2025 Your Benefit Guide

Medicare members

READY TO HELP

MICHIGAN

50 YEARS OF SERVICING PUBLIC SCHOOL RETIREES

Michigan Public School Employees' Retirement System

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Table of Contents

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 1, 2025. 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 Blue℠ Group PPO *Evidence of Coverage*, then the terms and conditions of the Medicare Plus Blue 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 at **1-800-422-9146** (TTY: **711**) from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday.

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, deductible, coinsurance and copay requirements are jointly vested by law in the Michigan Department of Technology, Management & Budget (DTMB) and the Michigan Public School Employees' Retirement Board (Retirement Board). 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 provides the *Evidence of Coverage* and *Annual Notice of Changes* online. 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, unless you have the Personal Healthcare Fund, which only allows for enrollment at the time of retirement.

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 the Michigan Office of Retirement Services (ORS) receives your completed application and proofs. For example, if ORS receives your ***Insurance Enrollment/Change Request (R0452C)*** form with proofs on February 10, your coverage would begin August 1.

Coverage can begin sooner than six months if you, your spouse, 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, involuntary loss of coverage in a group plan (e.g., you lose your job or your employer stops offering healthcare benefits), and enrollment in Medicare Part B if your coverage was previously terminated or you were denied enrollment due to not having Part B. For retirees with Medicare, your coverage can begin the first of the second month after ORS receives your completed application and proofs.

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 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 medical plan.** You must provide your Medicare number and Medicare Part A and Part B effective dates to ORS more than one month prior to your Medicare effective date.

If you're eligible for Medicare and fail to enroll in Part A and Part B, your retirement system medical coverage will be canceled. Your coverage can be reinstated if you enroll in Part A and Part B and notify the retirement system within one month of obtaining Medicare Part A and Part B coverage. Your coverage will begin the first of the second 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 they are an eligible public school retiree, you will be covered together on one contract at ORS. However, each person on Medicare will have their own contract with Blue Cross Blue Shield of Michigan.
- Your child by birth, adoption, or legal guardianship until the end of the month in which they turn 26.
- Your unmarried child by birth, adoption, or legal guardianship who is totally and permanently disabled, dependent on you for support, and unable to self-sustain employment as described below.
- Either your parent(s) or parent(s)-in-law residing in your household — one set of parents or the other, but not both.

In the case of legal adoption, a child is eligible for coverage as of the date of placement. Placement occurs when you become legally obligated for the total or partial support of the child in anticipation of adoption. In the case of legal guardianship, official guardianship paperwork must be in place for a dependent to be eligible. Once a guardianship terminates, dependent eligibility ends.

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

Note: Stepchildren are not eligible for coverage.

Dependent children older than age 26 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 month in which your covered dependent reaches age 26, they 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 healthcare 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 dependents.

Coverage for your disabled dependent child

To ensure coverage for your incapacitated child, you will need to provide:

- A current letter from the attending physician detailing the disability, stating the child is:
  - Totally and permanently disabled.
  - Incapable of self-sustaining employment.
- IRS Form 1040 that identifies the child as your dependent.

Coverage for a disabled dependent can begin the first of the month after ORS approves their eligibility, so it is important to provide documentation as early as possible. In some cases, we may ask for additional information to determine medical eligibility. This may delay enrollment.

Your child may be eligible for Medicare medical benefits under Social Security disability coverage. If your child is eligible, you must enroll them 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.

Required proof(s) for coverage

You will be asked to provide photocopies of the following to ORS:

- If you're adding a spouse, a government-issued marriage certificate **or** matching addresses on your valid driver's license and your spouse's valid driver's license **and** your most recent IRS Form 1040 showing filing married.
- If you're enrolling your child, a government-issued birth certificate as proof of age and relationship.
- Court order to prove legal guardianship (if applicable).
- Driver's license or tax returns as proof of residence for your parent(s) or parent(s)-in-law.

These documents are referred to as *proofs*, proving eligibility for coverage.

Note: The time frame to submit enrollment request and proofs for dependents is the same as enrolling yourself in insurances.

Continuing medical coverage for your survivor

If you chose a survivor option for your pension and you have the premium subsidy benefit, your designated pension beneficiary can enroll in or continue group insurances after your death. If you chose your spouse as your survivor pension beneficiary, your eligible dependents who were covered at the time of your death will also continue to receive insurance benefits, as long as they remain eligible.

If you chose a survivor option for your pension and you have the Personal Healthcare Fund, any eligible beneficiaries and dependents who were already enrolled in insurance plans at the time of your death may continue to be enrolled in those insurance plans and they will continue to be responsible for the entire premium. If they terminate the plan at any time, they will not be able to reenroll.

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 retirement system medical plan at the time of a qualifying event that results in the loss of eligibility, 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.

If your dependent has been terminated from coverage and a duplicate copy of the COBRA application is needed, use the ORS 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 of Michigan, 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 Blue Shield of Michigan health plan advisors at **1-855-237-3501**. TTY users should call **711**. Information is also available at **bcbsm.com**.

Coordination of Benefits

Medicare members

When you enrolled in the medical plan, the application asked for information about other group health coverage. **Enrolling in another health or prescription drug plan may result in termination of your retiree coverage for you, your spouse, and enrolled dependents.**

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 healthcare provider, hospital and pharmacy. If you have Medicare because of ESRD, and you also have commercial health coverage with another group, the other group commercial health plan will pay first for the first 30 months, starting when you became eligible for Medicare. 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 Customer Service at **1-800-422-9146** (TTY: **711**) from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday.

Non-Medicare members

Refer to the benefit booklet for non-Medicare eligible members for information on coordination of benefits for individuals not enrolled in Medicare at **bcbsm.com/mpsers**.

Other insurance

You are not eligible for coverage under the Medicare Plus Blue Group PPO plan if you enroll in another Medicare Advantage plan.

If you have other group health insurance that is not a Medicare Advantage Plan from an employer or another retiree group, Blue Cross will coordinate with the other health insurance plan to determine which plan pays first and ensure your claims are paid correctly.

Coordinating your medical plan coverage with automobile coverage

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

In the case of an auto accident in Michigan, your auto insurance carrier has the first obligation to pay for medical care costs if your auto policy includes personal injury protection (PIP) coverage. Your auto insurance carrier will review the claim first to pay its share of the claim. After your auto insurance carrier reviews the claim, Blue Cross will review any remaining balance for payment. In the case of an auto accident outside of Michigan: 1) Out of state laws apply; and 2) Your auto insurance carrier would have the obligation to pay before your medical plan if your auto policy includes PIP coverage.

Personal injury protection coverage

Michigan drivers need to choose a level of personal injury protection (PIP) coverage appropriate for their needs and budget. In the case of an auto accident, Michigan No Fault PIP coverage pays for services that are not covered by your retirement system plan such as:

- Household services.
- Long-term and custodial care.
- Transportation to and from medical appointments.
- Vehicle and housing modifications.

Contact your auto insurance carrier if you have specific questions regarding PIP coverage.

Proof of qualified health coverage

When choosing your level of PIP coverage under your auto insurance policy, your auto insurance carrier may ask you to provide proof of qualified health coverage, including all individuals covered under your plan. To request a qualified health coverage letter, log in to your Blue Cross online member account or call Blue Cross Customer Service at **1-800-422-9146** (TTY: **711**) from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday.

Filing a claim

In most instances, your provider will file your claim. However, if your provider will not file your claim, you will need to do so. If your provider will not file your claim, you must notify Blue Cross Customer Service at **1-800-422-9146** (TTY: **711**) from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday.

Discontinuing your coverage

You may voluntarily cancel your medical plan coverage or your dependent's coverage at any time by going to **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 the cancellation request is received unless a future date is indicated.

If you choose to reenroll 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

Notify ORS if you have any of the following changes:

- Address*.
- Adoption.
- Birth.
- Death.
- Divorce.
- Email address.
- Involuntary loss of coverage in another group plan.
- Marriage.
- Name.
- Phone number.
- Power of attorney (if someone else has the legal authority to act for you).

*Address: 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. Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it. If you plan to move outside the service area, you must contact ORS prior to moving. It is also important that you notify Social Security if you move or change your mailing address. Visit **ssa.gov** or call Social Security at 1-800-772-1213 Monday through Friday, 8 a.m. to 7 p.m., Eastern time. TTY users call 1-800-325-0778. Calls are free.

The ORS miAccount is the fastest way to access and make changes to your account. You'll use MiLogin to access miAccount, giving you secure access to change your insurance information, update your address and much more. Log in to your ORS miAccount for more information at **michigan.gov/orsmiaccount**.

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 p.m. Eastern time, Monday through Friday.

1-800-381-5111 (TTY: **711**)

Fax: **517-284-4416**

Any changes or updates you make in your ORS miAccount or with an ORS customer service representative are automatically forwarded to Blue Cross. Blue Cross **cannot** change your records without notification from the retirement system.

