Blue Cross Group Medicare Advantage℠

Continuity of Care

As you move to your new Blue Cross Group Medicare Advantage Open Access (PPO) plan, our team of Care Coordinators works to make sure you don't have any gaps in care or coverage. This is called Continuity of Care. It applies if you are being treated now or have treatments planned.

Our goal is to make sure the services you receive now or have scheduled will continue:

- By Medicare contracted providers
- For Medicare covered services
- For 90 days from your enrollment date

Care Coordinators help by:

- Working with you to document and communicate established and scheduled services
- Shifting your care to providers who accept Medicare
- Making sure services you have been receiving are covered by Medicare
- Determining if a transition of care plan is necessary after 90 days
- Keeping an active Care Management Plan that was already set up by a Health Advocate.

Care Coordinators also work closely with our medical, mental health and pharmacy teams to:

- Support you as you receive needed care for sensitive health issues (e.g., cancer, heart disease, depression, etc.), even if your Medicare contracted providers are not in the network
- Help you manage a chronic condition
- Make sure choices are available if benefits run out and you still need care

Coverage/Claims

- If your provider is contracted with us for Medicare Advantage, they must get a prior authorization (pre-approval) for certain services. A claim may pay without a prior authorization if continuity of care is documented within the

90-day transition period. To do this, call the number on the back of your member ID card.

If a prior authorization or claim is denied for services that are in a continuity of care timeframe, a care coordinator or customer service representative can help to resolve the issue.

- You have an open access PPO, and you may see any Medicare Contracted provider who agrees to see you as a patient and will send claims to the plan. Non-contracted providers are not required to follow our prior authorization requirements. However, we suggest that all providers request a medical necessity prior authorization before treatment begins so you will know if your plan will cover the treatment. All services must meet Medicare benefit and medical necessity criteria to be covered.
- To ask about care coordination, or if you have questions about your group retiree Medicare Advantage plan benefits, call the customer service number on the back of your member ID card. We are open 8 a.m. – 8 p.m., local time, 7 days a week. If you are calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays.