

2026

READY
TO HELP



Medicare Plus BlueSM Group PPO

Evidence of Coverage

Your Medicare Health Benefits and Services as a Member of Medicare Plus BlueSM Group PPO

This document gives you the details about your Medicare health care coverage from January 1 – December 31, 2026.

This is an important legal document. Please keep it in a safe place.

For questions about this document, please contact Blue Cross Blue Shield of Michigan Customer Service at 1-800-422-9146. TTY users should call 711. Hours are 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday. This call is free.

This plan, Medicare Plus Blue Group PPO, is offered by Blue Cross Blue Shield of Michigan. (When this Evidence of Coverage says “we,” “us,” or “our,” it means Blue Cross Blue Shield of Michigan. When it says “plan” or “your plan,” it means Michigan Public School Employees’ Retirement System’s Medicare Plus Blue Group PPO.)

Benefits, premium, coinsurance, copayments and/or deductible may change on January 1, 2027.

The provider network may change at any time. You will receive notice when necessary.

We will notify affected enrollees about changes at least 30 days in advance.

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

- Your plan premium and cost sharing;
- Your medical benefits;
- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us if you need further assistance; and,
- Other protections required by Medicare law.

Michigan Public School Employees’ Retirement System

bcbsm.com/mpsers

Notice of Availability

English: Call 1-800-422-9146 to connect with a complimentary interpreter who speaks English or to receive additional support you may need.

Spanish: Llame al 1-800-422-9146 para conectarse de forma gratuita con un intérprete que hable español o para recibir apoyo adicional que pueda necesitar.

Arabic: اتصل على 1-800-422-9146 للتواصل مع مترجم مجاني يتحدث اللغة العربية أو لتلقي المزيد من الدعم الذي قد تحتاجه.

Chinese Mandarin: 拨打1-800-422-9146联系一位会说普通话的免费翻译，或获取您可能需要的其他支持。

Albanian: Telefononi në numrin 1-800-422-9146 për t'u lidhur me një interpret pa pagesë që flet shqip ose për të marrë mbështetje shtesë që mund t'ju nevojitet.

German: Rufen Sie 1-800-422-9146 an, um einen kostenlosen Dolmetscher zu finden, der Deutsch spricht, oder um weitere Unterstützung zu erhalten.

Amharic: አጠቃላይ ከአጠቃላይ ገን ተርጓሚ ጋር ለማግኘት ወይም ሊያስፈልግዎ የሚችል ተጨማሪ ድጋፍ ለማግኘት 1-800-422-9146 ላይ ይደውሉ።

Bengali: বিনামূল্যে বাংলা ভাষায় কথা বলতে পারেন এমন একজন সহায়ক দোভাষীর সাথে যোগাযোগ করতে অথবা আপনার প্রয়োজনীয় অতিরিক্ত সহায়তা পেতে 1-800-422-9146 নম্বরে কল করুন।

French: Appelez le 1-800-422-9146 pour entrer en contact avec un interprète gratuit qui parle français ou pour bénéficier d'un soutien supplémentaire dont vous pourriez avoir besoin.

Hindi: किसी ऐसे मानार्थ (कंप्लीमेंटरी) दुभाषिण से संपर्क करने के लिए जो हिंदी बोलता हो या ऐसी अतिरिक्त सहायता प्राप्त करने के लिए जिसकी आपको आवश्यकता हो सकती है, 1-800-422-9146 पर कॉल करें।

Korean: 한국어 무료 통역사와 연결하시거나 필요한 추가 지원을 받으시려면 1-800-422-9146로 전화해 주십시오.

Polish: Zadzwoń pod numer 1-800-422-9146, aby połączyć się z nieodpłatnym tłumaczem posługującym się językiem polskim lub aby – w razie potrzeby – uzyskać dodatkową pomoc.

Telugu: తెలుగు మాట్లాడే ఉచిత ఇంటర్‌ప్రెటీటర్‌తో కనెక్ట్ కావడానికి లేదా మీకు అవసరం కాగల అదనపు మద్దతును పొందడానికి 1-800-422-9146 కు కాల్ చేయండి.

Vietnamese: Xin gọi 1-800-422-9146 để kết nối với một thông dịch viên tiếng Việt miễn phí hoặc để được hỗ trợ thêm nếu quý vị cần.

Pennsylvania Dutch: Call 1-800-422-9146 fer schwetze mit en Interpreter as Deitsch schwetzt odder fer ennichi Hilf griege as du brauchsch. Des zellt dich nix koschde.

Tagalog: Tumawag sa 1-800-422-9146 upang kumonekta sa isang walang bayad na interpreter na nagsasalita ng Tagalog o upang makatanggap ng karagdagang suporta na maaaring kailanganin mo.

Discrimination is against the law

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes). Blue Cross Blue Shield of Michigan and Blue Care Network do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network:

- Provide people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provide free language services to people whose primary language is not English, which may include:
 - Qualified interpreters
 - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call the Customer Service number on the back of your card. If you're not already a member, call 1-877-469-2583 or, if you're 65 or older, call 1-888-563-3307, TTY: 711.

Here's how you can file a civil rights complaint

If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with:

Office of Civil Rights Coordinator
600 E. Lafayette Blvd., MC 1302
Detroit, MI 48226
Phone: 1-888-605-6461, TTY: 711
Fax: 1-866-559-0578
Email: CivilRights@bcbsm.com

If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal website at

<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail, phone or email at:

U.S. Department of Health & Human Services
200 Independence Avenue, SW, Room 509F, HHH Building
Washington, D.C. 20201
Phone: 1-800-368-1019, TTD 1-800-537-7697
Email: OCRComplaint@hhs.gov

Complaint forms are available on the U.S. Department of Health & Human Services Office for Civil Rights website at <https://www.hhs.gov/civil-rights/filing-a-complaint/index.html>.

This notice is available at Blue Cross Blue Shield of Michigan and Blue Care Network's website:

<https://www.bcbsm.com/Important-Information/policies-practices/nondiscrimination-notice/>.

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CHAPTER 1: Get started as a member

SECTION 1 You're a member of Medicare Plus Blue Group PPO

Section 1.1 You're enrolled in Medicare Plus Blue Group PPO, which is a Medicare PPO

You're covered by Medicare, and you choose to get your Medicare healthcare coverage through the Michigan Public School Employees' Retirement System's Medicare Plus Blue Group PPO plan. This plan covers all Part A and Part B services. However, cost sharing and provider access in this plan differs from Original Medicare.

There are different types of Medicare health plans. Medicare Plus Blue Group PPO is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). The plan is approved by Medicare and administered by Blue Cross Blue Shield of Michigan. This plan does not include Part D prescription drug coverage. Your retirement system offers a prescription drug plan administered by Optum Rx.

Section 1.2 Legal information about the *Evidence of Coverage*

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

The contract is in effect for the months you're enrolled in Medicare Plus Blue Group PPO between Jan. 1, 2026, and Dec. 31, 2026.

Medicare allows changes to plans we offer each calendar year. This means the costs and benefits of Medicare Plus Blue Group PPO may change after Dec. 31, 2026. We can also choose to stop offering this plan in your service area after Dec. 31, 2026.

Medicare (the Centers for Medicare & Medicaid Services) must approve Medicare Plus Blue Group PPO each year. You can continue to get Medicare coverage as a member of this plan as long as you meet the eligibility requirements of this plan, and we choose to continue offering this plan and Medicare renews its approval of this plan.

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

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

- Have both Medicare Part A and Medicare Part B.
- Meet the eligibility requirements for the Michigan Public School Employees' Retirement System.
 - Please contact the Michigan Office of Retirement Services (ORS) at **1-800-381-5111**, Monday through Friday, 8:30 a.m. to 5 p.m. Eastern time,

for more information. You can also visit michigan.gov/orsmiaccount and use the online Message Board for secure access to a representative.

- Live in our geographic service area (described in Section 2.2). Incarcerated individuals are not considered to be in the geographic service area even if they're physically located in it.
- Are a U.S. citizen or lawfully present in the U.S.

Section 2.2 Plan service area for Medicare Plus Blue Group PPO plan

Medicare Plus Blue Group PPO is only available to people eligible for the Michigan Public School Employees' Retirement System health plan and who live in our service area. Our service area is the U.S. and its territories. You need a physical address within our service area, on file with ORS, to be enrolled in this plan.

To remain a member of this plan, you must continue to stay in our service area. If you move out of the service area, you will be disenrolled from this plan. If you plan to move out of the service area, you must contact ORS. Address and other demographic updates can be made online at michigan.gov/orsmiaccount.

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

Section 2.3 U.S. citizen or lawful presence

You must be a U.S. citizen or lawfully present in the U.S. to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify Blue Cross if you're not eligible to stay a member of this plan on this basis. We must disenroll you if you do not meet this requirement.

SECTION 3 Important membership materials

Section 3.1 Your plan member identification (ID) card — Use it to get all covered care

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



Do NOT use your red, white and blue Medicare card for covered medical services while you're a member of this plan. If you use your Medicare card instead of your Medicare Plus Blue Group PPO member ID card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospice services or participate in Medicare-approved clinical research studies (also called clinical trials).

If your plan member ID card is damaged, lost or stolen, call Blue Cross Customer Service at **1-800-422-9146** (TTY: **711**) right away and we will send you a new card.

Section 3.2 Network provider

The 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.

Network providers are the doctors and other healthcare professionals, medical groups, durable medical equipment suppliers, hospitals and other healthcare facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full. We have arranged for these providers to deliver covered services to members in this plan.

You can use our *Find a Doctor* tool at **bcbsm.com/mpsers** or contact Blue Cross Customer Service to locate network providers. Both Blue Cross Customer Service and the website can give you the most up-to-date information about changes in our network. You can contact Blue Cross Customer Service at **1-800-422-9146** (TTY: **711**) for more information about our network providers, including their qualifications.

To locate network providers for your routine hearing exams and hearing aids, refer to the Routine Hearing Care section located in Chapter 4, Section 2.1.

SECTION 4 Your monthly costs for Medicare Plus Blue Group PPO

	Costs in 2026
Monthly plan premium	You're required to pay a <u>premium</u> contribution defined by ORS. You, or others on your behalf, must also continue to pay your Medicare Part B premium.
Deductible Note: Deductible is waived for insulin supplied through an item of durable medical equipment.	\$800
Maximum out-of-pocket amount This is the <u>most</u> you'll pay out of pocket for your covered services. Note: Your <u>out-of-pocket maximum</u> consists of your \$800 deductible, plus the annual <u>coinsurance/copayment</u> maximum of \$900. Routine hearing care costs are not included in the maximum.	\$1,700
Primary care office visits	You pay 10% of the approved amount, after deductible, per visit.
Specialist office visits	You pay 10% of the approved amount, after deductible, per visit.
Inpatient hospital stays	You pay 10% of the approved amount, after deductible. You pay \$0 for Medicare-approved clinical lab services. Deductible does not apply to these services.

Your costs may include the following:

- Plan premium (Section 4.1).
- Monthly Medicare Part B premium (Section 4.1).

Section 4.1 Plan premium

Your retirement system charges a premium for Medicare Plus Blue Group PPO coverage in 2026. Contact ORS at **1-800-381-5111** (TTY: **711**) if you have questions about your premium.

Many members are required to pay other Medicare premiums.

In addition to paying the monthly plan premium, you must continue paying your Medicare premiums to remain a member of the plan.

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

SECTION 5 Keep your plan membership record up to date

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

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

You must contact ORS to update the following information:

- Changes to your name, physical and/or mailing address, email address or phone number. You can go online to **michigan.gov/orsmiaccount** or call ORS at **1-800-381-5111**.
- Corrections to your date of birth or other demographic information.

If you have any of the following changes, let Blue Cross Blue Shield of Michigan Customer Service know:

- Any liability claims, such as claims from an automobile accident.
- If you're admitted to a nursing home.
- If you get care in an out-of-area or out-of-network hospital or emergency room.
- If your designated responsible party (such as a caregiver) changes.
- This must also be reported to ORS at **1-800-381-5111**.

If any of this information changes, let us know by calling Blue Cross Customer Service at **1-800-422-9146** (TTY: **711**).

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

SECTION 6 How other insurance works with the plan

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

You're not eligible for coverage for any services under the Medicare Plus Blue Group PPO plan if you have other Medicare Advantage group health coverage or 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.

If you have Medicare because of end-stage renal disease, 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.

The following types of coverage are not group health coverage and usually pay first. You must call Blue Cross Customer Service if you have claims involving any of the following types of coverage:

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

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

CHAPTER 2: Phone numbers and resources

SECTION 1 Blue Cross Medicare Plus Blue Group PPO contacts

For help with claims, billing or member ID card questions, call or write to Blue Cross Medicare Plus Blue Group PPO Customer Service. We'll be happy to help you.

Customer Service – Contact Information	
CALL	1-800-422-9146 Calls to this number are free. Available from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday. Customer Service also has free language interpreter services for non-English speakers.
TTY	711 Calls to this number are free. Available from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday.
FAX	1-866-458-9342
WRITE	Blue Cross Blue Shield of Michigan MPERS-Medicare Plus Blue Group PPO Customer Service Inquiry Department P.O. Box 441790 600 E. Lafayette Blvd. Detroit, MI 48226-1790
WEBSITE	bcbsm.com/mpsers

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

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

Coverage Decisions and Appeals for Medical Care — Contact Information	
CALL	1-800-422-9146 Calls to this number are free. Available from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday.
TTY	711 Calls to this number are free. Available from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday.

Coverage Decisions and Appeals for Medical Care — Contact Information	
FAX	1-877-348-2251 — All appeals and complaints
WRITE	Blue Cross Blue Shield of Michigan Grievances and Appeals Department P.O. Box 2627 Detroit, MI 48231-2627

How to make a complaint about your medical care

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

Complaints About Medical Care — Contact Information	
CALL	1-800-422-9146 Calls to this number are free. Available from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday.
TTY	711 Calls to this number are free. Available from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday.
FAX	1-877-348-2251 — All appeals and complaints
WRITE	Blue Cross Blue Shield of Michigan Grievances and Appeals Department P.O. Box 2627 Detroit, MI 48231-2627
MEDICARE WEBSITE	To submit a complaint about Medicare Plus Blue Group PPO directly to Medicare, go to medicare.gov/my/medicare-complaint .

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

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

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

Payment Requests — Contact Information	
CALL	1-800-422-9146 Calls to this number are free. Available 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday.
TTY	711 Calls to this number are free. Available 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday.
FAX	1-877-348-2251
WRITE	Blue Cross Blue Shield of Michigan Imaging and Support Services P.O. Box 32593 Detroit, MI 48232-0593
WEBSITE	bcbsm.com/content/dam/microsites/medicare/documents/medical-claim-form-ppo.pdf

SECTION 2 Get help from Medicare

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

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

Medicare — Contact Information	
CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
CHAT LIVE	Chat live at medicare.gov/talk-to-someone .
WRITE	Write to Medicare at P.O. Box 1270, Lawrence, KS 66044
WEBSITE	medicare.gov

Medicare — Contact Information

Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide.

Find Medicare-participating doctors or other healthcare providers and suppliers.

Find out what Medicare covers, including preventive services (like screenings, shots or vaccines and yearly “Wellness” visits).

Get Medicare appeals information and forms.

Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities and long-term care hospitals.

Look up helpful websites and phone numbers.

You can also visit **medicare.gov** to tell Medicare about any complaints you have about Medicare Plus Blue Group PPO.

To submit a complaint to Medicare, go to **medicare.gov/my/medicare-complaint**. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

SECTION 3 State Health Insurance Assistance Program

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information and answers to your Medicare questions. In Michigan, the SHIP is called MI Options.

MI Options is an independent state program (not connected with any insurance company or health plan) that gets money from the federal government to give free local health insurance counseling to people with Medicare.

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

MI Options — Contact Information

CALL	1-800-803-7174
TTY	711

MI Options — Contact Information	
WRITE	MI Options P.O. Box 30676 Lansing, MI 48909
WEBSITE	Visit shiphelp.org . (Click SHIP LOCATOR in middle of page.) Select your STATE from the list. This will take you to a page with phone numbers and resources specific to your state.

SHIPs in other states are listed in *Exhibit 1* of the Appendix. Contact information may change throughout the year.

SECTION 4 Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state. For Michigan, the QIO is called Commence Health.

Commence Health has a group of doctors and other healthcare professionals who are paid by Medicare to check on and help improve the quality of care for people with Medicare. Commence Health is an independent organization. It is not connected with Blue Cross.

You should contact Commence Health in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home healthcare, skilled nursing facility care or Comprehensive Outpatient Rehabilitation Facility (CORF) service is ending too soon.

Commence Health — Contact Information	
CALL	1-888-524-9900 24 hour voicemail service is available Monday-Friday: 9:00 a.m. - 5:00 p.m. (local time) Sat/Sun and Holidays: 10:00 a.m. - 4:00 p.m. (local time) .
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. 24-hour voicemail service is available. Available 9:00 a.m. to 5:00 p.m. local time, Monday through Friday. Available 10:00 a.m. to 4:00 p.m. (local time), Saturday and Sunday.
WRITE	Commence Health LLC BFCC-QIO P.O. Box 2678 Virginia Beach, VA 23450
WEBSITE	<u>livantaqio.cms.gov/en/States/Michigan</u>

QIOs in other states are listed in *Exhibit 2* of the Appendix. Contact information is subject to change throughout the year.

SECTION 5 Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment. If you move or change your mailing address, it's important that you contact Social Security, in addition to ORS, to let them know.

Method	Social Security — Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 8 a.m. to 7 p.m. local time, Monday through Friday. Use Social Security’s automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8 a.m. to 7 p.m. local time, Monday through Friday.
WEBSITE	ssa.gov

SECTION 6 Medicaid

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

Qualified Medicare Beneficiary (QMB): Helps pay Medicare Part A and Part B premiums, and other cost sharing (like coinsurance, copayments and deductible). Some people with QMB are also eligible for full Medicaid benefits (QMB+).

Specified Low-Income Medicare Beneficiary (SLMB): Helps pay Part B premiums. Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).

Qualifying Individual (QI): Helps pay Part B premiums.

Qualified Disabled & Working Individuals (QDWI): Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact the Michigan Department of Health and Human Services.

Michigan Department of Health and Human Services — Contact Information	
CALL	1-800-642-3195
WRITE	Michigan Department of Health and Human Services 333 S. Grand Ave. P.O. Box 30195 Lansing, MI 48909
WEBSITE	michigan.gov/medicaid

Medicaid programs in other states are listed in *Exhibit 3 of the Appendix*. Contact information may change throughout the year.

SECTION 7 Railroad Retirement Board (RRB)

The Railroad Retirement Board (RRB) is an independent federal agency that administers comprehensive benefit programs for the nation’s railroad workers and their families. If you get Medicare through the RRB, let them know if you move or change your mailing address. For questions about your benefits from the RRB, contact the agency.

Railroad Retirement Board — Contact Information	
CALL	1-877-772-5772 Calls to this number are free. Press “3” to speak with an RRB representative from 9 a.m. to 3:30 p.m., Monday through Friday. Press “1” to access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are <i>not</i> free.
WEBSITE	rrb.gov

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

If you (or your spouse or domestic partner) are enrolled in other group health insurance 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.

CHAPTER 3: Using your plan for your medical services

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

This chapter explains what you need to know about using this plan to get your medical care covered.

For details on what medical care this plan covers and how much you pay when you get care, go to the **Medical Benefits Chart** in *Chapter 4*.

Section 1.1 Network providers and covered services

- Providers are doctors and other healthcare professionals licensed by the state to provide medical services and care. The term providers also include hospitals and other healthcare facilities.
- Network providers are the doctors and other healthcare professionals, medical groups, hospitals and other healthcare facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We arranged for these providers to deliver covered services to members in this plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- Covered services include all the medical care, healthcare services, supplies and equipment that are covered by this plan. Your covered services for medical care are listed in the **Medical Benefits Chart** in *Chapter 4*.

To locate network providers for your routine hearing exams and hearing aids, refer to the **Routine Hearing Care** section located in *Chapter 4, Section 2.1*.

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

As a Medicare health plan, Medicare Plus Blue Group PPO must cover all services covered by Original Medicare and follow Original Medicare's coverage rules.

The plan will generally cover your medical care as long as:

- **The care you get is included in our Medical Benefits Chart** in *Chapter 4*.
- **The care you get is considered medically necessary.** Medically necessary means that the services, supplies, equipment or prescription drugs are needed for the prevention, diagnosis or treatment of your medical condition and meet accepted standards of medical practice.
- **You get your care from a provider who is eligible to provide services under Original Medicare.** As a member of this plan, you can get care from either a network provider or an out-of-network provider. Go to *Section 2* for more information.
 - To locate providers in our network, visit our website at bcbsm.com/mpsers and use the *Find a Doctor* search tool.
 - If you use an out-of-network provider, your share of the costs for your covered services may be higher.

- While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you go to a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before getting services to confirm that they're eligible to participate in Medicare.
- Although Original Medicare does not cover routine hearing exams and hearing aids, these services are covered by your retirement system plan. To locate network providers for your routine hearing exams and hearing aids, refer to the **Routine Hearing Care** section located in *Chapter 4, Section 2.1*.

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

Section 2.1 How to get care from specialists and other network providers

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

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

You don't need to get a referral when you get care from in-network providers.

When a specialist or another provider leaves our network

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

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.
- We'll notify you that your provider is leaving our network so that you have time to choose a new provider.
 - If your primary care or behavioral health provider leaves the plan, we'll notify you if you visited that provider within the past three years.
 - If any of your other providers leave this plan, we'll notify you if you're assigned to the provider, currently get care from them or visited them within the past three months.
- We'll help you choose a new qualified in-network provider for continued healthcare.
- If you're currently undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.

- If you find out your doctor or specialist is leaving our network, contact us so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file a quality of care complaint to the Quality Improvement Organization, a quality of care grievance to the plan or both. For more information, go to *Chapter 7*.

Section 2.2 How to get care from out-of-network providers

As a member of this plan, you can choose to get most of your care from out-of-network providers. However, your routine hearing exams and hearing aids are not covered unless you call TruHearing at **1-855-205-6305** (TTY: **711**) from 8 a.m. to 8 p.m., Monday through Friday and follow the instructions you're given. You have no routine hearing care benefits if you see a non-TruHearing provider.

Providers that do not contract with us are under no obligation to treat you, except in emergency situations. Your plan will cover most services from either in-network or out-of-network providers, as long as the services are covered benefits and are medically necessary. However, **if you use an out-of-network provider, your share of the costs for covered services may be higher.** Here are other important things to know about using out-of-network providers:

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

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

Section 3.1 Get care if you have a medical emergency

A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb or function of a limb or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain or a medical condition that is quickly getting worse. This includes emergencies related to mental health conditions and substance use disorder.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your primary care provider (PCP).

Covered services in a medical emergency

You may get covered emergency medical care whenever you need it, anywhere in the U.S. or its territories. Your plan covers emergency services for mental health conditions and substance use disorder. Your plan covers ambulance services in situations when getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency.

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

After the emergency is over, you're entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by the plan.

What if it wasn't a medical emergency?

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

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

A service that requires immediate medical attention (but isn't an emergency) is an urgently needed service if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network

providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

Section 3.3 Getting care during a disaster

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

Visit [bcbsm.com/medicare](https://www.bcbsm.com/medicare) for information on how to get needed care during a disaster.

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

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

Section 4.1 If services are not covered by the plan, you must pay the full cost

Medicare Plus Blue Group PPO covers all medically necessary services as listed in the Medical Benefits Chart in *Chapter 4*. If you get services not covered by this plan, you're responsible for paying the full cost of services.

For covered services that have a benefit limitation, you pay the full cost of any services you get after you use up your benefit for that type of covered service.

SECTION 5 Medical services in a clinical research study

Section 5.1 What is a clinical research study?

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

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for covered services you get as part of the study. If you tell us you're in a qualified clinical trial, you're only responsible for the in-network cost sharing for the services in that trial. If you paid more — for example, if you already paid the Original Medicare cost-

sharing amount — we'll reimburse the difference between what you paid and the in-network cost sharing. You'll need to provide documentation to show us how much you paid.

If you want to participate in any Medicare-approved clinical research study, you're not required to tell Blue Cross or get approval from Blue Cross. The providers that deliver your care as part of the clinical research study do *not* need to be part of the Blue Cross network of providers (this does not apply to covered benefits that require a clinical trial or registry to access the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDEs) studies. These benefits may also be subject to prior authorization and other plan rules).

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

Section 5.2 Who pays for services in a clinical research study

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

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

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

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

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

- Generally, Medicare won't pay for the new item or service the study is testing unless Medicare would cover the item or service even if you weren't in a study.

- Items or services provided only to collect data, and not used in your direct healthcare. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.
- Items and services provided by the research sponsors free-of-charge for people in the trial.

Get more information about joining a clinical research study

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

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

Section 6.1 A religious non-medical healthcare institution

A religious non-medical healthcare institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, you have coverage for inpatient non-medical services provided by religious non-medical healthcare institutions. This benefit is provided only for Part A inpatient services (non-medical healthcare services).

Section 6.2 How to get care from a religious non-medical healthcare institution

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

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

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

- The facility providing the care must be certified by Medicare.
- This plan only covers *non-religious* aspects of care.
- If you get services from this institution provided to you in a facility, you must meet the following conditions:
 - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.

- -and-you must get approval in advance from us before you're admitted to the facility or your stay won't be covered.

For more information, go to the Medical Benefits Chart in *Chapter 4*.

SECTION 7 Rules for ownership of durable medical equipment

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

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

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 consecutive months. **As a member of Medicare Plus Blue Group PPO, you usually won't acquire ownership of rented DME items no matter how many copayments you make for the item while a member of this plan.** You won't get ownership even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined this plan. Under certain limited circumstances we'll transfer ownership of the DME item to you. Call Blue Cross Customer Service at **1-800-422-9146** (TTY: **711**) for more information.

What happens to payments you made for DME if you switch between this plan and Original Medicare?

If you did not get ownership of the DME item while in this plan, in order to own the item, you'll have to make 13 new consecutive payments after you switch to Original Medicare to own the DME item. The payments you made while enrolled in this plan do not count toward these 13 payments.

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined this plan. The payments you made in Original Medicare do not count. You will have to make 13 payments to the plan before owning the item (if you're eligible to acquire ownership of the DME item).

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined this plan. You did not get ownership of the item while in this plan. You then go back to Original Medicare. You will have to make 13 consecutive new payments to own the item once you rejoin Original Medicare. Any previous payments you made (whether to this plan or to Original Medicare) do not count.

SECTION 8 Rules for oxygen equipment, supplies and maintenance

If you qualify for Medicare oxygen equipment coverage, Medicare Plus Blue Group PPO will cover:

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

If you leave Medicare Plus Blue Group PPO or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

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

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

The Medical Benefits Chart lists your covered services and shows how much you'll pay for each covered service as a member of your retirement system's Medicare Plus Blue Group PPO plan. This section also gives information about medical services that are not covered. It also explains limits on certain services.

Section 1.1 Types of out-of-pocket costs you may pay for your covered services

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

- Deductible: The amount you must pay for medical services before your retirement system begins to pay its share. *Section 1.2* tells you more about your out-of-pocket costs, including deductible.
- Coinsurance: The percentage you pay of the total cost of certain medical services after you have met your deductible. You pay a coinsurance at the time you get the medical service (for example, 10%). The Medical Benefits Chart tells you more about your coinsurance.
- A copayment (copay): The flat dollar amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service and your retirement system pays the rest. The Medical Benefits Chart tells you more about your copayments.

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance. If you're in one of these programs, be sure to show your proof of Medicaid or QMB eligibility to your provider.

Section 1.2 What is the most you will pay for Medicare Part A and Part B covered medical services?

This plan limits how much you pay out of pocket each year for certain covered medical services. This is called your annual out-of-pocket maximum. Your annual out-of-pocket maximum includes your deductible, coinsurance and your emergency room and urgent care copays. Costs for routine hearing exams and hearing aids are not included in the out-of-pocket maximum. Once you reach your out-of-pocket maximum, not including routine hearing exams and hearing aids, you won't have to pay any out-of-pocket costs for the remainder of the year. You'll continue to pay your premium as required by the retirement system.

Section 1.3 Providers are not allowed to balance bill you

As a member of Medicare Plus Blue Group PPO, you have an important protection because you only have to pay your cost-sharing amount when you get services covered by this plan.

Providers cannot bill you for additional separate charges, called balance billing. This protection applies even if we pay the provider less than the provider charges for a service and even if there's a dispute and we don't pay certain provider charges.

Here is how protection from balance billing works:

- If your cost sharing is a copayment (a set amount of dollars, for example, \$65), then you pay only that amount for the covered service.
- If your cost sharing is a coinsurance (a percentage of the approved amount), then you never pay more than that percentage plus your deductible. For both quality of care and cost savings, we encourage you to use network providers because your cost depends on the approved amount for the type of provider you see:
 - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our reimbursement rate (as this is set in the contract between the provider and Blue Cross).
 - If you get the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
 - If you get the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- If you believe a provider has balance billed you, call Blue Cross Customer Service at **1-800-422-9146** (TTY: 711).

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

The Medical Benefits Chart on the following pages lists the services Medicare Plus Blue Group PPO covers and what you pay out of pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to Medicare coverage guidelines.
- Your services (including medical care, services, supplies, equipment and medical plan drugs) *must* be medically necessary. Medically necessary means that the services, supplies or prescription drugs are needed for the prevention, diagnosis or treatment of your medical condition and meet accepted standards of medical practice.
- For new enrollees, your Medicare Advantage coordinated care plan must provide a minimum 90-day transition period, during which time the new Medicare Advantage Plan may not require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network

provider.

- Some services listed in the Medical Benefits Chart are covered as in-network services *only* if your doctor or other network provider gets approval (sometimes called prior authorization) from Blue Cross in advance.
 - Covered services that need approval in advance to be covered as in-network services are marked by an asterisk in the Medical Benefits Chart.
 - You never need approval in advance for out-of-network services from out-of-network providers.
 - While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.
- If your coordinated care plan provides approval of a prior authorization request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, your medical history and the treating provider's recommendation.
- Like all Medicare health plans, your medical plan covers everything that Original Medicare covers. We also cover everything your retirement system covered before you had Medicare. For most services, you pay less in this plan than you would in Original Medicare. For others you may pay more. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2026* handbook. View it online at **medicare.gov** or ask for a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, seven days a week. TTY: **1-877-486-2048**.)
- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you're also treated or monitored for an existing medical condition during the visit when you get the preventive services, cost sharing will apply for the care you got for the existing medical condition.
- If Medicare adds coverage for any new services during 2026, either Medicare or our plan will cover those services.

Deductible and limits on how much you pay for covered services	
Annual deductible for covered medical services	\$800
Coinsurance/copay maximum Note: Copayments for routine hearing exams and hearing aids are NOT included in the coinsurance/copay maximum.	\$900
Maximum out of pocket for member cost sharing Note: Costs for routine hearing exams and hearing aids are not included in the out-of-pocket maximum.	\$1,700

Medical Benefits Chart

- Services with * may require prior authorization. Your network provider will arrange for this authorization, if needed. If treatment or service is denied, you'll receive a written explanation of the reason, your right to appeal the denial and the appeal process. You won't be held responsible for the charge if the denial is due to lack of prior authorization.



You'll see this apple next to the preventive services in the benefits chart.

Covered Services	What you pay
Inpatient Care	
<p>Hospice care</p> <p>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.</p> <p>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.</p> <p>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:</p> <ul style="list-style-type: none"> • All items and services needed for pain relief and symptom management. • Medical, nursing and social services. • Drugs. • Certain durable medical equipment. 	<p>You pay nothing for hospice services.</p> <p>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.</p> <p>Note: If you need non-hospice care (care that is not related to your terminal condition), you should contact us to arrange the services. Getting your non-hospice care through our network providers may lower your share of the costs for the services.</p>

Covered Services	What you pay
<p>Hospice care, <i>continued</i></p> <ul style="list-style-type: none"> • Aide and homemaker services. • Other covered services, as well as services Medicare usually doesn't cover, like spiritual and grief counseling. • Inpatient respite care in a Medicare-approved facility so that your usual caregiver can rest (you can stay up to five days each time you get respite care). <p>A Medicare-approved hospice usually gives hospice care in your home or other facility where you live, like a nursing home.</p> <p>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, like a hospice facility, hospital or skilled nursing facility that contracts with the hospice.</p> <p>You can continue to get hospice care as long as the hospice medical director or hospice doctor recertifies that you're terminally ill.</p>	
<p>Inpatient hospital care*</p> <p>Hospital care includes the care you get in acute care hospitals, critical access hospitals, inpatient rehabilitation facilities and long-term care hospitals. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Semiprivate room (or private room if medically necessary). • Meals, including special diets. • Physician services. • Regular nursing services. 	<p>In-network and Out-of-network:</p> <p>Your coinsurance is 10% of the approved amount, after deductible.</p> <p>The deductible and coinsurance apply to the annual out-of-pocket maximum. You pay nothing for clinical lab services.</p> <p>You have unlimited days for inpatient care.</p>


Covered Services	What you pay
<p>Inpatient hospital care,* <i>continued</i></p> <ul style="list-style-type: none">• Costs 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, including storage and administration. Coverage of whole blood, packed red cells and all other components begin with the first pint used.• 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're hospitalized.• Routine nursery care of a newborn during the mother's eligible stay.• Substance use disorder services.	

Covered Services	What you pay
<p>Inpatient hospital care,* <i>continued</i></p> <p>*Inpatient hospital services rendered by plan providers will require prior authorization. Your plan provider will arrange for this authorization. If treatment or service is denied, you'll receive a written explanation of the reason, your right to appeal the denial, and the appeal process.</p> <p>You won't be held responsible for the charge if the denial is due to a lack of prior authorization.</p> <p>Transplants</p> <p>Under certain conditions, the following types of transplants are covered:</p> <ul style="list-style-type: none">• Bone marrow/stem cell.• Corneal.• Duodenum.• Heart.• Heart-lung.• Intestine.• Kidney.• Liver.• Lung.• Lobar lung.• Pancreas and/or intestinal/multivisceral.• Pancreas, liver, intestine and pancreatic tissue.• Stomach. <p>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. Coverage for travel and lodging expenses 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).</p>	<p>Deductible and coinsurance do not apply to travel and lodging associated with Medicare-covered transplants.</p>


Covered Services	What you pay
<p>Inpatient hospital care,* <i>continued</i></p> <p>Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Keep in mind, Medicare drug coverage (Part D) covers immunosuppressive drugs if Part B doesn't cover them.</p> <p>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 won't pay for any services or items, including immunosuppressive drugs, for patients who are not entitled to Medicare.</p> <p>Note: To be admitted 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 <i>outpatient</i>. If you're not sure if you're inpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called <i>Medicare Hospital Benefits</i>.</p> <p>This fact sheet is available at medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.</p>	
<p>Inpatient services in a psychiatric hospital*</p> <p>Covered services include mental healthcare services that require a hospital stay.</p> <p>*Inpatient mental health/behavioral health services rendered by plan providers require prior authorization. Your plan provider will arrange for this authorization.</p>	<p>In-network and Out-of-network:</p> <p>Your coinsurance is 10% of the approved amount, after deductible.</p> <p>The deductible and coinsurance apply to the annual out-of-pocket maximum. You have unlimited days of inpatient care coverage.</p>




Covered Services	What you pay
<p>Inpatient services in a psychiatric hospital,* continued</p> <p>If treatment or service is denied, you'll receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You won't be held responsible for the charge if the denial is due to a lack of prior authorization.</p>	
<p>Religious non-medical healthcare institution</p> <p>In these facilities, religious beliefs prohibit conventional and unconventional medical care. If you qualify for hospital or skilled nursing facility care, the plan will only cover the inpatient, non-religious, non-medical items and services. An example is room and board, or any items and services that don't require a doctor's order or prescription, like unmedicated wound dressings or use of a simple walker.</p>	<p>In-network and Out-of-network:</p> <p>ork: In a Medicare-certified institution, your coinsurance is 10% of the approved amount, after deductible.</p> <p>The deductible and coinsurance apply to the annual out-of-pocket maximum.</p>
<p>Skilled nursing facility (SNF) care*</p> <p>(For a definition of skilled nursing facility care, go to <i>Chapter 10</i>. Skilled nursing facilities are sometimes called SNFs.)</p> <p>To qualify for care in a SNF, your doctor must certify that you need daily skilled care, like intravenous injections or physical therapy.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Semiprivate room (or a private room if medically necessary). • Meals, including special diets. • General and skilled nursing care. • Physician/practitioner services. • Physical therapy, occupational therapy and speech therapy. 	<p>In-network and Out-of-network:</p> <p>Your coinsurance is 10% of the approved amount, after deductible.</p> <p>The deductible and coinsurance apply to the annual out-of-pocket maximum. The plan will cover up to 100 days of medically necessary care in a SNF. Your days renew after you've been out of a SNF or hospital for 60 consecutive days.</p>



Covered Services	What you pay
<p>Skilled nursing facility (SNF) care,* continued</p> <ul style="list-style-type: none"> • Drugs administered to you as part of your plan of care (this includes substances that are naturally present in the body, such as blood clotting factors). • Blood, including storage and administration. Coverage of whole blood, packed red cells and all other components begin with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs. • Laboratory tests ordinarily provided by SNFs. • X-rays and other radiology services ordinarily provided by SNFs. • Use of appliances such as wheelchairs ordinarily provided by SNFs. <p>Generally, you get SNF care from network facilities. Under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts your plan's amounts for payment.</p> <ul style="list-style-type: none"> • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). • A SNF where your spouse or domestic partner is living at the time you leave the hospital. <p>*SNF care rendered by plan providers will require prior authorization. Your plan provider will arrange for this authorization. If treatment or service is denied, you'll receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You won't be held responsible for the charge if the denial is due to a lack of prior authorization.</p>	


Covered Services	What you pay
<p>Services covered when you exhaust your skilled nursing facility (SNF) days or when you're not inpatient (inpatient services covered during a non-covered inpatient stay)</p> <p>If you remain in a SNF after you've exhausted your SNF benefits, or you're not admitted to a SNF because the stay is not reasonable and necessary, but you live in a nursing facility, you still have coverage under this plan. Covered services that are provided by doctors and other medical care suppliers include, but are not limited to:</p> <ul style="list-style-type: none"> • Physician services. • Diagnostic tests (like lab tests). • X-ray, radium and isotope therapy including technician materials and services. • Surgical dressings. • Splints, casts and other devices used to reduce fractures and dislocations. • Prosthetics and orthotics devices. • Durable medical equipment. • Physical therapy, speech therapy and occupational therapy. 	<p>In-network and Out-of-network:</p> <p>Your cost share depends on the service provided. Refer to the description of the service elsewhere in this Medical Benefits Chart for cost-share information.</p>
Outpatient Services	
<p> Abdominal aortic aneurysm screening</p> <p>A one-time screening ultrasound for people at risk. The plan only covers this screening if you get a referral for it from your physician, physician assistant, nurse practitioner or clinical nurse specialist.</p> <p>Note: If you have a family history of abdominal aortic aneurysms, or you're a man aged 65-75 and you've smoked at least 100 cigarettes in your lifetime, you're considered at risk.</p>	<p>In-network and Out-of-network:</p> <p>Covered at 100% of the approved amount.</p> <p>If you receive other services during the visit, your out-of-pocket costs for those services will still apply.</p>



Covered Services	What you pay
<p>Acupuncture for chronic low back pain</p> <p>Up to 12 visits in 90 days are covered for chronic low back pain, defined as:</p> <ul style="list-style-type: none">• 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; and• Not associated with pregnancy. <p>An additional eight sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments will be covered annually.</p> <p>Treatment is not covered if you're not improving or are regressing.</p> <p>Provider Requirements:</p> <p>Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements.</p> <ul style="list-style-type: none">• Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine.• A current, full, active, and unrestricted license to practice acupuncture in the state where care is being provided.	<p>In-network and Out-of-network:</p> <p>Your coinsurance is 10% of the approved amount, after deductible.</p> <p>The deductible and coinsurance apply to the annual out-of-pocket maximum.</p>


Covered Services	What you pay
<p>Acupuncture for chronic low back pain <i>continued</i></p> <p>Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.</p>	
<p> Alcohol misuse screening and counseling</p> <p>The plan covers one alcohol misuse screening per calendar year for adults who use alcohol but don't meet the medical criteria for alcohol dependency. If your primary care provider or other healthcare provider 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 primary care provider or other qualified healthcare provider must provide the counseling in a primary care setting (like a doctor's office).</p>	<p>In-network and Out-of-network:</p> <p>Covered at 100% of the approved amount.</p>
<p>Ambulance services</p> <p>The 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 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 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.</p>	<p>In-network and Out-of-network:</p> <p>Your coinsurance is 10% of the approved amount, after deductible.</p> <p>The deductible and coinsurance apply to the annual out-of-pocket maximum.</p>


Covered Services	What you pay
<p>Ambulance services, <i>continued</i></p> <p>The plan will only cover ambulance services to the nearest appropriate medical facility that's able to give you the care you need.</p>	
<p>Ambulance services not requiring transportation to a facility</p> <p>The plan covers ambulance services even if you're not transported to a facility. This coverage applies if you're stabilized at your home or another location.</p> <p>This service is not covered outside the U.S. or its territories.</p>	<p>In-network and Out-of-network:</p> <p>Your coinsurance is 10% of the approved amount, after deductible.</p> <p>The deductible and coinsurance apply to the annual out-of-pocket maximum.</p>
<p> Annual routine physical</p> <p>An annual routine physical is comprised of updating your health history, checking vital signs, a visual exam and a physical exam.</p>	<p>In-network and Out-of-network:</p> <p>Covered at 100% of the approved amount.</p>
<p> Annual standard, routine laboratory tests</p> <p>Laboratory tests performed as a result of, or during, an annual routine physical and are not diagnostic in nature.</p>	<p>In-network and Out-of-network:</p> <p>Covered at 100% of the approved amount when done in conjunction with an annual routine physical exam.</p>
<p> Annual wellness visit</p> <p>If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. The annual wellness visit can occur anytime throughout the year, regardless of the date of your previous annual wellness visit.</p> <p>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.</p> <p>Your provider may also perform a cognitive assessment to look for signs of dementia, including Alzheimer's disease.</p>	<p>In-network and Out-of-network:</p> <p>Covered at 100% of the approved amount.</p> <p>Note: If advance care planning is done outside the annual wellness visit, your coinsurance is 10% of the approved amount, after deductible. You may also be charged cost sharing if a service performed (e.g., diagnostic test) is outside the scope of the annual wellness visit.</p> <p>The deductible and coinsurance apply to the annual out-of-pocket maximum.</p>



Covered Services	What you pay
<p> Annual wellness visit <i>continued</i></p> <p>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.</p> <p>Your doctor or 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.</p> <p>Note: Your first annual wellness visit can’t take place within 12 months of your Welcome to Medicare exam. However, you don’t need to have had a Welcome to Medicare exam to be covered for annual wellness visits after you’ve had Part B for 12 months.</p>	
<p> Bone mass measurement</p> <p>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 people 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.</p>	<p>In-network and Out-of-network:</p> <p>Covered at 100% of the approved amount.</p>



Covered Services	What you pay
<p> Breast cancer screening (mammograms)</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • One baseline mammogram between the ages of 35 and 39. • One routine, screening mammogram (breast X-ray) every calendar year. • Clinical breast exam once every 24 months. • Clinical breast exam 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. 	<p>In-network and Out-of-network:</p> <p>Covered at 100% of the approved amount.</p> <p>If you have a medical condition, a follow-up (second) mammogram and/or biopsy on a separate day from the screening, the procedure is considered diagnostic. If a diagnostic test is performed, your coinsurance is 10% of the approved amount, after deductible. The deductible and coinsurance apply to the annual out-of-pocket maximum.</p>
<p>Cardiac rehabilitation services</p> <p>The plan covers comprehensive programs that include exercise, education and counseling for patients who meet these conditions:</p> <ul style="list-style-type: none"> • 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. <p>The 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.</p>	<p>In-network and Out-of-network:</p> <p>Your coinsurance is 10% of the approved amount, after deductible.</p> <p>The deductible and coinsurance apply to the annual out-of-pocket maximum.</p>




Covered Services	What you pay
<p> Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)</p> <p>Your plan covers one visit per year with your primary care provider to help lower your risk for cardiovascular disease. During your visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure and give you tips to make sure you're eating well.</p>	<p>In-network and Out-of-network:</p> <p>Covered at 100% of the approved amount.</p> <p>If you have a medical condition or further testing is required, the procedure and/or the subsequent testing is considered diagnostic and diagnostic procedures and out-of-pocket costs will apply. Refer to the Diagnostic tests section in <i>Chapter 4 Medical Benefits Chart</i> of this booklet for more information.</p>
<p> Cardiovascular disease screening test</p> <p>These screenings include blood tests that help detect conditions that may lead to a heart attack or stroke. The plan covers these screening tests once every five years to test your cholesterol, lipid, lipoprotein and triglyceride levels.</p>	<p>In-network and Out-of-network:</p> <p>Covered at 100% of the approved amount.</p> <p>If you have a medical condition or further testing is required, the procedure and/or the subsequent testing is considered diagnostic and diagnostic procedures and out-of-pocket costs will apply. Refer to the Diagnostic tests section in <i>Chapter 4 Medical Benefits Chart</i> of this booklet for more information.</p>
<p>Caregiver training resources</p> <p>Training that helps your caregiver learn and develop skills to care for you (like 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.</p>	<p>In-network and Out-of-network:</p> <p>Your coinsurance is 10% of the approved amount, after deductible.</p> <p>The deductible and coinsurance apply to the annual out-of-pocket maximum.</p>


Covered Services	What you pay
<p> Cervical and vaginal cancer screening</p> <p>Pap tests and pelvic exams are covered once every calendar year.</p>	<p>In-network and Out-of-network:</p> <p>Covered at 100% of the approved amount.</p> <p>If you have a medical condition or further testing is required, the procedure and/or the subsequent testing is considered diagnostic and diagnostic procedures and out-of-pocket costs will apply. Refer to the Diagnostic tests section in <i>Chapter 4 Medical Benefits Chart</i> of this booklet for more information.</p>
<p>Chemotherapy</p> <p>The plan covers chemotherapy in a doctor's office, freestanding clinic or hospital outpatient setting for people with cancer.</p>	<p>In-network and Out-of-network:</p> <p>Your coinsurance is 10% of the approved amount, after deductible.</p> <p>The deductible and coinsurance apply to the annual out-of-pocket maximum.</p>
<p>Chiropractic services</p> <p>Covered services are limited to:</p> <ul style="list-style-type: none"> • Manual manipulation of the spine to correct subluxation. • Spine X-rays and chiropractic radiology services. 	<p>In-network and Out-of-network:</p> <p>Your coinsurance is 10% of the approved amount, after deductible.</p> <p>The deductible and coinsurance apply to the annual out-of-pocket maximum.</p>
<p>Chronic pain management and treatment services</p> <p>Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than three months). Services may include pain assessment, medication management and care coordination and planning.</p>	<p>In-network and Out-of-network:</p> <p>Your coinsurance is 10% of the approved amount, after deductible.</p> <p>The deductible and coinsurance apply to the annual out-of-pocket maximum.</p>

Covered Services	What you pay
<p>Clinical research studies</p> <p>Clinical research studies test how well different types of medical care work and if they're safe.</p> <p>Most costs for clinical research studies 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 services.</p> <p>The plan covers some costs in qualifying clinical research studies. Refer to <i>Chapter 3</i> for additional information.</p>	<p>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, this plan will pay the difference between Original Medicare's cost sharing and the cost sharing under Medicare Plus Blue Group PPO.</p>
<p> Colorectal cancer screening</p> <p>The plan covers these screenings to help find precancerous growths or find cancer early, when treatment is most effective. One or more of these tests may be covered:</p> <ul style="list-style-type: none"> • Fecal occult blood test — This test is covered once every calendar year if you're 45 or older. • Flexible sigmoidoscopy — This test is generally covered once every 48 months if you're 45 or older, or 120 months after a previous screening colonoscopy for those not at high risk. • 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. If you initially have a non-invasive stool-based screening test and receive a positive result, the plan also covers a follow-up colonoscopy as a screening test. • Barium enema — This test is generally covered once every 48 months if you're 45 or older (high risk, every 24 months) when used instead of a sigmoidoscopy or colonoscopy. 	<p>In-network and Out-of-network:</p> <p>Covered at 100% of the approved amount.</p> <p>Note: If a polyp or other tissue is found and removed during the colonoscopy, your coinsurance is 10% of the approved amount. The coinsurance applies to the annual out-of-pocket maximum.</p> <p>If you receive other services during this visit out-of-pocket cost share may apply.</p>

Covered Services	What you pay
<p> Colorectal cancer screening, <i>continued</i></p> <ul style="list-style-type: none"> • Computed tomography colonography — This test is covered for patients 45 years and older who are not at high risk of colorectal cancer once every 60 months, or 48 months after a previous flexible sigmoidoscopy or screening colonoscopy. For patients at high risk for colorectal cancer, this screening is covered every 24 months. • Multi-target stool DNA and blood-based biomarker tests — These lab tests are generally covered once every three years if you meet all these conditions: <ul style="list-style-type: none"> - Are between ages 45-85. - Show no signs or 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: <ul style="list-style-type: none"> ○ 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. 	
<p> COVID-19 vaccine</p> <p>The plan covers FDA-authorized COVID-19 vaccines.</p>	<p>In-network and Out-of-network: Covered at 100% of the approved amount.</p>


Covered Services	What you pay
<p>Dental services</p> <p>The plan doesn't cover most dental care, dental procedures, or supplies, like cleanings, fillings, tooth extractions, dentures, dental plates or other dental devices. You have coverage for certain dental services that you get when you're in a hospital. You also have coverage for services required for the initial treatment of an injury to the jaws, sound natural teeth, mouth or face.</p> <p>The injury must have occurred after the effective date of your coverage with your retirement system. Services must be performed by a physician or dentist. The plan does not cover injuries resulting from biting or chewing, or preventive or maintenance services.</p>	<p>In-network and Out-of-network:</p> <p>Your coinsurance is 10% of the approved amount, after deductible.</p> <p>The deductible and coinsurance apply to the annual out-of-pocket maximum.</p>
<p> Depression screening</p> <p>The plan covers one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and referrals.</p>	<p>In-network and Out-of-network:</p> <p>Covered at 100% of the approved amount.</p>
<p> Diabetes Prevention Program</p> <p>The 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:</p> <ul style="list-style-type: none"> • Training to make realistic, lasting behavior changes around diet and exercise. • Tips on how to get more exercise. • Strategies to control your weight. • A specially trained coach to help keep you motivated. • Support from people with similar goals and challenges. 	<p>In-network and Out-of-network:</p> <p>Covered at 100% of the approved amount.</p>


Covered Services	What you pay
<p> Diabetes Prevention Program, <i>continued</i> Once you complete the core sessions, you'll get:</p> <ul style="list-style-type: none"> • Six monthly follow-up sessions to help you maintain healthy habits. • An additional 12 monthly ongoing maintenance sessions if you meet certain weight loss and attendance goals. <p>To be eligible, you must have:</p> <ul style="list-style-type: none"> • A hemoglobin A1c test result between 5.7% and 6.4%, a fasting plasma glucose of 110-125mg/dL, or a 2-hour plasma glucose of 140-199 mg/dL (oral glucose tolerance test) within 12 months before 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. • Never participated in the Diabetes Prevention Program. 	
<p> Diabetes screening</p> <p>Your plan covers these screenings if your doctor determines you're at risk for diabetes or diagnosed with prediabetes.</p> <p>You may be eligible for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.</p>	<p>In-network and Out-of-network:</p> <p>Covered at 100% of the approved amount.</p>
<p> Diabetes self-management training*</p> <p>The plan covers diabetes outpatient self-management training to teach you to cope with and manage your diabetes. The program may include tips for eating healthy, being active, monitoring blood sugar, taking medication and reducing risks.</p>	<p>In-network and Out-of-network:</p> <p>Your coinsurance is 10% of the approved amount, after deductible.</p> <p>The deductible and coinsurance apply to the annual out-of-pocket maximum.</p>



Covered Services	What you pay
<p> Diabetes self-management training,* continued</p> <p>You must have diabetes and a written order from your doctor or other qualified healthcare provider.</p>	
<p>Diabetes supplies*</p> <p>Includes:</p> <ul style="list-style-type: none"> • Blood sugar testing monitors (portable blood glucose meters, called glucometers, that monitor blood sugar and continuous glucose monitors). • Blood sugar test strips. • Lancet devices and lancets. • Blood sugar control solutions. • Therapeutic shoes and inserts for the shoes. <p>Note: Injectable insulin and needles and syringes for injectable insulin are covered under your prescription drug plan when prescribed by your physician. Refer to Prescription drugs (limited) section in <i>Chapter 4 Medical Benefits Chart</i> of this booklet for additional insulin information.</p> <p>*Diabetic services and supplies may require prior authorization; your plan provider will arrange for this authorization, if needed.</p>	<p>In-network and Out-of-network:</p> <p>Covered up to 100% of the approved amount, including at network pharmacies.</p> <p>To use an in-network supplier for continuous glucose monitors, you must go to any network pharmacy.</p> <p>To find a network pharmacy, visit our website at bcbsm.com/pharmaciesmedicare.</p>
<p>Diagnostic tests</p> <p>Covered services include, but are not limited to:</p> <p>X-rays, ECG, EKGs, MRAs,* MRIs,* CT scans,* PET scans* and nuclear medicine.*</p> <p>Radiation (radium and isotope) therapy including technician materials and supplies.</p> <p>Clinical laboratory services including certain blood tests and urinalysis.</p> <p>Pathology services (examination of body tissue).</p>	<p>In-network and Out-of-network:</p> <p>Clinical lab services are covered up to 100% of the approved amount.</p> <p>For all other services, your coinsurance is 10% of the approved amount, after deductible.</p> <p>The deductible and coinsurance apply to the annual out-of-pocket maximum.</p>




Covered Services	What you pay
<p>Diagnostic tests, <i>continued</i></p> <p>*High-tech radiology services rendered by plan providers require prior authorization. Your plan provider will arrange for this authorization. If treatment or service is denied, you'll receive a written explanation of the reason, your right to appeal the denial and the appeal process. You won't be held responsible for the charge if the denial is due to a lack of prior authorization.</p>	
<p>Doctor and other healthcare provider services</p> <p>The plan covers medically necessary doctor services and services provided by other healthcare providers, such as physician assistants, nurse practitioners, social workers, physical therapists and psychologists.</p> <p>Coverage includes, but is not limited to:</p> <ul style="list-style-type: none"> • Consultation, diagnosis and treatment by a specialist. • Second surgical opinions, and in some cases third opinions, when performed by a network plan provider. 	<p>In-network and Out-of-network:</p> <p>Your coinsurance is 10% of the approved amount, after deductible.</p> <p>The deductible and coinsurance apply to the annual out-of-pocket maximum.</p>
<p>Durable medical equipment (DME) and related medical supplies*</p> <p>(For a definition of DME, see <i>Chapter 10</i> and <i>Chapter 3</i>.)</p> <p>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 a Certificate of Medical Necessity from a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) to obtain DME.</p> <p>Covered items include, but are not limited to:</p> <ul style="list-style-type: none"> • Hospital beds ordered by a provider for use in the home, wheelchairs, walkers, canes and crutches. • Respiratory equipment such as oxygen concentrators, apnea monitors, nebulizers and CPAP machines. 	<p>In-network:</p> <p>Your coinsurance is 10% of the approved amount, after deductible.</p> <p>The deductible and coinsurance apply to the annual out-of-pocket maximum. Diabetic testing supplies, diabetic supplies and therapeutic shoes for people with severe diabetic foot disease are covered up to 100% of the approved amount.</p> <p>Out-of-network:</p> <p>Your coinsurance is 30% of the approved amount, after deductible.</p> <p>The deductible and coinsurance apply to the annual out-of-pocket maximum.</p>

Covered Services	What you pay
<p>Durable medical equipment (DME) and related medical supplies,* <i>continued</i></p> <ul style="list-style-type: none">• Home dialysis equipment and supplies.• Medical supplies such as surgical dressings, adult disposable diapers, gradient compression stockings (up to eight per year or four pair), IV infusion pumps, powered mattress systems and speech generating devices.• Defibrillator (implantable automatic). <p>Equipment setup and training is covered when medically necessary, such as assistance by an RN or respiratory therapist.</p> <p>People who have diabetes and severe diabetic foot disease have coverage for the furnishing and fitting of either one pair of custom-molded shoes (including inserts provided with such shoes) or one pair of extra-depth shoes each calendar year, prescribed by a podiatrist or other qualified doctor and provided by a podiatrist, orthotist, prosthetist, pedorthist or other qualified individual. The plan covers two additional pairs of inserts each calendar year for custom-molded shoes and three pairs of inserts each calendar year for extra-depth shoes. Note: The plan will cover shoe modifications instead of inserts.</p> <p>We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order for you. The most recent list of suppliers is available on our website at bcbsm.com/providersmedicare.</p> <p>If you (or your provider) don't agree with our coverage decision, you or your provider can file an appeal. You can also file an appeal if you don't agree with your provider's decision about what product or brand is appropriate for your medical condition. For more information about appeals, go to <i>Chapter 7</i>.</p>	<p>Diabetic testing supplies, diabetic supplies and therapeutic shoes for people with severe diabetic foot disease are covered up to 100% of the approved amount.</p> <p>Continuous glucose monitors must be obtained from a network pharmacy.</p>

Covered Services	What you pay
<p>Durable medical equipment (DME) and related medical supplies,* <i>continued</i></p> <p>*Durable medical equipment and related supplies may require prior authorization; your plan provider will arrange for this authorization, if needed.</p>	
<p>Emergency care</p> <p>Emergency care refers to services that are:</p> <ul style="list-style-type: none"> • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition, mental health condition or substance use disorder condition. <p>Your 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 loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain or a medical condition that is quickly getting worse.</p> <p>You have coverage for emergency/urgently needed services, worldwide.</p>	<p>In-network and Out-of-network:</p> <p>You pay a \$150 copayment for the hospital emergency department visit (waived if admitted within 72 hours).</p> <p>The copay applies to the annual out-of-pocket maximum.</p> <p>Cost sharing for necessary emergency services you get out of network is the same as when you get these services in network.</p>
<p> Flu/influenza shots</p> <p>Covered once each flu/influenza season, in the fall or winter.</p>	<p>In-network and Out-of-network:</p> <p>Covered at 100% of the approved amount.</p>
<p>Foot exams and treatment (podiatry)</p> <p>Your plan covers foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.</p>	<p>In-network and Out-of-network:</p> <p>Your coinsurance is 10% of the approved amount, after deductible.</p> <p>The deductible and coinsurance apply to the annual out-of-pocket maximum.</p>

Covered Services	What you pay
<p> Glaucoma tests</p> <p>Covered once per year for people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, African Americans aged 50 or older or Hispanic Americans aged 65 or older.</p>	<p>In-network and Out-of-network:</p> <p>Covered at 100% of the approved amount.</p>
<p>Health fitness program</p> <p>Members are covered for a fitness benefit through SilverSneakers®. SilverSneakers is a comprehensive program that can improve overall well-being and social connections. Designed for all levels and abilities, SilverSneakers provides convenient access to a nationwide fitness network, a variety of programming options and activities beyond the gym that incorporate physical well-being and social interaction.</p> <p>Benefits include:</p> <ul style="list-style-type: none"> • Use of exercise equipment, classes and other amenities at thousands of participating locations. • SilverSneakers LIVE online classes and workshops taught by instructors trained in senior fitness. • SilverSneakers On-Demand online library with hundreds of workout videos. • SilverSneakers GO mobile app with on-demand videos and live classes. • Online fitness tips and healthy eating information. • Social connections through events such as shared meals, holiday celebrations, and class socials. <p>Fitness services must be provided at SilverSneakers® participating locations. Go to silversneakers.com to learn more or call 1-866-584-7352, 8 a.m. to 8 p.m. Eastern time, Monday through Friday. TTY: 711.</p>	<p>In-network:</p> <p>Covered at 100% of the approved amount when provided through SilverSneakers.</p> <p>Out-of-network:</p> <p>Not covered.</p>

Covered Services	What you pay
<p>Health fitness program, <i>continued</i></p> <p>SilverSneakers is a registered trademark of Tivity Health, Inc. © 2025 Tivity Health, Inc. All rights reserved.</p>	
<p>Hearing and balance exams</p> <p>The plan covers these exams if your doctor or other qualified healthcare provider orders them to see if you need medical treatment.</p>	<p>In-network and Out-of-network:</p> <p>Your coinsurance is 10% of the approved amount, after deductible.</p> <p>The deductible and coinsurance apply to the annual out-of-pocket maximum.</p>
<p>Hearing aids</p> <p>Refer to the Routine Hearing Care section located in <i>Section 2.1</i> for benefit information.</p>	<p>Refer to the Routine Hearing Care section located in <i>Section 2.1</i> for benefit information.</p>
<p> Hepatitis B vaccine</p> <p>The plan covers these shots if you're at medium or high risk for Hepatitis B. Some risk factors include hemophilia, end-stage renal disease, 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.</p> <p>Check with your doctor to see if you're at medium or high risk for Hepatitis B.</p>	<p>In-network and Out-of-network:</p> <p>Covered at 100% of the approved amount.</p>
<p> Hepatitis B Virus (HBV) infection screening</p> <p>The plan covers HBV infection screenings if you meet one of these conditions:</p> <ul style="list-style-type: none"> You're at high risk for HBV infection. You're pregnant. <p>The plan will only cover HBV infection screenings if they're ordered by a primary care provider.</p>	<p>In-network and Out-of-network:</p> <p>Covered at 100% of the approved amount.</p>


Covered Services	What you pay
<p> Hepatitis B Virus (HBV) infection screening</p> <p>HBV infection screenings are covered:</p> <ul style="list-style-type: none"> • Annually, only for those with continued high risk who don't get a Hepatitis B vaccination. • For pregnant women: <ul style="list-style-type: none"> ○ At the first prenatal visit for each pregnancy. ○ At the time of delivery for those with new or continued risk factors. ○ At the first prenatal visit for future pregnancies, even if you previously got the Hepatitis B shot or had negative HBV screening results. 	
<p> Hepatitis C screenings</p> <p>The plan covers one Hepatitis C screening test if you meet one of these conditions:</p> <ul style="list-style-type: none"> • You're at high risk because you're currently using illicit injection drugs. • You're at high risk because you have a history of illicit injection drug use. • You had a blood transfusion before 1992. • You were born between 1945-1965. <p>The plan also covers yearly repeat screenings for people at high risk.</p>	<p>In-network and Out-of-network: Covered at 100% of the approved amount.</p>
<p> HIV screening</p> <p>For people who ask for an HIV screening test or are at increased risk for HIV infection, the plan covers one screening exam every 12 months.</p> <p>The plan also covers up to three screening exams during a pregnancy.</p>	<p>In-network and Out-of-network: Covered at 100% of the approved amount.</p>


Covered Services	What you pay
<p>Home health agency care*</p> <p>Medically necessary home healthcare is covered for patients confined to home. Your physician must prescribe the care and prepare a treatment plan.</p> <p>Confined to home means both of the following are true:</p> <ul style="list-style-type: none">• You have trouble leaving your home without help (like using a cane, wheelchair, walker or crutches; special transportation; or help from another person) because of an illness or injury.• Leaving your home isn't recommended because of your condition, and you're normally unable to leave your home because it's a major effort. <p>At each visit, the plan will cover:</p> <ul style="list-style-type: none">• Part-time or intermittent skilled nursing care by an employee of the home healthcare agency.• Part-time or intermittent <u>home health aide services</u>.• 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 Durable medical equipment (DME) and related medical supplies section in <i>Chapter 4 Medical Benefits Chart</i> of this booklet 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.	<p>In-network and Out-of-network:</p> <p>Covered up to 100% of the approved amount.</p>


Covered Services	What you pay
<p>Home health agency care*, <i>continued</i></p> <p>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.</p> <p>*Home health agency care may require prior authorization; your plan provider will arrange for this authorization, if needed.</p>	
<p>Home infusion therapy</p> <p>Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters).</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Professional services, including nursing services, furnished in accordance with your plan of care. • Patient training and education not otherwise covered under the durable medical equipment benefit. • Remote monitoring. • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier. 	<p>In-network and Out-of-network:</p> <p>Your coinsurance is 10% of the approved amount, after deductible.</p> <p>The deductible and coinsurance apply to the annual out-of-pocket maximum.</p>
<p>Hospital services*</p> <p>The plan covers medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</p>	<p>In-network and Out-of-network:</p> <p>Clinical lab services are covered up to 100% of the approved amount.</p> <p>For other services, your coinsurance is 10% of the approved amount, after deductible.</p>

Covered Services	What you pay
<p>Hospital services,* <i>continued</i></p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none">• Services in an outpatient clinic, such as observation services or outpatient surgery.• Laboratory and diagnostic tests billed by the hospital.• Mental healthcare, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it.• X-rays and other radiology services billed by the hospital.• Medical supplies such as splints and casts.• Certain drugs and biologicals that you can't give yourself.• Blood, including storage and administration. Coverage of whole blood, packed red cells and all other components begin with the first pint used.• Substance use disorder services.* <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you're not sure if you're an outpatient, you should ask the hospital staff.</p> <p>Get more information in the Medicare fact sheet <i>Medicare Hospital Benefits</i>. This fact sheet is available at medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.</p>	<p>The deductible and coinsurance apply to the annual out-of-pocket maximum.</p>


Covered Services	What you pay
<p>Hospital services,* <i>continued</i></p> <p>*Outpatient mental health/substance use disorder services rendered by plan providers may require prior authorization. Your plan provider will arrange for this authorization.</p> <p>If treatment or service is denied, you'll receive a written explanation of the reason, your right to appeal the denial and the appeal process. You won't be held responsible for the charge if the denial is due to a lack of prior authorization.</p>	
<p>Kidney disease treatment, services, supplies and education</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease, when referred by their doctor, the plan covers up to six sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in <i>Chapter 3</i>, or when your provider for this service is temporarily unavailable or inaccessible). • Inpatient dialysis treatments (if you're admitted as an inpatient to a hospital for special care). • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments). • Home dialysis equipment and supplies. 	<p>In-network and Out-of-network:</p> <p>Kidney disease education is covered at 100% of the approved amount.</p> <p>Your coinsurance for dialysis is 10% of the approved amount, after deductible.</p> <p>The deductible and coinsurance apply to the annual out-of-pocket maximum.</p> <p>Refer to the Durable medical equipment (DME) and related medical supplies section in <i>Chapter 4 Medical Benefits Chart</i> of this booklet for cost-share information on home dialysis equipment and supplies.</p>


Covered Services	What you pay
<p>Kidney disease treatment, services, supplies and education, <i>continued</i></p> <ul style="list-style-type: none"> 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). <p>Certain drugs for dialysis are covered under your medical plan. For information about coverage for medical plan drugs, please go to the Prescription drugs (limited) section in <i>Chapter 4 Medical Benefits Chart</i> of this booklet for additional insulin information.</p>	
<p> Lung cancer screening with low dose computed tomography (LDCT)</p> <p>The plan covers a lung cancer screening with LDCT once every 12 months if you meet all these conditions:</p> <ul style="list-style-type: none"> You're 50-77. You're asymptomatic (don't have signs or symptoms of lung cancer). You're either a current smoker or have quit smoking within the last 15 years. You have a tobacco smoking history of at least 20 "pack years" (an average of one pack a day for 20 years). You get an order from a doctor or other qualified healthcare provider. <p><i>For LDCT lung cancer screenings after the initial LDCT screening:</i> You must receive an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.</p>	<p>In-network and Out-of-network: Covered at 100% of the approved amount.</p>

Covered Services	What you pay
<p> Medical nutrition therapy (MNT)</p> <p>The plan covers MNT services if you have diabetes or kidney disease, or you've had a kidney transplant in the last 36 months, and your doctor refers you for services. MNT services are furnished only by registered dietitians or nutrition professionals who meet certain requirements.</p>	<p>In-network and Out-of-network:</p> <p>Covered at 100% of the approved amount.</p>
<p>Mental healthcare*</p> <p>The plan covers mental healthcare services to help with conditions like depression, eating disorders, anxiety or substance use disorder. Coverage includes services generally provided in an outpatient setting (like a doctor's or other healthcare provider's office, virtual care visit 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. Coverage also includes services provided in a residential treatment center.</p> <p>Laboratory tests are also covered. Certain limits and conditions apply. Your coverage includes:</p> <ul style="list-style-type: none"> • Psychological testing when administered by a fully licensed psychologist employed by or having privileges at the facility. • Counseling for your family members. <p>*Mental healthcare services rendered by plan providers will require prior authorization. Your plan provider will arrange for this authorization. If treatment or service is denied, you'll receive a written explanation of the reason, your right to appeal the denial and the appeal process. You won't be held responsible for the charge if the denial is due to a lack of prior authorization.</p>	<p>In-network and Out-of-network:</p> <p>Your coinsurance is 10% of the approved amount, after deductible.</p> <p>The deductible and coinsurance apply to the annual out-of-pocket maximum.</p>

Covered Services	What you pay
<p> Obesity screening and therapy to promote sustained weight loss</p> <p>If you have a body mass index of 30 or more, the plan covers intensive counseling to help you lose weight. Up to 22 sessions over a 12-month period are covered. This counseling is covered if you get it in a primary care setting where it can be coordinated with your comprehensive prevention plan. Talk to your primary care provider to find out more.</p>	<p>In-network and Out-of-network:</p> <p>Covered at 100% of the approved amount.</p>
<p>Occupational therapy</p> <p>The 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 you need it.</p>	<p>In-network and Out-of-network:</p> <p>Your coinsurance is 10% of the approved amount, after deductible.</p> <p>The deductible and coinsurance apply to the annual out-of-pocket maximum.</p>
<p>Opioid treatment program services</p> <p>The plan covers:</p> <ul style="list-style-type: none"> • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications. This includes certain drugs, such as methadone for pain management for medical conditions and treatment for opioid use disorder. • Dispensing and administration of MAT medications (if applicable). • Substance use disorder counseling. • Individual and group therapy. • Toxicology testing. • Intake activities. • Periodic assessments. 	<p>In-network and Out-of-network:</p> <p>Your coinsurance is 10% of the approved amount, after deductible.</p> <p>The deductible and coinsurance apply to the annual out-of-pocket maximum.</p>


Covered Services	What you pay
<p>Outpatient hospital observation</p> <p>Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged.</p> <p>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.</p> <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you're 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're not sure if you're outpatient, you should ask the hospital staff.</p> <p>Get more information on the Medicare fact sheet <i>Medicare Hospital Benefits</i>. This fact sheet is available at medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.</p>	<p>In-network and Out-of-network:</p> <p>Your coinsurance is 10% of the approved amount, after deductible.</p> <p>The deductible and coinsurance apply to the annual out-of-pocket maximum.</p>
<p>Partial hospitalization services and intensive outpatient services*</p> <p>Partial hospitalization is a structured program of active psychiatric treatment provided in a hospital outpatient setting or by a community mental health center, that is more intense than the care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT) or licensed professional counselor's office and is an alternative to inpatient hospitalization.</p>	<p>In-network and Out-of-network:</p> <p>Your coinsurance is 10% of the approved amount, after deductible.</p> <p>The deductible and coinsurance apply to the annual out-of-pocket maximum.</p>


Covered Services	What you pay
<p>Partial hospitalization services and intensive outpatient services,* <i>continued</i></p> <p>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 you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT) or licensed professional counselor's office but less intense than partial hospitalization.</p> <p>*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'll receive a written explanation of the reason, your right to appeal the denial and the appeal process. You won't be held responsible for the charge if the denial is due to a lack of prior authorization.</p>	
<p>Physical therapy</p> <p>The 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.</p>	<p>In-network and Out-of-network:</p> <p>Your coinsurance is 10% of the approved amount, after deductible.</p> <p>The deductible and coinsurance apply to the annual out-of-pocket maximum.</p>
<p> Pneumococcal vaccine</p> <p>The 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 plan covers the first shot at any time, and covers a different second shot if it's given one year (or later) after the first shot.</p> <p>Talk with your doctor or other healthcare provider to see if you need one or both pneumococcal shots.</p>	<p>In-network and Out-of-network:</p> <p>Covered at 100% of the approved amount.</p>

Covered Services	What you pay
<p> Pre-exposure prophylaxis (PrEP) for HIV prevention</p> <p>If you don't have HIV, but your doctor or other healthcare practitioner determines you're at an increased risk for HIV, the plan covers PrEP medication and related services.</p> <p>If you qualify, covered services include:</p> <ul style="list-style-type: none"> • FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, the plan also covers the fee for injecting the drug. • Up to eight individual counseling sessions (including HIV risk assessment, HIV risk reduction and medication adherence) every 12 months. • Up to eight HIV screenings every 12 months. <p>A one-time Hepatitis B virus screening.</p>	<p>In-network and Out-of-network:</p> <p>Covered at 100% of the approved amount</p>
<p>Prescription drugs (limited)*</p> <p>The plan covers a limited number of prescription drugs. Examples of prescription drugs covered under this plan include:</p> <ul style="list-style-type: none"> • Drugs that usually aren't self-administered by the patient and are injected or infused while you're 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). • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan. 	<p>In-network and Out-of-network:</p> <p>Your coinsurance is 10% of the approved amount, after deductible.</p> <p>The deductible and coinsurance apply to the annual out-of-pocket maximum.</p> <p>You won't pay more than \$35 for a one month's supply of insulin.</p> <p>Retail and mail-order Part D prescription drugs are not covered by your Medicare Plus Blue Group PPO plan.</p> <p>Certain drugs require prior authorization. Step therapy may be required.</p>

Covered Services	What you pay
<p>Prescription drugs (limited),* <i>continued</i></p> <ul style="list-style-type: none">• 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.• Clotting factors you give yourself by injection if you have hemophilia.• Injectable osteoporosis drugs if you’re homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis and cannot self-administer the drug.• Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision.• Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug.• Oral anti-nausea drugs: Medicare covers oral 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.• Certain end-stage renal disease (ESRD) drugs.	


Covered Services	What you pay
<p>Prescription drugs (limited),* <i>continued</i></p> <ul style="list-style-type: none"> • Certain drugs, such as methadone for pain management and substance use disorder conditions. • Calcimimetic medications under the ESRD payment system, including the intravenous medication Parsabiv® and the oral medication Sensipar®. • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, and topical anesthetics. • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have ESRD or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa). • Intravenous immunoglobulin for the home treatment of primary immune deficiency diseases. • Parenteral and enteral nutrition (intravenous and tube feeding). <p>Self-administered drugs you take on your own that are covered under your prescription drug plan are not covered by this plan.</p> <p>Covered prescription drugs that may be subject to <u>step therapy</u> include: anticancer 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:</p>	

Covered Services	What you pay
<p>Prescription drugs (limited),* <i>continued</i></p> <p>bcbsm.com/amslibs/content/dam/public/consumer/forms-documents/pharmacy/prior-authorization-and-step-therapy-guidelines.pdf.</p> <p>Refer to Transplants, in the Inpatient hospital care section in <i>Chapter 4 Medical Benefits Chart</i> of this booklet for more information on coverage for immunosuppressant drugs.</p>	
<p> Prostate cancer screening exams</p> <p>For men aged 50 and older, covered services include the following once every calendar year:</p> <ul style="list-style-type: none"> • Digital rectal exam. • Prostate-specific antigen (PSA) test. 	<p>In-network and Out-of-network:</p> <p>Covered at 100% of the approved amount.</p>
<p>Prosthetic/orthotic items*</p> <p>The plan covers arm, leg, back and neck braces; artificial eyes; artificial limbs; some types of breast prostheses (after mastectomy); a surgical brassiere after a mastectomy; and prosthetic and/or orthotic devices needed to replace an internal body part or function (including ostomy supplies and parenteral and enteral nutrition therapy) when ordered by a doctor or other healthcare provider.</p> <p>Coverage includes repair and/or replacement of prosthetic and/or orthotic devices.</p> <p>*You must have a prescription or a Certificate of Medical Necessity from your doctor to obtain durable medical equipment (DME) or prosthetic and orthotic (P&O) items and services.</p>	<p>In-network:</p> <p>Your coinsurance is 10% of the approved amount, after deductible.</p> <p>The deductible and coinsurance apply to the annual out-of-pocket maximum.</p> <p>Out-of-network:</p> <p>Your coinsurance is 30% of the approved amount, after deductible.</p> <p>The deductible and coinsurance apply to the annual out-of-pocket maximum.</p>


Covered Services	What you pay
<p>Pulmonary rehabilitation services</p> <p>Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.</p>	<p>In-network and Out-of-network:</p> <p>Your coinsurance is 10% of the approved amount, after deductible.</p> <p>The deductible and coinsurance apply to the annual out-of-pocket maximum.</p>
<p> Sexually transmitted infections (STIs) screening and counseling</p> <p>The plan covers STI screenings for chlamydia, gonorrhea, syphilis and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. The plan covers these tests once every 12 months or at certain times during pregnancy.</p> <p>The plan also covers up to two individual 20- to 30-minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. The plan will only cover these counseling sessions as a preventive service if they're provided by a primary care provider and take place in a primary care setting, such as a doctor's office.</p>	<p>In-network and Out-of-network:</p> <p>Covered at 100% of the approved amount.</p>
<p>Speech-language pathology services</p> <p>The 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.</p>	<p>In-network and Out-of-network:</p> <p>Your coinsurance is 10% of the approved amount, after deductible.</p> <p>The deductible and coinsurance apply to the annual out-of-pocket maximum.</p>
<p>Substance use disorder services*</p> <p>Outpatient substance use disorder services include counseling, medical testing and diagnostic evaluation in a hospital, residential treatment center or outpatient substance use disorder treatment facility.</p>	<p>In-network and Out-of-network:</p> <p>Your coinsurance is 10% of the approved amount, after deductible.</p>

Covered Services	What you pay
<p>Substance use disorder services,* continued</p> <p>Coverage is available for treatment services that are provided in the outpatient department of a hospital to patients who, for example, have been discharged from an inpatient stay for the treatment of substance use disorder or who require treatment but do not require the availability and intensity of services found only in the inpatient hospital setting.</p> <p>The coverage available for these services is subject to the same rules generally applicable to the coverage of outpatient hospital services.</p> <p>Coverage includes:</p> <ul style="list-style-type: none"> • 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. • Counseling for your family members. <p>*Outpatient mental/substance use disorder services rendered by plan providers may require prior authorization. Your plan provider will arrange for this authorization. If treatment or service is denied, you'll receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You won't be held responsible for the charge if the denial is due to a lack of prior authorization.</p>	<p>The deductible and coinsurance apply to the annual out-of-pocket maximum.</p>
<p>Supervised Exercise Therapy (SET)</p> <p>SET is covered for members who have symptomatic peripheral artery disease (PAD) and an order for SET from the physician responsible for PAD treatment.</p> <p>Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.</p>	<p>In-network and Out-of-network:</p> <p>Your coinsurance is 10% of the approved amount, after deductible.</p> <p>The deductible and coinsurance apply to the annual out-of-pocket maximum.</p>

Covered Services	What you pay
<p>Supervised Exercise Therapy (SET), continued</p> <p>The SET program must:</p> <ul style="list-style-type: none"> • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication. • Be conducted in a hospital outpatient setting or a physician's office. • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms and who are trained in exercise therapy for PAD. • 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. <p>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.</p>	
<p>Surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers*</p> <p>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.</p> <p>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.</p>	<p>In-network and Out-of-network:</p> <p>Your coinsurance is 10% of the approved amount, after deductible.</p> <p>The deductible and coinsurance apply to the annual out-of-pocket maximum.</p>

Covered Services	What you pay
<p>Surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers,* <i>continued</i></p> <p>Note: If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.</p>	
<p> Tobacco-use cessation counseling</p> <p>The plan covers up to eight face-to-face visits in a 12-month period.</p>	<p>In-network and Out-of-network: Covered at 100% of the approved amount.</p>
<p>Urgently needed services</p> <p>The plan covers urgently needed services and only charges you in-network cost sharing. You also have coverage for urgently needed services worldwide. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside your plan's service area or your plan network is temporarily unavailable.</p>	<p>In-network and Out-of-network:</p> <p>You pay a \$65 copay.</p> <p>The copay applies to the annual out-of-pocket maximum.</p>
<p>Virtual care</p> <p>Virtual care visits, sometimes called telehealth, give you the opportunity to meet with a healthcare provider through electronic forms of communication. This allows you to meet with a healthcare provider for minor illnesses or conditions that require medical attention when it's not possible for you to meet with your doctor in the office.</p>	<p>In-network and Out-of-network:</p> <p>Your coinsurance is 10% of the approved amount, after deductible.</p> <p>The deductible and coinsurance apply to the annual out-of-pocket maximum.</p>

Covered Services	What you pay
<p>Virtual care, <i>continued</i></p> <p>Certain telehealth services, including primary care provider services and individual sessions for mental health specialty services, are covered.</p> <p>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 U.S. You may choose to have an online visit with your own provider, if your provider offers this service. Or, you can visit bcbsm.com/virtualcare.</p> <p>Virtual care is available through Teladoc Health®, an independent company and your plan-approved vendor. This service is separate from any virtual care your personal doctor might offer.</p>	
<p>Vision care services</p> <p>The plan covers exams to diagnose and treat medical conditions of the eye in case of disease or injury.</p> <p>Refraction tests received with a medical eye exam are covered by the plan. Refraction tests involve measuring the eye's ability to focus light correctly.</p> <p>The plan covers one pair of eyeglasses with standard frames (or one set of contact lenses) after cataract surgery that implants an intraocular lens.</p> <p>Routine eye exams and glasses are not covered by this medical plan.</p>	<p>In-network and Out-of-network:</p> <p>Your coinsurance is 10% of the approved amount, after deductible.</p> <p>The deductible and coinsurance apply to the annual out-of-pocket maximum.</p>

Covered Services	What you pay
<p> Welcome to Medicare preventive visit</p> <p>The plan covers a one-time Welcome to Medicare preventive visit, which includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed.</p> <p>The plan covers a one-time screening EKG/ECG if referred by your doctor or other healthcare provider as part of your one-time Welcome to Medicare preventive visit.</p> <p>Important: You must have the physical exam within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your Welcome to Medicare preventive visit.</p>	<p>In-network and Out-of-network:</p> <p>Covered at 100% of the approved amount within the first 12 months after you have your Medicare Part B coverage.</p> <p>For EKG/ECG screening, your coinsurance is 10% of the approved amount, after deductible. You may also be charged cost sharing if a service performed (e.g., diagnostic test) is outside the scope of the Welcome to Medicare preventive visit. The deductible and coinsurance apply to the annual out-of-pocket maximum.</p> <p>Note: If you're treated or monitored for an existing medical condition during a visit when you receive preventive services, your 10% coinsurance and deductible will apply to the care received for the existing medical condition.</p>

Worldwide Medical Care

Foreign travel

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 U.S. For covered services performed abroad, your plan will pay the approved amount at the rate of exchange in effect on the date of service. You're responsible for costs that exceed the Medicare Plus Blue Group PPO approved amount plus your coinsurance, copay and deductible. For non-emergency inpatient medical care outside of the U.S., call the BlueCross BlueShield Global Core Service Center at **1-800-810-2583**.

Section 2.1 Routine hearing care benefit details

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., Monday through Friday and follow the directions you're given. (Non-routine hearing and balance exams are covered under your medical plan; for more information, see **Hearing and balance exams** section located in *Chapter 4 Medical Benefits Chart* of this booklet.)

Your routine hearing care benefits are not subject to the annual deductible and include the following services:

- **Audiometric examination** — Measures hearing ability, including test for air and bone conduction, speech reception and speech discrimination.
- **Hearing aid evaluation test** — Determines what type of hearing aid should be prescribed to compensate for loss of hearing.
- **Hearing aids** — Monaural (one ear) and binaural (involving both ears) in the TruHearing catalog in various fits, styles and colors are covered under your health benefits. When you use TruHearing providers you have:
 - Unlimited follow-up visits.
 - 60-day trial period.
 - Three-year full manufacturer warranty on all devices.
 - 80 batteries per non-rechargeable hearing aid.

<i>What you pay</i>	
TruHearing provider	Non-TruHearing provider
<ul style="list-style-type: none"> • \$45 copay for routine hearing exam. • \$499 copay per TruHearing Advanced hearing aid. • \$799 copay per TruHearing Premium hearing aid. • You have a \$700 allowance per aid toward the cost of a hearing aid in the TruHearing catalog (not including TruHearing Advanced or Premium hearing aids). If there is a 	<ul style="list-style-type: none"> • You pay all costs.

balance after the allowance is applied, you would be responsible for the balance.	
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Frequency limitation

- Routine hearing exams are covered every year.
- Up to two hearing aids in the TruHearing catalog are covered every 24 months.
- **Note:** Binaural hearing aids, or two hearing aids to correct hearing loss in both ears, are covered only when they're purchased on the same date. Two hearing aids provided to you on different dates are not considered binaural hearing aids and only one will be paid during a 24-month period.

Payment provisions

- Hearing services must be received from a TruHearing provider to be covered.
- Copays for routine hearing exams and hearing aids are **not** counted toward your deductible and are not included in the annual coinsurance/copayment maximum or annual out-of-pocket maximum.
- The \$700 allowance per aid toward the cost of a hearing aid and, if applicable, any balance you pay after the allowance is applied aren't counted toward your deductible and aren't included in the annual coinsurance/copayment maximum or annual out-of-pocket maximum.

Using your hearing care benefits

Call TruHearing at **1-855-205-6305** (TTY: **711**) from 8 a.m. to 8 p.m., Monday through Friday to schedule an appointment.

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.

Routine hearing care appeals and complaints — What to do if you have a problem or concern

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

- If you're unsure about whether a particular service or item is covered.
- You have a complaint about a TruHearing provider, including a complaint about the quality of your care.

All questions about the hearing care benefits should be directed to TruHearing.

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

This section tells you what services are *excluded* and therefore are not covered by this plan.

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

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

Services not covered	Covered only under specific conditions
Acupuncture	Covered for people with chronic low back pain under certain circumstances.
Cosmetic surgery or procedures	<ul style="list-style-type: none"> • Covered in cases of an accidental injury or for improvement of the functioning of a malformed body part. • Covered for all stages of reconstruction of a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Custodial care <u>Custodial care</u> is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.	Not covered under any condition.
Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, anti-	Covered only when medically necessary.

Services not covered	Covered only under specific conditions
aging and mental performance)	
<p>Experimental medical and surgical procedures, equipment and medications</p> <p>Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.</p>	<p>May be covered by Original Medicare under a Medicare-approved clinical research study.</p> <p>See <i>Chapter 3, Section 5</i> for more information on clinical research studies.</p>
<p>Fees charged for care by your immediate relatives or members of your household</p>	<p>Not covered under any condition.</p>
<p>Full-time nursing care in your home</p>	<p>Not covered under any condition.</p>
<p>Home-delivered meals</p>	<p>Not covered under any condition.</p>
<p>Homemaker services and basic household help including light housekeeping or light meal preparation</p>	<p>Not covered under any condition.</p>
<p>Immunizations needed for travel</p>	<p>Not covered under any condition.</p>
<p>Naturopath services (uses natural or alternative treatments)</p>	<p>Not covered under any condition.</p>
<p>Non-routine dental care</p>	<p>Dental care required to treat illness or injury may be covered as inpatient or outpatient care.</p>
<p>Personal items in your room at a hospital or a skilled nursing facility,</p>	<p>Not covered under any condition.</p>

Services not covered	Covered only under specific conditions
such as a telephone or a television	
Private duty nursing	Not covered under any condition.
Private room in a hospital	Covered only when medically necessary.
Reversal of sterilization procedures and contraceptive supplies Note: Check with your prescription drug plan about coverage for oral contraceptives.	Not covered under any condition.
Routine chiropractic care	Manual manipulation of the spine to correct a subluxation is covered.
Routine dental care, such as cleanings, fillings or dentures	Not covered under any condition.
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, vision therapy and other low vision aids	Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery.
Routine foot care	Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes).
Routine hearing care: <ul style="list-style-type: none"> • Hearing aids other than those in the TruHearing catalog. • Ear molds. • Hearing aid accessories. • Extra batteries beyond the first 80 provided per aid (additional batteries may be purchased from TruHearing on a discounted basis). 	Not covered under any condition.

Services not covered	Covered only under specific conditions
<ul style="list-style-type: none"> • Charges associated with loss and damage warranty claims (may cost up to \$250 per hearing aid for manufacturer and provider programming fees). • 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. 	
<p>Routine hearing exams and hearing aids</p>	<p>Only covered when you call TruHearing at 1-855-205-6305 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday and follow the instructions you're given.</p>
<p>Services considered not reasonable and necessary, according to Original Medicare standards <u>unless these services are listed by this plan as covered services</u></p>	<p>Not covered under any condition.</p>
<p>Services provided to veterans in Veterans Affairs (VA) hospitals</p>	<p>When emergency services are received at a VA hospital and the VA cost sharing is more than the cost sharing under this plan, the plan will reimburse veterans for the difference. Members are still responsible for the plan's cost-sharing amounts.</p>
<p>Shingles shot</p>	<p>Not covered under any condition.</p>

Services not covered	Covered only under specific conditions
Note: The shingles shot isn't covered by the plan. Check with your prescription drug plan about coverage for the shingles shot.	
Travel expenses	Covered only for certain organ transplants. (See the Transplants, in the Inpatient hospital care section in <i>Chapter 4 Medical Benefits Chart</i> of this booklet for more information on travel expenses for organ transplants.)
Wilderness and outdoor therapy, recreational and lifestyle programs, outdoor skills programs, relaxation programs, health resort programs and services provided in conjunction with (or as part of) wilderness therapy programs at a residential treatment center.	Not covered under any condition.

**CHAPTER 5: Asking us to pay the plan's share of a bill for covered
medical services**

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

Sometimes when you get medical care, you may need to pay the full cost up front. Other times, you may pay more than you expected under the plan's coverage rules or you may get a bill from a provider. In these cases, you can ask us to pay you back (*reimburse* you). It's your right to be paid back whenever you've paid more than your share of the cost for medical services covered by this plan. There may be deadlines that you must meet to get paid back. Please go to *Section 2* of this chapter.

There may also be times when you get a bill from a provider for the full cost of medical care you got or for more than your share of the cost. First, try to resolve the bill with the provider. If that doesn't work, send the bill to us instead of paying it. We'll look at the bill and decide whether the services should be covered. If we decide they should be covered, we'll pay the provider directly. If we decide not to pay it, we'll notify the provider. You should never pay more than plan-allowed cost sharing. If this provider is contracted, you still have the right to treatment.

Routine hearing exams and hearing aids are not covered unless you call TruHearing at **1-855-205-6305** (TTY: **711**) from 8 a.m. to 8 p.m., Monday through Friday and follow the instructions you're given. You have no benefits if you see a non-TruHearing provider.

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

1. When you got medical care from a provider who is not in our network

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

- Emergency providers are legally required to provide emergency care. You're only responsible for paying your share of the cost for emergency or urgently needed services. If you pay the entire amount yourself at the time you get the care, ask us to pay you back for the plan's share of the cost. Send us the bill, along with documentation of any payments you made.
- You may get a bill from the provider asking for payment you think you do not owe. Send us this bill, along with documentation of any payments you already made.
 - If the provider is owed anything, we'll pay the provider directly.
 - If you already paid more than your share of the cost of the service, we'll determine how much you owed and pay you back for the plan's share of the cost.
- While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If the provider is not eligible

to participate in Medicare, you will be responsible for the full cost of the services you receive.

2. When a network provider sends you a bill you think you should not pay

Network providers should always bill us directly and ask you only for your share of the cost. But sometimes they make mistakes and ask you to pay more than your share.

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

3. If you're retroactively enrolled in this plan

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

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

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

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

Send us your request for payment, along with your bill and documentation of any payment you've made. It's a good idea to make a copy of your bill and receipts for your records.

You must submit your claim to us within 12 months of the date you got the service or item.

