situations in this chapter:

- **Section 5** Medical care: How to ask for a coverage decision or make an appeal
- **Section 6**: How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon
- **Section 7**: 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 information applies to you, call Member Services at 833-536-2001 (TTY users call 711). You can also get help or information from your SHIP.

SECTION 5 Medical care: How to ask for a coverage decision or make an appeal

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

Your benefits for medical care are described in Chapter 4 in the Medical Benefits Chart. In some cases, different rules apply to ask for a Part B drug. In those cases, we'll explain how the rules for Part B drugs are different from the rules for medical items and services.

This section tells what you can do if you're in any of the 5 following situations:

1. You aren't getting certain medical care you want, and you believe this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**
2. Our plan won't approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**
3. You got medical care that you believe should be covered by our plan, but we said we won't pay for this care. **Make an Appeal. Section 5.3.**
4. You got and paid for medical care that you believe should be covered by our plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5.**
5. You're told that coverage for certain medical care you've been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an Appeal. Section 5.3.**
   Note: **If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services**, go to Sections 6 and 7 of this Chapter. Special rules apply to these types of care.

Section 5.2 How to ask for a coverage decision

Legal Terms:

A coverage decision that involves your medical care is called an **organization determination.**

A *fast coverage decision* is called an **expedited determination.**

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

A standard coverage decision is usually made within 7 calendar days when the medical item or service is subject to our prior authorization rules, 14 calendar days for all other medical items and services, or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. To get a fast coverage decision, you must meet 2 requirements:

- You may *only ask* for coverage for medical care items and/or services (not requests for payment for items and/or services you already got).
- You can get a fast coverage decision *only* if using the standard deadlines could cause serious harm to your health or hurt your ability to regain function.

If your doctor tells us that your health requires a fast coverage decision, we'll automatically agree to give you a fast coverage decision.

If you ask for a fast coverage decision on your own, without your doctor's support, we'll decide whether your health requires that we give you a fast coverage decision. If we don't approve a fast coverage decision, we'll send you a letter that:

- Explains that we'll use the standard deadlines.
- Explains if your doctor asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
- Explains that you can file a *fast complaint* about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for.

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

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

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

For standard coverage decisions we use the standard deadlines.

This means we'll give you an answer within 7 calendar days after we get your request for a medical item or service that is subject to our prior authorization rules. If your requested medical item or service is not subject to our prior authorization rules, we'll give you an answer within 14 calendar days after we get your request. If your request is for a Part B drug, we'll give you an answer within 72 hours after we get your request.

- **However,** if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.

- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. We'll give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. Go to Section 9 of this chapter for information on complaints.)

For fast coverage decisions we use an expedited timeframe.

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

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

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

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

Section 5.3 How to make a Level 1 appeal

Legal Terms:

An appeal to our plan about a medical care coverage decision is called a plan **reconsideration.**

A fast appeal is also called an **expedited reconsideration.**

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

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

- If you're appealing a decision we made about coverage for care, you and/or your doctor will need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we'll give you a fast appeal.
- The requirements for getting a *fast appeal* are the same as those for getting a fast coverage decision in Section 5.2 of this chapter.

Step 2: Ask our plan for an appeal or a fast appeal

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

- **If you're asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.**

Step 3: We consider your appeal, and we give you our answer.

- When our plan is reviewing your appeal, we take a careful look at all of the information. We check to see if we were following all the rules when we said no to your request.
- We'll gather more information if needed and may contact you or your doctor.

Deadlines for a fast appeal

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

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn’t get yet, we’ll give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if your health condition requires us to.

- However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we shouldn't take extra days, you can file a fast complaint. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (Go to Section 9 of this chapter for information on complaints.)
- If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Part B drug.
- **If our plan says no to part or all of your appeal**, we'll automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 5.4 The Level 2 appeal process

Legal Term:

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

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

Step 1: The independent review organization reviews your appeal.

- We'll send the information about your appeal to this organization. This information is called your **case file. You have the right to ask us for a copy of your case file**.
- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all the information related to your appeal.

If you had a fast appeal at Level 1, you'll also have a fast appeal at Level 2.

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

If you had a standard appeal at Level 1, you'll also have a standard appeal at Level 2.