To avoid misdirected communications or potential coverage problems, it is important that you contact ORS to report any of the changes noted above. 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 Blue Cross on behalf of your ex-spouse for services provided subsequent to your divorce date.

When to contact Blue Cross

You must contact Blue Cross Customer Service at **1-800-422-9146** (TTY: **711**) to notify Blue Cross of the following:

- If you have enrolled in another group medical insurance plan (such as from an employer, your spouse's employer, workers' compensation, or Medicaid) or in another medical plan.
- 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.

Note: You are not required to tell Blue Cross about the clinical research studies you intend to participate in, but we encourage you to do so.

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 Part 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 Part 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 provides online each year. In the fall, you'll receive notification on how to access these documents online. If you have an online member account, you'll receive an email when these documents become available. The EOC gives you details about the plan and the ANOC lists plan changes in the new year.

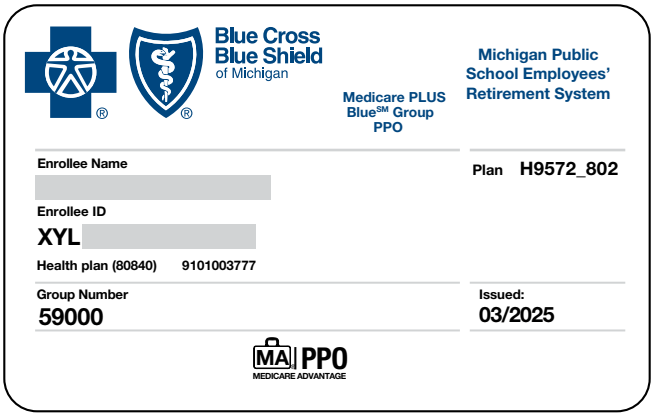
Most people become eligible for Medicare coverage at age 65. If you are disabled or if you have end-stage renal disease (ESRD), you may be eligible for Medicare at an earlier age. **As soon as you or anyone else covered by your medical insurance becomes eligible for Medicare, that person must enroll in both Part A (hospital) and Part B (medical). You must have Medicare Part A and Part B to enroll in the retirement system medical and prescription drug programs. You must provide your Medicare number and Medicare Part A and Part B effective dates to ORS more than one month prior to your Medicare effective date.**

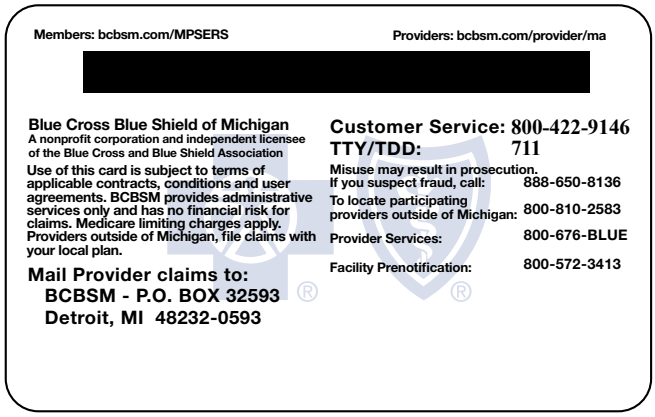
If you're eligible for Medicare and fail to enroll in Part A and Part B, your retirement system medical coverage will be canceled. Your coverage can be reinstated if you enroll in Part A and Part B and notify the retirement system within one month of obtaining Medicare Part A and Part B coverage. Your coverage will begin the first of the second month after ORS receives your completed application and proofs.

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 **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.

Accessing your virtual membership ID card

When you need your Blue Cross membership ID card, you can pull up your card information online or on Blue Cross Blue Shield of Michigan's mobile app. To access your virtual ID card, log in on Blue Cross Blue Shield of Michigan's mobile app or at **bcbsm.com/mpsers** and select *ID Cards*. It's important that you and your covered dependents create a Blue Cross online member account to see the ID card information anytime, anywhere.

If you haven't registered for a Blue Cross online member account, click *Register Now* and follow the instructions to create your account.

Lost or stolen membership card

If your membership ID card is lost or stolen, immediately call Blue Cross Customer Service at **1-800-422-9146** (TTY: **711**) from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday to report the loss.

You can save time by ordering your replacement membership ID card online.

1. Log in at **bcbsm.com/mpsers** or Blue Cross Blue Shield of Michigan's mobile app and click *ID cards*.
2. Select *Order* below the card image.
3. Make sure your address is correct and select *Confirm order*.

Things to be aware of throughout the year

Medicare Advantage Health Assessment

You will receive a Medicare Advantage Health Assessment and instructions on how to complete the health assessment from Blue Cross. The assessment helps evaluate your current health conditions and identify any potential health risks. The health assessment is easy to do and usually takes about 20-30 minutes. The instructions letter will explain that you can either fill out an enclosed paper survey or complete the health assessment online.

LivingWell program

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

Maintain your health by visiting your primary care provider for your annual routine physical or annual wellness visit. Both are covered at no cost to you. Ask your primary care provider which preventive service is right for you. Your plan covers in-network standard, routine laboratory tests at no cost to you when done in conjunction with an annual routine physical.

To get the most out of the LivingWell program, select a patient-centered medical home (PCMH) doctor as your primary care provider.

In a patient-centered medical home, one doctor leads a care team that focuses on keeping you healthy instead of just treating you when you're sick. It's a partnership between you and your doctor.

1. **Your PCMH health 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 PCMH health team may consist of your primary care provider, nurses, specialty doctors, pharmacists, a nutritionist, therapist, care coordinators and others depending on your needs.

2. **Your care team works together to help you manage your health.** Your PCMH doctor tracks your care and coordinates your care between doctors and healthcare settings. If you need to see a specialist, your PCMH doctor will help you find the right one and coordinate your visit. Because all your tests and treatments by other doctors are tracked to your primary care provider, you have a centralized home for your medical history. You won't have to re-explain every symptom and test result each time you visit your doctor. Your doctor also uses e-prescribing (or an electronic prescription system) to alert your pharmacist of any possible drug interactions and help 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.

PCMH practices aim to prevent problems from occurring and put control of your health where it belongs — with you and your care team. 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 **bcbsm.com/mpsers** or on Blue Cross Blue Shield of Michigan's mobile app.

Best of Health newsletter

The *Best of Health* newsletter aims to help you understand your medical coverage, improve nutrition and fitness, manage chronic conditions and more. Visit **bcbsm.com/mpsers** and select *For Members* and click on *View all issues* to view the latest issue or sign up to receive your newsletter electronically. Members who provided an email address to the ORS will automatically receive the quarterly newsletter electronically. The newsletter is released at the end of March, June, September and December of each year.

Plan updates

Plan updates are announced in the *Best of Health* newsletter and annual retiree healthcare plan seminar.

Taking care of your health

SilverSneakers® fitness program

SilverSneakers is a fitness and well-being benefit that includes fun and energizing programs that help you live a healthy, active lifestyle by encouraging staying active, making friends and connecting with your community.

SilverSneakers fitness program is provided at no additional cost to you. Fitness services are covered at 100 percent of the approved amount when provided through SilverSneakers. Out-of-network fitness services are not covered.

The fitness program is designed to improve overall fitness by increasing muscular strength, endurance, flexibility, agility and balance. You'll have access to thousands of participating fitness locations across the country.

Your membership includes:

- Thousands of participating locations nationwide, where you can take classes plus use exercise equipment and other amenities.
- GetSetUp virtual mental enrichment program with classes on topics ranging from healthy cooking to online banking.
- SilverSneakers LIVE™ classes and workshops taught by instructors trained in senior fitness.
- SilverSneakers On-Demand™ which gives you access to 200+ workout videos designed for all levels and abilities. In addition, get information on nutrition, fitness challenges and more.
- SilverSneakers GO™ mobile app with digital workout programs. You can modify exercises to different levels with just one click, schedule activities and get notifications to stay on track.
- Social connections through events such as shared meals, holiday celebrations, and class socials.
- Burnalong® access with a supportive virtual community and thousands of classes for all interests and abilities.
- GetSetUp virtual enrichment program with classes on topics ranging from healthy eating to aging in place.

To get your SilverSneakers ID number, find a participating location or request information about the SilverSneakers program visit **silversneakers.com/starthere** or call SilverSneakers at **1-866-584-7352** (TTY: **711**) from 8 a.m. to 8 p.m. Eastern time, Monday through Friday.

Always talk with your primary care provider before starting an exercise program.

GetSetUp is a third-party provider and is not owned or operated by Tivity Health, Inc. ("Tivity") or its affiliates. Users must have internet service to access GetSetUp service. Internet service charges are responsibility of user.

Blue Cross Well-Being℠

Whether you are looking for ways to improve your lifestyle or manage a chronic illness such as asthma or high blood pressure, Blue Cross Well-Being has the support system you need. You can get to Blue Cross Well-Being by logging in to your account at **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.
- Get personalized daily tip cards based on your interests and health goals.
- Watch videos, listen to podcasts and use other online tools to learn about various health topics.

Blue Cross Well-Being also provides:

24-Hour Nurse Line

Supported by board-certified physicians, Blue Cross nurses are available — day or night — from the comfort of your home or anywhere in the United States to help you decide where to go for care or provide you with recommended treatment options for minor illnesses.

To speak to a registered nurse, call Blue Cross Well-Being, toll free 24 hours a day, seven days a week at **1-855-624-5214**. TTY users, call **711**.

Health assessment

The health assessment provides you with a picture of your current health and your health risks. In an easy-to-read format, the assessment asks you questions designed to evaluate your health risks and provides steps which you can take to improve those risks.

 Online well-being resources

Personify Health provides a platform designed to empower you to make lasting changes toward a healthy lifestyle. Personify Health is available to you and your covered family members. To get started, log in to your Blue Cross online member account, then click on the *Programs & Services* tab. From there, select *Blue Cross Well-Being* under *Quick Links*.

 Tobacco Coaching

The Tobacco Cessation Coaching program offers personalized support to help you stop smoking, vaping or using nicotine. The same coach stays with you throughout your journey to quit. You can connect with your coach by phone, app or email. To get started, log in to your Blue Cross online member account, then click on the *Programs & Services* tab. From there, select *Blue Cross Well-Being* under *Quick Links*.

Blue Cross Coordinated Care

Blue Cross Coordinated Care program identifies members with complex or chronic conditions that could benefit from care management support and connects them to care. Registered nurses work directly with you to coordinate the best care to meet your specific needs. The Coordinated Care team includes doctors, medical directors, pharmacists, dietitians, social workers and behavioral health specialists.

Blue365®

Through Blue365, a Blue Cross member discount program, you have access to exclusive discounts on national and local healthy products and services, including gym memberships, fitness products, healthy eating programs and more. The Blue365 program offers savings and special discounts, making it easier and less expensive to get the balanced lifestyle you deserve in these categories:

- **Fitness and well-being** – Gym memberships, fitness gear, fitness wearable devices and health magazines.
- **Nutrition** – Meal delivery kits and weight-loss programs.
- **Lifestyle** – Landscaping materials, pet supplies and multivitamins.
- **Travel** – Hotel reservations, car rentals and vacation activities.

Log in to your account at **bcbsm.com/mpsers** or Blue Cross Blue Shield of Michigan's mobile app. Once you're logged in, select *Blue365 Rewards & Discounts* from the *Programs & Services* menu. Scroll down to *Blue365 Member Discounts* and tap or click the button to link to the Blue365 site.

Visit the Blue Cross website

Information is available online 24 hours a day, seven days a week at **bcbsm.com/mpsers**. From **bcbsm.com/mpsers** you can log in to your online Blue Cross member account 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 name, specialty, network; view side by side comparisons of providers, including patient reviews.

Visit **bcbsm.com/mpsers** to view plan documents, such as the *Evidence of Coverage*, *Annual Notice of Change* and *Summary of Benefits*.

Going paperless

Going paperless is easy. Here's how:

1. Go to **bcbsm.com/mpsers**. Click *Log in*. Enter your username and password. If you haven't registered, click *Register Now* and follow the instructions to create your account.
2. Click on your name listed in the top right corner.
3. Click on *Paperless Options* from the list.
4. Under *Paperless Options*, click on *Paperless* to select paperless delivery of the documents you want to get online.

Blue Cross webcasts and webinars

Informative webcasts and webinars can be found under *For Members* at **bcbsm.com/mpsers**, including:

- Blue Cross Virtual Well-Being.
- The Basics of Medicare.
- Fall Retiree Healthcare 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 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:

- Annual deductible.
- Coinsurance (up to the coinsurance maximum).
- Copayment (copay).
- Additional costs for using out-of-network providers.
- Additional costs for using providers that don't participate with Medicare.

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 while enrolled in the retirement system's non-Medicare Blue Preferred® PPO plan are carried over to this Medicare Plus Blue℠ Group PPO plan. Deductible amounts paid under a different medical plan not administered by your retirement system 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 Blue Group PPO-approved amount, not the provider's charge.

Coinsurance

Coinsurance is a percentage you pay of the total cost of certain medical services after you have met your deductible. Your coinsurance is different from your deductible and is applied to services after you have met your deductible. The amount of your coinsurance is based on the Medicare Plus Blue Group PPO-approved amount for covered services. If the provider's charge is less than the Medicare Plus Blue Group PPO-approved amount, then your coinsurance is based on the provider's charge. For most covered services, the medical plan pays 90 percent of the approved amount, and your coinsurance is 10 percent.

Copayment (copay)

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

Additional costs for using out-of-network providers

You pay 10 percent of the Medicare Plus Blue Group PPO-approved amount if you use in-network providers or out-of-network providers. However, you pay an additional 20 percent of the Medicare Plus Blue Group PPO-approved amount if you use independent medical suppliers that are not in the Medicare Plus Blue Group PPO network. This means that you will pay 30 percent of the Medicare Plus Blue Group PPO-approved amount: 10 percent coinsurance plus the additional 20 percent for using an independent medical supplier that is not part of the Medicare Plus Blue Group PPO network.

Routine hearing exams and hearing aids are only covered when you call TruHearing at **1-855-205-6305** (TTY: **711**) from 8 a.m. to 8 p.m. Eastern time, Monday through Friday and follow the instructions you are given.

IMPORTANT: You may save money when you use in-network providers because your 10 percent coinsurance is based on the Medicare Plus Blue 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

While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare (except for emergency care). If you go to a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare. Before getting services from out-of-network providers you may want to ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary. Without a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. Refer to *Coverage decisions, appeals and complaints* section in this booklet to learn how to make an appeal.

Routine hearing exams and hearing aids are only covered when you call TruHearing at **1-855-205-6305** (TTY: **711**) from 8 a.m. to 8 p.m. Eastern time, Monday through Friday and follow the instructions you're given.

Annual coinsurance/copay maximum

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

- Deductible amounts.
- Additional costs for using providers that do not participate with Medicare.
- Charges for non-covered services.
- Copays for routine hearing exams and hearing aids.

Annual out-of-pocket maximum

In accordance with Medicare rules, the medical plan limits the amount you will pay each year. The out-of-pocket maximum equals the annual deductible ($800) plus the annual coinsurance/copay maximum ($900). Excluding routine hearing care exams and hearing aids, 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.
- Copays for routine hearing exams and hearing aids.
- Additional costs for using providers that do not participate with Medicare.

How your annual deductible and coinsurance are applied

The examples below show how a member's costs are calculated for four different claims.

	Total cost (allowed amount the plan has approved)	Amount you owe toward your annual deductible		Amount you owe in coinsurance		Your share of cost	Retirement system pays the remaining balance
Claim example 1							
Before you've paid any deductible	$1,500	$800	+	$70 ($1,500 - $800 = $700; 10% of $700 = $70)	=	$870	$630
Claim example 2							
After you've paid $500 toward the deductible	$700	$300	+	$40 ($700 - $300 = $400; 10% of $400 = $40)	=	$340	$360
Claim example 3							
After you've paid the annual deductible	$2,000	$0	+	$200 ($2,000 - $0 = $2,000; 10% of $2,000 = $200)	=	$200	$1,800
Claim example 4							
After you've paid the annual deductible and coinsurance/ copay maximum	$1,650	$0	+	$0	=	$0	$1,650

Benefit dollar maximum

The medical plan will pay up to $10,000 for travel and lodging for Medicare-covered organ transplants. You have coverage for reasonable and necessary travel and lodging expenses for you and one companion (two companions if 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 who's right for you

If you don't already have a primary care provider, 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 they 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 primary care provider is important. The doctor-patient relationship and the advantages that go along with it are at the core of the 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 cost 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 Blue Cross (sometimes called "prior authorization"). Your network provider will arrange for this prior 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.

Blue Cross will notify you if your provider is leaving the Blue Cross network.

- If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.
- If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.

Your routine hearing care benefits are exclusively available through a national network of TruHearing providers. Routine hearing exams and hearing aids are only covered when you call TruHearing at **1-855-205-6305** (TTY: **711**) from 8 a.m. to 8 p.m. Eastern time, Monday through Friday and follow the instructions you're given.

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 Blue Cross later determines that the services are not covered or were not medically necessary, you will be responsible for the entire cost. If Blue Cross 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.

Routine hearing exams and hearing aids are only covered when you call TruHearing at **1-855-205-6305** (TTY: **711**) from 8 a.m. to 8 p.m. Eastern time, Monday through Friday and follow the instructions you're given.