To make sure you're giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it will help us process the information faster.
- You can download a copy of the form from our website at bcbsm.com/medicare/resources/forms-documents/manage-account/ and select *Medicare Plus Blue PPO Member Reimbursement Form* link, complete the online reimbursement claim form from your Blue Cross online member account at bcbsm.com/mpsers or call Blue Cross Customer Service at **1-800-422-9146** (TTY: **711**) and ask for the form.

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

Medicare Plus Blue Group PPO Part C Claims Department

Blue Cross Blue Shield of Michigan
Imaging and Support Services
P.O. Box 32593
Detroit, MI 48232-0593

**SECTION 3 We will consider your request for payment and say
yes or no**

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

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

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

If you think we made a mistake in turning down your request for payment or the amount we're paying, you can make an appeal. If you make an appeal, it means you're asking us to change the decision we made when we turned down your request for payment.

The appeals process is a formal process with detailed procedures and important deadlines. For details on how to make this appeal, go to *Chapter 7*.

CHAPTER 6: Your rights and responsibilities

SECTION 1 This plan must honor your rights and cultural sensitivities

Section 1.1 We must provide information in a way that works for you and is consistent with your cultural sensitivities (in languages other than English, in audio CD, large print or other alternate formats)

This plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity or those with diverse cultural and ethnic backgrounds. Examples of how this plan may meet these accessibility requirements include, but are not limited to: provision of translator services, interpreter services, teletypewriters or TTY (text telephone or teletypewriter phone) connection.

We have free interpreter services available to answer questions from non-English speaking members. We can also give you information in audio CD, large print or other alternate formats at no cost if you need it. We're required to give you information about our plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, call Blue Cross Customer Service at **1-800-422-9146** (TTY: **711**).

This plan is required to give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive healthcare services.

If specialty providers in this plan's network aren't available, it's this plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you'll only pay in-network cost sharing. If you find yourself in a situation where there are no specialists in the plan's network that cover a service you need, call Blue Cross Customer Service at **1-800-422-9146** (TTY: **711**) for information on where to go to get this service at in-network cost sharing.

If you have any trouble getting information from us in a format that is accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with Blue Cross Customer Service at **1-800-422-9146** (TTY: **711**). You may also file a complaint with Medicare by calling **1-800-MEDICARE (1-800-633-4227)** or directly with the Office for Civil Rights by calling **1-800-368-1019** or TTY: **1-800-537-7697**.

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

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

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

If you think you're not getting your medical care within a reasonable amount of time, *Chapter 7* tells what you can do.

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

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

- Your *personal health information* includes the personal information you provided when you enrolled in this plan as well as your medical records and other medical and health information.
- You have rights related to your information and controlling how your health information is used. We give you a written notice later in this section, called a *Notice of Privacy Practices*, that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

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

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

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

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

If you have questions or concerns about the privacy of your personal health information, please call Blue Cross Customer Service at **1-800-422-9146** (TTY: **711**).

Blue Cross[®] Blue Shield[®] of Michigan Blue Care Network of Michigan

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Affiliated entities covered by this notice

This notice applies to the privacy practices of the following affiliated covered entities that may share your protected health information as needed for treatment, payment, and healthcare operations.

- Blue Cross Blue Shield of Michigan
- Blue Care Network of Michigan

Our commitment regarding your protected health information

We understand the importance of your Protected Health Information (hereafter referred to as “PHI”) and follow strict policies (in accordance with state and federal privacy laws) to keep your PHI private. PHI is information about you, including demographic data, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health, the provision of healthcare to you or the payment for that care. Our policies cover protection of your PHI whether oral, written or electronic.

In this notice, we explain how we protect the privacy of your PHI, and how we will allow it to be used and given out (“disclosed”). We must follow the privacy practices described in this notice while it is in effect. This notice takes effect September 30, 2016 and will remain in effect until we replace or modify it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that applicable law permits such changes. These revised practices will apply to your PHI regardless of when it was created or received. Before we make a material change to our privacy practices, we will provide a revised notice to our subscribers.

Where multiple state or federal laws protect the privacy of your PHI, we will follow the requirements that provide greatest privacy protection. For example, when you authorize disclosure to a third party, state laws require BCBSM to condition the disclosure on the recipient’s promise to obtain your written permission to disclose your PHI to someone else.

Our uses and disclosures of protected health information

We may use and disclose your PHI for the following purposes without your authorization:

- **To you and your personal representative:** We may disclose your PHI to you or to your personal representative (someone who has the legal right to act for you).
- **For treatment:** We may use and disclose your PHI to healthcare providers (doctors, dentists, pharmacies, hospitals, and other caregivers) who request it in connection with your treatment. For example, we may disclose your PHI to healthcare providers in connection with disease and case management programs.
- **For payment:** We may use and disclose your PHI for our payment-related activities and those of healthcare providers and other health plans, including:
 - Obtaining premium payments and determining eligibility for benefits
 - Paying claims for healthcare services that are covered by your health plan
 - Responding to inquiries, appeals and grievances
 - Coordinating benefits with other insurance you may have
- **For healthcare operations:** We may use and disclose your PHI for our healthcare operations, including for example:
 - Conducting quality assessment and improvement activities, including peer review, credentialing of providers and accreditation
 - Performing outcome assessments and health claims analyses
 - Preventing, detecting, and investigating fraud and abuse
 - Underwriting, rating, and reinsurance activities (although we're prohibited from using or disclosing any genetic information for underwriting purposes)
 - Coordinating case and disease management activities
 - Communicating with you about treatment alternatives or other health-related benefits and services
 - Performing business management and other general administrative activities, including systems management and Customer Service

We may also disclose your PHI to other providers and health plans who have a relationship with you for certain healthcare operations. For example, we may disclose your PHI for their quality assessment and improvement activities or for healthcare fraud and abuse detection.

Note: We won't use race/ethnicity, language, gender identity and sexual orientation information for underwriting and denial of services, coverage and benefits, as applicable.

- **To others involved in your care:** We may, under certain circumstances, disclose to a member of your family, a relative, a close friend or any other person you identify, the PHI directly relevant to that person's involvement in your healthcare or payment for healthcare. For example, we may discuss a claim

decision with you in the presence of a friend or relative, unless you object.

- **When required by law:** We will use and disclose your PHI if we're required to do so by law. For example, we will use and disclose your PHI in responding to court and administrative orders and subpoenas, and to comply with workers' compensation laws. We will disclose your PHI when required by the Secretary of the Department of Health and Human Services and state regulatory authorities.
- **For matters in the public interest:** We may use or disclose your PHI without your written permission for matters in the public interest, including for example:
 - Public health and safety activities, including disease and vital statistic reporting, child abuse reporting, and Food and Drug Administration oversight
 - Reporting adult abuse, neglect, or domestic violence
 - Reporting to organ procurement and tissue donation organizations
 - Averting a serious threat to the health or safety of others
- **For research:** We may use and disclose your PHI to perform select research activities, provided that certain established measures to protect your privacy are in place.
- **To communicate with you about health-related products and services:** We may use your PHI to communicate with you about health-related products and services that we provide or are included in your benefits plan. We may use your PHI to communicate with you about treatment alternatives that may be of interest to you.

These communications may include information about the healthcare providers in our networks, about replacement of or enhancements to your health plan, and about health-related products or services that are available only to our enrollees and add value to your benefits plan.

- **To our business associates:** From time to time, we engage third parties to provide various services for us. Whenever an arrangement with such a third party involves the use or disclosure of your PHI, we will have a written contract with that third party designed to protect the privacy of your PHI. For example, we may share your information with business associates who process claims or conduct disease management programs on our behalf.
- **To group health plans and plan sponsors:** We participate in an organized healthcare arrangement with our underwritten group health plans. These plans, and the employers or other entities that sponsor them, receive PHI from us in the form of enrollment information (although we're prohibited from using or disclosing any genetic information for underwriting purposes). Certain plans and their sponsors may receive additional PHI from Blue Cross and BCN. Whenever we disclose PHI to plans or their sponsors, they must follow applicable laws governing use and disclosure of your PHI including amending the plan documents for your

group health plan to establish the limited uses and disclosures it may make of your PHI.

You may give us written authorization to use your PHI or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation won't affect any use or disclosure permitted by your authorization while it was in effect. Some uses and disclosures of your PHI require a signed authorization:

- **For marketing communications:** Uses and disclosures of your PHI for marketing communications won't be made without a signed authorization except where permitted by law.
- **Sale of PHI:** We won't sell your PHI without a signed authorization except where permitted by law.
- **Psychotherapy notes:** To the extent (if any) that we maintain or receive psychotherapy notes about you, disclosure of these notes won't be made without a signed authorization except where permitted by law.

Any other use or disclosure of your protected health information, except as described in this Notice of Privacy Practices, won't be made without your signed authorization.

Disclosures you may request

You may instruct us, and give your written authorization, to disclose your PHI to another party for any purpose. We require your authorization to be on our standard form. To obtain the form, call the Customer Service number on the back of your membership card or call **1-313-225-9000**.

Individual rights

You have the following rights. To exercise these rights, you must make a written request on our standard forms. To obtain the forms, call the Customer Service number on the back of your membership ID card or call 1-313-225-9000. These forms are also available online at bcbsm.com.

- **Access:** With certain exceptions, you have the right to look at or receive a copy of your PHI contained in the group of records that are used by or for us to make decisions about you, including our enrollment, payment, claims adjudication, and case or medical management notes. We reserve the right to charge a reasonable

cost-based fee for copying and postage. You may request that these materials be provided to you in written form or, in certain circumstances, electronic form. If you request an alternative format, such as a summary, we may charge a cost-based fee for preparing the summary. If we deny your request for access, we will tell you the basis for our decision and whether you have a right to further review.

- **Disclosure accounting:** You have the right to an accounting of disclosures we, or our business associates, have made of your PHI in the six years prior to the date of your request. We're not required to account for disclosures we made before April 14, 2003, or disclosures to you, your personal representative or in accordance with your authorization or informal permission; for treatment, payment, and healthcare operations activities; as part of a limited data set; incidental to an allowable disclosure; or for national security or intelligence purposes; or to law enforcement or correctional institutions regarding persons in lawful custody.

You're entitled to one free disclosure accounting every 12 months upon request. We reserve the right to charge you a reasonable fee for each additional disclosure accounting you request during the same 12-month period.

- **Restriction requests:** You have the right to request that we place restrictions on the way we use or disclose your PHI for treatment, payment, or healthcare operations. We're not required to agree to these additional restrictions; but if we do, we will abide by them (except as needed for emergency treatment or as required by law) unless we notify you that we're terminating our agreement.
- **Amendment:** You have the right to request that we amend your PHI in the set of records we described above under Access. If we deny your request, we will provide you with a written explanation. If you disagree, you may have a statement of your disagreement placed in our records. If we accept your request to amend the information, we will make reasonable efforts to inform others, including individuals you name, of the amendment.
- **Confidential communication:** We communicate decisions related to payment and benefits, which may contain PHI, to the subscriber. Individual members who believe that this practice may endanger them may request that we communicate with them using a reasonable alternative means or location. For example, an individual member may request that we send an Explanation of Benefits to a post office box instead of to the subscriber's address. To request confidential communications, call the Customer Service number on the back of your membership ID card or **1-313-225-9000**.
- **Breach notification:** In the event of a breach of your unsecured PHI, we will provide you with notification of such a breach as required by law or where we otherwise deem appropriate.

Questions and complaints

If you want more information about our privacy practices, or a written copy of this notice, please contact us at:

Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
MC 1302
Detroit, MI 48226-2998
Attn: Privacy Official
Telephone: 1-313-225-9000

For your convenience, you may also obtain an electronic (downloadable) copy of this notice online at **bcbsm.com**.

If you're concerned that we may have violated your privacy rights, or you believe that we have inappropriately used or disclosed your PHI, call us at 1-800-552-8278. You also may complete our Privacy Complaint form online at **bcbsm.com**.

You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with their address to file your complaint upon request. We support your right to protect the privacy of your PHI. We won't retaliate in any way if you file a complaint with us or with the U.S. Department of Health and Human Services.

Last Reviewed Date: 7/31/2025

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

As a member of Medicare Plus Blue Group PPO, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call Blue Cross Customer Service at **1-800-422-9146** (TTY: **711**):

- **Information about the plan.** This includes, for example, information about our plan's financial condition.
- **Information about our network providers.**
 - You have the right to get information about the qualifications of the providers in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.**
 - *Chapter 3* and *Chapter 4* provide information regarding medical services.
- **Information about why something is not covered and what you can do about it.**
 - *Chapter 7* provides information on asking for a written explanation on why a medical service is not covered, or if your coverage is limited.

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

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

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

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

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

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

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself. Submit a copy of the completed form to any entity that your selected representative may need to talk to on your behalf, including ORS and Blue Cross.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

Legal documents you can use to give your directions in advance in these situations are called advance directives. Documents like a living will and power of attorney for healthcare are examples of advance directives. An advance directive is not technically needed to conduct business with ORS but may provide guidance to your family members about the kind of healthcare you wish to receive at the end of your life.

How to set up an advance directive to give instructions:

- **Get a form.**
You can get an advance directive form from your lawyer, a social worker or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Blue Cross Customer Service at **1-800-422-9146** (TTY: **711**) to ask for the forms.
- **Fill out the form and sign it.**
No matter where you get this form, it is a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people.**
Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

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

Filling out an advance directive is your choice (including whether you want to sign one if you're in the hospital). According to law, no one can deny you care or discriminate against you based on whether you signed an advance directive.

If your instructions are not followed

If you sign an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you can file a complaint.

In Michigan, visit: michigan.gov/lara and click *I Need to ...* then scroll and click *Make a Complaint About a Licensed Professional or Business*.

To file a complaint against a hospital or other healthcare facility, contact:

Department of Licensing & Regulatory Affairs
Bureau of Survey and Certification
P.O. Box 30828
Lansing, MI 48909

Call: 1-800-882-6006, 8 a.m. to 5 p.m. Eastern time, Monday through Friday. TTY: **711**.

Fax: 1-517-763-0214

Email: lara-bcs-complaints@michigan.gov

To file a complaint against a doctor, nurse or any medical professional licensed with the state of Michigan, contact:

Bureau of Professional Licensing
Investigations and Inspections Division
P.O. Box 30670
Lansing, MI 48909-8170

Call: 1-517-241-0205, 8 a.m. to 5 p.m. Eastern time, Monday through Friday. TTY: **711**.

Fax: 1-517-241-2389 (Attn: Complaint Intake)

Email: BPL-Complaints@michigan.gov

Outside Michigan, contact your state department of health agency or State Health Insurance Assistance Program (SHIP) for assistance. See *Exhibit 1* in the back of this booklet for SHIP listings.

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

If you have any problems, concerns or complaints and need to ask for coverage or make an appeal, *Chapter 7* of this document tells what you can do.

Whatever you do — ask for a coverage decision, make an appeal or make a complaint — **we're required to treat you fairly.**

Section 1.7 If you believe you're being treated unfairly or your rights are not being respected

If you believe you've been treated unfairly or your rights haven't been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age or national origin, call the

Department of Health and Human Services' **Office for Civil Rights** at **1-800-368-1019** (TTY: **1-800-537-7697**), or call your local Office for Civil Rights.

If you believe you've been treated unfairly or your rights haven't been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you have by calling:

- **Blue Cross Customer Service** at **1-800-422-9146** (TTY: **711**).
- **Michigan State Health Insurance Assistance Program (SHIP)** at **1-800-803-7174**.
- **Medicare** at **1-800-MEDICARE (1-800-633-4227)** (TTY: **1-877-486-2048**).

