Michigan Public School Employees Retirement System

Medicare members

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.
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Welcome to the Michigan Public School Employees Retirement System medical plan

Blue Cross Blue Shield of Michigan and the Michigan Public School Employees Retirement System are pleased to provide you and your family with this booklet that explains your medical care benefits, effective January 2017. Please take time to carefully read your benefit booklet and keep it handy for reference. This booklet replaces all previously distributed benefit documents.

In this booklet, the words “you” and “your” refer to the public school retiree and covered dependents.

Every effort has been made to ensure the accuracy of this information. However, if statements in the description differ from the Medicare Plus BlueSM Group PPO Evidence of Coverage, then the terms and conditions of the Medicare Plus BlueSM Group PPO Evidence of Coverage will prevail. New benefits and benefit changes will be announced annually. If you have questions that are not answered in this book, please call Blue Cross Blue Shield of Michigan’s customer service center at 1-800-422-9146 or visit a Blue Cross walk-in center near you.

Blue Cross Blue Shield of Michigan administers the medical plan for the Michigan Public School Employees Retirement System. Benefits and future modifications in benefit coverage and coinsurance, copay and deductible requirements are jointly vested by law in the Michigan Department of Technology, Management and Budget (DTMB) and the Michigan Public School Employees Retirement Board (Retirement Board). The DTMB and the Retirement Board reserve the right to change these benefits at any time in accordance with Medicare and existing law.

Only you and your eligible dependents may use the benefits provided under the retirement system medical care plans. Allowing anyone not eligible to use these benefits is illegal and subject to possible fraud investigation and termination of coverage.

Each year Blue Cross Blue Shield of Michigan sends an Evidence of Coverage and Annual Notice of Changes to members covered by Medicare. We encourage you to set aside some time to read this benefit booklet, the Evidence of Coverage and the Annual Notice of Changes.
Eligibility and enrollment

The Michigan Public School Employees Retirement System offers all pension recipients and their eligible dependents coverage in the health plans. You are eligible to enroll at the time of your retirement or any time after that provided you do not have a Personal Healthcare Fund.

If you have the Premium Subsidy benefit and you are enrolling yourself, your spouse, or a dependent in insurance after retirement, your coverage will begin on the first day of the sixth month after ORS receives your completed application and proofs. For example, if Office of Retirement Services (ORS) receives your Insurance Enrollment/Change Request and/or HMO enrollment form with proofs on February 10, your coverage would begin August 1.

The waiting period does not apply if you or a dependent has a qualifying event and ORS gets the request and proofs within 30 days of a qualifying event. Qualifying events include adoption, birth, death, divorce, marriage, or involuntary loss of coverage in a group plan (e.g. you lose your job or your employer stops offering health care benefits).

For retirees who do not have Medicare, coverage can begin the first of the month after the month ORS receives:

1. A completed application, and
2. Acceptable proofs: a letter on letterhead from the carrier including name of the previously insured member, their coverage end date, and the reason coverage ended.

Medical coverage

Medicare has rules that determine when you can enroll in Medicare. If you do not enroll in Medicare when you are first able to, you may have to wait close to a year before your Medicare coverage becomes effective. Do not delay your enrollment in Medicare. As soon as you or anyone else covered by your retirement system’s medical plan becomes eligible for Medicare, that person must enroll in both Part A (hospital) and Part B (medical) in order to remain eligible for coverage in the retirement system’s medical plan.

If you’re eligible for Medicare and fail to enroll in Part A and Part B, your retirement system coverage will be cancelled retroactive to the date you were first eligible for Medicare coverage and you will be liable for any claims paid during that time period. Your coverage can be restored on the first day of the next month if you enroll in Part A and Part B within one month after your coverage is cancelled and notify the retirement system within that month.

If your retirement system coverage is cancelled because you did not enroll in Part A and Part B when you were eligible for Medicare, and you do not enroll in Part A and Part B within one month after your coverage is cancelled and notify the retirement system, re-enrollment will begin on the first day of the sixth month after ORS receives your completed application and proofs.

Coverage for your dependents

The medical plan provides coverage to eligible dependents. An eligible dependent is:

- Your spouse. If he or she is an eligible public school retiree, you will be covered together on one Michigan Public School Employees Retirement System contract at the Office of Retirement Services. However, each person on Medicare will have their own contract with Blue Cross Blue Shield of Michigan.
- Your unmarried child by birth or legal adoption until December 31 of the year in which he or she turns age 19.
- Your unmarried child by legal guardianship until age 18.
• Your unmarried child, by birth or legal adoption until December 31 of the year in which he or she reaches age 25 if a full-time student and eligible to be claimed as a dependent under Section 152 of the Internal Revenue Code.

• Your unmarried child by birth or legal adoption who is totally and permanently disabled, dependent on you for support, and unable to self-sustain employment.

• Either your parent(s) or parent(s)-in-law residing in your household — one set of parents or the other, but not both.

Coverage for your Medicare eligible dependents is the same as yours.

In the fall of each year, Blue Cross will contact you to verify that your dependent children continue to meet the criteria for coverage. When you receive the letter, please read it carefully, complete the requested information, sign the form and return it with all appropriate documentation. If you don’t return the form, coverage for your 19 to 25-year-old dependent will be cancelled automatically effective January 1st of the following year. To enroll again, your coverage will begin on the first day of the sixth month after ORS receives your completed application and proofs.

Dependent children older than age 25 are not eligible for coverage on your contract unless they qualify as a disabled dependent, as described in the next section. At the end of the year in which your covered dependent student reaches age 25, he or she will be removed automatically from your medical plan coverage.

Enrolling children who do not meet the enrollment criteria, maintaining ineligible dependents on your coverage or providing false information on your enrollment application are considered health care fraud and are punishable by law. Further, when fraud is detected, you will be required to repay the retirement system for all medical services paid by Blue Cross Blue Shield of Michigan for the ineligible dependent.

**Coverage for your disabled dependent child**

The medical plan will provide dependent coverage beyond the age of 19 if your child is physically or mentally disabled. The child must meet all of the requirements below:

• Unmarried

• Eligible to be claimed as a dependent under Section 152 of the Internal Revenue Code, and

• Incapable of self-sustaining employment as a result of the disability

Your child may be eligible for Medicare medical benefits under Social Security disability coverage. If your child is eligible, you must enroll him or her in Medicare in order to maintain coverage under the retirement system medical plan. Contact the Social Security Administration about enrollment. Once eligible for Medicare, your child will have coverage under the retirement system’s plan for Medicare members as long as you (or your survivor, if you chose a survivor option) have coverage in the medical plan.

If your child is not enrolled in Medicare, Blue Cross’ clinical staff will evaluate whether your child’s condition meets the criteria for continued coverage under the retirement system. Blue Cross will ask you to submit documentation from your physician that describes the nature of your child’s condition and verifies the disability. Blue Cross may also contact your child’s attending physician to discuss the disability and review pertinent medical records.

**Continuing medical coverage for your survivor**

A designated beneficiary may continue in the medical plan after your death only if you chose a survivor option when you retired (50%, 75% or 100% Survivor Option) that provides an ongoing monthly benefit under the pension plan.

If you chose no survivor option when you retired, coverage for your dependents stops at your death.
Continuing medical coverage for your dependents

When your dependents lose eligibility for coverage under the medical plan, there are options that enable them to purchase their own medical benefits: COBRA coverage or a Blue Cross Blue Shield of Michigan individual plan.

COBRA coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) enables dependents who lose their group medical plan coverage (due to certain reasons) to purchase that coverage for up to 36 months. To qualify, a dependent must be enrolled in the Michigan Public School Employees Retirement System medical plan at the time of a qualifying event, which is the death of the retiree, divorce or legal separation, or loss of dependent eligibility under the requirements of the medical plan.

Qualified applicants have 60 days from the date of the qualifying event to apply to ORS for COBRA continuation of coverage. They’ll receive an application and information on eligibility, monthly rates for coverage and payment information. Dependents can purchase COBRA coverage for up to 36 months.

For a COBRA application and information, go to www.michigan.gov/orsmiaccount, and use the miAccount Message Board to request a COBRA application.

Blue Cross Blue Shield Individual Coverage

Your enrolled dependents may purchase individual coverage through Blue Cross Blue Shield of Michigan when they no longer qualify for coverage under the retirement system. Individual Coverage is an alternative to COBRA.

Your dependent can choose from various benefit levels. There will be no interruption of medical coverage if the initial bill and all subsequent bills are paid when due. Your dependent must reside in Michigan.

To ensure continuous coverage under Blue Cross Blue Shield, your dependents must apply within 30 days from the date they are no longer eligible for coverage through the retirement system. For an application form, rates and benefit information call Blue Cross customer service at 1-855-237-3501. Information is also available at www.bcbsm.com.

Coordination of Benefits

Medicare members

When you enrolled in the medical plan, the application asked for information about other group health coverage. You are not eligible for coverage under the Medicare Plus Blue℠ Group PPO plan if you have other group medical coverage. You must immediately notify ORS by calling 1-800-381-5111 if you have or enroll in other group medical coverage.

The following types of coverage are not group health coverage and usually pay first:

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

Medicaid and TRICARE are not group medical coverage and never pay first for Medicare-covered services. Some people with Medicare are also eligible for Medicaid or TRICARE. If you have Medicaid or TRICARE, your Medicare Plus Blue℠ Group PPO plan pays first.

If you have other insurance, tell your doctor, hospital, and pharmacy. You may need to give your plan member ID number to your other insurers (once you have confirmed their identify) so your bills are paid correctly and on time. If you have questions about who pays first call Blue Cross at 1-800-422-9146. If you need to update your other insurance information, call ORS at 1-800-381-5111.
Non-Medicare members
Refer to the benefit booklet for non-Medicare eligible members for information on coordination of benefits for individuals not on Medicare.

Only one Medicare plan
You are not eligible for coverage under the Medicare Plus Blue℠ Group PPO plan if you enroll in another Medicare Advantage plan. You must immediately notify ORS by calling 1-800-381-5111 if you enroll in another Medicare Advantage plan.

Coordinating your medical plan coverage with automobile coverage
If you or an eligible dependent are involved in an automobile accident, payment for hospital and medical services will be coordinated between Blue Cross and your automobile insurance carrier.

The auto coverage has the first obligation to pay for medical care expenses. The Medicare Plus Blue℠ Group PPO plan will pay benefits second. In most instances, your provider will directly bill the carrier that has the first obligation to pay. However, if your provider will not file your claim, you will need to do so. If your provider will not directly bill the carrier that has first obligation to pay, you must notify Blue Cross Blue Shield of Michigan by calling a customer service representative at 1-800-422-9146.

Discontinuing your coverage
You may voluntarily cancel your medical plan coverage or your dependent’s coverage at any time by going to www.michigan.gov/orsmiaccount or by completing ORS’ Insurance Enrollment/Change Request (R0452C) form. The cancellation date will be the last day of the month in which a premium is paid.

If you choose to re-enroll after you cancel your coverage, enrollment will begin on the first day of the sixth month after ORS receives your completed application and proofs.

Updating your information

When to contact ORS
You must contact ORS to notify the retirement system of the following changes:

- Address change*
- Adoption
- Birth
- Death
- Divorce
- Enrollment in another group medical insurance plan (such as from an employer, your spouse’s employer, workers’ compensation, or Medicaid) or in another Medicare Advantage plan
- Involuntary loss of coverage in another group plan
- Marriage
- Name change
- New phone number
- Power of Attorney (if someone else has the legal authority to act for you)
* Address change: Medicare Plus Blue℠ Group PPO is available only to individuals who live in the service area. The service area is the entire 50 states and territories of the United States. To remain covered by the Medicare Plus Blue℠ Group PPO plan, you must continue to reside in the service area. If you plan to move outside the service area, you must contact ORS prior to moving. **It is also important that you call Social Security if you move or change your mailing address. Call Social Security at 1-800-772-1213 Monday through Friday, 7:00 a.m. to 7:00 p.m., Eastern Standard Time. TTY users call 1-800-325-0778. Calls are free.**

miAccount is the fastest way to access and make changes to your account. When you log in, you have secure access to change your insurance information, update your address, and much more. Log in to miAccount for more information at www.michigan.gov/ors.

You can also report membership and address changes by calling ORS or by completing and submitting the Insurance Enrollment/Change Request (R0452C) form to ORS.

ORS Customer Contact Center office hours are 8:30 a.m. to 5:00 p.m., Monday through Friday.

- Lansing area telephone number: (517) 322-5103
- From outside the Lansing area: (800) 381-5111
- Fax: (517) 322-1116

miAccount Message Board

Any changes or updates you make to your miAccount or with an ORS Customer Service Representative are automatically forwarded to Blue Cross Blue Shield of Michigan. Blue Cross Blue Shield of Michigan **cannot** change your records without notification from the retirement system.

**To avoid delays in payments, misdirected communications or potential coverage problems, it is important that you contact ORS to report membership and address changes. This is especially important when adding or removing a dependent from your contract because you can be liable for claims paid in error.**

Example: If you fail to give timely notice of divorce, you will be responsible for payments made by BCBSM on behalf of your ex-spouse for services provided subsequent to your divorce date.

**When to contact BCBSM**

You must contact a Blue Cross customer service representative at 1-800-422-9146 to notify Blue Cross Blue Shield of the following:

- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If you receive care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study
How the medical plan works

When you are eligible for Medicare

If you or your covered dependents are eligible for Medicare, you’ll receive medical benefits through Medicare Plus Blue℠ Group PPO. Under Medicare Plus Blue℠ Group PPO you will enjoy the same covered services as non-Medicare Michigan public school retirees, plus the additional benefits provided by Original Medicare Part A and Part B.

There are different types of Medicare medical plans. Medicare Plus Blue℠ Group PPO is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization) that combines benefits under Medicare Part A (hospital insurance) and B (medical insurance) with benefits under the Michigan Public School Employees Retirement System to form one plan. As a Medicare medical plan, Medicare Plus Blue℠ Group PPO must cover all services covered by Original Medicare Part A and B and must follow Original Medicare’s coverage rules.

Under Medicare Plus Blue℠ Group PPO you still have Medicare, but, with the exception of Hospice care and qualifying Clinical Research Studies, you get your Part A and Part B coverage from Blue Cross Blue Shield of Michigan. Medicare Plus Blue℠ Group PPO does not include Part D prescription drug coverage. Like all Medicare medical plans, Medicare Plus Blue℠ Group PPO is approved by Medicare.

Review the Evidence of Coverage (EOC) and Annual Notice of Changes (ANOC) that Blue Cross Blue Shield sends you each year. The EOC gives you details about the plan and the ANOC lists plan changes in the new year.

You are eligible for Medicare coverage at age 65. If you are disabled or if you have end stage renal disease (ESRD), you are eligible for Medicare at an earlier age.

As soon as you or anyone else covered by your medical insurance becomes eligible for Medicare, that person must enroll in both Part A (hospital) and Part B (medical). You must have Medicare Parts A and B to enroll in retiree insurance and prescription drug programs. If you, your spouse, or your dependents don’t enroll in Medicare Part B when first eligible, the insurance for that person will be cancelled and re-enrollment will begin on the first day of the sixth month after ORS receives your completed application and proofs.

If you’re eligible for Medicare and fail to enroll in Part A and Part B, your retirement system coverage will be cancelled retroactive to the date you were first eligible for Medicare coverage and you will be liable for any claims paid during that time period. Your coverage can be restored on the first day of the next month if you enroll in Part A and Part B within one month after your coverage is cancelled and notify the retirement system within that month.

Example: If you were eligible for Medicare but did not enroll in Part A and Part B, and your retirement system coverage was cancelled on July 1, your retirement system coverage will be restored on August 1 as long as you enroll in Medicare Part A and Part B during the month of July and notify the retirement system during the month of July.

If your retirement system coverage is cancelled because you did not enroll in Part A and Part B when you were eligible for Medicare, and you do not enroll in Part A and Part B within one month after your coverage is cancelled and notify the retirement system, re-enrollment will begin on the first day of the sixth month after ORS receives your completed application and proofs.

Example: If you were eligible for Medicare but did not enroll in Part A and Part B, and your retirement system coverage was cancelled on July 1, and you enroll in Part A and Part B in August and notify the retirement system, your coverage will be restored on February 1.

Medicare also has rules that determine when you can enroll in Medicare. If you do not enroll in Medicare when you are first able, you may have to wait close to a year before your Medicare coverage becomes effective. For more information, contact Medicare through your local Social Security office. You can also visit www.medicare.gov.
Membership ID card

As a member of the medical plan, you receive a Blue Cross Blue Shield of Michigan membership ID card. Present this membership card every time you seek medical care services that are covered by the medical plan.

You do not need to use your red, white, and blue Medicare card to get covered medical services, with the exception of hospice services and routine clinical research studies. Keep your red, white and blue Medicare card in a safe place in case you need it later.

Lost or stolen membership card
If your membership ID card is lost or stolen, immediately call a Blue Cross Blue Shield customer service representative at 1-800-422-9146 to report the loss. There’s no charge for a replacement card, and you can still receive services until your new card arrives.

Things to be aware of throughout the year

LivingWell program
LivingWell is a program that helps you track your health, identify areas for improvement and work on an action plan with your doctor.

Each year you will receive a Medicare Advantage Health Assessment from Blue Cross Blue Shield of Michigan. To participate in the LivingWell program, complete the Assessment, identify your primary care physician and visit that doctor for your annual wellness exam. The wellness exam is covered by the medical plan at no cost to you.

To get the most out of the LivingWell program, select a Patient-Centered Medical Home (PCMH) doctor as your primary care physician and have that doctor perform your wellness exam.

A PCMH is a care team led by a primary care physician that focuses on your health goals and needs and works with you to help you manage your care. Here are three reasons to consider choosing a PCMH:

1. Your PCMH medical care team revolves around you. When you choose a PCMH doctor, your doctor leads a team of medical care professionals committed to improving your health. Your team may consist of your regular doctor, specialists, or a nutritionist depending on your health needs. Do you need support to quit smoking or manage a condition such as diabetes? Your PCMH doctor will put the right team together for you.

2. Your care team works together to help you manage your health. Your PCMH doctor tracks your care and coordinates with the other medical care providers. If you need to see a specialist, your PCMH doctor will help you find the right one and coordinate your visit. Your test results and treatments by other doctors are sent to your PCMH, so you won’t have to re-explain each test or symptom. Your doctor also uses e-prescribing to alert your pharmacist of any possible drug interactions and eliminate errors.
3. You’ll have more access to your medical team. PCMH practices offer extended office hours, making it easier to get same-day appointments when you have a health issue. Your PCMH also provides 24-hour access to your care team. If you have a medical question in the middle of the night or on a weekend, you can call your PCMH and possibly avoid a trip to the emergency room.

All of these features add up to you receiving the care you need, when you need it, and experiencing improved health. PCMH doctors are located in many, but not all, areas in Michigan.

Find a PCMH. To find a patient centered medical home doctor, use the Find a Doctor tool at www.bcbsm.com/mpsers. Check the “Patient-Centered Medical Home” box when selecting options to narrow your search.

Verification of Coverage

Medicare and your retirement system requires collecting information from you about any other medical or drug insurance that you have. Each year you will receive a Verification of Coverage (VOC) form to obtain current information about other medical care coverage for you and your covered dependents in addition to your retirement system coverage. It’s important that you respond to the VOC promptly.

You must adhere to ORS’ Verification of Coverage rules and processes. If you do not adhere to the rules and processes, your Medicare Plus BlueSM Group PPO coverage will be cancelled. Re-enrollment will begin on the first day of the sixth month after ORS receives your completed application and proofs.

Best of Health newsletter

The Best of Health, aims to help you understand your medical coverage, improve nutrition and fitness, manage chronic conditions, and more. Go to www.bcbsm.com/mpsers for recent and previous issues of Best of Health.

Plan updates

Plan updates are announced in the Best of Health newsletter and annual member benefit seminars.
Taking care of your health

Blue Cross® Health & Wellness

Whether you are looking for ways to improve your lifestyle or manage a chronic illness such as asthma or high blood pressure, Blue Cross® Health & Wellness has the support system you need. You can get to Blue Cross® Health & Wellness by logging into your account at www.bcbsm.com/mpsers. Once you’re logged in, you can:

- Research topics specific to men, women, and mature adults.
- Use calculators to determine healthy weight, calorie burn rate, target heart rate and much more.
- Take quizzes on a number of health topics.
- Watch videos, listen to podcasts and use other online tools to learn about various health topics.

Blue Cross® Health & Wellness also provides:

24-Hour Nurse Line
Supported by board-certified physicians, BCBSM nurses assist individuals who may be uncertain about whether to seek medical care.

To speak to a registered nurse or order health education brochures, call Blue Cross® Health & Wellness, toll free 24 hours a day, seven days a week at: 1-855-678-1705. TTY users should call 711.

Health assessment
An online questionnaire helps you pinpoint specific health issues and risks, and guides you to healthy behaviors.

Online health programs
A team of online experts outlines a personal plan for you and helpful tips on how to live a healthier lifestyle.

Chronic condition management
Experienced, licensed registered nurses help you learn how to manage your chronic condition with a number of support resources and services.

Case management
Experience, licensed registered case managers help coordinate your care and provide information to help you deal with your chronic condition.

If you have questions and want more information on Blue Cross® Health & Wellness, visit www.bcbsm.com and log in to Member Secured Services.

Blue365
Take advantage of Blue365. The Blue365 program offers savings and special discounts, making it easier and less expensive to get the balanced lifestyle you deserve in these categories:

- **Food and nutrition** – great savings home meal delivery service and fresh produce at stores
- **Health and fitness** – enjoy a massage at 20 percent off and save on fitness club memberships, classes and consultations
- **Home and garden** – get discounts on plants, flowers and other products for your home, such as a home security system
- **Travel and recreation** – pay less at Michigan’s top resorts and destinations for budget-friendly vacations and getaways, and save on family activities and outings like golf and kayaking
- **Safety** – looking for a security system? HealthyBlueXtras has savings for you

Log in to your account at bcbsm.com/mpsers to check out the latest member discounts.
Visit the BCBSM website

Information is available online 24 hours a day, seven days a week at: [www.bcbsm.com](http://www.bcbsm.com). From [bcbsm.com/mpsers](http://bcbsm.com/mpsers) you can log in to Member Secured Services from your computer or via the mobile version from your smartphone for the following:

- **Claim information** – view claim information and out-of-pocket costs
- **Provider search** – search for providers by doctor’s name, specialty, network; view side by side comparisons of doctors, including patient reviews

Visit [www.bcbsm.com/mpsers](http://www.bcbsm.com/mpsers) to view plan documents, such as the *Evidence of Coverage*, *Annual Notice of Changes*, *Summary of Benefits* and *Best of Health* newsletters.

**BCBSM webcasts and webinars**

Informative webcasts and webinars can be found under For Members at [www.bcbsm.com/mpsers](http://www.bcbsm.com/mpsers), including:

- The Basics of Medicare
- MPSERS 2017 Medical Plan Seminar
- Patient-Centered Medical Home Program

**Out-of-pocket costs**

The medical plan is designed to cover most costs associated with your medical care. You pay a minimal portion of the cost of covered benefits in addition to any monthly premium deducted from your pension payment. The medical plan features cost-sharing that applies to all members:

- Coinsurance (up to the out-of-pocket maximum)
- Copay
- Annual deductible
- Additional costs for using out-of-network providers
- Additional costs for using providers that do not participate with Medicare

You have a benefit dollar maximum that extends over your lifetime and dollar limits on certain transplant-related services.

**Coinsurance**

A coinsurance requires you to pay a portion of the cost of certain medical care services. Your coinsurance is different from your deductible and is applied before and in addition to the deductible amount. The amount of your coinsurance is based on the *Medicare Plus BlueSM Group PPO*-approved amount for covered services. If the provider’s charge is less than the *Medicare Plus BlueSM Group PPO*-approved amount, then your coinsurance is based on the provider’s charge. For most covered services, the medical plan pays 90% of the approved amount, and your coinsurance is 10%.

**Copay**

A copay is a flat dollar amount that you pay when you receive certain medical care services.
Annual deductible

Each calendar year, you are required to meet a deductible before the medical plan will pay benefits. Your current deductible is $800 per Medicare member. Your medical plan deductible renews on January 1 of each year, regardless of whether you paid your full deductible for the prior year.

Deductible amounts paid under a different medical plan do not carry over to this medical plan. In cases where an enrolled dependent loses eligibility and obtains individual coverage, deductible amounts paid for that dependent under this medical plan do not carry over to the new coverage. If you chose a survivor option at retirement, amounts paid toward your deductible at the time of your death will not be counted toward your surviving spouse and any other dependents’ deductible. Your survivors will be credited only for deductible amounts paid for their own covered services.

The amount applied to your deductible is based on the Medicare Plus BlueSM Group PPO-approved amount, not the provider’s charge.

Additional costs for using out-of-network providers

With one exception you pay 10% of the Medicare Plus BlueSM Group PPO-approved amount if you use in-network providers or out-of-network providers. The exception is that you pay an additional 20% of the Medicare Plus BlueSM Group PPO-approved amount if you use independent medical suppliers that are not in the Medicare Plus BlueSM Group PPO network. This means that you will pay 30% of the Medicare Plus BlueSM Group PPO-approved amount: 10% coinsurance plus the additional 20% for using an independent medical supplier that is not part of the Medicare Plus BlueSM Group PPO network.

IMPORTANT: You may save money when you use in-network providers because your 10% coinsurance is based on the Medicare Plus BlueSM Group PPO-approved amount. In-network providers that agree to accept a lower approved amount for the services they provide means you pay less out-of-pocket.

Additional costs for using providers that do not participate with Medicare

If you receive covered services from an out-of-network provider who does not participate with Medicare, your coinsurance percentage is multiplied by the payment rate for nonparticipating providers. This means your out-of-pocket costs may be higher.

Annual coinsurance maximum

The medical plan limits the amount you pay each year in coinsurance for medical services. Once coinsurance payments total $900 per Medicare member, no further coinsurance will be applied for the rest of the calendar year. You may not use the following charges to meet your coinsurance maximum:

- Copay
- Deductible amounts
- Additional costs for using providers that do not participate with Medicare
- Charges for noncovered services
### Annual out-of-pocket maximum

In accordance with Medicare rules, the medical plan limits the amount you will pay each year in coinsurance, copay and deductible for medical services. Once you reach your $1,700 out-of-pocket maximum, all covered services will be paid at 100% of the approved amount for the rest of the calendar year.

You may not use the following charges to meet your out-of-pocket maximum:

- Charges for non covered services

#### Example: How your coinsurance and annual deductible are applied

An in-network provider charges $2,000 for services rendered to a retiree. Medicare Plus Blue℠ Group PPO approves $1,500 for the services. Here’s how the claim would be paid:

<table>
<thead>
<tr>
<th>The retiree has...</th>
<th>The medical plan...</th>
<th>The retiree’s out-of-pocket cost...</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>not met</strong> the annual deductible</td>
<td>reduces the approved amount $1,500 by the 10% coinsurance $150 and the deductible $800 and pays $550</td>
<td>10% coinsurance $150 and the deductible $800</td>
</tr>
<tr>
<td><strong>met</strong> the annual deductible</td>
<td>reduces the approved amount $1,500 by the 10% coinsurance $150 and pays $1,350</td>
<td>10% coinsurance $150</td>
</tr>
</tbody>
</table>

### Benefit dollar maximums

The medical plan will pay up to the maximum amount for the following:

- **Outpatient services** — payable up to a lifetime maximum of $1 million for outpatient services not covered by Original Medicare. Your Evidence of Coverage identifies these services. When you reach the $1 million maximum, an additional $1,000 per calendar year will be restored as long as uninterrupted coverage is in effect. The additional $1,000 allowance is renewed on January 1 of the following calendar year.

- **Immunosuppressive Drugs for specified organ transplants** — If you received a heart, heart-lung, liver, lung, pancreas or intestine transplant before your enrollment in Medicare, you have coverage for immunosuppressive and other transplant-related prescription drugs up to a maximum of $10,000 per year. Refer to the Transplant section in this benefit booklet for more information.

- **Travel and lodging for specified organ transplants** — Coverage for reasonable and necessary travel and lodging expenses is very limited for most transplants. However, if you have a heart, heart-lung, lung, liver, pancreas and/or intestine transplant, you have coverage for reasonable and necessary travel and lodging up to a $10,000 maximum for you and one companion (two companions you’re under age 18 or the transplant involves a living donor related to you).
Selecting your providers and using the Medicare Plus Blue℠ Group PPO network

Select a physician that’s right for you

If you don’t already have a personal physician, consider choosing one to help you manage and coordinate all your medical needs. This physician will get to know your medical history and lifestyle so that he or she will be in the best position to perform your regular checkups, refer you to specialists or coordinate any necessary hospital care.

Having a good relationship with your doctor is important. The doctor-patient relationship and the advantages that go along with it are at the core of the Patient-Centered Medical Home (PCMH) concept. Refer to the LivingWell program section in this booklet for more information about PCMH.

Using a network provider

The medical plan offers the Medicare Plus Blue℠ Group PPO provider network for retirees and their dependents on Medicare. You get the maximum benefit with the lowest out-of-pocket expense when you use Medicare Plus Blue℠ Group PPO network providers for your covered services.

You also have some added assurance that your treatment or services will be covered when you use a network provider. Some services are covered in-network only if your provider gets approval in advance from BCBSM (sometimes called “prior authorization”). Your network provider will arrange for this authorization and, if treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization. Refer to the Coverage Determination, Appeals and Complaints section of this booklet for information about appeals.

Using an out-of-network provider

Many providers that are not part of the PPO network may still participate with Medicare. You can choose to receive care from out-of-network providers, but consider the cost. For example, if you rent or purchase items from an independent medical supplier that is not in the Medicare Plus Blue℠ Group PPO network, your coinsurance will be higher.

You don’t need to get a referral or prior authorization when you get care from out-of-network providers, but you may want to ask for a pre-visit coverage decision to confirm that the services you are getting are covered and medically necessary. This is important because, without a pre-visit coverage decision, if BCBSM later determines that the services are not covered or were not medically necessary, you will be responsible for the entire cost. If BCBSM will not cover your services, you have the right to appeal the decision. Refer to the Coverage Decisions, Appeals and Complaints section of this booklet for information about appeals.

If you receive care from a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive, except for emergency care. Check with your out-of-network provider before receiving services to confirm they are eligible to participate with Medicare.
<table>
<thead>
<tr>
<th>In-network provider</th>
<th>Out-of-network provider that participates in Medicare</th>
<th>Out-of-network provider that does not participate in Medicare</th>
<th>Provider not eligible to participate in Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>your provider</strong></td>
<td>• Member of the Medicare Plus Blue℠ Group PPO network</td>
<td>• Not a member of the Medicare Plus Blue℠ Group PPO network but participates with Original Medicare</td>
<td>• No affiliation with Medicare or Medicare Plus Blue℠ Group PPO</td>
</tr>
<tr>
<td></td>
<td>• Blue Cross selects for quality of care, ability to provide cost-effective services and meet Medicare Plus Blue℠ Group PPO standards</td>
<td>• Medicare selects for quality of care, ability to provide cost-effective services</td>
<td>• No quality screening by Medicare or Medicare Plus Blue℠ Group PPO</td>
</tr>
<tr>
<td><strong>your cost</strong></td>
<td>• Lowest out-of-pocket cost</td>
<td>• Low out-of-pocket cost</td>
<td>• Highest out-of-pocket cost</td>
</tr>
<tr>
<td></td>
<td>• Coinsurance or copay</td>
<td>• Coinsurance or copay</td>
<td>• You pay all cost except for emergency needed care, which is subject to coinsurance or copay and deductible</td>
</tr>
<tr>
<td></td>
<td>• Deductible</td>
<td>• Deductible</td>
<td>• Deductible</td>
</tr>
<tr>
<td><strong>claim filing</strong></td>
<td>• Provider submits claim for you and Blue Cross pays provider directly</td>
<td>• Provider submits claim for you and Blue Cross pays provider directly</td>
<td>• You may have to file claims for covered services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• You file claims for covered services</td>
<td></td>
</tr>
</tbody>
</table>

Locating network providers in the United States

There are three ways to locate a Medicare Plus Blue℠ Group PPO provider:

- If you already have a physician, call and ask if he or she is a Medicare Plus Blue℠ Group PPO physician.
- Visit the Blue Cross Blue Shield of Michigan Website at [www.bcbsm.com/medicare/find-a-doctor.html](http://www.bcbsm.com/medicare/find-a-doctor.html). The online directory is easy to use and is frequently updated.
- Call Blue Cross customer service at **1-800-422-9146** for help in locating a network provider in your area.

If you select a network physician and later wish to change physicians, there is no waiting period or paperwork. Just select another physician in the Medicare Plus Blue℠ Group PPO network and make your appointment. You don’t have to notify Blue Cross.
You can save when you use network providers

The Medicare Plus Blue℠ Group PPO plan offers choice when it comes to selecting providers, but you may pay more when you use non-network providers. Blue Cross carefully selects providers for the quality of care they provide and ability to provide cost-effective care and negotiates discounts for medical care services. That means you can save when you use Medicare Plus Blue℠ Group PPO providers.

Locating network providers outside the United States

For nonemergency inpatient medical care outside of the United States, you must call the BlueCard® Worldwide Service Center to arrange access to a BlueCard® Worldwide hospital. Call 1-800-810-BLUE (2583) and select international option or call collect at 1-804-673-1177 if you are calling outside the United States. If your hospitalization is arranged through the BlueCard® Worldwide Service Center, the hospital will file the claim for you. You will need to pay the hospital the coinsurance and deductible. For a current list of these hospitals, visit the BlueCard® Worldwide website: www.bluecardworldwide.com.

For outpatient and doctor care or inpatient care not arranged through the BlueCard® Worldwide Service Center, you will need to pay the provider and submit a claim form with original bills to Blue Cross Blue Shield of Michigan.

Your covered hospital and medical benefits and cost share is the same when you travel to a foreign country as if the services were rendered in the United States. For covered services performed abroad, the medical plan will pay the approved amount at the rate of exchange in effect on the date of service. You are responsible for costs that exceed Medicare Plus Blue℠ Group PPO approved amount plus your coinsurance, copay and deductible.

Note: If you receive care out of the country, try to get all receipts itemized in English. Cash register receipts, cancelled checks or money stubs may accompany your itemized receipts, but may not substitute for an itemized statement.

Medical providers not included in the Medicare Plus Blue℠ Group PPO network

Prior to obtaining services from the providers below, you must confirm that the provider is Blue Cross-approved. If not, you may be responsible for all or a portion of the charges. For assistance, call Blue Cross customer service at 1-800-422-9146.

Types of facilities and providers that are not part of the Medicare Plus Blue Group PPO network include:

- Hearing aid providers
- Private duty

Your medical benefits

This chapter describes the medical benefits provided under the medical plan. If you have other medical coverage, refer to the Coordination of Benefits section of the Eligibility and Enrollment chapter in this booklet for additional information.

You can log in to the secured Member Portal at www.bcbsm.com/mpsers to view claim information and track out-of-pocket costs.

Your medical plan is designed to pay for medical care when you need it. Unless otherwise specified, a service must be medically necessary to be covered by the medical plan. If the service is not medically necessary, you’ll be responsible for all of the cost. For a full explanation of medical necessity for hospital and physician services, see “Medical necessity” in the Glossary of Medical Care Terms.

Federal and state laws protect the privacy of your medical records and personal health information. Your personal health information is protected as required by these laws.
Hospital benefits

Inpatient hospital care

<table>
<thead>
<tr>
<th>What you pay</th>
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<tbody>
<tr>
<td><strong>In-network and Out-of-network</strong></td>
</tr>
<tr>
<td>10% coinsurance and the annual deductible, except for clinical lab services.</td>
</tr>
<tr>
<td>Clinical lab services are covered at no cost to you.</td>
</tr>
</tbody>
</table>

Refer to the Exclusions and Limitations section of this booklet for additional information.

The medical plan provides unlimited days for inpatient hospital care for the diagnosis and treatment of medical and mental health conditions. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor’s order. The day before you are discharged is your last inpatient day.

Hospital care includes the care you get in acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, and long-term care hospitals.

Covered services include:

- Semiprivate room (or private room if medically necessary)
- Meals including special diets
- Regular nursing services
- Cost of special care units (such as intensive care or coronary care units)
- Operating and recovery room costs
- Drugs and medications
- Lab tests
- X-rays, CAT scans, MRIs, PET scans and other radiology services
- Anesthesia, including administration, cost of equipment, supplies and the services of a hospital anesthesiologist when billed as a hospital service
- Blood used for each condition or diagnosis, including storage for blood before surgery
- Diagnostic tests, such as EEGs, EKGs, ECGs and EMGs
- Chemotherapy and radiation therapy
- Customary, standard and medically-accepted artificial prosthetic devices when permanently implanted internally, such as heart valves and hip joints
- Oxygen and other gas therapy
- Necessary surgical and medical supplies
- Use of appliances and equipment, such as wheelchairs
- Physical, occupational, and speech language therapy for the treatment of the condition for which you are hospitalized
- Routine nursery care of a newborn during the mother’s eligible stay
- Substance abuse services
- Mental health/behavioral health services
Inpatient hospital care, including substance abuse and mental health/behavioral health services, rendered by plan providers will require prior authorization.

Are you an inpatient?
Staying overnight in a hospital doesn’t always mean you’re an inpatient. You only become an inpatient when a hospital formally admits you as an inpatient, after a doctor orders it. You’re still an outpatient if you haven’t been formally admitted as an inpatient, even if you’re getting emergency department services, observation services, outpatient surgery, lab tests, or X-rays. You or a family member should always ask if you’re an inpatient or an outpatient each day during your stay, since it can affect whether you’ll qualify for coverage in a skilled nursing facility.

### Inpatient physician care

<table>
<thead>
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<th>What you pay</th>
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<tbody>
<tr>
<td><strong>In-network and Out-of-network</strong></td>
</tr>
<tr>
<td>10% coinsurance and the annual deductible</td>
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</tbody>
</table>

Refer to the Exclusions and Limitations section of this booklet for additional information.

Your hospital benefit covers:

- **Inpatient physician visits** — You’re covered for inpatient medical care from a physician, including care for general medical conditions and mental health conditions.
- **Inpatient care from a specialist** — You’re covered when you’re being treated by more than one physician only if the doctors have different specialties and you’re being treated for more than one medical condition.
- **Inpatient physician consultations** — In complicated situations, the physician in charge of your case may consult another physician for assistance or advice in making a diagnosis or providing treatment. Inpatient consultations are covered when medically necessary and requested by your attending physician.

### Outpatient hospital care

<table>
<thead>
<tr>
<th>What you pay</th>
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<tbody>
<tr>
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<tr>
<td>10% coinsurance and the annual deductible, except for clinical lab services.</td>
</tr>
<tr>
<td>Clinical lab services are covered at no cost to you.</td>
</tr>
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</table>

Refer to the Exclusions and Limitations section of this booklet for additional information.

The services listed under inpatient hospital benefits are also covered when performed in the outpatient department of a hospital. Refer to Emergency Services for information on cost-share for emergency room care.

Partial hospitalization is covered for active psychiatric treatment provided in a hospital outpatient setting or by a community mental health center. Partial hospitalization is a structured program that is more intense than the care received in a doctor’s or therapist's office and is an alternative to inpatient hospitalization.
Dialysis

<table>
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<tr>
<th>What you pay</th>
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<tbody>
<tr>
<td><strong>In-network and Out-of-network</strong></td>
</tr>
<tr>
<td>10% coinsurance and the annual deductible</td>
</tr>
</tbody>
</table>

Refer to the Exclusions and Limitations section of this booklet for additional information.

The medical plan covers treatment for chronic, irreversible kidney disease in the outpatient department of a hospital and renal dialysis facility when arranged by your doctor. Dialysis is also covered if you are admitted as an inpatient to a hospital for special care and if outpatient dialysis is required when you are temporarily outside the Medicare Plus BlueSM Group PPO service area.

The medical plan covers home dialysis services, including the acquisition and installation of a dialysis machine, training in the operation of the machine, necessary laboratory tests, visits by trained dialysis workers, support services, drugs required during dialysis, and consumable supplies. Refer to the Medical equipment and supplies section in this booklet for cost-share on home dialysis equipment and supplies.

Emergency services

Emergency room care

<table>
<thead>
<tr>
<th>What you pay</th>
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</thead>
<tbody>
<tr>
<td><strong>In-network and Out-of-network</strong></td>
</tr>
<tr>
<td>$75 copay per visit</td>
</tr>
<tr>
<td>The $75 copay is waived if you are admitted to the hospital within 72 hours.</td>
</tr>
</tbody>
</table>

Refer to the Exclusions and Limitations section of this booklet for additional information.

A medical emergency is when you, or any other prudent layperson with an average knowledge of medical and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Examples of covered emergency services include:

- Severe chest pain
- Loss of consciousness
- Convulsions
- Broken bones
- Cuts requiring prompt medical treatment
- Frostbite

Other services that may be provided in treating the emergency (for example, laboratory, X-ray, etc.), are discussed elsewhere in this booklet.
Urgently needed care

<table>
<thead>
<tr>
<th>What you pay</th>
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<tbody>
<tr>
<td>In-network and Out-of-network</td>
<td></td>
</tr>
<tr>
<td>10% coinsurance</td>
<td></td>
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</tbody>
</table>

Refer to the Exclusions and Limitations section of this booklet for additional information.

Urgently needed care is nonemergency, unforeseen medical illness, injury, or a condition that requires immediate medical care. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.

What type of treatment should you get?
Is it a minor illness, or something more serious? Should you go to the emergency room or wait for an appointment with your doctor? Or can you take care of yourself at home? The Blue Cross® Health & Wellness 24-Hour Nurse Line may help you. This 24-hour, seven day a week nurse hotline is available free to all enrolled members. You can speak directly with a registered nurse by calling the Blue Cross® Health & Wellness 24-Hour Nurse Line at 1-855-678-1705 (TTY users can call 711). Refer to the Blue Cross® Health & Wellness section for more information.

Ambulance services

<table>
<thead>
<tr>
<th>What you pay</th>
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<tbody>
<tr>
<td>In-network and Out-of-network</td>
<td></td>
</tr>
<tr>
<td>10% coinsurance and the annual deductible</td>
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</tbody>
</table>

Refer to the Exclusions and Limitations section of this booklet for additional information.

The medical plan covers ground ambulance transportation when you need to be transported to a hospital, critical access hospital, or skilled nursing facility for medically necessary services, and transportation in any other vehicle could endanger your health. The medical plan may pay for emergency ambulance transportation in an airplane or helicopter to a hospital if you need immediate and rapid ambulance transportation that ground transportation can’t provide. In some cases, the medical plan may pay for limited, medically necessary, non-emergency ambulance transportation if you have a written order from your doctor stating that ambulance transportation is necessary due to your medical condition. The medical plan will only cover ambulance services to the nearest appropriate medical facility that’s able to give you the care you need.

Surgical services

<table>
<thead>
<tr>
<th>What you pay</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>In-network and Out-of-network</td>
<td></td>
</tr>
<tr>
<td>10% coinsurance and the annual deductible</td>
<td></td>
</tr>
</tbody>
</table>

Refer to the Exclusions and Limitations section of this booklet for additional information.

Surgical procedures are covered when required for the diagnosis and treatment of a disease or injury and performed in an approved location, such as a hospital, physician’s office or ambulatory surgical center. Services received in an ambulatory surgical center generally include elective surgery that does not require the use of hospital facilities and support systems, but is not routinely performed in an office setting.
In addition to general surgery, the following surgeries and surgical services are covered:

- **Dental surgery** to remove impacted teeth or to perform multiple extractions is covered only when you’re hospitalized for the surgery because of a concurrent medical condition, such as a heart condition. The inpatient admission for the dental surgery must be considered medically necessary to safeguard your life.

- **Cosmetic surgery** is limited to the correction of deformities present at birth, conditions caused by accidental injuries and deformities resulting from cancer surgery, such as breast reconstruction following a mastectomy. Your doctor must pre-authorize the procedure and your benefits are subject to specific medical criteria. Surgery primarily for improving your appearance is not covered.

- **Anesthesia** — Covered services include drugs or gases and their administration when medically necessary for a covered service and when given by a physician other than the operating surgeon or an assistant. Anesthesia provided by a Certified Registered Nurse Anesthetist under the direction of an anesthesiologist is also covered.

- **Technical surgical assistance** — Surgical assistance provided by another physician when requested by the operating surgeon is covered. However, it is payable only when an intern or hospital physician is not available for assistance. The surgery requiring the assistance must be an approved major-surgical procedure.

- **Multiple surgeries** — Two or more surgical procedures performed during the same operative session are subject to payment limitations.

### Doctor visits and other medical services

<table>
<thead>
<tr>
<th>What you pay</th>
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</thead>
<tbody>
<tr>
<td>In-network and Out-of-network</td>
</tr>
<tr>
<td>10% coinsurance and the annual deductible, unless otherwise noted</td>
</tr>
</tbody>
</table>

Refer to the Exclusions and Limitations section of this booklet for additional information.

Your medical plan covers visits to a physician for the examination, diagnosis and treatment of general medical conditions. Services such as medical care, including urgent medical care, consultations, injections and medications are payable in the physician’s office, clinic (including a Federally qualified health center and Rural Health Clinic) or in your home.

In addition to physicians, the medical plan also covers medically appropriate services provided by other qualified medical care providers, like physician assistants, nurse practitioners, social workers, physical therapists, and psychologists.

The medical plan does not cover routine physical examinations or routine office visits.

**Allergy treatment**
Covered services include tests to help arrive at a diagnosis.

**Cardiac rehabilitation**
The medical plan covers comprehensive programs that include exercise, education, and counseling for patients who meet these conditions:

- A heart attack in the last 12 months
- Coronary artery bypass surgery
- Current stable angina pectoris (chest pain)
- A heart valve repair or replacement
• A coronary angioplasty (a medical procedure used to open a blocked artery) or coronary stenting (a procedure used to keep an artery open)
• A heart or heart-lung transplant

The medical plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than regular cardiac rehabilitation programs. Services are covered in a doctor’s office or hospital outpatient setting.

Chemotherapy services
The medical plan covers chemotherapy, including administration of therapy, doctor services and the cost of drugs, except when the treatment or drugs are considered experimental or investigative. Drugs covered under the retirement system’s Prescription Drug Plan are not covered under the Medicare Plus BlueSM Group PPO Plan.

Chiropractic services
Chiropractic benefits are limited to spinal X-rays and spinal manipulations for diagnoses related to the spine (subluxation of the spine). The medical plan covers medically necessary spinal manipulations.

Clinical research studies
Clinical research studies test how well different types of medical care work and if they’re safe. The medical plan covers some costs, in qualifying clinical research studies. Refer to the Clinical Research Study Services chapter in this booklet for additional information.

Dental services
The plan doesn’t cover most dental care, dental procedures, or supplies, like cleanings, fillings, tooth extractions, dentures, dental plates, or other dental devices. You have coverage for certain dental services that you get when you’re in a hospital. You also have coverage for services required for the initial treatment of an injury to the jaws, sound natural teeth, mouth or face. The injury must have occurred after the effective date of your coverage. Services must be performed by a physician or dentist. The medical plan does not cover injuries resulting from biting or chewing, or preventive or maintenance services.

Infusion therapy
Infusion therapy is the continuous, slow administration of a controlled drug, nutrient, antibiotic or other fluid into a vein or other tissue on a daily, weekly or monthly basis, depending on the condition being treated and type of therapy. The medical plan covers infusion therapy in a doctor's office, outpatient Ambulatory Infusion Center and in the patient’s home.

The drugs used in infusion therapy must be approved by Medicare Plus BlueSM Group PPO.

Home infusion therapy is covered when it is:
• Prescribed by a physician within his or her scope of practice to:
  — Manage an incurable or chronic condition
  — Treat a condition that requires acute care if it can be managed safely at home
• Certified by the physician as medically necessary for the treatment of the condition
• Appropriate for use in the patient’s home
• Medical IV therapy, injectable therapy or total parenteral nutrition therapy

Home infusion therapy coverage includes:
• Nursing visits needed to:
  — Administer home infusion therapy or parenteral nutrition
  — Instruct patient or caregivers on infusion administration techniques
  — Provide IV access care (catheter care)
• Durable medical equipment, medical supplies and solutions needed for home infusion therapy or parenteral nutrition
Medication
The medical plan covers a limited number of prescription drugs like injections you get in a doctor’s office, certain oral anti-cancer drugs, drugs used with some types of durable medical equipment (like a nebulizer or external infusion pump) and immunosuppressant drugs. Self-administered drugs (drugs you would normally take on your own and are covered under your prescription drug plan) are not covered. Refer to the Specified Organ and Tissue Transplants section of this booklet for more information on coverage for immunosuppressant drugs. Certain drugs require prior authorization.

Pain management
Pain management is an integral part of a complete disease treatment plan. You have coverage for the comprehensive evaluation and treatment of diseases, including the management of symptoms such as intractable pain that may be associated with these diseases.

Physical and occupational therapy, and speech therapy
The medical plan covers evaluation and treatment for injuries and diseases that change your ability to function when your doctor or other medical care provider certifies your need for it. These services are covered only when the services are specific, safe and an effective treatment for your condition. The amount, frequency and time period of the services needs to be reasonable, and they need to be complex or only qualified therapists can do them safely and effectively. To be eligible your condition must be expected to improve in a reasonable and generally-predictable period of time.

Physical or occupational therapy and speech therapy services can be performed in offices of privately practicing therapists, many medical offices, rehabilitation agencies (sometimes called “other rehabilitation facilities”), comprehensive outpatient rehabilitation facilities, and at home from certain therapy providers, like privately practicing therapists and certain home health agencies (if you aren’t under a home health plan of care).

Pulmonary rehabilitation
The medical plan covers a comprehensive pulmonary rehabilitation program if you have moderate to very severe chronic obstructive pulmonary disease (COPD) and have a referral from the doctor treating this chronic respiratory disease.

Radiation therapy
The medical plan covers radiation therapy including X-rays, radium, external radiation or radioactive isotopes, except when the treatment is considered experimental or investigative.

Second opinion on surgery
The medical plan covers second surgical opinions in some cases for surgery that isn’t an emergency. In some cases the medical plan covers third surgical opinions.

Telehealth (telemedicine)
The medical plan covers limited medical or other health services like office visits and consultation provided using an interactive, two-way telecommunications system (like real-time audio and video) by an eligible provider who isn’t at your location. These services are available in some rural areas, under certain conditions, and only if you’re located at: a doctor’s office, hospital, rural health clinic, federally qualified health center, hospital-based dialysis facility, skilled nursing facility, or community mental health center.

Temporomandibular (TMJ) or Jaw-Joint Disorder
The medical plan will cover reversible treatment for jaw-joint disorders. Reversible treatment is treatment of the mouth, teeth or jaw that is not intended to effect a permanent alteration of the bite (occlusion) and is directed at managing symptoms. It can include, but is not limited to, physical medicine, medications or reversible appliance therapy.
The medical plan does not cover irreversible medical, surgical and/or dental treatment of the mouth, jaw and associated structures. Irreversible treatment is treatment of the mouth, teeth or jaw that is intended to effect a permanent change in the positioning of the jaws or permanent alteration of the vertical bite dimension. It includes, but is not limited to, crowns, inlays, caps, restorations, grinding, orthodontics and the installation of removable or fixed appliances such as dentures, partial dentures or bridges.

Exceptions: The medical plan does cover irreversible surgery directly to the temporomandibular joint, X-rays (including MRIs) and arthrocenteses (injections), regardless of the cause of the jaw-joint disorder. Jaw-joint disorders include, but are not limited to, muscle tension and spasms of musculature related to the temporomandibular joint, skeletal defects and occlusal defects (problem of the bite), that cause pain, loss of function, neurological and personality dysfunctions. This also includes temporomandibular joint syndrome, craniofacial disorders and myofacial pain dysfunction syndrome.

Vision services
The medical plan covers the examination and fitting of one pair of corrective lenses prescribed by a physician following cataract surgery in one or both eyes. The medical plan does not cover routine eye examinations, preparation, fitting or procurement of eyeglasses or other corrective visual appliances except as described above.

Preventive services

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<th>What you pay</th>
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<td>In-network and Out-of-network</td>
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<tr>
<td>Nothing, unless otherwise noted</td>
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</table>

Refer to the Exclusions and Limitations section of this booklet for additional information.

If you are treated or monitored for an existing medical condition when you receive a preventive service, cost-sharing applies for the care received for the existing medical condition.

Abdominal aortic aneurysm screening
The medical plan covers a one-time screening abdominal aortic aneurysm ultrasound for people at risk. You must get a referral from your doctor or other practitioner.

Alcohol misuse screening and counseling
The medical plan covers one alcohol misuse screening per calendar year for adults (including pregnant women) who use alcohol but don’t meet the medical criteria for alcohol dependency. If your primary care doctor or other primary care practitioner determines you’re misusing alcohol, you can get up to 4 brief face-to-face counseling sessions per year (if you’re competent and alert during counseling). A qualified primary care doctor or other primary care practitioner must provide the counseling in a primary care setting (like a doctor’s office).

Annual wellness visit
If you’ve had Part B Medicare for longer than 12 months, you can get an annual wellness visit to develop or update a personalized plan to prevent disease or disability based on your current health and risk factors. This visit is covered once every calendar year.

Your first annual wellness visit can’t take place within 12 months of your enrollment in Medicare Part B or your “Welcome to Medicare” preventive visit. However, you don’t need to have had a “Welcome to Medicare” preventive visit to qualify for an annual wellness visit.
Bone mass measurement
This test helps to see if you’re at risk for broken bones. It’s covered once every 24 months (more often if medically necessary) for people who have certain medical conditions or meet certain criteria. Qualified individuals are people at risk of losing bone mass or at risk of osteoporosis. Coverage includes procedures to identify bone mass, detect bone mass, or determine bone quality, including a physician’s interpretation of the results.

Breast cancer screening
The medical plan covers:

- One routine, screening mammogram (breast X-ray) for women every calendar year
- One clinical breast exam every calendar year

Cardiovascular disease behavioral therapy
You have coverage for one visit per calendar year with a primary care doctor in a primary care setting (like a doctor’s office) 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 are eating well.

Cardiovascular disease screenings
These screenings include blood tests that help detect conditions that may lead to a heart attack or stroke. The medical plan covers these screening tests once every 5 years to test your cholesterol, lipid, lipoprotein, and triglyceride levels.

Cervical and vaginal cancer screening
Pap tests and pelvic exams to check for cervical and vaginal cancers are covered once every calendar year.

Colorectal cancer screening
The medical plan covers:

- Screening barium enema – This test is generally covered once every 48 months if you’re 50 or older (high risk every 24 months) when used instead of a sigmoidoscopy or colonoscopy.
- Screening colonoscopy – This test is generally covered once every 120 months (high risk every 24 months) or 48 months after a previous flexible sigmoidoscopy. There’s no minimum age.
  NOTE: If a polyp or other tissue is found and removed during the colonoscopy, your coinsurance is 10% of the approved amount. The coinsurance applies to the annual out-of-pocket maximum.
- Screening fecal occult blood test – This test is covered once every 12 months if you’re 50 or older.
- Screening flexible sigmoidoscopy – This test is generally covered once every 48 months if you’re 50 or older, or 120 months after a previous screening colonoscopy for those not at high risk.

Depression screening
The medical plan covers one depression screening per year. The screening must be done in a primary care setting (like a doctor’s office) that can provide follow-up treatment and referrals.

Diabetes screening
The medical plan covers these screenings (includes fasting glucose tests) if your doctor determines you’re at risk for diabetes. Risk factors include: 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. Based on the results of these tests, you may be eligible for up to 2 diabetes screenings each year.
**Diabetes self-management training**
The medical plan covers diabetes outpatient self-management training to teach you to cope with and manage your diabetes. The program may include tips for eating healthy, being active, monitoring blood sugar, taking medication, and reducing risks. You must have diabetes and a written order from your doctor or other qualified medical care provider.

**Foot exams and treatment**
The medical plan covers foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions. The 10% coinsurance and annual deductible applies In-network and Out-of-network.

**Flu shots**
You have coverage for one flu shot per flu season (fall or winter).

**Glaucoma tests**
These tests are covered once every 12 months for people at high risk for the eye disease glaucoma. You’re at high risk if you have diabetes, a family history of glaucoma, are African-American and 50 or older, or are Hispanic and 65 or older. An eye doctor who’s legally allowed by the state must do the tests.

**Hearing and balance exams**
The medical plan covers these exams if your doctor or other qualified medical care provider orders them to see if you need medical treatment. The 10% coinsurance and annual deductible applies In-network and Out-of-network.

**Hepatitis B shots**
The medical plan covers these shots for people at medium or high risk for Hepatitis B. Some risk factors include hemophilia, End-Stage Renal Disease (ESRD), diabetes, if you live with someone who has Hepatitis B, or if you’re a medical care worker and have frequent contact with blood or body fluids. Check with your doctor to see if you’re at medium or high risk for Hepatitis B.

**Hepatitis C screening**
The medical plan covers one Hepatitis C screening test and yearly repeat screening for certain people at high risk.

**HIV screening**
The medical plan covers HIV (Human Immunodeficiency Virus) screenings for people at increased risk for the virus, people who ask for the test, or pregnant women. The test is covered once every 12 months or up to 3 times during a pregnancy.

**Kidney disease education services**
The medical plan covers up to 6 sessions of kidney disease education services if you have State IV chronic kidney disease, and your doctor or other medical care provider refers you for the service.

**Lung cancer screening**
The medical plan covers a lung cancer screening with Low Dose Computed Tomography once per year for people 55-77 that are either a current smoker or have quick smoking within the last 15 years, have a tobacco smoking history of at least 30 “pack years” (an average of one pack a day for 30 years) and have a written order from their physician or qualified non-physician practitioner.

**Medical nutrition therapy services**
The medical plan may cover medical nutrition therapy and certain related services if you have diabetes or kidney disease, or you have had a kidney transplant in the last 36 months, and your doctor or other qualified medical care provider refers you for the service.
Obesity screening and counseling
If you have a body mass index (BMI) of 30 or more, the medical plan may cover up to 22 face-to-face intensive counseling sessions over a 12-month period to help you lose weight. This counseling is covered when provided in a primary care setting (like a doctor’s office). Talk to your primary care doctor or primary care practitioner to find out more.

Pneumococcal shot
The medical plan covers pneumococcal shots to help prevent pneumococcal infections (like certain types of pneumonia). Most people only need this shot once in their lifetime. Talk with your doctor or other qualified medical care provider to see if you should get this shot.

Prostate cancer screenings
The medical plan covers a Prostate Specific Antigen (PSA) test and a digital rectal exam once every calendar year for men over 50 (beginning the day after your 50th birthday).

Sexually transmitted infections screening and counseling
The medical plan covers sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for people who are pregnant and for certain people who are at increased risk for an STI when the tests are ordered by a primary care doctor or other primary care practitioner. The medical plan covers these tests once every 12 months or at certain times during pregnancy.

The medical plan also covers up to 2 individual, 20-30 minute, face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. The medical plan will only cover these counseling sessions if they’re provided by a primary care doctor or other primary care practitioner and take place in a primary care setting (like a doctor’s office.) Counseling conducted in an inpatient setting, like a skilled nursing facility, won’t be covered as a preventive service.

Tobacco-use cessation counseling
If you use tobacco and you’re diagnosed with an illness caused or complicated by tobacco use, or you take a medication that’s affected by tobacco, the medical plan covers up to 8 face-to-face visits in a 12-month period.

If you haven’t been diagnosed with an illness caused or complicated by tobacco use, the medical plan covers up to 8 face-to-face visits in a 12-month period at no cost to you.

“Welcome to Medicare” preventive visit
During the first 12 months that you have Medicare Part B, you can get a “Welcome to Medicare” preventive visit. This visit includes a review of your medical and social history related to your health, and education and counseling about preventive services, including certain screenings, shots, and referrals for other care, if needed. When you make your appointment, let your doctor’s office know that you would like to schedule your “Welcome to Medicare” preventive visit.

EKG or ECG (electrocardiogram) screening is covered one-time if referred by your doctor or other qualified medical care provider as part of your one-time “Welcome to Medicare” preventive visit.

If your doctor or other qualified medical care provider performs additional tests or services during the same visit that aren’t covered under this preventive benefit, you may have to pay your 10% coinsurance and annual deductible.
Laboratory services
Laboratory services are tests of body fluid or tissue that help your doctor diagnose a disease or an injury.

Medicare-approved clinical labs

<table>
<thead>
<tr>
<th>What you pay</th>
<th>In-network and Out-of-network</th>
<th>Nothing</th>
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</table>

Refer to the Exclusions and Limitations section of this booklet for additional information.

Covered services include:

- Pap test for routine cancer screening once every calendar year (more frequent tests are covered if requested by your physician because of a suspected or actual presence of disease)
- Prostate Specific Antigen (PSA) test for routine cancer screening once every calendar year (more frequent tests are covered if requested by your physician because of a suspected or actual presence of disease)
- Blood tests
- Urine tests

Pathology services

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<tr>
<th>What you pay</th>
<th>In-network and Out-of-network</th>
<th>10% coinsurance and the annual deductible</th>
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Refer to the Exclusions and Limitations section of this booklet for additional information.

Pathology services involve the laboratory examination of tissue performed by a physician.

Other diagnostic services

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<tr>
<th>What you pay</th>
<th>In-network and Out-of-network</th>
<th>10% coinsurance and the annual deductible</th>
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</table>

Refer to the Exclusions and Limitations section of this booklet for additional information.

When medically necessary and performed in an approved location, the medical plan covers diagnostic services, including:

- X-rays, CAT scans, MRIs, PET scans and other radiology services
- EEGs, EKGs, ECGs and EMGs
- Mammograms if requested by the physician because of a suspected or actual presence of disease or when required as a post-operative procedure
- Nerve conduction studies
- Ultrasounds
The medical plan requires that network providers preauthorize specific high technology diagnostic radiology services. Your provider will arrange for this authorization. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. Preauthorization does not apply to emergency care.

**Outpatient mental health treatment**

The medical plan covers mental health care services to help with conditions like depression or anxiety. Coverage includes services generally provided in an outpatient setting (like a doctor’s or other medical care provider’s office or hospital outpatient department), including visits with a psychiatrist or other doctor, clinical psychologist, licensed master social worker, nurse practitioner, physician assistant, or clinical nurse specialist. Laboratory tests are also covered. Certain limits and conditions apply.

**Services in an outpatient mental health facility**

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<th>What you pay</th>
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<td><strong>In-network and Out-of-network</strong></td>
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<td>10% coinsurance and the annual deductible</td>
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Refer to the Exclusions and Limitations section of this booklet for additional information.

Mental health treatment in an outpatient mental health facility that participates with Medicare includes:

- All services of professional and other trained staff, and related services necessary for your care
- Prescribed drugs and medications related to your treatment administered in the facility
- Electroshock therapy and anesthesia administered by a physician
- Psychological testing once every 12 months when administered by a fully licensed psychologist employed by or having privileges at the facility
- Counseling for your family members

**Services in a physician’s office**

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<td><strong>In-network and Out-of-network</strong></td>
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<tr>
<td>10% coinsurance and the annual deductible</td>
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Refer to the Exclusions and Limitations section of this booklet for additional information.

Mental health treatment is also payable for services rendered in a physician’s office, including counseling for you and your family members, and psychological testing prescribed, rendered and billed by a fully licensed psychologist once every 12 months.
Substance abuse treatment

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<th>What you pay</th>
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<tr>
<td><strong>In-network and Out-of-network</strong></td>
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<tr>
<td>10% coinsurance and the annual deductible, except for clinical lab services.</td>
</tr>
<tr>
<td>Clinical lab services are covered at no cost to you.</td>
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</tbody>
</table>

Refer to the Exclusions and Limitations section of this booklet for additional information.

Treatment for substance abuse is payable for services rendered in a residential or outpatient substance abuse treatment facility. A residential substance abuse treatment facility may be a freestanding facility exclusively treating substance abuse, or a hospital-based treatment center. Services include:

- Services of professional and trained staff, and services necessary for your care and treatment, including diagnostic tests
- Individual and group therapy or counseling
- Psychological testing once every 12 months
- Laboratory examinations related to your treatment in the program
- Drugs, biologicals and solutions related to your treatment in the program
- Supplies and use of equipment required for detoxification or rehabilitation
- Counseling for your family members

If you are admitted to a residential substance abuse treatment program, the medical plan also covers bed, board and general nursing care during your admission, in addition to the services listed above. Inpatient care for up to five days of detoxification is payable under the inpatient hospital benefit.

Nursing care

Private duty nursing

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<td><strong>In-network and Out-of-network</strong></td>
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<td>10% coinsurance and the annual deductible</td>
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Refer to the Exclusions and Limitations section of this booklet for additional information.

When your condition requires continuous skilled care by a professional nurse on a one-to-one basis, the medical plan will pay for services prescribed and arranged by a physician and rendered by a registered nurse (RN), a licensed practical nurse (LPN) or a licensed vocational nurse (LVN). The benefit is payable only if you meet clinical criteria, as determined by BCBSM, establishing your need for private nursing care. Payment for private duty nursing services is generally made directly to you.

Private duty nursing requires more skilled care than can be provided by a skilled nursing visit as described in the Home Health Care benefit. Private duty nursing does not cover services provided by, or within the scope of practice of, medical assistants, nurse’s aides, home health aides or other non-nurse level caregivers.

Private duty nursing tasks are required so frequently that the need for care is continuous whether delivered by a skilled professional or a trained family member. The benefit is not intended to supplement the care-giving responsibility of the family, guardian or other responsible parties. The services are temporary, with the goal of training caregivers to provide the necessary services as competently, independently and completely as possible.
8 hours per day of skilled care must be required to meet your needs. Generally, more than 16 hours per day will not be approved. However, up to 16 hours per day may be approved up to 30 days while you are being transitioned from an inpatient setting to your home.

Your attending physician must certify every three months that you require continuous private duty nursing to restore or maintain your maximal level of function and health. Examples of continuous skilled care include:

- Respirator or ventilator care
- 24-hour intravenous (in the vein) or intramuscular (in the muscle) medications
- Nasopharyngeal and tracheotomy aspiration (removal of fluid or gases by suction from the nose/throat and the windpipe)

The private duty nursing benefit does not cover:

- Preparing and serving food or feeding you
- Forcing liquids, or measuring your intake and output
- Your personal or oral hygiene, including bathing or changing linen and clothing, laundry and housekeeping
- Helping you walk or get in and out of bed or a wheelchair
- Giving you oral or topical medications
- Routine checking of your vital signs
- Giving insulin injections or checking your blood sugar
- Inpatient private duty nursing services requested by you and your family, and care provided by a hospital employee
- Respite care
- Care provided by a nurse who ordinarily resides in your home or is a member of your immediate family
- Care that is non-medical in nature
- Care that can be provided by a non-skilled professional — even though it may be performed by a RN, LPN or LVN
- Travel expenses

*Not all nursing care is covered*

Although your doctor may prescribe private duty nursing, the fact that your doctor prescribes such care does not guarantee payment. How do you know when nursing care will be covered? Call a Blue Cross customer service representative at 1-800-422-9146 before care begins.

**Skilled nursing facility care**

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<td>In-network and Out-of-network</td>
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<td>10% coinsurance and the annual deductible</td>
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Refer to the Exclusions and Limitations section of this booklet for additional information.
The medical plan will cover 100 days of medically-necessary care in a Blue Cross-approved skilled nursing facility. After you've been discharged from the skilled nursing facility for at least 60 consecutive days, you become eligible for another 100 days of care. To qualify for care in a skilled nursing facility, your doctor must certify that you need daily skilled care, like intravenous injections or physical therapy.

Your skilled nursing benefits include:

- Semiprivate room and board (or a private room if medically necessary)
- Meals, including special diets
- General and skilled nursing care
- Physician/practitioner services
- Physical and occupational therapy, and speech therapy
- Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors)
- Blood, including storage and administration
- Medical and surgical supplies ordinarily provided by the facility
- Laboratory tests ordinarily provided by the facility
- X-rays and other radiology services ordinarily provided by the facility
- Use of appliances, such as wheelchairs, ordinarily provided by the facility

The medical plan does **not** cover custodial or domiciliary care, or care for intellectual disability or senile deterioration.

Skilled nursing facility care rendered by plan providers will require prior authorization.

**Home health agency care**

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<td><strong>In-network and Out-of-network</strong></td>
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<td>Nothing</td>
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<tr>
<td>Refer to the Medical equipment and supplies section for information on medical equipment</td>
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*Refer to the Exclusions and Limitations section of this booklet for additional information.*

Medically necessary home health care is covered for patients confined to home. Your physician must prescribe the care and prepare a treatment plan.

Confined to home means both of these are true:

- You have trouble leaving your home without help (like using a cane, wheelchair, walker, or crutches; special transportation; or help from another person) because of an illness or injury
- Leaving your home isn’t recommended because of your condition, and you’re normally unable to leave your home because it’s a major effort

A doctor, or certain qualified medical care professionals who work with a doctor, must see you face-to-face before a doctor can certify that you need home health services.

At each visit, the medical plan will cover:

- Part-time or intermittent skilled nursing care by an employee of the home health care agency
- Part-time or intermittent home health aide services such as meal preparation, bathing and feeding
- Nutritional guidance and medical social services
• Medical and surgical supplies such as catheters and colostomy supplies, oxygen, laboratory services and medications for use at home (refer to the medical equipment and supplies section for information on your costs)

• Physical, occupational and speech therapy (may be covered outside the home when equipment cannot be brought into the home). These services are covered only when the services are specific, safe and an effective treatment for your condition. The amount, frequency and time period of the services needs to be reasonable, and they need to be complex or only qualified therapists can do them safely and effectively. To be eligible your condition must be expected to improve in a reasonable and generally-predictable period of time.

Note: To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than eight hours per day and 35 hours per week.

**Hospice care**

Your Hospice services are paid for by Original Medicare, not Medicare Plus Blue SM Group PPO. You must use your red, white, and blue Medicare membership card to get hospice services.

You pay nothing for hospice care.

You can get a one-time only hospice consultation with a hospice medical director or hospice doctor to discuss your care options, pain, and management of your symptoms. You can get this one-time consultation even if you decide not to get hospice care.

To qualify for hospice care, a hospice doctor and your doctor (if you have one) must certify that you’re terminally ill, meaning you have a life expectancy of 6 months or less. If you’re already getting hospice care, a hospice doctor or nurse practitioner will need to see you about 6 months after your hospice care started to certify that you’re still terminally ill. Coverage includes:

• All items and services needed for pain relief and symptom management
• Medical, nursing, and social services
• Certain durable medical equipment
• Aide and homemaker services
• Other covered services, as well as services Medicare usually doesn’t cover, like spiritual and grief counseling
• Inpatient respite care in a Medicare-approved facility so that your usual caregiver can rest (you can stay up to 5 days each time you get respite care)

A Medicare-approved hospice usually gives hospice care in your home or other facility where you live, like a nursing home.

Hospice care doesn’t pay for your stay in a facility (room and board) unless the hospice medical team determines that you need short-term inpatient stays for pain and symptom management that can’t be addressed at home. These stays must be in a Medicare-approved facility, like a hospice facility, hospital, or skilled nursing facility that contracts with the hospice.

You can continue to get hospice care as long as the hospice medical director or hospice doctor re-certifies that you’re terminally ill.

Call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week, or visit the Medicare website at [www.medicare.gov](http://www.medicare.gov), if you have questions or want more information about your Original Medicare hospice benefit. TTY users call 1-877-486-2048.

**Services that are not related to your terminal illness are still covered by the Medicare Plus Blue SM Group PPO plan.** If you need care that is not related to your terminal condition, contact a Blue Cross representative at 1-800-422-9146.
Medical equipment, prosthetics, orthotics and supplies

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<th>What you pay</th>
<th>In-network</th>
<th>Out-of-network</th>
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<tr>
<td></td>
<td>10% coinsurance and the annual deductible, unless otherwise noted</td>
<td>30% of the Medicare Plus BlueSM Group PPO – approved amount, and the annual deductible, unless otherwise noted</td>
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</table>

Refer to the Exclusions and Limitations section of this booklet for additional information.

Refer to the chapter in this booklet about hospital benefits for information about obtaining items from that location. This section does not apply to items you use during a hospital stay.

The plan covers medically necessary items that you purchase or rent from an independent medical supplier for use at home. You must have a prescription or Certificate of Medical Necessity from a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) to obtain Durable Medical Equipment (DME).

If you need medical supplies the quantity you receive will be based on your prescription and the medical necessity guidelines used by Medicare Plus BlueSM Group PPO.

Types of equipment, supplies and services include:

- Hospital beds, wheelchairs, walkers, canes and crutches
- Respiratory equipment such as oxygen concentrators, apnea monitors and nebulizers
- Home dialysis equipment and supplies
- Prosthetic devices such as artificial limbs and mastectomy supplies
- Orthotic devices such as leg braces, back braces and ankle or wrist supports
- Medical supplies such as surgical dressings, adult disposable diapers, surgical stockings (up to eight per year or 4 pair) and IV infusion pumps
- Equipment setup and training when medically necessary, such as assistance by an RN or respiratory therapist.

**Diabetic supplies and medications**

Some diabetic supplies are covered under your medical plan while others are covered under your prescription drug benefit plan.

The medical plan covers diabetic supplies blood sugar testing monitors, blood sugar test strips, lancet devices and lancets, blood sugar control solutions and (in some cases) therapeutic shoes. These items are covered at no cost to you when you use in-network and out-of-network providers.

People who have diabetes and severe diabetic foot disease have coverage for the furnishing and fitting of either one pair of custom-molded shoes or inserts or one pair of extra-depth shoes each calendar year, prescribed by a podiatrist or other qualified doctor and provided by a podiatrist, orthotist, prosthetist, pedorthist or other qualified individual. The medical plan covers 2 additional pairs of inserts each calendar year for custom-molded shoes and 3 pairs of inserts each calendar year for extra-depth shoes. The medical plan will cover shoe modifications instead of inserts.

Injectable insulin and needles and syringes for injectable insulin are covered under your Prescription Drug Plan when prescribed by your physician.
Transplants

What you pay

<table>
<thead>
<tr>
<th>In-network and Out-of-network Designated as Medicare-approved facility</th>
<th>Not Designated as Medicare-approved facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>10% coinsurance and the annual deductible, unless otherwise noted</td>
<td>You pay all costs</td>
</tr>
<tr>
<td>Clinical lab services are not subject to cost-share</td>
<td></td>
</tr>
<tr>
<td>Approved travel and lodging expenses for heart, heart-lung, lung, liver, pancreas and intestine transplants are not subject to cost-share</td>
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</table>

Refer to the Exclusions and Limitations section of this booklet for additional information.

The medical plan will pay for organ and tissue transplants, and for bone marrow and stem cell transplants, approved by Medicare Plus BlueSM Group PPO and performed at an approved, designated transplant facility.

Transplant coverage includes:

- hospital and medical expenses
- transplant-related services, such as tests, labs, and exams before surgery
- services needed to treat a condition arising out of the organ transplant surgery
- immunosuppressive drugs (under certain conditions)
- travel and lodging (under certain conditions)
- evaluation and surgical removal of the donated part from a living or nonliving donor and surgically transplanting the part to you
- procurement of organs
- follow up care

Organ and tissue transplants

Covered services include the evaluation and surgical removal of the donated part (skin, corneas, kidneys, heart, heart-lung, lung, liver, pancreas and intestine) from a living or nonliving donor and surgically transplanting the part to you.

Bone marrow and stem cell transplants

Bone marrow transplants involve replacing the bone marrow of a patient with bone marrow of another person (called allogeneic transplants) or using the patient’s own bone marrow or peripheral blood stem cells (called autologous transplants) for transplantation back into the patient. This procedure is used to treat certain types of cancer.

Bone marrow transplants are payable only for approved diagnoses. Because this list frequently changes, your physician may wish to obtain preauthorization from Blue Cross Blue Shield of Michigan prior to your surgery to ensure your diagnosis is covered under the bone marrow transplant benefit and will be performed in an approved facility.

Additional covered services for autologous and allogeneic bone marrow and/or peripheral stem cell transplants include:

- Blood tests on first-degree relatives to evaluate them as donors (if these services are not already covered by their medical insurance)
- A search of a bone marrow donor registry for a donor (A search will begin only when the need for a donor is established. The registry’s name and charges must be submitted for approval to Blue Cross Blue Shield of Michigan by the bone marrow transplant center)
• Infusion of colony-stimulating growth factors
• Harvesting of bone marrow and/or stem cells and associated storage costs if transplant is intended within one year
• ECP (Extracorporeal Photopheresis for Graft vs. Host Disease) for treatment of transplanted cells/tissues that attack and destroy the tissues/organs of the transplant recipient
• Hospitalization in an intensive care or special care unit
• Infusion of bone marrow and/or stem cells into the patient
• Services received when you donate bone marrow and/or peripheral blood stem cells

**Immunosuppressive drugs**

Immunosuppressive and other transplant-related prescription drugs covered under your prescription drug plan are not covered under *Medicare Plus BlueSM Group PPO*.

*Medicare Plus BlueSM Group PPO* covers a limited number of outpatient prescription drugs. Prescription drugs not covered under *Medicare Plus BlueSM Group PPO* may be covered under your prescription drug plan.

If you’re entitled to Medicare only because of permanent kidney failure, your Medicare coverage will end 36 months after the month of your transplant. *Medicare Plus BlueSM Group PPO* will not pay for any services or items, including immunosuppressive drugs, for patients who are not entitled to Medicare.

If you’re entitled to Medicare for reasons other than permanent kidney failure, you have coverage for reasonable and necessary immunosuppressive drugs with no time limit and no benefit dollar maximum if your transplant occurred after your enrollment in Medicare.

If you received a heart, heart-lung, liver, lung, pancreas or intestine transplant before your enrollment in Medicare, you have coverage for immunosuppressive and other transplant-related prescription drugs up to a maximum of $10,000 per year. Refer to the Transplant section in this benefit booklet for more information.

**Travel and lodging**

You have coverage for travel and lodging to and from the designated transplant facility if it is farther away than the normal community patterns of care and you choose to have the transplant at this distant location.

Coverage for travel and lodging expenses is very limited for most transplants. However, if you have a heart, heart-lung, liver, lung, pancreas and/or intestine transplant, you have coverage for reasonable and necessary travel and lodging up to a $10,000 maximum for you and one companion (two companions if you’re under age 18 or the transplant involves a living donor related to you).

**Clinical research study services**

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. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of the Medicare Plus BlueSM Group PPO plan. Medicare first needs to approve the research study. **If you participate in a study that Medicare has not approved, you will be responsible for paying all costs for your participation in the study.**

If you are approved by Original Medicare to participate in a study, you must use your red, white, and blue Medicare membership card to get services paid by Original Medicare. You do not need approval from BCBSM to participate in a clinical research study. However, **before you start, you do need to tell BCBSM you are participating in a study.** BCBSM will:

1. Let you know whether the clinical research study is Medicare-approved.
2. Tell you what services you will get from clinical research study providers instead of from your Medicare Plus BlueSM Group PPO plan.
The providers that deliver your care as part of the clinical research study do not need to be part of the Medicare Plus Blue℠ Group PPO network.

Original Medicare covers most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost, BCBSM will pay the difference between Original Medicare’s cost-sharing and the cost-sharing under your Medicare Plus Blue℠ Group PPO plan. You will need to submit a request for payment and send BCBSM a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the study and how much you owe.

Call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week, or visit the Medicare website at www.medicare.gov, if you have questions or want more information about your Original Medicare benefit for clinical research studies. TTY users call 1-877-486-2048. Calls are free.

### Religious non-medical health care institution

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<th>What you pay</th>
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<td>Institution certified by Medicare</td>
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<td>10% coinsurance and the annual deductible</td>
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In these facilities, religious beliefs prohibit conventional and unconventional medical care. If you qualify for hospital or skilled nursing facility care, the medical plan will only cover the inpatient, non-religious, non-medical items and services. An example is room and board, or any items and services that don’t require a doctor’s order or prescription, like unmedicated wound dressings or use of a simple walker.

### Hearing care

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<th>What you pay</th>
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<tr>
<td>Blue Cross approved provider</td>
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<td>10% coinsurance and the annual deductible</td>
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Your hearing benefits include the following services:

- **Audiometric examination** — Measures hearing ability, including tests for air and bone conduction, speech reception and speech discrimination.

- **Hearing aid evaluation test** — Determines what type of hearing aid should be prescribed to compensate for loss of hearing.

- **Hearing aid** — Includes standard monaural (one ear) and binaural (involving both ears) in-the-ear, behind-the-ear and basic hearing aids worn on the body – with ear molds, if necessary. Not all models of hearing aids are covered under your hearing benefits.

- **Conformity test** — Evaluates the performance of a hearing aid and its conformity to the original prescription after it is fitted.
**Frequency limitation**
Covered hearing program benefits are payable once every 36 consecutive months.

**Note:** Binaural hearing aids, or two hearing aids to correct hearing loss in both ears, are covered only when they’re purchased on the same date. Two hearing aids provided to you on different dates are not considered binaural hearing aids and only one will be paid during a 36-month period.

**Payment provisions**

1. Hearing program services are payable only when all of the following provisions are met: You receive all hearing services from a participating provider. In Michigan, this means the provider participates with Blue Cross Blue Shield of Michigan. Outside Michigan, the provider must participate with either the Blue Cross Blue Shield plan in that state or any other medical insurer or carrier. **Hearing services and supplies provided by a nonparticipating provider are not payable.**

2. Before any hearing benefits will be approved, you must receive a medical examination of the ear, sometimes called a medical clearance exam. This only applies the first time you purchase hearing aids. The exam must be performed by a participating board-certified or board-eligible otologist, otolaryngologist or otorhinolaryngologist. The medical examination of the ear is covered under the medical plan benefit for doctor visits and is subject to the medical plan coinsurance and deductible.

3. If a hearing aid is prescribed, you must receive an audiometric exam and a hearing aid evaluation test. This can be performed by an audiologist or approved hearing aid dealer. You must obtain your hearing aid and undergo a conformity test within six (6) months of your medical examination of the ear.

**Exclusions and limitations**

The following exclusions and limitations apply to your medical plan benefits. These conditions are in addition to other applicable exclusions and limitations listed elsewhere in this booklet.

- Services provided before the effective date of coverage or after the coverage termination date
- Any charges for care, treatment, service or supplies to the extent such charges exceed Blue Cross Blue Shield’s determination of the amount of reasonable charges
- Services and supplies considered not reasonable and necessary, according to the standards of Original Medicare, for the diagnosis or treatment of the illness or injury, unless these services are listed as covered elsewhere in this benefit booklet
- Routine health screenings and preventive services except as otherwise specified in this booklet.
- Services for premarital and pre-employment examinations
- Medical nutrition therapy services, except as described elsewhere in this booklet
- Vaccinations not listed as covered elsewhere in this booklet, including shingles shot
- Services for cosmetic or beautifying purposes unless required for the correction of a defect incurred through an injury or for the correction of a congenital anomaly or breast reconstruction
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary
- Voluntary sterilization, reversal of sterilization, sex change operations, contraceptive supplies
• Surgical treatment for morbid obesity, except when it is considered medically necessary and covered by Original Medicare

• Services for detoxification for drug addiction or alcoholism except for treatment of the underlying causes and for services leading to rehabilitation

• Mental health services extending beyond the period necessary for evaluation and diagnosis for intellectual disability

• Services and supplies not medically necessary. For a definition of medical necessity, refer to the Glossary of Medical Care Terms

• Private room in a hospital, except when it is considered medically necessary

• Custodial or domiciliary care

• Rest therapy and care in nursing or rest home facilities

• Care for intellectual disability or senile deterioration

• Personal care items

• Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television

• Hospital admissions principally for observation or diagnostic evaluation, physical therapy, X-ray or laboratory tests, weight reduction (with or without medication), basal metabolism tests, electrocardiography, ultrasound studies or nuclear medicine studies

• Treatment for conditions that do not require substantially continuous bed care under the constant care of licensed physicians and registered nurses

• Hospital care for dental services except for services rendered when you are a hospital bed patient for either multiple extractions or the removal of unerupted teeth, performed under a general anesthesia when a concurrent hazardous medical condition exists

• Treatment of temporomandibular joint (TMJ) syndrome and related jaw-joint problems by any method other than direct surgery on the jaw joint, X-rays or arthrocenteses (injections)

• Routine dental care, such as cleanings, fillings or dentures

• Chiropractic care, other than manual manipulation of the spine and spinal x-rays

• Routine foot care, except for the limited coverage according to Original Medicare guidelines

• Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a person with diabetic foot disease

• Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease

• Items such as air purifiers, air conditioners and exercise equipment

• Adjustment or replacement of eligible appliances unless required because of wear or a change in your condition

• Eyeglasses, routine eye examinations, radial keratotomy, LASIK surgery, vision therapy and other low vision aids, except for corrective lenses covered following cataract surgery as described elsewhere in this booklet

• Prescription drugs except as otherwise specified in this booklet

• Separate charges for infiltration of a local anesthetic during a surgical procedure

• Physical, occupational and speech language pathology (speech therapy) to treat long-standing, chronic conditions
• Massage therapy
• Physical therapy solely for pain management
• Tests to measure physical capacities, such as strength, dexterity, coordination or stamina unless part of a complete physical therapy treatment program
• Recreational services
• Services and items primarily for your comfort and convenience
• Cost of transportation and travel, except for ambulance service and specified organ transplant benefits specified in this booklet
• Ambulance transportation not medically necessary
• Transportation in a vehicle not state-certified as an ambulance
• Services rendered by fire departments, rescue squads or other carriers whose fee is paid as a voluntary donation
• Cadaver transport
• Transportation in connection with outpatient care for a non-accidental illness
• Transportation for your and your family’s convenience or doctor and hospital preference
• Homemaker services and household assistance, including light housekeeping or light meal preparation
• Fees charged by your immediate relatives or members of your household
• Meals delivered to your home
• Charges for the completion of claim forms
• Charges for missed appointments
• Services, care, supplies or devices considered experimental or investigative, except the difference in Original Medicare’s cost-sharing and the cost-sharing in this Medicare Plus Blue℠ Group PPO plan for clinical research studies covered by Original Medicare. For a definition of experimental/investigative, refer to the Glossary of Medical Care Terms
• Acupuncture
• Naturopath services (use of natural or alternative treatments)
• Treatment of an illness or injury caused by military action or war, declared or undeclared
• Care and services you receive at no cost to you when provided in a veteran’s, marine or other federal hospital or any hospital maintained by any state or governmental agency, unless required by law
• Services provided to veterans in Veterans Affairs (VA) facilities except for the difference in cost-share if emergency services are received and the VA cost-share is more than the cost-share under this medical plan
• Care and services payable by another government-sponsored health care program, such as TRICARE, for which a member is eligible. These services are not payable even if you have not signed up to receive the benefits provided by such programs
• Cost of care and services covered by another insurance plan that has primary responsibility for first payment
• Injury or sickness covered by Workers Compensation
• Care of an occupational injury or disease for which the employer is obligated to provide reimbursement for services
• Cost of installation of water, electrical or waste systems in a residence where such systems are not present
• Cost of water or electricity used in the operation of a dialysis machine
• Expenses incurred in the installation of a dialysis machine which are not essential to its operation
• Installation cost incurred in moving a dialysis machine to another location within the patient’s residence
• An examination performed by an audiologist or hearing aid dealer but not prescribed by an otologist or otolaryngologist
• A hearing aid ordered while you are a member, but delivered more than 60 days after your coverage terminates
• Replacement of lost or broken hearing aids within the frequency limitation
• Repairs of hearing aids or replacement parts for hearing aids
• A hearing aid that does not meet Food and Drug Administration and Federal Trade Commission requirements
• The cost difference between digital-controlled programmable hearing devices and analog hearing devices
• The cost difference between an eyeglass-type hearing aid and a behind-the-ear hearing aid
• All hearing program services and supplies provided by a nonparticipating provider

**Subrogation**

In certain cases, another person, insurance company or organization may be legally obligated to pay for medical services that Blue Cross has paid. Subrogation is the legal process by which Blue Cross recovers these payments. If you are awarded compensation for medical services already paid by Blue Cross:

• Your right to recover payment from the other person, insurance company or organization is automatically transferred to Blue Cross.
• You’re required to fully cooperate with Blue Cross to help enforce its right to recovery.
• If you receive money through a lawsuit, settlement or other means for services paid under your medical coverage, you must reimburse Blue Cross.

**Filing claims**

Providers that participate with Medicare (in-network and out-of-network) must bill Blue Cross Blue Shield for covered services.

Providers that do not participate with Medicare, but choose to accept assignment for individual services, are supposed to submit a claim for any Medicare-covered services they provide to you. They can’t charge you for submitting a claim. Ask your provider to bill Blue Cross Blue Shield for covered services. If they don’t submit the claim once you ask them to, you can call 1-800-422-9146 to discuss whether you can submit your own claim.

If you receive services from a provider that does not participate with Medicare, and the provider will not file your claim, unless otherwise noted, you must file your claim to Blue Cross within 12 months of the date of service. Remember: payment from Blue Cross Blue Shield of Michigan is made to you; it’s your responsibility to pay the provider.
How to file a claim

1. Ask for an itemized statement of services at the time of service. Your itemized receipt must contain the following:
   - Name, address and telephone number of the provider (physician, hospital, etc.)
   - Provider’s identification number (outside Michigan, you need the tax ID)
   - Your nine-digit identification number from your Blue Cross membership card
   - Patient’s full name and date of birth
   - Exact date (month, day, year) the service was performed or supplied
   - Diagnosis
   - Type of service performed or item supplied
   - Amount charged for each service performed or item supplied
   - For services received from a physician in a clinic, make sure the name and license number of the physician who provided the service is indicated on the receipt plus the name of the clinic.
   - For ambulance services, ask for an itemization of the provider’s base rate, total miles traveled, location of patient pickup and delivery, and reason for ambulance service. Include the names of hospitals if you are moved from one hospital to another; the accident scene or home address if you are moved to, or from a hospital.
   - For private duty nursing, ask for an itemized statement that includes the name and contract number of retiree (cardholder), the patient’s name, the location of service (such as your home), exact number of hours the nurse worked, doctor’s statement of medical necessity, including diagnosis and care requirements, nurse’s name, degree and license (registration) number and copy of photo ID, the nurse’s duties and hour-by-hour nursing notes.

2. File your claims immediately after receiving covered services. It’s easier to obtain information needed to process your claim when dates of service are recent.

3. Use one Medicare Advantage Member Application for Payment Consideration claim form per member on your contract. You can use one claim form for multiple services for the same patient.
   - You can download a copy of the form from www.bcbsm.com/medicare/help/forms-documents.html or call 1-800-422-9146 and ask for one to be mailed to you. You don’t have to use the form, but it will help Blue Cross process the claim faster.

4. Review claim forms to ensure the information is accurate and complete and be sure to sign the form.

5. Make copies of all statements and forms for your files before sending the originals.

6. Mail your request for payment together with any bills or receipts to Blue Cross Blue Shield of Michigan at this address:

   **Medicare Plus Blue℠ Group PPO Claims Department**
   Blue Cross Blue Shield of Michigan
   Imaging and Support Services
   PO Box 32593
   Detroit, MI 48232-0593

If Blue Cross decides that the medical care is covered and you have followed all the rules for getting the care, Blue Cross will pay its share of the cost. If you have already paid for the service, reimbursement of Blue Cross’ share of the cost will be mailed to you. If you have not paid for the service yet, payment will be mailed to the provider.
If Blue Cross decides that the medical care is not covered, or you did not follow all the rules, Blue Cross will not pay for the care and you will be sent a letter explaining the reason(s) it was not paid and your rights to appeal the decision.

_Why you should always file claims as soon as possible_
You have 12 months from the date of service to file your claims, but why wait? If Blue Cross has questions about the claim, your memory – and certainly your provider’s– won’t be as clear on the details of the diagnosis and services rendered. But most important, if you’ve paid for services, why not get your reimbursement now…instead of a year from now?

**Explanation of Benefit Payments**

Once your claim is processed, Blue Cross Blue Shield of Michigan will send you an Explanation of Benefit Payments statement. This statement is not a bill. It is provided to help you understand how your benefits were paid and shows:

- Date of service
- Name of the hospital, physician or other medical care professional that provided each service.
- Amount billed by your provider
- Blue Cross Blue Shield-approved amount for each service
- Any amount you may owe your provider for coinsurance, copays, deductibles and non-covered services
- Any amount applied toward your annual deductible and out-of-pocket maximum
- An explanation when payment is denied

The Report is also provided to make sure the information received was correct. Therefore, it’s important that you carefully review your EOB of Medical and Hospital Claims to make sure that payments agree with services you actually received and that names and dates agree with your records. If you do find an error, immediately tell your provider and request a corrected statement. If you have questions about your Report, call Blue Cross Blue Shield customer service at **1-800-422-9146**.

_Keep a copy for your records_
When you submit claims, always make a photocopy of the claim form, receipts and any other supporting documentation that you send to Blue Cross. That way, you’ll have a reference in case you have to call us with a question, as well as a permanent record for your files.

**How to reach**

Blue Cross Blue Shield of Michigan

For assistance with benefit questions, claims or billing, please call or write to Medicare Plus Blue℠ Group PPO Customer Service. When calling or visiting, please be prepared to provide your nine digit identification number from your Blue Cross Medicare Plus Blue℠Group PPO membership card.
Blue Cross Blue Shield of Michigan Customer Service Contact Information

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<tr>
<th>Call</th>
<th>1-800-422-9146</th>
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<tr>
<td></td>
<td>Monday through Friday, 8:30 a.m. to 5:00 p.m., Eastern Standard Time</td>
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<td>Toll free from the United States or Canada</td>
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<td>Call 1-313-225-9000 outside the United States or Canada and ask to be transferred to the customer area that services Michigan public school retirees.</td>
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<td>Customer Service also has free language interpreter services available for non-English speakers</td>
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<td>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking</td>
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<th>Fax</th>
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Visit a Walk-in Center

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<th>Visit a Walk-in Center</th>
<th>Visit <a href="http://www.bcbsm.com">www.bcbsm.com</a> for locations and business hours</th>
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<tr>
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<td>Service centers are open weekdays.</td>
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<td>Some offices close for lunch</td>
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<th>Write</th>
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<tr>
<td></td>
<td>Medicare Plus Blue℠ Group PPO for Michigan Public School Retirees</td>
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<tr>
<td></td>
<td>Customer Service Inquiry Department – Mail Code X521</td>
</tr>
<tr>
<td></td>
<td>600 Lafayette East</td>
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<td></td>
<td>Detroit, MI 48226-2998</td>
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Website

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Contact information for Coverage Decisions, Appeals or Complaints

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<tr>
<th>Call</th>
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Fax

| Fax   | 1-877-348-2251 — all appeals and complaints |

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<tr>
<td></td>
<td>Grievance and Appeals Department</td>
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<td></td>
<td>PO Box 2627</td>
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<td>Detroit, MI 48231-2627</td>
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Coverage decisions, appeals and complaints

What to do if you have a problem or concern

For some types of problems you need to use the process for coverage decisions and appeals. For other types of problems you need to use the process for making complaints.

- A coverage decision is a decision made by Blue Cross Blue Shield of Michigan about your benefits and coverage or about the amount paid for your medical services. You or your doctor can contact Blue Cross and ask for a coverage decision if you are unsure whether a particular medical service is covered. If you disagree with Blue Cross’ coverage decision, you can make an appeal.

- An appeal is a formal way of asking Blue Cross Blue Shield of Michigan to review and change a coverage decision. When you make an appeal, Blue Cross will review the coverage decision to check to see if all rules were properly followed. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When Blue Cross has completed the review, you will be given the decision. If Blue Cross says no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to Blue Cross Blue Shield of Michigan. If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

- You can make a complaint about Blue Cross Blue Shield of Michigan or a network provider, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes.

How to ask for a coverage decision

Call, fax or write Blue Cross asking for a coverage decision on the medical care you are requesting. Blue Cross will give you an answer within 14 days after your request is received. However, Blue Cross can take up to 14 more calendar days if you ask for more time to gather additional information needed by Blue Cross or if Blue Cross needs more information that may benefit you, such as medical records. You’ll be told in writing if Blue Cross needs extra days to make a decision. If you believe Blue Cross should not take extra days, you can file a “fast complaint” about the decision to take extra days and Blue Cross will respond to your complaint within 24 hours. If you do not receive an answer within 14 days (or if there was an extended time period, by the end of that period), you have the right to an appeal.

- **If the answer is Yes** to part or all of what you requested, Blue Cross will authorize medical care coverage within 14 days after your request was received (or if there was an extended time period, by the end of that time period).

- **If the answer is No** to part or all of what you requested, Blue Cross will send you a written explanation as to why the answer was no. You have the right to ask Blue Cross to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want. If you decide to make an appeal, it means you are going on to Level 1 of the appeals process.
If your health requires a quick response, you can ask Blue Cross to make a “fast coverage decision” and Blue Cross will give you an answer within 72 hours after your request is received. However, Blue Cross can take up to 14 more calendar days if you ask for more time to gather additional information needed by Blue Cross or if Blue Cross needs more information that may benefit you, such as medical records. You’ll be told in writing if Blue Cross needs extra days to make a decision. If you believe Blue Cross should not take extra days, you can file a “fast complaint” about the decision to take extra days and Blue Cross will respond to your complain within 24 hours. Blue Cross will call you as soon as a decision has been made. If you do not receive an answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to an appeal.

- If the answer is Yes to part or all of what you requested, Blue Cross will authorize medical care coverage within 72 hours after your request was received (or if there was an extended time period, by the end of that time period).

- If the answer is No to part or all of what you requested, Blue Cross will send you a written explanation as to why the answer was no. You have the right to ask Blue Cross to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want. If you decide to make an appeal, it means you are going on to Level 1 of the appeals process.

To get a “fast coverage decision” you must meet two requirements:

1. You are only asking for coverage for medical care you have not yet received
2. Using the 14 day standard deadline for coverage decisions could cause serious harm to your health or hurt your ability to function
   - If your doctor tells Blue Cross that your health requires a “fast coverage decision,” Blue Cross will automatically agree to provide a fast coverage decision.
   - If you ask for a “fast coverage decision” on your own, Blue Cross will decide whether your health requires that you be given a fast coverage decision. If Blue Cross decides your medical condition does not meet the requirements for a fast coverage decision, you will be sent a letter that says so and the 14 day standard deadline will be used.

How to ask for a Level 1 Appeal

If you don’t agree with a coverage decision made by Blue Cross, you must make your appeal request within 60 calendar days from the date on the written notice Blue Cross sent you to tell you the answer to your request for a coverage decision. (Refer to “How to ask for a coverage decision” in this section for more information.) If you miss the deadline and have a good reason for missing it, Blue Cross may give you more time to make your appeal.

You can ask for a copy of the information regarding the medical decision and add more information to support your appeal. You have the right to ask Blue Cross for a copy of the information regarding your appeal. If you wish, you and your doctor may give Blue Cross additional information to support your appeal.

To begin the process, you, your doctor or your representative submit a written appeal. If you have someone appealing Blue Cross’ decision other than your doctor, your appeal must include an “Appointment of Representative” form authorizing this person to represent you. To get the form, call customer service at 1-800-422-9146 or download the form from [www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf](http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf). While Blue Cross can accept your appeal request without the form, the appeal cannot be completed until the form is provided. If the form is not received within 44 days after receiving your appeal request, your appeal request will be dismissed. If this happens, Blue Cross will send you a written notice explaining your right to ask the Independent Review Organization to review the decision.

Blue Cross will consider your appeal, take another careful look at all the information about your request for coverage of medical care, check to see if all the rules were properly followed, and give you an answer
within 30 calendar days after your appeal is received. However, Blue Cross can take up to 14 more calendar days if you ask for more time to gather additional information needed by Blue Cross or if Blue Cross needs more information that may benefit you, such as medical records. If you believe Blue Cross should not take extra days, you can file a “fast complaint” about the decision to take extra days and Blue Cross will respond to your complaint within 24 hours. Blue Cross will call you as soon as a decision has been made. If you do not receive an answer within 30 calendar days (of if there was an extended time period, by the end of that period), Blue Cross will automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization.

- If the answer is Yes to part or all of what you requested, Blue Cross will authorize medical care coverage within 30 days after your appeal was received (or if there was an extended time period, by the end of that time period).

- If the answer is No to part or all of what you requested, Blue Cross will send you a written denial notice informing you that your appeal was sent on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization.

If your health requires a quick response, you can call or write Blue Cross to make a “fast appeal.” If you are appealing a decision Blue Cross made about coverage for care you have not yet received, you and/or your doctor will need to decide if you need a “fast appeal.” The requirements and procedures for getting a “fast appeal” are the same as those for getting a “fast coverage decision.”

Blue Cross will consider your appeal, take another careful look at all the information about your request for coverage of medical care, check to see if all the rules were properly followed, and give you an answer within 72 hours after your appeal is received. However, Blue Cross can take up to 14 more calendar days if you ask for more time to gather additional information needed by Blue Cross or if Blue Cross needs more information that may benefit you, such as medical records. You’ll be told in writing if Blue Cross needs extra days to make a decision. If you believe Blue Cross should not take extra days, you can file a “fast complaint” about the decision to take extra days and Blue Cross will respond to your complaint within 24 hours. Blue Cross will call you as soon as a decision has been made. If you do not receive an answer within 72 hours (or if there is an extended time period, by the end of that period), Blue Cross will automatically send your request on to Level 2 of the appeals process, where it will be reviewed by and Independent Review Organization.

Level 2 Appeals

An Independent Review Organization, hired by Medicare and not connected to Blue Cross, reviews Level 2 appeals. The Organization is not a government agency.

Blue Cross sends your “case file” – the information about your appeal – to the Independent Review Organization. You have the right to ask Blue Cross for a copy of your case file and to give the Independent Review Organization additional information to support your appeal.

If you did not have a “fast” Level 1 appeal, reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal and give you an answer within 30 calendar days of when it receives your appeal. However, if the Independent Review Organization needs to gather more information that may benefit you, it can take up to 14 more calendar days.

If you had a “fast” Level 1 appeal, you will also have a “fast” appeal at Level 2 and reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal and give you an answer within 72 hours of when it receives your appeal. However, if 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 will tell you its decision in writing and explain the reasons for it.

- If the answer is Yes to part or all of what you requested, Blue Cross will authorize medical care coverage within 72 hours after receiving the decision from the review organization.

- If the answer is No to part or all of what you requested, it means the Independent Review Organization agrees with Blue Cross that your request (or part of your request) for coverage for medical care should not be approved.
Further Appeals

There is a certain dollar amount that must be in dispute to continue with the appeals process. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means the decision at Level 2 is final. The written notice you get from the Independent Review Organization will tell you the dollar amount to continue the appeals process.

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

There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). The details on how to appeal further are in the written notice you get from the Independent Review Organization Level 2 Appeal.

The Level 3 Appeal is handled by an administrative law judge. A judge who works for the federal government will review your appeal and give you an answer.

- **If the judge says Yes** to your appeal, the appeals process may or may not be over. Blue Cross will decide whether to appeal the judge’s decision.
  - If Blue Cross decides not to appeal the judge’s decision, Blue Cross will authorize medical care within 60 calendar days after receiving the judge’s decision.
  - If Blue Cross decides to appeal the judge’s decision, Blue Cross will send you a copy of the Level 4 Appeal request with any accompanying documents and may wait for the Level 4 Appeal decision before authorizing the service in dispute.
- **If the judge says No** to your appeal, the appeals process may or may not be over. You must decide whether to appeal the judge’s decision.
  - If you decide to accept the judge’s decision, the appeals process is over.
  - If you do not want to accept the judge’s decision, you can continue to the next level of the review process. The notice you get from the decision will tell you what to do next.

The Level 4 Appeal is handled by the Medicare Appeals Council. The Medicare Appeals Council will review your appeal and give you an answer. The Medicare Appeals Council works for the federal government.

- **If the Medicare Appeals Council says Yes** to your appeal, the appeals process may or may not be over. Blue Cross will decide whether to appeal the decision.
  - If Blue Cross decides not to appeal the decision, Blue Cross will authorize medical care within 60 calendar days after receiving the Medicare Appeals Council’s decision.
  - If Blue Cross decides to appeal the decision, Blue Cross will let you know in writing.
- **If the Medicare Appeals Council says No** to your appeal, the appeals process may or may not be over. You must decide whether to appeal the decision.
  - If you decide to accept the Medicare Appeals Council’s decision, the appeals process is over.
  - If you do not want to accept the Medicare Appeals Council’s decision, you might be able to continue to the next level of the review process. The notice you get from the decision will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next.

The Level 5 Appeal is handled by a Federal District Court judge. A judge at the Federal District Court will review your appeal. This is the last step of the administrative appeals process.
How to file a complaint

You can make a complaint about Blue Cross Blue Shield of Michigan or a network provider, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. Refer to “How to ask for a coverage decision” and “How to ask for a Level 1 Appeal” in this section if you disagree with a coverage decision made by Blue Cross or wish to dispute a payment.