	In-network provider	Out-of-network provider that participates in Medicare	Out-of-network provider that does not participate in Medicare	Provider not eligible to participate in Medicare
Your provider	• Member of the Medicare Plus Blue Group PPO network. • Blue Cross selects for quality of care, ability to provide cost-effective services and ability to meet Medicare Plus Blue Group PPO standards.	• Not a member of the Medicare Plus Blue Group PPO network but participates with Original Medicare. • Medicare selects for quality of care, ability to provide cost-effective services.	• No affiliation with Medicare or Medicare Plus Blue Group PPO. • No quality screening by Medicare or Medicare Plus Blue Group PPO.	• No affiliation with Medicare or Medicare Plus Blue Group PPO. • No quality screening by Medicare or Medicare Plus Blue Group PPO.
Your cost	• Lowest out-of-pocket cost. • Deductible. • Coinsurance or copay.	• Low out-of-pocket cost. • Deductible. • Coinsurance or copay. • Additional cost for using independent medical suppliers outside the Medicare Plus Blue Group PPO network.	• Higher out-of-pocket cost. • Deductible. • Coinsurance based on payment rate for non-participating providers. • Copay. • Additional cost for using independent medical suppliers outside the Medicare Plus Blue Group PPO network.	• Highest out-of-pocket cost. • You pay all cost except for emergency needed care, which is subject to coinsurance or copay and deductible.
Claim filing	• Provider submits claim for you and Blue Cross pays provider directly.	• Provider submits claim for you and Blue Cross pays provider directly.	• You may have to file claims for covered services.	• You file claims for covered services.

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 they are a Medicare Plus Blue Group PPO provider.
- Visit the Blue Cross website at **bcbsm.com** or mobile app. The online directory is easy to use and is frequently updated.
- Call Blue Cross Customer Service at **1-800-810-2583** for help in locating a network provider in your area. TTY users should call **711**.

If you select a network provider and later wish to change providers, there is no waiting period or paperwork. Just select another provider in the Medicare Plus Blue Group PPO network and make your appointment. You don't have to notify Blue Cross.

Routine hearing exams and hearing aids are only covered when you call TruHearing at **1-855-205-6305** (TTY: **711**) from 8 a.m. to 8 p.m. Eastern time, Monday through Friday and follow the instructions you're given.

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 out-of-network providers. Blue Cross carefully selects providers for the quality of care they provide and ability to provide cost-effective medical care services. That means you can save when you use Medicare Plus Blue Group PPO providers.

Virtual visits

With Virtual Care by Teladoc Health®, you and everyone on your medical plan can get virtual medical and mental healthcare from a smartphone, tablet or computer.

Medical care

Have a virtual visit with a U.S. board-certified doctor for minor illnesses such as colds, sore throats, urinary tract infections and pink eye. Medical visits are available 24/7, anywhere in the U.S., when your primary care provider isn't available. You don't need an appointment and the average wait time is 10 minutes. Prescriptions, if needed, can be sent to your preferred pharmacy.

Mental healthcare

Through the Mental Health option, you can connect with a licensed therapist or U.S. board-certified psychiatrist when you're dealing with stressful situations or issues such as grief, anxiety and depression. Mental health visits require an appointment, but many therapists and psychiatrists have evening and weekend availability. Therapy visits are scheduled for 45 minutes. Psychiatry visits are 30 to 40 minutes for the initial visit; follow-up visits are 15 minutes.

Visit **bcbsm.com/virtualcare** for a link to download the Teladoc Health app. Family members ages 18 and older will need to create their own Virtual Care account. If you have questions or need help with your Virtual Care account or an online visit, call **1-855-838-6628** (TTY: **711**). Help is available 24 hours a day, seven days a week.

Remember to coordinate all your care with your primary care provider and follow up with them after receiving care.

Refer to the *Doctor visits, virtual visits and other medical services* section of this booklet for additional information.

Teladoc Health® is an independent company that provides Virtual Care Solutions for Blue Cross Blue Shield of Michigan and Blue Care Network.

Locating network providers outside the United States

For nonemergency inpatient medical care outside of the United States, you must call the Blue Cross Blue Shield Global® Core to arrange access to a Blue Cross Blue Shield Global Core 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. TTY users should call **711**. If your hospitalization is arranged through the Blue Cross Blue Shield Global Core, 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 Blue Cross Blue Shield Global Core website at **bcbsglobalcore.com** or download the Blue Cross Blue Shield Global Core mobile app.

For outpatient and doctor care, or inpatient care not arranged through the Blue Cross Blue Shield Global Core 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, canceled checks or money stubs may accompany your itemized receipts, but may not substitute for an itemized statement.*

Routine hearing exams and hearing aids are only covered when you call TruHearing at **1-855-205-6305** (TTY: **711**) from 8 a.m. to 8 p.m. Eastern time, Monday through Friday and follow the instructions you're given.

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 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** (TTY: **711**) from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday.

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

- Hearing aid providers – Your routine hearing care benefits are available through a national network of TruHearing providers.

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 online member account at **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* section of this booklet.

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

What you pay
In-network and Out-of-network
10% coinsurance, after the annual deductible, except for clinical lab services. Unlimited days for inpatient care. Clinical lab services are covered at no cost to you.

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.
- Physician services.
- 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.
- Behavioral health, mental health and substance use disorder services.

Inpatient hospital care, including behavioral health, mental health and substance use disorder 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

What you pay
In-network and Out-of-network
10% coinsurance, after the annual deductible.

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

What you pay
In-network and Out-of-network
10% coinsurance, after the annual deductible, except for clinical lab services. Clinical lab services are covered at no cost to you.

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. Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. 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, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's, therapist's or licensed professional counselor's office but less intense than partial hospitalization. Partial hospitalization services rendered by plan providers will require prior authorization. Your plan 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. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.

Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff.

Emergency services

Emergency room care

What you pay
In-network and Out-of-network
$140 copay per visit. The $140 copay is waived if you are admitted to the hospital within 72 hours.

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

The medical plan covers medical emergency care when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent your loss of life, loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that 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 services

What you pay
In-network and Out-of-network
$65 copay per visit.

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

Urgently needed services are covered services that require immediate medical attention but are not considered emergencies. These services are covered by your plan even when you are temporarily outside the service area of the plan, or even if you are inside the service area of the plan and unable to obtain the service from network providers due to time, location or circumstances. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable.

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 primary care provider? Or can you take care of yourself at home? The Blue Cross Well-Being 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 Well-Being 24-Hour Nurse Line at **1-800-775-2583**. TTY users can call **711**. Refer to the *Blue Cross Well-Being* section for more information.

Ambulance services

What you pay
In-network and Out-of-network
10% coinsurance, after the annual deductible.

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. Ambulance services without transportation are also covered.

Surgical services

What you pay
In-network and Out-of-network
10% coinsurance, after the annual deductible.

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 obtain prior authorization for 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, virtual visits and other medical services

What you pay
In-network and Out-of-network
10% coinsurance, after the annual deductible, unless otherwise noted.

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, such as physician assistants, nurse practitioners, social workers, physical therapists and psychologists.

Acupuncture for chronic low back pain

The medical plan covers up to 12 visits in 90 days for chronic low back pain, defined as:

- Lasting 12 weeks or longer.
- Nonspecific, in that it has no known cause (not related to cancer that has spread, inflammatory or infectious disease).
- Not associated with surgery.
- Not associated with pregnancy.

An additional eight sessions will be covered if you are demonstrating an improvement. No more than 20 acupuncture treatments will be covered annually. Acupuncture treatment and services are not covered for any condition other than chronic low back pain. Treatment is not covered if you are not improving or are regressing.

You must get acupuncture from a doctor, or by another healthcare provider (like a nurse practitioner or physician assistant) who has both of these:

- A masters, or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine.
- A current, full, active, and unrestricted license to practice acupuncture in the state where care is being provided.

Allergy treatment

Covered services include tests to help arrive at a diagnosis.

Behavioral health integration services

If you have a behavioral health condition (like depression, anxiety, or another behavioral health condition), the medical plan may pay for a healthcare provider's help to manage that condition if your provider offers the Psychiatric Collaborative Care Model. The Psychiatric Collaborative Care Model is a set of integrated behavioral health services that includes care management support if you have a behavioral health condition. This care management support may include care planning for behavioral health conditions, ongoing assessment of your condition, medication support, counseling, or other treatments that your provider recommends. Your healthcare provider will ask you to sign an agreement for you to get this set of services on a monthly basis.

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.
- Stable, chronic heart failure.

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.

Caregiver training resources

The medical plan covers training that helps your caregiver learn and develop skills to care for you (such as, giving medications, personalized care, and more) as part of your treatment plan. If your healthcare provider determines that caregiver training is appropriate for your treatment plan, your caregiver can get individual or group training sessions from your provider without requiring you to be present. Training must focus on your health goals and your treatment must require a caregiver's help to succeed.

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. The medical plan covers chemotherapy in a doctor's office, freestanding clinic, or hospital outpatient setting for people with cancer. Drugs covered under the retirement system's prescription drug plan are not covered under the Medicare Plus Blue Group PPO Plan.

Chiropractic services

Chiropractic benefits are limited to chiropractic radiology services, 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* section in this booklet for additional information.