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

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

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

- **If the independent review organization says yes to part or all of a request for a medical item or service,** we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we get the decision from the independent review organization for **standard requests**. For **expedited requests**, we have **72 hours** from the date we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of a request for a Part B drug**, we must authorize or provide the Part B prescription drug within **72 hours** after we get the decision from the independent review organization for **standard requests .** For **expedited requests** we have **24 hours** from the date we get the decision from the independent review organization**.**
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care shouldn't be approved. (This is called **upholding the decision** or **turning down your appeal**.) In this case, the independent review organization will send you a letter:
  - Explains the decision.
  - Lets you know about your right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
  - Tells you how to file a Level 3 appeal.

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

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

Section 5.5 If you're asking us to pay you for our share of a bill you got for medical care

Chapter 5 describes when you may need to ask for reimbursement or to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you're asking for a coverage decision. To make this coverage decision, we'll check to see if the medical care you paid for is covered. We'll also check to see if you followed all the rules for using your coverage for medical care.

- **If we say yes to your request:** If the medical care is covered and you followed all the rules, we'll send you the payment for the cost typically within 30 calendar days, but no later than 60 calendar days after we get your request. If you haven't paid for the medical care, we'll send the payment directly to the provider.
- **If we say no to your request:** If the medical care is not covered, or you did *not* follow all the rules, we won't send payment. Instead, we'll send you a letter that says we won't pay for the medical care and the reasons why.

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

To make this appeal, follow the process for appeals in Section 5.3. For appeals concerning reimbursements, note:

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

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

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

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day you leave the hospital. They'll 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're being asked to leave the hospital too soon, you can ask for a longer hospital stay, and your request will be considered.

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

Within 2 calendar days of being admitted to the hospital, you'll be given a written notice called *An Important Message from Medicare about Your Rights.* Everyone with Medicare gets a copy of this notice. If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Member Services at 833-536-2001 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:
   - Your right to get Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay.
   - Where to report any concerns, you have about the quality of your hospital care.
   - Your right to **request an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date, so we'll cover your hospital care for a longer time.
2. **You'll be asked to sign the written notice to show that you got it and understand your rights.**
   - You or someone who is acting on your behalf will be asked to sign the notice.
   - Signing the notice shows *only* that you have got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date.
3. **Keep your copy** of the notice so you'll have the information about making an appeal (or reporting a concern about quality of care) if you need it.
   - If you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
   - To look at a copy of this notice in advance, call Member Services at 833-536-2001 (TTY users call 711) or 1-800 MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can also get the notice online at www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Section 6.2 How to make a Level 1 appeal to change your hospital discharge date

To ask us to cover inpatient hospital services for a longer time, use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**

- **Ask for help if you need it**. If you have questions or need help, call Member Services at 833-536-2001 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. Call State Health Insurance Assistance Program (Maryland) at 410-767-1100 or 800-243-3425 or Health Insurance Counseling Project (Washington D.C.) at 202-727-8370. SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you. The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts aren't part of our plan.

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

How can you contact this organization?

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

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge.**
  - **If you meet this deadline**, you can stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
  - **If you don't meet this deadline, contact us**. If you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you get after your planned discharge date.
- Once you ask for an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we're contacted, we'll give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it's right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling Member Services at 833-536-2001 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227). (TTY users should call 1-877-486-2048.) Or you can get a sample notice online at www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

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

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

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

What happens if the answer is yes?

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

What happens if the answer is no?

- If the independent review organization says *no*, they're saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the independent review organization says *no* to your appeal and you decide to stay in the hospital, **you may have to pay the full cost** of hospital care you after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

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

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

Section 6.3 How to make a Level 2 appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at its decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

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

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

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

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

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

If the review organization says yes:

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

If the review organization says no:

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

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

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

SECTION 7 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

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

When we decide it's time to stop covering any of these 3 types of care for you, we're required to tell you in advance. When your coverage for that care ends, *we'll stop paying our share of the cost for your care.*

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

Section 7.1 We'll tell you in advance when your coverage will be ending

Legal Term:

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

1. **You get a notice in writing** at least 2 calendar days before our plan is going to stop covering your care. The notice tells you:
   - The date when we'll stop covering the care for you.
   - How to ask for a fast-track appeal to ask us to keep covering your care for a longer period of time.
2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you got it.** Signing the notice shows *only* that you got the information about when your coverage will stop. **Signing it doesn't mean you agree** with our plan's decision to stop care.