To make a complaint, promptly call Blue Cross. If there is anything else you need to do, the customer service representative will let you know. If you do not wish to call, or you called and were not satisfied, you can put your complaint in writing and mail it to Blue Cross. Contact information is at the beginning of this section.

Whether you call or write, your complaint must be made within 60 calendar days after you had the problem you want to complain about. If you are making a complaint because Blue Cross denied your request for a “fast coverage decision” or “fast appeal,” Blue Cross will automatically give you a “fast complaint.” A “fast complaint” means Blue Cross will give you an answer within 24 hours.

Blue Cross will look into your complaint and, if possible, will answer you right away – sometimes on the same phone call. If your health condition requires a quick answer, Blue Cross will do that. However, most complaints will be answered in 30 calendar days. If Blue Cross needs more information and the delay is in your best interest, or if you ask for more time, Blue Cross can take up to 14 more calendar days to answer your complaint. Blue Cross’ response will include the reason for the answer.

If you have a complaint about the quality of care you received, you can make your complaint to Blue Cross and/or the designated Quality Improvement Organization for your state. The Quality Improvement Organization is a group of practicing doctors and other medical care experts paid by the federal government to check and improve the care given to Medicare patients. For Michigan, the Quality Improvement Organization is KEPRO. You can reach KEPRO by calling 1-855-408-8557. If you live outside Michigan, call Blue Cross at 1-800-422-9146 if you would like contact information for your state.

You can also submit a complaint about Medicare Plus Blue℠ Group PPO directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx.
Glossary of medical care terms

**Acute**
A condition that occurs suddenly and rapidly with severe symptoms and short course. This condition is not chronic.

**Ambulatory infusion center**
An outpatient center, not part of a hospital, where patients can receive medication administered intravenously.

**Ambulatory surgical center**
An outpatient facility, not part of a hospital, where surgery is performed and care related to the surgery is given. Procedures performed in this facility can be performed safely without overnight inpatient hospital care.

**Appeal**
An appeal is something you do if you disagree with Blue Cross’ decision to deny a request for coverage of medical care services or payment of services you already received.

**Approved amount**
The maximum payment level approved by Blue Cross Blue Shield of Michigan or the provider’s charge for the covered service, whichever is lower. Applicable coinsurance, copay and deductible amounts are deducted from the approved amount. All reference to approved amount in this booklet refers to the approved amount as determined by Blue Cross Blue Shield of Michigan.

**Benefit**
Coverage for medical care services available in accordance with the terms of your medical coverage.

**Chronic condition**
A disease or other health condition of long duration or frequent recurrence. Chronic conditions usually show little change or are of slow progression.

**Coordination of Benefits**
A program that coordinates your medical benefits when you or your covered dependents have coverage under another insurance plan.

**COBRA coverage**
A federal requirement that allows departing members to continue group medical coverage at their own expense for a fixed period of time.

**Coinsurance, copay**
The designated portion of the approved amount you are required to pay for services covered under the medical plan. A coinsurance is a percentage of the approved amount and it applied before the deductible. A copay is a flat dollar amount.

**Comprehensive Outpatient Rehabilitation Facility (CORF)**
A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.
Cosmetic treatment
Treatment primarily for improving appearance rather than medically treating a disease or other health condition.

Cost-sharing
Amounts that you have to pay when services are received.

Covered service
A service, procedure, treatment, device or supply identified as payable under the medical plan.

Custodial care
Care that is primarily for the purpose of meeting an individual's personal needs or the convenience of the family and can be provided by a person without skills or training. The term also includes care that does not require medical supervision that is administered to help a person with activities of daily living such as walking, getting in and out of bed, bathing, dressing, eating and taking medicine, etc. This care may be given with or without routine nursing care, training in personal hygiene and other forms of self-care, or care supervised by a physician.

Deductible
A specific dollar amount you must pay during each calendar year before the medical plan will begin to pay for covered services and supplies. The deductible is applied after the coinsurance.

Dialysis
Treatment of kidney disease using equipment to remove harmful substances from the blood. Dialysis is one of the primary treatments for end stage renal disease.

Durable medical equipment
Equipment that is able to withstand repeated use, is primarily and customarily used to serve a medical purpose and is not generally useful to a person in the absence of illness or injury. This equipment must be prescribed by a physician and includes items such as wheelchairs, canes, and access railings for the bath.

Emergency, medical emergency
A condition that occurs suddenly and unexpectedly and that could result in serious bodily harm or threaten life unless immediately treated. Examples of medical emergencies include loss of consciousness, severe chest pain, convulsions, etc. Symptoms or conditions such as the common cold, slight fever, headaches, etc., are not considered life-threatening and do not qualify as a medical emergency.

ESRD (end stage renal disease)
Permanent kidney failure which requires a regular course of dialysis or a kidney transplant to maintain life.

Experimental/investigative
A service or treatment that has not been scientifically demonstrated to be as safe and effective for treatment of a condition as a conventional or standard treatment. Experimental/investigative services are not covered under the medical plan. This includes facility services and physician services, including diagnostic tests, which are related to experimental/investigative procedures. The Blue Cross Blue Shield of Michigan medical director is responsible for determining whether the use of any service is experimental or investigational. The service may be determined to be experimental or investigational when there is:

- A written experimental or investigational plan by the attending provider or another provider studying the same service; or
- A written informed consent used by the treating provider in which the service is referred to as experimental, investigational or other than conventional or standard therapy.
The Blue Cross Blue Shield of Michigan medical director uses the following information in the evaluation process:

- Scientific data such as controlled studies in peer-reviewed journals or medical literature.
- Information from the Blue Cross and Blue Shield Association or other local or national bodies.
- Information from local and national medical societies, other appropriate professional societies, organizations, committees or government agencies.
- Approval, when applicable, by the Food and Drug Administration (FDA), the Office of Health Technology Association (OHTA) and other governmental agencies.
- Accepted national standards of practice in the medical profession.
- Approval by the Institutional Review Board of the hospital or medical center.

**Facility, approved facility**

A hospital or clinic that offers acute care or specialized treatment, such as substance abuse, rehabilitation treatment, skilled nursing care or physical therapy. An approved facility must meet all applicable local and state licensing and certification requirements and be accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association and participate with Medicare.

**Grievance**

A type of complaint you make about Blue Cross or a network provider, including a complaint about the quality of your care.

**Home health care agency, approved home health care agency**

A centrally administered agency that provides physician-directed nursing and other paramedical services to patients at home. An approved home health care agency is required to be affiliated with a participating hospital, must meet all local and state licensure and certification requirements and must participate with Medicare.

**Hospice, approved hospice**

A public agency or private program that primarily provides medical, psychological, social and spiritual services to terminally ill individuals and their families. Hospice care may take place in the patient’s home, or in an approved facility. An approved hospice program must meet the State licensure requirements and must be certified by Medicare. Hospice benefits are provided by Original Medicare, not the Medicare Plus BlueSM Group PPO plan.

**Hospital, approved hospital**

A facility that, in return for compensation from its patients, provides diagnostic and therapeutic services on a continuous inpatient or outpatient basis for the surgical, medical or psychiatric diagnosis, treatment and care of injuries or acutely sick persons. These services are provided by or under the supervision of a professional staff of licensed physicians and surgeons. A hospital continuously provides 24 hour-a-day nursing services by registered nurses. A hospital is not, other than incidentally, a place for custodial, convalescent, pulmonary tuberculosis, rest or domiciliary care; an institution for exceptional children; an institution for the treatment of the aged or substance abusers; or a skilled nursing facility or other nursing care facility. An approved hospital meets all applicable local and state licensure and certification requirements, is accredited as a hospital by state or national medical or hospital authorities or associations, and participates with Medicare.

**Injury**

Physical damage caused by an action, object or substance outside the body. Examples include injuries from automobile accidents, sprains or cuts requiring prompt medical treatment, broken bones and frostbite.

**Investigative services**

See experimental/investigative.
Laboratory services
Tests of body fluid or tissue that help your doctor diagnose a disease or an injury. Examples are blood tests, urine tests and Pap smears.

Mammogram
A low-dose radiograph of the breast, featuring two views per breast. The radiation machine must be state authorized and specifically designed and used to perform mammography.

Medicaid
A joint federal and state government program that helps with medical costs for certain people with limited incomes and resources.

Medicare
The federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease.

Medical necessity
Services and treatments that are necessary to treat an illness or injury. Unless otherwise specified, only medically necessary services are covered under the medical plan.

Medical necessity for payment of professional provider services:
Medical care services that a professional provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the member’s illness, injury or disease and not primarily for the convenience of the member, professional provider, or other medical care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that member’s illness, injury or disease.

NOTE: “Generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician or provider society recommendations and the views of physicians or providers practicing in relevant clinical areas and any other relevant factors.

Medical necessity for payment of hospital and LTACH services:
Determination by BCBSM that allows for the payment of covered hospital services when all of the following conditions are met:

- The covered service is for the treatment, diagnosis or symptoms of an injury, condition or disease.
- The service, treatment, or supply is appropriate for the symptoms and is consistent with the diagnosis. Appropriate means that the type, level and length of care, treatment or supply and setting is needed to provide safe and adequate care and treatment.
- For inpatient hospital stays, acute care as an inpatient must be necessitated by the patient’s condition because safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.
- The services are not mainly for the convenience of the member or medical care provider.
- The treatment is not generally regarded as experimental by BCBSM.
- The treatment is not determined to be medically inappropriate by the Utilization Quality and Health Management Programs (applies only to hospitals, not to LTACHs).
Medical necessity for payment of services of other providers:
Determination by physicians acting for BCBSM, based on criteria and guidelines developed by physicians for BCBSM who are acting for their respective provider type or medical specialty, that:

- The covered service is accepted as necessary and appropriate for the patient’s condition.
- It is not mainly for the convenience of the member or physician.
- In the case of diagnostic testing, the results are essential to and are used in the diagnosis or management of the patient’s condition.

NOTE: In the absence of established criteria, medical necessity will be determined by physicians according to accepted standards and practices.

**Medicare**
The federally-funded program that pays for medical services for U.S. citizens age 65 or older, persons of any age who are permanently disabled, or persons with End-Stage Renal Disease.

**Medicare Advantage**
A plan offer by a private company that contracts with Medicare to provide individuals with Medicare Part A and Part B benefits. Medicare Plus Blue℠ Group PPO is a Medicare Advantage plan administered by Blue Cross Blue Shield of Michigan.

**Network provider**
Doctors and other medical care professionals, medical groups, hospitals, and other medical care facilities that have an agreement with Blue Cross Blue Shield of Michigan to provide medical services through the Medicare Plus Blue℠ Group PPO plan. These providers have signed participating agreements with Blue Cross Blue Shield of Michigan agreeing to accept the approved amount and any plan cost-sharing as payment in full for covered services.

**Nonparticipating provider**
A medical care provider who has not signed participating agreements with Medicare. Nonparticipating providers are not part of the Medicare Plus Blue℠ Group PPO network and may include doctors, hospitals, specialty care facilities and certain other medical care professionals.

**Original Medicare**
Also known as “Traditional” Medicare. Original Medicare is offered by the government, not by a private medical plan. Original Medicare has two parts: Part A (hospital) and Part B (medical).

**Out-of-pocket**
A member’s cost-sharing requirement to pay for a portion of services received.

**Out-of-pocket maximum**
This is the most you will pay in a year for all covered services from both in-network and out-of-network providers.

**Outpatient psychiatric facility, approved outpatient psychiatric facility**
A legally constituted, centrally administered facility providing comprehensive mental health services to the community. An approved facility is an administratively distinct governmental, public, private or independent unit or part of such unit that provides outpatient mental health services and participates with Medicare. These include centers for the care of adults or children, such as hospitals, clinics, day treatment centers and Community Mental Health Centers as defined in the Federal Community Mental Health Act of 1963, as amended.
Outpatient substance abuse treatment program, approved substance abuse treatment program
An outpatient program that provides medical and other services specifically for persons who are physiologically or psychologically dependent upon or abusing alcohol or drugs. An approved program meets all state licensure requirements and participates with Medicare.

Participating provider
A medical care provider who has signed participating agreements with Medicare agreeing to accept the Medicare approved amount as payment in full for covered services. Participating providers may or may not be part of the Medicare Plus Blue℠ Group PPO network. Participating providers include doctors, hospitals, specialty care facilities, and certain other medical care professionals licensed by the state to provide medical services and care.

Patient
The retiree (subscriber) or eligible dependent (member) who is awaiting or receiving medical care and treatment.

Physician
A doctor of medicine or osteopathy legally qualified and licensed to practice medicine and perform surgery at the time and place services are performed. For the purpose of this booklet, a dentist, a podiatrist or a doctor of chiropractic who is legally qualified and licensed to practice dentistry, podiatry or chiropractic at the time and place services are performed is deemed to be a physician to the extent that the doctor renders covered services which the doctor is legally qualified to prescribe or perform.

Prosthetic device
An artificial device that replaces all or part of a body part, or replaces all or part of the functions of a permanently-inoperative malfunctioning body part.

Psychologist
A mental health practitioner who is certified or licensed, whichever is applicable, as a psychologist at the time and place services are performed. Where there are no certification or licensure requirements, a psychologist is one who is recognized as such by the appropriate professional society at the time and place services are performed.

Residential substance abuse treatment program, approved substance abuse treatment program
A program that provides medical and other services specifically for people who are physiologically or psychologically dependent upon or abusing alcohol or drugs. Residential substance abuse programs must be administered in a licensed facility that operates 24 hours a day, seven days a week. An approved residential program meets all state licensure requirements and participates with Medicare.

Routine service
A procedure or test ordered for you without direct relationship to the diagnosis or treatment of a specific disease or injury.

Semiprivate room
A hospital room with two beds.

Service area
The geographic area served by the Medicare Plus Blue℠ Group PPO plan, which is the entire 50 states and territories of the United States.
Services
Surgery, care, treatment, supplies, devices, drugs and equipment given by a medical provider to diagnose or treat disease, injury, condition or pregnancy, and which are based on valid medical need according to accepted standards of medical practice.

Skilled nursing facility, approved skilled nursing facility
A facility that provides convalescent and short- or long-term care for illness with continuous nursing and other medical care services by or under the supervision of a physician and a registered nurse. The facility may be operated independently or as part of an accredited acute care hospital. An approved facility is accredited by the Joint Commission on Accreditation of Hospitals and is recognized as an extended-care facility by the Secretary of Health and Human Services of the U.S., and participates with Medicare.

Special care unit
A designated care unit within a hospital such as a cardiac care, burn care or intensive care unit that contains all necessary types of equipment, together with skilled nursing and support services needed for care of critically ill patients and is recognized as such by Medicare.

Specialty drugs
Prescription medications used to treat complex, chronic conditions like cancer, rheumatoid arthritis and multiple sclerosis. Specialty drugs often require special handling, such as refrigeration during shipping, and administration, such as injection or infusion.

Substance abuse
Taking alcohol or other drugs in amounts that can:

- Harm a person’s physical, mental, social and economic well-being.
- Cause the person to lose self-control.
- Endanger the safety or welfare of others because of the substance’s habitual influence on the person.

TRICARE
A health care program of the United States Department of Defense Military Health System.

Urgently needed care
Care provided to treat a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care.