Dental services

The medical plan doesn't cover most dental care, dental procedures, or supplies, such as 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.

Foot exams and treatment

The medical plan covers foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.

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. Refer to the *Routine hearing care* section of this booklet for more information on hearing care services and hearing aids.

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 the home, at a doctor's office and at an ambulatory infusion center.

The drugs used in infusion therapy must be approved by Blue Cross.

Home infusion therapy is covered when it is:

- Prescribed by a physician within their 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.
- Remote monitoring and monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.

Medication

The medical plan covers a limited number of prescription drugs. Examples of prescription drugs covered under this plan include:

- Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services.
- Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump). You won't pay more than $35 for a month's supply. Injectable insulin and needles and syringes for injectable insulin are covered under your prescription drug plan when prescribed by your physician. Refer to the *Diabetes treatment, services and supplies* section of this booklet for more information.
- Clotting factors you give yourself by injection if you have hemophilia.
- Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug.
- Antigens.

- Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoisis-stimulating agents.
- Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases.
- Calcimimetic medications under the ESRD payment system, including the intravenous medication Parsabiv® and the oral medication Sensipar®.
- Oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug.
- Parenteral and enteral nutrition (intravenous and tube feeding).
- Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan.
- The Alzheimer's drug, Leqembi®, (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor or other healthcare provider.
- Certain oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, your Medicare Plus Blue Group PPO plan may cover them. If Blue Cross doesn't cover them, your retirement system prescription drug plan will cover them.
- Certain End-Stage Renal Disease (ESRD) drugs if the same drug is available in injectable form and your Medicare Plus Blue Group PPO plan ESRD benefit covers it.
- Erythropoiesis-stimulating agents.

Self-administered drugs (drugs you would normally take on your own and are covered under your prescription drug plan) are not covered. Covered prescription drugs that may be subject to step therapy include: anti-cancer agents and cancer-supportive therapy agents, anti-gout agents, anti-inflammatory agents, antirheumatic agents, antispasticity agents, bisphosphonates, blood products, gastrointestinal agents, immunosuppressive agents, knee injections, ophthalmic agents and respiratory agents. The following link will take you to a list of drugs that may be subject to step therapy: **bcbsm.com/individuals/resources/forms-documents/drug-lists/group/**. Refer to the *Transplants* section of this booklet for more information on coverage for immunosuppressant drugs. Certain drugs require prior authorization.

Occupational therapy

The medical plan covers evaluation and treatment to help you perform activities of daily living (like dressing or bathing) to maintain current capabilities or slow decline, when your doctor or other healthcare provider certifies your need for it.

Office visits

The medical plan covers primary and specialist visits to a physician for the examination, diagnosis and treatment of general medical conditions. Refer to the *Preventive Services* section of this booklet for annual physical exam, annual wellness visit and "Welcome to Medicare" preventive visit information.

Opioid treatment program services

The medical plan covers:

- United States Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications.
- Dispensing and administration of medications (if applicable).
- Substance use disorder counseling.
- Individual and group therapy.

- Toxicology testing.
- Intake activities.
- Periodic assessments.

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 therapy

The medical plan covers evaluation and treatment for injuries and diseases that change your ability to function, or to maintain current function or slow decline, when your doctor or other healthcare provider certifies your need for it.

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.

Speech therapy

The medical plan covers evaluation and treatment to regain and strengthen speech and language skills, including cognitive and swallowing skills, or to maintain current function or slow decline, when your doctor or other healthcare provider certifies you need it.

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, craniomandibular disorders and myofacial pain dysfunction syndrome.

Virtual visits

The medical plan covers virtual visits, sometimes called telehealth. Virtual visits give you the opportunity to meet with a healthcare provider through electronic forms of communications. This allows you to meet with a healthcare provider for minor illnesses or conditions that require medical attention when it is not possible for you to meet with your primary care provider in the office. Certain telehealth services including primary care provider services and individual sessions for mental health specialty services, are covered.

You have the option of getting these services either through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, then you must use a provider who offers the service by telehealth.

You can access online medical and behavioral health services anywhere in the United States. You may choose to have a virtual visit with your own provider, if your provider offers this service. Refer to the *Virtual visits* section of this booklet for more information.

Vision services

The medical plan covers medical eye exams which produce a diagnosis, such as cataracts, glaucoma, dry eye or conjunctivitis. The medical plan covers the examination and fitting of one pair of corrective lenses (eyeglasses with standard frames) or one set of contact lenses prescribed by a physician following cataract surgery in one or both eyes.

A medical eye exam differs from a routine vision exam in that it is an exam where you are evaluated or treated for some sort of medical condition. Routine eye exams check your vision, screen for eye diseases, and/or updating eyeglasses or contact lenses.

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

What you pay
In-network and Out-of-network
You pay nothing, unless otherwise noted.

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, you'll have an out-of-pocket cost 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 physician, physician assistant, nurse practitioner or clinical nurse specialist.

Note: If you have a family history of abdominal aortic aneurysms, or you're a man 65–75 and you've smoked at least 100 cigarettes in your lifetime, you're considered at risk.

Advance care planning

The medical plan covers voluntary advance care planning as part of the annual wellness visit. This is planning for care you would want to get if you become unable to speak for yourself. You can talk about an advance directive with your healthcare professional, and they can help you fill out the forms, if you want to. An advance directive is an important legal document that records your wishes about medical treatment at a future time, if you're not able to make decisions about your care.

Note: If advance care planning is done outside the annual wellness visit, your coinsurance is 10 percent of the Blue Cross approved amount, after the annual deductible.

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 provider or other healthcare practitioner determines you're misusing alcohol, you can get up to four brief face-to-face counseling sessions per year (if you're competent and alert during counseling). A qualified primary care provider or other healthcare practitioner must provide the counseling in a primary care setting (such as a doctor's office).

Annual physical exam

The medical plan covers an annual routine physical exam once per calendar year. Standard, routine lab tests done in conjunction with an annual routine physical are also covered. An annual routine physical is more comprehensive than an annual wellness visit. Your primary care provider can help you determine which service is right for you.

Annual wellness visit

If you've had Medicare Part B 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 can occur anytime throughout the calendar year, regardless of the date of your previous annual wellness visit.

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.

Advance care planning is also covered as part of the annual wellness visit. This is planning for care you would want to get if you become unable to speak for yourself.

Your provider may also perform a cognitive assessment to look for signs of dementia, including Alzheimer's disease. If you have a current prescription for opioids, your provider will review your potential risk factors for opioid use disorder, evaluate your severity of pain and current treatment plan, provide information on non-opioid treatment options, and may refer you to a specialist, if appropriate.

Your primary care provider or other healthcare provider may also use a questionnaire to better understand your social needs and refer you for appropriate services and support. This is called a "social determinants of health risk assessment," and it's free when you get it as part of your yearly wellness visit.

Bone mass measurement (bone density)

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 (mammograms)

The medical plan covers:

- One routine, screening mammogram (breast X-ray) every calendar year.
- One clinical breast exam every 24 months and once every 12 months for those at high risk.
- 3-D mammograms when medically necessary.
- Diagnostic mammograms more frequently than once a year when medically necessary.

Note: If a diagnostic test is performed, your coinsurance is 10 percent of the Blue Cross approved amount, after the annual deductible. The annual deductible and coinsurance apply to the annual out-of-pocket maximum.

Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)

You have coverage for one visit per calendar year with a primary care provider 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 five 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. Human Papillomavirus (HPV) tests (when received with a Pap test) are covered once every five years if you're 30-65 without HPV symptoms.

Colorectal cancer screening

The medical plan covers these screenings to help find precancerous growths or find cancer early, when treatment is most effective. Colorectal cancer screening tests include a follow-up screening colonoscopy after a non-invasive stool-based colorectal cancer screening test returns a positive result.

Note: If a polyp or other tissue is found and removed during the colonoscopy, your coinsurance is 10 percent of the approved amount. The coinsurance applies to the annual out-of-pocket maximum.

- **Barium enema** – This test is generally covered once every 48 months if you're 45 years old or older (high risk every 24 months) when used instead of a sigmoidoscopy or colonoscopy.
- **Multi-target stool DNA and blood-based biomarker tests** – These lab tests are generally covered once every three years if you meet all of these conditions:
  - Are between 45-85.
  - Show no symptoms of colorectal disease including, but not limited to, lower gastrointestinal pain, blood in stool, positive guaiac fecal occult blood test or fecal immunochemical test.
  - At average risk for developing colorectal cancer, meaning you:
    - Have no personal history of adenomatous polyps, colorectal cancer, inflammatory bowel disease, including Crohn's Disease and ulcerative colitis.
    - Have no family history of colorectal cancer or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer.
- **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.
- **Fecal occult blood test** – This test is covered once every 12 months if you're 45 years or older.
- **Flexible sigmoidoscopy** – This test is generally covered once every 48 months if you're 45 years or older, or 120 months after a previous screening colonoscopy for those not at high risk.