Section 7.2 How to make a Level 1 appeal to have our plan cover your care for a longer time

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

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it**. If you have questions or need help, call Member Services at 833-536-2001 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. Call State Health Insurance Assistance Program (Maryland) at 410-767-1100 or 800-243-3425 or Health Insurance Counseling Project (Washington D.C.) at 202-727-8370. SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate. The **Quality Improvement Organization** is a group of doctors and other health care experts who are paid by the federal government to check on and improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts aren't part of our plan.

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

How can you contact this organization?

- The written notice you got (*Notice of Medicare Non-*Coverage) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.)
- If you miss the deadline, and you wish to file an appeal, you still have appeal rights. Contact your Quality Improvement Organization.

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the *Notice of Medicare Non-Coverage*.
- If you miss the deadline, and you want to file an appeal, you still have appeal rights. Contact the Quality Improvement Organization using the contact information on the *Notice of Medicare Non-coverage*. The name, address, and phone number of the Quality Improvement Organization for your state may also be found in Chapter 2.

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

Legal Term:

Detailed Explanation of Non-Coverage. Notice that gives details on reasons for ending coverage.

What happens during this review?

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

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

What happens if the reviewers say yes?

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

What happens if the reviewers say no?

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

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

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

Section 7.3 How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

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

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

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

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

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

What happens if the independent review organization says yes?

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

What happens if the independent review organization says no?

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

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

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

SECTION 8 Taking your appeal to Levels 3, 4, and 5

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

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

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

For most situations that involve appeals, the last 3 levels of appeal work in much the same way at the first 2 levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

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

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

Level 4 appeal

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

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

Level 5 appeal

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

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

MAKING COMPLAINTS

SECTION 9 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 9.1 What kinds of problems are handled by the complaint process?

The complaint process is *only* used for certain types of problems. This includes problems related to quality of care, waiting times, and 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 got (including care in the hospital)?

Complaint	Example
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Member Services? • Do you feel you're being encouraged to leave our plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at our plan? ◦ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all about the *timeliness* of our actions related to coverage decisions and appeals)	If You asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a *fast coverage decision* or a *fast appeal*, and we said no; you can make a complaint. • You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we aren't meeting deadlines for covering or reimbursing you for certain medical items or services that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 9.2 How to make a complaint

Legal Terms:

- A **complaint** is also called a **grievance.**
- **Making a complaint** is called **filing a grievance.**
- **Using the process for complaints** is called **using the process for filing a grievance.**
- A **fast complaint** is called an **expedited grievance.**

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

- **Calling Member Services at 833-536-2001 (TTY users call 711) is usually the first step.** If there's anything else you need to do, Member Services will let you know.
- **If you don't wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing.
- Standard Grievance Process - You can file a grievance through a call to Member Services at the number on the back of this booklet. Often we can resolve your grievance during the call. If we cannot resolve your grievance during the call we will forward your concern for more investigation. You can also send your concern to us in writing.

Send written complaints about your medical coverage to:

CareFirst BlueCross BlueShield Medicare Advantage
Attention: Appeals & Grievances Department
P.O. Box 915
Owings Mills, MD 21117

Your grievance must be forwarded to us orally or in writing within 60 days of the event or incident. We will respond to your grievance within 30 calendar days.

- **Expedited Grievances -** If you have an Expedited Grievance, which is a complaint about:
  - Our decision to request an extension to a coverage determination or appeal which would extend the timeframe to provide a decision by 14 days, or;
  - Our decision not to expedite your request for a coverage determination or appeal; you should call Member Services. An expedited grievance will be reviewed within 24 hours of receipt. We will call you with the outcome of your expedited grievance.
- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

Step 2: We look into your complaint and give you our answer.

- **If possible, we'll answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.

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

Section 9.3 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you also have 2 extra options:

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

  Or

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

Section 9.4 You can also tell Medicare about your complaint

You can submit a complaint about CareFirst BlueCross BlueShield Advantage Salute directly to Medicare. To submit a complaint to Medicare, go to www.Medicare.gov/my/medicare-complaint. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 8:
Ending your membership in our plan

SECTION 1 Ending your membership in our plan

Ending your membership in CareFirst BlueCross BlueShield Advantage Salute may be **voluntary** (your own choice) or **involuntary** (not your own choice):

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

If you're leaving our plan, our plan must continue to provide your medical care, and you'll continue to pay your cost share until your membership ends.

SECTION 2 When can you end your membership in our plan?

Section 2.1 You can end your membership during the Open Enrollment Period

You can end your membership in our plan during the **Open Enrollment Period** each year. During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- **The Open 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 drug coverage,
  - Original Medicare *with* a separate Medicare drug plan,
  - Original Medicare *without* a separate Medicare drug plan.
- **Your membership will end in our plan** when your new plan's coverage starts on January 1.

Section 2.2 You can end your membership during the Medicare Advantage Open Enrollment Period

You can make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period** each year.

- **The Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and also for new Medicare enrollees who are enrolled in an MA plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.
- **During the Medicare Advantage Open Enrollment Period** you can:
  - Switch to another Medicare Advantage Plan with or without drug coverage.
  - Disenroll from our plan and get coverage through Original Medicare. If you switch to Original Medicare during this period, you can also join a separate Medicare drug plan at the same time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan, or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare drug plan, your membership in the drug plan will start the first day of the month after the drug plan gets your enrollment request.

Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of CareFirst BlueCross BlueShield Advantage Salute may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply to you. These are just examples. For the full list you can contact our plan, call Medicare, or visit www.medicare.gov.

- Usually, when you move
- If you have Medicaid
- If we violate our contract with you
- If you're getting care in an institution, such as a nursing home or long-term care (LTC) hospital
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE).

Enrollment time periods vary depending on your situation.

To find out if you're eligible for a Special Enrollment Period, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. If you're eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and drug coverage. You can choose:

- Another Medicare health plan with or without drug coverage.
- Original Medicare *with* a separate Medicare drug plan.
- – *or* – Original Medicare *without* a separate Medicare drug plan.
- **Your membership will usually end** on the first day of the month after your request to change our plan.

Section 2.4 Get more information about when you can end your membership

If you have questions about ending your membership you can:

- **Call Member Services at 833-536-2001 (TTY users call 711)**
- Find the information in the ***Medicare & You 2026*** handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227) TTY users call 1-877-486-2048.

SECTION 3 How to end your membership in our plan

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

To switch from our plan to:	This is what you should do:
• **Another Medicare health plan**	• Enroll in the new Medicare health plan. • You'll automatically be disenrolled from CareFirst BlueCross BlueShield Advantage Salute when your new plan's coverage starts.
• **Original Medicare *with* a separate Medicare drug plan**	• Enroll in the new Medicare drug plan. • You'll automatically be disenrolled from CareFirst BlueCross BlueShield Advantage Salute when your new plan's coverage starts.
• **Original Medicare *without* a separate Medicare drug plan**	• **Send us a written request to disenroll.** Contact Member Services at 833-536-2001 (TTY users call 711) if you need more information on how to do this. • You can also contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), and ask to be disenrolled. TTY users can call 1-877-486-2048. • You'll be disenrolled from CareFirst BlueCross BlueShield Advantage Salute when your coverage in Original Medicare starts.

Note: If you also have creditable drug coverage (e.g., a separate Medicare drug plan) and disenroll from that coverage, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later after going without creditable prescription drug coverage for 63 days or more in a row.

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

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

- **Continue to use our network providers to get medical care.**
- **If you're hospitalized on the day that your membership ends, your hospital stay will be covered by our plan until you're discharged** (even if you're discharged after your new health coverage starts).

SECTION 5 CareFirst BlueCross BlueShield Advantage Salute must end our plan membership in certain situations

CareFirst BlueCross BlueShield Advantage Salute must end your membership in our 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're away from our service area for more than 6 months
  - If you move or take a long trip, call Member Services at 833-536-2001 (TTY users call 711) 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're no longer a United States citizen or lawfully present in the United States
- If you intentionally give us incorrect information when you're enrolling in our plan, and that information affects your eligibility for our plan. (We can't 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 can't 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 can't make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

If you have questions or want more information on when we can end your membership, call Member Services at 833-536-2001 (TTY users call 711).

Section 5.1 We <u>can't</u> ask you to leave our plan for any health-related reason

CareFirst BlueCross BlueShield Advantage Salute isn't allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel that you're being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 5.2 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

CHAPTER 9: Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, (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 aren't included or explained in this document.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, age, 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, 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, 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.html.

If you have a disability and need help with access to care, call Member Services at 833-536-2001 (TTY users call 711). If you have a complaint, such as a problem with wheelchair access, Member Services 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, CareFirst BlueCross BlueShield Advantage Salute, 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.