COVID-19 vaccine

The medical plan covers FDA-authorized COVID-19 vaccines.

Depression screening

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

Flu shot (influenza vaccine)

You have coverage for one flu shot once per flu season.

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 years old or older, or Hispanic Americans 65 years old or older. An eye doctor who's legally allowed by the state must do the tests.

Hepatitis B vaccine

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 primary care provider to see if you're at medium or high risk for Hepatitis B.

Hepatitis B virus (HBV) infection screening

See: Sexually transmitted infections screening and counseling

The medical plan covers HBV infection screenings if you're at high risk for HBV infection or you're pregnant. The screening must be ordered by your primary care provider or other healthcare provider. HBV screenings are covered annually for those with continued high risk and don't get a Hepatitis B vaccination.

Hepatitis C screening

The medical plan covers one Hepatitis C screening test and yearly repeat screening for certain people at high risk. You're at high risk if you have a current or past history of illicit injection drug use, had a blood transfusion before 1992 or were born between 1945 to 1965.

Human Immunodeficiency Virus (HIV) screening

The medical plan covers HIV 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 three times during a pregnancy.

Lung cancer screening

The medical plan covers a lung cancer screening with low dose computed tomography (LDCT) once per year for people 50 to 77 years old who are asymptomatic (don't have signs or symptoms of lung cancer), either a current smoker or have quit smoking within the last 15 years, have a tobacco smoking history of at least 20 "pack years" (an average of one pack a day for 20 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 primary care provider or other qualified medical care provider refers you for the service. Only a registered dietitian or nutrition professional who meets certain requirements can provide medical nutrition services.

Obesity screening and counseling

If you have a body mass index (BMI) of 30 or more, the medical plan covers face-to-face individual behavioral therapy sessions to help you lose weight. Up to 22 sessions over a 12-month period are covered. This counseling may be covered if you get it in a primary care setting (like a doctor's office), where it can be coordinated with your other care and a personalized prevention plan. Session limits and weight loss requirements apply.

Pneumococcal shot (pneumonia vaccine)

The medical plan covers pneumococcal shots to help prevent pneumococcal infections (like certain types of pneumonia). The two shots protect against different strains of the bacteria. The medical plan covers the first shot at any time, and also covers a different second shot if it's given one year (or later) after the first shot. Talk with your primary care provider or other healthcare provider to see if you need one or both of the pneumococcal shots.

Prostate cancer screenings

The medical plan covers a Prostate Specific Antigen (PSA) test and a digital rectal exam once every calendar year for men older than 50 years old (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 provider or other healthcare practitioner. The medical plan covers these tests once every 12 months or at certain times during pregnancy.

The medical plan also covers up to two 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 provider or other healthcare practitioner and take place in a primary care setting (such as 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

The medical plan covers up to eight face-to-face visits in a 12-month period.

"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 primary care provider or other qualified medical care provider as part of your one-time "Welcome to Medicare" preventive visit. For EKG or ECG screening, your coinsurance is 10% of the approved amount and the annual deductible applies.

If your primary care provider 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 percent coinsurance after the annual deductible.

Diabetes treatment, services and supplies

Diabetes prevention program

What you pay
In-network and Out-of-network
You pay nothing.

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

The medical plan covers a once-per-lifetime health behavior change program to help you prevent type 2 diabetes. The program begins with weekly core sessions in a group setting over a six-month period. In these sessions, you'll get:

- Training to make realistic, lasting behavior changes around diet and exercise.
- Tips on how to get more exercise.
- Strategies to control your weight.
- Specially trained coach to help keep you motivated.
- Support from people with similar goals and challenges.

Once you complete the core sessions, you'll get:

- Six monthly follow-up sessions to help you maintain healthy habits.
- Twelve monthly ongoing maintenance sessions if you meet certain weight loss and attendance goals.

To be eligible, you must have:

- A hemoglobin A1c test result between 5.7% and 6.4%, a fasting plasma glucose of 110-125mg/dL, or a two-hour plasma glucose of 140-199 mg/dL (oral glucose tolerance test) within 12 months prior to attending the first core session.
- A body mass index (BMI) of 25 or more (BMI of 23 or more if you're Asian).
- Never been diagnosed with type 1 or type 2 diabetes, or end-stage renal disease (ESRD).
- Never participated in the Diabetes Prevention Program.

Diabetes screening

What you pay
In-network and Out-of-network
You pay nothing.

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

The medical plan covers these screenings (includes fasting glucose tests) if your primary care provider or other qualified medical care provider determines you're at risk for diabetes or diagnosed with prediabetes. 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. You may be eligible for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.

Diabetes self-management training

What you pay
In-network and Out-of-network
10% coinsurance, after the annual deductible.

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

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 the risk of diabetes complications. You must have diabetes and a written order from your primary care provider or other qualified medical care provider.

Diabetes supplies and medications

What you pay
In-network and Out-of-network
You pay nothing, unless otherwise noted.

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 will receive will be based on your prescription and the medical necessity guidelines used by Medicare Plus Blue Group PPO.

Some diabetic supplies are covered under your medical plan while others are covered under your prescription drug plan. Injectable insulin and needles and syringes for injectable insulin are covered under your prescription drug plan when prescribed by your physician. Insulin furnished through an item of DME (such as a medically necessary insulin pump) is covered under the medical plan. You won't pay more than $35 for a month's supply. Refer to the *Doctor visits, virtual visits and other medical services* section of this booklet for more information.

The medical plan covers blood sugar testing monitors, blood sugar test strips, lancet devices and lancets, blood sugar control solutions and continuous glucose monitors. Continuous glucose monitors must be obtained from a network pharmacy.

The medical plan covers the following for people who have diabetes and severe diabetic foot disease:

- The furnishing and fitting of either one pair of custom-molded shoes, one pair of extra-depth shoes, inserts, or shoe modifications each calendar year.
- Two additional pairs of inserts for custom-molded shoes and three pairs of inserts for extra-depth shoes each calendar year.

The therapeutic shoes and inserts listed above must be prescribed by a podiatrist or other qualified doctor and provided by a podiatrist, orthotist, prosthetist, pedorthist or another qualified individual.

Kidney disease treatment, services and supplies

Kidney disease education services

What you pay
In-network and Out-of-network
You pay nothing.

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

Kidney disease education services teach kidney care and help members make informed decisions about their care.

The medical plan covers up to six sessions of kidney disease education services per lifetime if you have stage IV chronic kidney disease, and your primary care provider or other medical care provider refers you for the service.

Dialysis treatment and services

What you pay
In-network and Out-of-network
10% coinsurance, after the annual deductible.

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 primary care provider or other qualified medical care provider. 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 Blue 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.

Types of treatment and services:

- Outpatient dialysis treatments.
- Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care).
- Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments).

Dialysis supplies

What you pay	
In PPO network	**Outside PPO network**
10% coinsurance, after the annual deductible.	30% of the Medicare Plus Blue Group PPO – approved amount and the annual deductible.

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

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 Blue Group PPO.

Types of services, equipment and supplies:

- Home dialysis equipment and supplies.
- Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply).

Laboratory services

Laboratory services are tests of body fluid or tissue that help your primary care provider or other qualified medical care provider diagnose a disease or an injury.

Medicare-approved clinical labs

What you pay
In-network and Out-of-network
You pay nothing.

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

What you pay
In-network and Out-of-network
10% coinsurance, after the annual deductible.

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

What you pay
In-network and Out-of-network
10% coinsurance, after the annual deductible.

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.
- Colorectal cancer screenings if a physician finds and/or removes an abnormality, polyp or other tissue.
- 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 obtain prior authorization for specific high technology diagnostic radiology services. Your provider will arrange for the prior 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. Prior authorization does **not** apply to emergency care.

Behavioral health, mental health and substance use disorder services

The medical plan covers behavioral health, mental health and substance use disorder services to help with conditions like depression or anxiety. Coverage includes services generally provided in an outpatient setting (such as 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, licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or clinical nurse specialist. Treatment for substance use disorder is payable for services rendered in an approved residential facility. A residential substance use disorder treatment facility may be a freestanding facility exclusively treating substance use disorder, or a hospital-based treatment center. Laboratory tests are also covered. Outpatient behavioral health, mental health and substance use disorder services rendered by plan providers may require prior authorization. Your plan provider will arrange for prior authorization, if needed. 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 lack of prior authorization.

Services in an outpatient behavioral health and mental health facility

What you pay
In-network and Out-of-network
10% coinsurance, after the annual deductible.

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

Behavioral and 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 substance use disorder facility

What you pay
In-network and Out-of-network
10% coinsurance, after the annual deductible. Clinical lab services are covered at no cost to you.

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

Substance use disorder 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 use disorder 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.

Services in a physician's office

What you pay
In-network and Out-of-network
10% coinsurance, after the annual deductible.

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

Behavioral and 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.

Supervised Exercise Therapy (SET)

What you pay
In-network and Out-of-network
10% coinsurance, after the annual deductible.

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

SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for SET from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a healthcare provider.

The SET program must:

- Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication.
- Be conducted in a hospital outpatient setting or physician's office.
- Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD.
- Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques.

Nursing care

Skilled nursing facility care

What you pay
In-network and Out-of-network
10% coinsurance, after the annual deductible.

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 primary care provider or other qualified medical care provider 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, occupational and speech therapy.
- Drugs administered to you as part of your plan of care (including 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

What you pay
In-network and Out-of-network
You pay nothing. Refer to the *Medical equipment, prosthetics, orthotics and supplies* section for information on medical equipment.

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

Medically necessary home healthcare 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 (such as 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 healthcare.

At each visit, the medical plan will cover:

- Part-time or intermittent skilled nursing care by an employee of the home healthcare 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, prosthetics, orthotics 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.

Note: To be covered under the home healthcare 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 Group PPO. You must use your red, white, and blue Medicare membership card to get hospice services.

You pay nothing for hospice care. When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Medicare Plus Blue Group PPO.

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 six months or less. If you're already getting hospice care, a hospice doctor or nurse practitioner will need to see you about six 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.
- Drugs provided in a hospice setting.
- Aide and homemaker services.
- Other covered services, as well as services Medicare usually doesn't cover, such as spiritual and grief counseling.
- Inpatient respite care in a Medicare-approved facility so that your usual caregiver can rest (you can stay up to five days each time you get respite care).

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

Hospice care doesn't include 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, such as 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, seven days a week, or visit the Medicare website at **medicare.gov**, if you have questions or want more information about your Original Medicare hospice benefit. TTY users should call **1-877-486-2048**.

If you need non-hospice (care that is not related to your terminal condition), contact a Blue Cross representative at **1-800-422-9146**. Getting your non-hospice care through our network providers will lower your share of the costs for the services.

Medical equipment, prosthetics, orthotics and supplies

What you pay	
In-network	**Out-of-network**
10% coinsurance, after the annual deductible.	30% of the Medicare Plus Blue Group PPO – approved amount, after the annual deductible.

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 Blue 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. Coverage includes repair and/or replacement of prosthetic devices.
- Orthotic devices such as leg braces, back braces and ankle or wrist supports. Coverage includes repair and/or replacement of orthotic devices.
- Medical supplies such as surgical dressings, adult disposable diapers, surgical stockings/gradient compression stocking, (up to eight per year or four pair) and IV infusion pumps, powered mattress systems and speech generating devices.
- Defibrillator (implantable automatic).
- Equipment setup and training when medically necessary, such as assistance by an RN or respiratory therapist.
- Orthopedic shoes are covered when medically necessary for people with a diabetes diagnosis and for people who do not have diabetes.

Transplants

What you pay	
In-network and Out-of-network designated as Medicare-approved facility	**Not designated as Medicare-approved facility**
10% coinsurance, after the annual deductible, unless otherwise noted. Clinical lab services are covered at no cost to you. Reasonable travel and lodging may be provided for certain transplants when the transplant is not available locally and we send you to a transplant center outside the normal community patterns of care. If you have a Medicare-covered organ 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).	You pay all costs.

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 Blue[SM] Group PPO and performed at an approved, designated transplant facility.

Transplant coverage includes:

- Hospital and medical costs.
- 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.

Note: To be an inpatient, your provider must write an order to admit you to the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient, you should ask the hospital staff. You can also find more information in the *Medicare Hospital Benefits* fact sheet on the Medicare Publication website at **medicare.gov/publications** or by calling **1-800-MEDICARE (1-800-633-4227**). TTY users should call **1-877-486-2048**. You can call these numbers 24 hours a day, seven days a week.

Organ and tissue transplants

Covered services include the evaluation and surgical removal of a whole or partial organ from one body to another, or from a donor site on the patient's own body, to replace the recipient's damaged or failing organ with a working one. Organ donors can be living or deceased. You have coverage for all transplant procedures that are covered by Original Medicare. Original Medicare covers corneal, duodenum, heart, heart-lung, intestine, intestine tissue, islet cell (covered in clinical trial only), kidney, liver, liver tissue, lung, lobar lung, multivisceral, pancreas, pancreas tissue and stomach transplant procedures.

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 prior authorization 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 Blue Group PPO.

Medicare Plus Blue Group PPO covers a limited number of outpatient prescription drugs. Immunosupressive prescription drugs not covered under Medicare Plus Blue 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 Blue 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 if your transplant occurred after your enrollment in Medicare.

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 costs is very limited for most transplants. However, if you have a Medicare-covered organ 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 Blue 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 Blue Cross to participate in a clinical research study.

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, Blue Cross 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 Blue Cross 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, seven days a week, or visit the Medicare website at **medicare.gov**, if you have questions or want more information about your Original Medicare benefit for clinical research studies. TTY users should call **1-877-486-2048**. Calls are free.

Religious non-medical healthcare institution

What you pay	
Institution certified by Medicare	**Institution not certified by Medicare**
10% coinsurance, after the annual deductible.	You pay all costs.

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

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, such as unmedicated wound dressings or use of a simple walker.

Routine hearing care

What you pay	
TruHearing provider	**Non-TruHearing provider**
• $45 copay for routine hearing exam. • $499 copay per TruHearing Advanced hearing aid. • $799 copay per TruHearing Premium hearing aid.	You pay all costs.

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

Your routine hearing care services and hearing aids are exclusively available through a national network of TruHearing providers. Routine hearing care services and hearing aids will be covered only when you call TruHearing at **1-855-205-6305** (TTY: **711**) from 8 a.m. to 8 p.m. Eastern time, Monday through Friday and follow the instructions you're given. Non-routine hearing and balance exams are covered under your medical plan. Refer to the *Doctor visits, virtual visits and other medical services* section of this booklet for more information on non-routine hearing and balance exam coverage. Your routine hearing care benefits are not subject to the annual deductible. Copays for routine hearing care are not included in the annual out-of-pocket maximum.

Your routine hearing care benefits include the following services:

Audiometric examination

Audiometric examination measures hearing ability, including test for air and bone conduction, speech reception and speech discrimination.

Hearing aid evaluation test

Hearing aid evaluation test determines what type of hearing aid should be prescribed to compensate for loss of hearing.

Hearing aids

TruHearing Advanced or TruHearing Premium hearing aid monaural (one ear) and binaural (involving both ears) in various fits, styles and colors are covered under your medical benefits. Other hearing aids are not covered. TruHearing provides the following:

- One year of follow-up visits.
- 60-day trial period.
- Three year manufacturer warranty.
- 80 batteries per non-rechargeable hearing aid.

Using your hearing care benefits

Call TruHearing at **1-855-205-6305** (TTY: **711**) from 8 a.m. to 8 p.m. Eastern time, Monday through Friday and follow the instructions you're given.

TruHearing will:

- Verify benefit eligibility and answer your questions.
- Schedule your appointment with a local provider.
- Send you an appointment reminder.
- Follow up after your hearing exam to ensure satisfaction.

Frequency limitation

Routine hearing exams and hearing aids are only covered when you call TruHearing at **1-855-205-6305** (TTY: **711**) from 8 a.m. to 8 p.m. Eastern time, Monday through Friday and follow the instructions you're given. Routine hearing exams are covered once every 36 months. Up to two TruHearing Advanced or TruHearing Premium hearing aids are available every 36 months.

Note: Binaural hearing aids, or two hearing aids to correct hearing loss in both ears, are covered only when they are 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. Routine hearing care services must be received from a TruHearing provider to be covered.
2. Copays for routine hearing exams and hearing aids aren't counted toward your deductible and not included in the annual out-of-pocket maximum.

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 preemployment examinations.
- Medical nutrition therapy services, except as described elsewhere in this booklet.
- Vaccinations not listed as covered elsewhere in this booklet, including shingles vaccine. Check with your prescription drug plan about coverage for additional vaccines.
- 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. Check with your prescription drug plan about coverage for oral contraceptives.
- 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.
- Private duty nursing.
- Full-time nursing care in your home.
- 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.
- Acupuncture, other than for chronic low back pain.
- 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.
- 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.
- 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.
- Home-delivered meals.
- 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.*
- 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 healthcare 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.
- Costs 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.
- Routine hearing exams and hearing aids are only covered when you call TruHearing at **1-855-205-6305** (TTY: **711**) from 8 a.m. to 8 p.m. Eastern time, Monday through Friday and follow the instructions you are given.
- Routine hearing care benefit does not include or cover any of the following items or services under any circumstances:
  - Hearing aids other than TruHearing Advanced and TruHearing Premium hearing aids.
  - Ear molds.
  - Hearing aid accessories.
  - Provider visits for hearing aid adjustments after the first year (additional visits may cost up to $65).
  - Extra batteries beyond the first 80 provided per aid (additional batteries may be purchased from TruHearing on a discounted basis).
  - Charges associated with loss and damage warranty claims (may cost up to $250 per hearing aid for manufacturer and provider programming fees).
  - All hearing care program services and supplies provided by a provider not associated with TruHearing.
  - Costs associated with excluded items.
  - Charges associated with seeing a provider outside of the TruHearing network.