SECTION 4 Third Party Liability and Subrogation

CareFirst BlueCross BlueShield Advantage Salute has subrogation and reimbursement rights. Subrogation requires that you turn over to CareFirst BlueCross BlueShield Advantage Salute any rights you may have against a third party. A third party is any person, corporation, insurer or other entity that may be liable to you for an injury or illness. This right applies to the amount of benefits paid by CareFirst BlueCross BlueShield Advantage Salute for injuries or illnesses where a third party could be liable. The Plan is given the same rights of subrogation and recovery that are available to the Medicare Program under the Medicare Secondary Payer rules. CareFirst BlueCross BlueShield Advantage Salute may use whatever rights of recovery are available to the Medicare program under 42 U.S.C. § 1395mm(e)(4), 42 U.S.C. §1395w-22(a)(4), 42 C.F.R. Part 411, and 42 C.F.R. Part 422.

Recovery means to be successful in a lawsuit, to collect or obtain an amount; to obtain a favorable or final judgment; to obtain an amount in any legal manner; an amount finally collected or the amount of judgment as a result of an action brought against a third party or involving uninsured or underinsured motorist claims. A Recovery does not include Chapter: 9 (eoc) : content payments made to you under a personal injury protection policy. CareFirst BlueCross BlueShield Advantage Salute will not recover medical expenses from you unless you recover for medical expenses in a cause of action.

- **A.** You must notify CareFirst BlueCross BlueShield Advantage Salute as soon as reasonably possible that a third party may be liable for the injuries or illnesses for which benefits are being provided or paid.
- **B.** To the extent that actual payments made by CareFirst BlueCross BlueShield Advantage Salute result from the occurrence that gave rise to the cause of action, CareFirst BlueCross BlueShield Advantage Salute shall be subrogated and succeed to any right of recovery you have against any person or organization.
- **C.** You shall pay CareFirst BlueCross BlueShield Advantage Salute the amount recovered by suit, settlement, or otherwise from any third party's insurer, any uninsured or underinsured motorist coverage, or as permitted by law, to the extent that any actual payments made by CareFirst BlueCross BlueShield Advantage Salute result from the occurrence that gave rise to the cause of action.
- **D.** You shall furnish information and assistance, and execute papers that CareFirst BlueCross BlueShield Advantage Salute may require to facilitate enforcement of these rights. You shall not commit any action prejudicing the rights and interests of CareFirst BlueCross BlueShield Advantage Salute.

E. In a subrogation claim arising out of a claim for personal injury, the amount recovered by CareFirst BlueCross BlueShield Advantage Salute may be reduced by:

1. Dividing the total amount of the personal injury recovery into the total amount of the attorney's fees incurred by the injured person for services rendered in connection with the injured person's claim; and

2. Multiplying the result by the amount of CareFirst BlueCross BlueShield Advantage Salute's subrogation claim. This percentage may not exceed one-third (1/3) of CareFirst BlueCross BlueShield Advantage Salute's subrogation claim.

F. On written request by CareFirst BlueCross BlueShield Advantage Salute, you or your attorney demanding a reduction of the subrogation claim shall provide CareFirst BlueCross BlueShield Advantage Salute with your certification that states the amount of the attorney's fees incurred.

CHAPTER 10: Definitions

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

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or payment for services you already got. You may also make an appeal if you disagree with our decision to stop services that you're getting.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than our plan's allowed cost-sharing amount. As a member of CareFirst BlueCross BlueShield Advantage Salute, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We don't allow providers to **balance bill** or otherwise charge you more than the amount of cost sharing our plan says you must pay.

Benefit Period – The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a skilled nursing facility. The benefit period ends when you haven't gotten any skilled care in a SNF for 60 days in a row. If you go into a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods. For our plan, a benefit period begins the day you go into an inpatient hospital. The benefit period ends when you are discharged from the hospital. If you go into an inpatient hospital after one benefit period has ended, a new benefit period begins in which copays restart. There's no limit to the number of benefit periods.

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

Chronic-Care Special Needs Plan - C-SNPs are SNPs that restrict enrollment to MA eligible people who have specific severe and chronic diseases.

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

Combined Maximum Out-of-Pocket Amount – This is the most you'll pay in a year for all Part A and Part B services from both network (preferred) providers and out-of-network (non-preferred) providers. Go to Chapter 4, Section 1.2 for information about your combined maximum out-of-pocket amount.