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. TTY users should call **711**.

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.

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 Plus Blue PPO Member Reimbursement 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 the plan documents list at **bcbsm.com/mpsers/medical-plans/medicare-ppo/** or call **1-800-422-9146** and ask for one to be mailed to you. TTY users should call **711**. 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 Benefits Statement

Once your claim is processed, Blue Cross Blue Shield of Michigan will send you an explanation of benefits statement (EOB). 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 EOB, call Blue Cross Blue Shield Customer Service at **1-800-422-9146**. TTY users should call **711**.

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 and you'll also have a permanent record for your files.

Routine hearing care appeals and complaints

What to do if you have a problem or concern

All questions and concerns about your routine hearing care benefits should be directed to TruHearing at **1-855-205-6305** (TTY: **711**) from 8 a.m. to 8 p.m. Eastern time, Monday through Friday. You can contact TruHearing with questions about your routine hearing care benefits, including your eligibility for the benefits or the amount you pay for your routine hearing care benefits or hearing aids. You should contact TruHearing in any of the following situations:

- If you need to know whether a particular service or item is covered.
- If you have a complaint about a TruHearing provider, including a complaint about the quality of your care.

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 care. For example, if your plan network provider refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either your network provider can show you received a standard denial notice for this medical specialist, or the Evidence of Coverage makes it clear that the referred service is never covered under any condition. You or your doctor can 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, your appeal will automatically 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 we receive your request for a medical item or service. If your request is for a medical plan drug, we will give you an answer within 72 hours after we receive your request. However, for a request for a medical item or service, 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. We can't take extra time to make a decision if your request is for a medical plan drug. 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 calendar days, or 72 hours if your request is for a medical plan drug, after we received your request. If Blue Cross extended the time needed to make the coverage decision on your request for a medical item or service, Blue Cross will authorize or provide the coverage by the end of that extended 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 if your request is for a medical item or service. If your request is for a medical plan drug, we will answer within 24 hours. However, for a request for a medical item or service, Blue Cross can take up to 14 more calendar days if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. We can't take extra time to make a decision if your request is for a medical plan drug. 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. The process for making a complaint is different from the process for coverage decisions and appeals. 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 or provide the medical care coverage within 72 hours after your request was received. If Blue Cross extended the time needed to make the coverage decision on your request for a medical item or service, Blue Cross will authorize or provide the coverage by the end of that extended 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. This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision. The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested.

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 65 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. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an 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 Blue Cross Customer Service at **1-800-422-9146** or download the form from **cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS012207** or on our website at **bcbsm.com/medicare/resources/forms-documents/manage-account/**. TTY users should call **711**. 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 on a request for a medical item or service within 30 calendar days after your appeal is received. We will give you an answer within seven calendar days after we received your appeal if your appeal is about coverage for a medical plan drug you have not yet received. However, Blue Cross can take up to 14 more calendar days if your request is for a medical item or service, 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. We can't take extra time to make a decision if your request is for a medical plan drug. 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 (or 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 or within seven calendar days if your request is for a medical plan drug, after your appeal was received.
- **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 your request is for a medical item or service, 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. We can't take extra time to make a decision if your request is for a medical plan drug. 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 an 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. If your request is for a medical item or service, the review organization must give you an answer within 30 calendar days of when it receives your appeal. If your request is for a medical plan drug, the review organization must give you an answer within seven calendar days of when it received your appeal. However, if your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, it can take up to 14 more calendar days. The Independent Review Organization can't take extra time to make a decision if your request is for a medical plan drug.

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 your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, it can take up to 14 more calendar days. The Independent Review Organization can't take extra time to make a decision if your request is for a medical plan drug.

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 a request for a medical item or service, Blue Cross will authorize medical care coverage within 72 hours after receiving the decision from the review organization for standard requests or within 24 hours from the date we receive the decision from the review organization for expedited requests.
- **If the answer is Yes** to part or all of a request for a medical plan drug, Blue Cross will authorize or provide the medical plan drug coverage within 72 hours after receiving the decision from the review organization for standard requests or within 24 hours from the date we receive the decision from the review organization for expedited requests.
- **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 listed in the *How to reach Blue Cross Blue Shield of Michigan Contact information for Coverage Decisions, Appeals or Complaints* section of this booklet.

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 Livanta, LLC. You can reach Livanta, LLC by calling **1-888-524-9900**. TTY users should call **1-855-843-4776**. If you live outside Michigan, call Blue Cross at **1-800-422-9146** if you would like contact information for your state. TTY users should call **711**.

You can also submit a complaint about Medicare Plus Blue Group PPO directly to Medicare. To submit a complaint to Medicare, go to **medicare.gov/MedicareComplaintForm/home.aspx**.

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 be prepared to provide your enrollee identification number from your Blue Cross Medicare Plus Blue Group PPO membership card.**

Blue Cross' Customer Service Contact Information	
Call	**1-800-422-9146** Monday through Friday, 8:30 a.m. to 5 p.m., Eastern time Toll free from the United States or Canada Call **313-225-9000** outside the United States or Canada and ask to be transferred to the customer area that services Michigan public school retirees. Customer Service also has free language interpreter services available for non-English speakers.
TTY	**711** Monday through Friday, 8:30 a.m. to 5 p.m., Eastern time Toll free This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Fax	**1-866-458-9342**
Write	Blue Cross Blue Shield of Michigan MPSERS Medicare Plus Blue Group PPO P.O. Box 441790 600 E. Lafayette Boulevard Detroit, MI 48226-1790
Website	**bcbsm.com/mpsers**

Contact information for Coverage Decisions, Appeals or Complaints	
Call	**1-800-422-9146** Monday through Friday, 8:30 a.m. to 5 p.m., Eastern time
TTY	**711** Monday through Friday, 8:30 a.m. to 5 p.m., Eastern time This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Fax	**1-877-348-2251** — all appeals and complaints
Write	Blue Cross Blue Shield of Michigan Grievance and Appeals Department P.O. Box 2627 Detroit, MI 48231-2627

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.

Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage
A federal requirement that allows departing members to continue group medical coverage at their own cost for a fixed period of time.

Coinsurance
The percentage you pay of the total cost of certain medical services after you have met your deductible. The amount of your coinsurance is based on the Medicare Plus Blue Group PPO approved amount for covered services.

Copay, copayment
A flat dollar amount that you pay when you receive certain medical care services.

Coinsurance/copay maximum
The maximum amount you will pay in coinsurance or copays during a calendar year, excluding copays for routine hearing care.

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 medical 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
The amount you must pay for medical services before your retirement system begins to pay its share.

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 (DME)
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. Blue Cross Blue Shield of Michigan's 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.

Blue Cross Blue Shield of Michigan's 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 use disorder, 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 healthcare agency, approved home healthcare agency

A centrally administered agency that provides physician-directed nursing and other paramedical services to patients at home. An approved home healthcare 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 Blue 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 use disorder; 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.

Laboratory services

Tests of body fluid or tissue that help your primary care provider or other qualified medical care provider 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.

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 long-term acute care hospital services:
Determination by Blue Cross 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 Blue Cross.
- The treatment is not determined to be medically inappropriate by the Utilization Quality and Health Management Programs (applies only to hospitals, not to long-term acute care hospitals).

Medical necessity for payment of services of other providers:
Determination by physicians acting for Blue Cross, based on criteria and guidelines developed by physicians for Blue Cross 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 United States citizens age 65 or older, persons of any age who are permanently disabled, or persons with end-stage renal disease.

Medicare Advantage

A plan offered 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

See also: TruHearing provider

Doctors and other healthcare 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 percentage of services received.

Out-of-pocket maximum

The most you will pay for covered medical expenses in a calendar year through coinsurance, copays and deductible. Copays for routine hearing exams and hearing aids are not included in the annual out-of-pocket maximum.

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 use disorder treatment program, approved substance use disorder 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 use disorder treatment program, approved substance use disorder 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 use disorder 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 United States, 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 such as rheumatoid arthritis, multiple sclerosis and certain cancers. Specialty drugs often require special handling, such as refrigeration during shipping, and administration, such as injection or infusion.

Substance use disorder
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 healthcare program of the United States Department of Defense Military Health System.

TruHearing provider
A hearing care provider selected by TruHearing to provide routine hearing care services and hearing aids through an arrangement between Blue Cross and TruHearing. TruHearing is an independent company that provides hearing care services. TruHearing does not provide Blue Cross branded products and services.

Urgently needed services
Covered services that require immediate medical attention but are not considered emergencies. These services are covered by your plan even when you are temporarily outside the service area of the plan, or even if you are inside the service area of the plan and unable to obtain the service from network providers due to time, location or circumstances. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable.

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Revised March 2025

Medicare W015060