Complaint – The formal name for making a complaint is **filing a grievance**. The complaint process is used *only* for certain types of problems. This includes problems about quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

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

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

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services are gotten. Cost sharing includes any combination of the following 3 types of payments: (1) any deductible amount a plan may impose before services are covered; (2) any fixed *copayment* amount that a plan requires when a specific service is gotten; or (3) any *coinsurance* amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is gotten.

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

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

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

Deductible – The amount you must pay for health care before our plan pays.

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

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll people who are entitled to both Medicare (Title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (Title XIX). States cover some Medicare costs, depending on the state and person's eligibility.

Dually Eligible Individual – A person who is eligible for Medicare and Medicaid coverage

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

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require

immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

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

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

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

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

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

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

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

Initial Enrollment Period – When you're first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

In-Network Maximum Out-of-Pocket Amount – The most you'll pay for covered Part A and Part B services gotten from network (preferred) providers. After you have reached this limit, you won't have to pay anything when you get covered services from network providers for the rest of the contract year. However, until you reach your combined out-of-pocket amount, you must continue to pay your share of the costs when you seek care from an out-of-network (non-preferred) provider.

Low Income Subsidy (LIS) – Go to Extra Help.

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

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Open Enrollment Period – The time period from January 1 to March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan or get coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after a person is first eligible for Medicare.

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

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and B. The term Medicare-Covered Services doesn't include the extra benefits, such as vision, dental, or hearing, that a Medicare Advantage plan may offer.

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

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

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill *gaps* in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or Plan Member) – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

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

Network Provider – Provider is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. **Network providers** have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called **plan providers**.

Open Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called coverage decisions in this document.

Original Medicare (Traditional Medicare or Fee-for-Service Medicare) – Original Medicare is offered by the government, and not a private health plan such as Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

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

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

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Part C – Go to Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they're received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are gotten from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

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

Preventive services – Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

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

Prior Authorization – Approval in advance to get covered services based on specific criteria. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other network provider gets prior authorization from our plan. In a PPO, you don't need prior authorization to get out-of-network services. However, you may want to check with our plan before getting services from out-of-network providers to confirm that the service is covered by our plan and what your cost-sharing responsibility is. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4.

Prosthetics and Orthotics –Medical devices including, but not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.

Referral – A written order from your primary care doctor for you to visit a specialist or get certain medical services. Without a referral, our plan may not pay for services from a specialist.

Rehabilitation Services – These services include inpatient rehabilitation care, physical therapy (outpatient), speech and language therapy, and occupational therapy.

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

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

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you move into a nursing home, or if we violate our contract with you.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who live in a nursing home, or who have certain chronic medical conditions.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits aren't the same as Social Security benefits.

Urgently Needed Services – A plan-covered service requiring immediate medical attention that’s not an emergency is an urgently needed service if either you’re temporarily outside our plan’s service area, or it’s unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren’t considered urgently needed even if you’re outside our plan’s service area or our plan network is temporarily unavailable.

CareFirst BlueCross BlueShield Advantage Salute Member Services

Method	Member Services – Contact Information
Call	833-536-2001 Calls to this number are free. 8am-8pm EST, 7 days a week October 1 - March 31, and 8am-8pm EST Monday - Friday, April 1 - September 30 Member Services 833-536-2001 (TTY users call 711) also has free language interpreter services available for non-English speakers.
TTY	711. Calls to this number are free. 8am-8pm EST, 7 days a week October 1 - March 31, and 8am-8pm EST Monday - Friday, April 1 - September 30
Fax	844-961-0696
Write	CareFirst BlueCross BlueShield Medicare Advantage Attention: Member Services Department P.O. Box 915 Owings Mills, MD 21117
Website	www.carefirst.com/medicareadvantage

The State Health Insurance Assistance Program

The State Health Insurance Assistance Program is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

Method	Maryland SHIP - Contact Information
Call	410-767-1100 or 800-243-3425
TTY	711.
Write	State Health Insurance Assistance Program Maryland Department of Aging 36 S Charles Street, 12th Floor Baltimore, MD 21201
Website	https://aging.maryland.gov/Pages/state-health-insurance-program.aspx

Method	Washington DC SHIP - Contact Information
Call	202-727-8370
TTY	711.
Write	Health Insurance Counseling Project D.C. Department of Aging 250 E Street SW Washington, DC 20024
Website	https://dacl.dc.gov/service/health-insurance-counseling

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