Section 1.8 How to get more information about your rights

Get more information about your rights:

- **Call Blue Cross Customer Service** at **1-800-422-9146** (TTY: **711**).
- **Call Michigan SHIP** at **1-800-803-7174**.
- **Contact Medicare.**
 - Visit **medicare.gov** to read the publication *Medicare Rights & Protections* (available at **medicare.gov/publications/11534-medicare-rights-and-protections.pdf**).
 - Call **1-800-MEDICARE (1-800-633-4227)** (TTY: **1-877-486-2048**).

SECTION 2 Your responsibilities as a member of this plan

Things you need to do as a member of this plan are listed below. For questions, call Blue Cross Customer Service at **1-800-422-9146** (TTY: **711**).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* to learn what is covered and the rules you need to follow to get covered services.
 - *Chapter 3* and *Chapter 4* give details about medical services.
- **If you have any other health coverage in addition to this plan, you're required to tell us.** *Chapter 1* tells you about coordinating these benefits.
- **You must call Blue Cross Customer Service if you have claims involving any of the following types of coverage:**
 - No-fault insurance (including automobile insurance).
 - Liability (including automobile insurance).
 - Black lung benefits.
 - Workers' compensation.

- **Tell your doctor and other healthcare providers that you're enrolled in this plan.** Show your plan member ID card whenever you get your medical care.
- **Help your doctors and other providers help you by giving them information, asking questions and following through on your care.**
 - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree on.
 - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins and supplements.
 - If you have questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals and other offices.
- **Pay what you owe.** As a plan member, you're responsible for these payments:
 - You must pay the plan premiums.
 - You must continue to pay your Medicare Part B premium to stay a member of this plan.
 - For some of your medical services covered by the plan, you must pay your share of the cost when you get the service.
- **Tell ORS if you move.** If you're going to move, contact ORS at **1-800-381-5111** immediately to update your records to ensure you receive all necessary correspondence.
 - **If you move outside our service area, you cannot stay a member of this plan.** (*Chapter 1* tells about our service area.)
 - **If you move, tell the Social Security Administration** (or the Railroad Retirement Board).

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

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

This chapter explains two types of processes for handling problems and concerns:

- For some problems, you need to use the **process for coverage decisions and appeals**.
- For other problems, you need to use the **process for making complaints**, also called grievances.

Both processes have been approved by Medicare. Each process has a set of rules, procedures and deadlines that must be followed by us and by you.

The information in this chapter will help you identify the right process to use and what you should do.

Section 1.1 Legal terms

There are legal terms for some of the rules, procedures and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people. To make things easier, this chapter uses more familiar words in place of some legal terms.

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

SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Blue Cross Customer Service for help at **1-800-422-9146** (TTY: **711**). In some situations, you may also want help or guidance from someone who is not connected with us. Two organizations that can help are:

State Health Insurance Assistance Program (SHIP).

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you're having. They can also answer questions, give you more information and offer guidance on what to do.

The services of SHIP counselors are free. In Michigan, you can contact SHIP at **1-800-803-7174** (TTY: **711**). You will find phone numbers in *Chapter 2, Section 3* of this booklet. For a list of SHIP organizations outside Michigan, refer to the **Appendix** at the back of this document.

Medicare

You can also contact Medicare for help:

- Call **1-800-MEDICARE (1-800-633-4227)**. TTY: **1-877-486-2048**.
- Visit **medicare.gov**.

SECTION 3 **Which process to use for your problem**

Is your problem or concern about your benefits or coverage?

This includes problems about whether medical care (medical items, services and/or medical plan drugs) is covered or not, the way it is covered and problems related to payment for medical services.

Yes.

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

No.

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

COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to coverage decisions and appeals

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

Asking for coverage decisions before receiving services

If you want to know if we'll cover medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical care. For example, if your network provider refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either you or your network doctor can show you got a standard denial notice for this medical specialist, or the *Evidence of Coverage* makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think you need.

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

We make a coverage decision whenever we decide what is covered for you and how much we pay. In some cases, we might decide medical care is not covered or is no longer covered for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after you get a benefit, and you're not satisfied, you can appeal the decision. An appeal is a formal way of asking us to review and change a coverage decision we made. Under certain circumstances, you can ask for an expedited or fast appeal of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we properly followed the rules. When we complete the review, we give you our decision.

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

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

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

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

Section 4.1 How to get help when asking for a coverage decision or making an appeal

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

- Call **Blue Cross Customer Service** at **1-800-422-9146** (TTY: **711**).
- **Get free help** from your State Health Insurance Assistance Program. Refer to *Exhibit 1* of the **Appendix** of this booklet. Contact information may change throughout the year.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call Blue Cross Customer Service at **1-800-422-9146** (TTY: **711**) and ask for the *Appointment of Representative* form. (The form is also available at **cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf**.)
 - For medical care or medical plan drugs, your doctor can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
- **You can ask someone to act on your behalf.** You can name another person to act for you as your *representative* to ask for a coverage decision or make an appeal.
 - If you want a friend, relative or another person to be your representative, call Blue Cross Customer Service at **1-800-422-9146** (TTY: **711**) and ask for the *Appointment of Representative* form. (The form is also available at **cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf**.) This form gives that person permission to act on your behalf. It must be

signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.

- We can accept an appeal request from a representative without the form, but we cannot begin or complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you're not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.2 Rules and deadlines for your different situations

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

- **Section 5:** Medical care: How to ask for a coverage decision or make an appeal.
- **Section 6:** How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon.
- **Section 7:** How to ask us to keep covering certain medical services if you think your coverage is ending too soon (*Applies only to these services:* home healthcare, skilled nursing facility care and Comprehensive Outpatient Rehabilitation Facility (CORF) services).

If you're not sure which information applies to you, call Blue Cross Customer Service at **1-800-422-9146** (TTY: **711**). You can also get help or information from your State Health Insurance Assistance Program.

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

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

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

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

1. You're not getting certain medical care you want, and you believe that this care is covered by this plan. **Ask for a coverage decision. Section 5.2.**
2. We won't approve the medical care your doctor or other medical provider wants to give you, and you believe this care is covered by the plan. **Ask for a coverage decision. Section 5.2.**
3. You got medical care that you believe should be covered by this plan, but we said we won't pay for this care. **Make an appeal. Section 5.3.**
4. You've received and paid for medical care that you believe should be covered by this plan, and you want to ask us to reimburse you for this care. **Send us the bill. Section 5.5.**
5. You're being told that coverage for certain medical care you've been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 5.3.**

Note: If the coverage that will be stopped is for hospital care, home healthcare, skilled nursing facility care or Comprehensive Outpatient Rehabilitation Facility (CORF) services, go to *Section 6* and *Section 7* of this chapter. Special rules apply to these types of care.

Section 5.2 How to ask for a coverage decision

Legal Terms

When a coverage decision involves your medical care, it's called an organization determination.

A fast coverage decision is also called an expedited determination.

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

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

- You may *only* ask for coverage for medical care items and/or services, not requests for payment for items and/or services you already got.
- You can get a fast coverage decision only if using the standard deadlines could *cause serious harm to your health or hurt your ability to regain function*.
- **If your doctor tells us that your health requires a fast coverage decision, we'll automatically agree to give you a fast coverage decision.**

- **If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we'll send you a letter that:
 - Explains that we'll use the standard deadlines.
 - Explains if your doctor asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
 - Explains that you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for.

Step 2: Ask the plan to make a standard coverage decision or fast coverage decision.

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

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

For standard coverage decisions, we use the standard deadlines.

- **This means we'll give you an answer within seven calendar days after we get your request for a medical item or service that is subject to our prior authorization rules. If your requested medical item or service is not subject to our prior authorization rules, we'll give you an answer within 14 calendar days after we get your request. If your request is for a medical plan drug, we'll give you an answer within 72 hours after we get your request. However,** if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a medical plan drug.
- If you believe we should *not* take extra days, you can file a fast complaint. We'll give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. Go to *Section 9* of this chapter for information on complaints.)

For fast coverage decisions, we use an expedited timeframe.

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

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

- If you believe we should *not* take extra days, you can file a fast complaint. Go to *Section 9* for information on complaints. We'll call you as soon as we make the decision.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no.

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

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

Section 5.3 How to make a Level 1 appeal

Legal Terms

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

A fast appeal is also called an expedited reconsideration.

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

A standard appeal is usually made within 30 calendar days or seven calendar days for medical plan prescription drugs. A fast appeal is generally made within 72 hours.

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

Step 2: Ask the plan for a standard appeal or a fast appeal.

- **If you're asking for a standard appeal, submit your standard appeal in writing.** *Chapter 2* has contact information.
- **If you're asking for a fast appeal, make your appeal in writing or call us.** *Chapter 2* has contact information.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that

prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.

- **You can ask for a copy of the information regarding your medical coverage decision. You and your doctor may add more information to support your appeal.**

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

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

Deadlines for a fast appeal

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

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a medical plan drug you did not get, we'll give you our answer **within seven calendar days** after we receive your appeal. We'll give you our decision sooner if your health condition requires.
 - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a medical plan drug.

- If you believe we should *not* take extra days, you can file a fast complaint. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. Go to *Section 9* of this chapter for information on complaints.
- If we do not give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal, where an independent review organization will review the appeal. *Section 5.4* explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage **within 30 calendar days** if your request is for a medical item or service, or **within seven calendar days** if your request is for a medical plan drug.
- **If the plan says no to part or all of your appeal**, we'll automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 5.4 The Level 2 appeal process

Legal Term

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

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

Step 1: The independent review organization reviews your appeal.

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

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

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

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

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

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

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

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

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal.

- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. *Section 8* explains the Levels 3, 4 and 5 appeals processes.

Section 5.5 Asking us to pay you for our share of a bill you got for medical care

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

Asking for reimbursement is asking for a coverage decision from us.

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

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

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

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

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

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

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

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day you leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your discharge date.
- When your discharge date is decided, your doctor or the hospital staff will tell you.
- If you think you're being asked to leave the hospital too soon, you can ask for a longer hospital stay, and your request will be considered.

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

Within two calendar days of being admitted to the hospital, you'll be given a written notice called *An Important Message From Medicare About Your Rights*. Everyone with Medicare gets a copy of this notice. If you do not get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, please call Blue Cross Customer Service at **1-800-422-9146** (TTY: **711**) or **1-800-MEDICARE (1-800-633-4227)**. TTY: **1-877-486-2048**.

- 1. Read this notice carefully and ask questions if you don't understand it.** It tells you:
 - Your right to get Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them and where you can get them.
 - Your right to be involved in any decisions about your hospital stay.
 - Where to report any concerns you have about the quality of your hospital care.
 - Your right to **request an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date, so we'll cover your hospital care for a longer time.
- 2. You will be asked to sign the written notice to show that you got it and understand your rights.**
 - You or someone who is acting on your behalf will be asked to sign the notice.
 - Signing the notice shows only that you got the information about your rights. The notice does not give your discharge date. **Signing the notice does *not* mean you're agreeing on a discharge date.**
- 3. Keep your copy** of the notice so you'll have the information about making an appeal (or reporting a concern about quality of care) if you need it.
 - If you sign the notice more than two calendar days before your discharge date, you will get another copy before you're scheduled to be discharged.

- To look at a copy of this notice in advance, you can call Blue Cross Customer Service at **1-800-422-9146** (TTY: **711**) or 1-800 MEDICARE (**1-800-633-4227**), TTY: **1-877-486-2048**. You can also see the notice online at **[cms.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im](https://www.cms.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im)**.

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

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

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, please call Blue Cross Customer Service at **1-800-422-9146** (TTY: **711**). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

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

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

How can you contact this organization?

- The written notice you got (*An Important Message From Medicare About Your Rights*) tells you how to reach this organization. Or find the name, address and phone number of the QIO for your state in *Chapter 2* or *Exhibit 1* of the **Appendix**.

Act quickly:

- To make your appeal, you must contact the QIO *before* you leave the hospital and **no later than midnight the day of your discharge**.
 - If you meet this deadline, you can stay in the hospital after your discharge date *without paying for it* while you wait to get the decision from the QIO.
 - If you do not meet this deadline, contact us if you decide to stay in the hospital after your planned discharge date. You may have to pay all the costs for hospital care you get after your planned discharge date.

- Once you ask for an immediate review of your original hospital discharge date, the QIO will contact us. By noon of the day after we're contacted, we'll give you a *Detailed Notice of Discharge*. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital and we think it's right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the *Detailed Notice of Discharge* by calling Blue Cross Customer Service at **1-800-422-9146** (TTY: **711**) or **1-800-MEDICARE (1-800-633-4227)**. TTY: **1-877-486-2048**. Or you can get a sample notice online at cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Step 2: The QIO conducts an independent review of your case.

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

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

What happens if the answer is yes?

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

What happens if the answer is no?

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

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

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

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

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

Step 1: Contact the QIO again and ask for another review.

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

Step 2: The QIO does a second review of your situation.

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

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

If the independent review organization says yes:

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

If the independent review organization says no:

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

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.

- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. *Section 8* in this chapter tells more about Levels 3, 4 and 5 of the appeals process.

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

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

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

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

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

Legal Term

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

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

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

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

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, please call Blue Cross Customer Service at **1-800-422-9146** (TTY: **711**). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

During a Level 1 appeal, the Quality Improvement Organization (QIO) reviews your appeal. It decides if the end date for your care is medically appropriate.

The QIO is a group of doctors and other healthcare experts who are paid by the federal government to check on and improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts are not part of this plan.

Step 1: Make your Level 1 appeal: Contact the QIO and ask for a fast-track appeal. You must act quickly.

How can you contact this organization?

- The written notice you got (*Notice of Medicare Non-Coverage*) tells you how to reach this organization. Or find the name, address and phone number of the QIO for your state in *Chapter 2* or *Exhibit 1* of the **Appendix**.

Act quickly:

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

Step 2: The QIO conducts an independent review of your case.

Legal Term

Detailed Explanation of Non-Coverage is a notice that gives details on reasons for ending coverage.

What happens during this review?

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

Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.

What happens if the reviewers say yes?

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

What happens if the reviewers say no?

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

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

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

Section 7.4 How to make a Level 2 appeal to have the plan cover your care for a longer time

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

Step 1: Contact the QIO again and ask for another review.

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

Step 2: The QIO does a second review of your situation.

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

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

What happens if the independent review organization says yes?

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

What happens if the independent review organization says no?

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

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

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

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

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

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

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

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

Level 3 appeal An Administrative Law Judge or an attorney adjudicator who works for the federal government will review your appeal and give you an answer.

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

Level 4 appeal The Medicare Appeals Council (Council) will review your appeal and give you an answer. The Council is part of the federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may or may not* be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We'll decide whether to appeal this decision to Level 5.
 - If we decide not to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after getting the Council's decision.
 - If we decide to appeal the decision, we'll let you know in writing.

- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal A judge at a **Federal District Court** will review your appeal.

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

MAKING COMPLAINTS

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

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

The complaint process is only used for certain types of problems. This includes problems related to quality of care, waiting times and your customer service experience. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	<ul style="list-style-type: none">• Are you unhappy with the quality of the care you got (including care in the hospital)?
Respecting your privacy	<ul style="list-style-type: none">• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service or other negative behaviors	<ul style="list-style-type: none">• Has someone been rude or disrespectful to you?• Are you unhappy with Blue Cross Customer Service?• Do you feel you're being encouraged to leave the plan?

Complaint	Example
Waiting times	<ul style="list-style-type: none">• Are you having trouble getting an appointment, or waiting too long to get it?• Have you been kept waiting too long by doctors or other health professionals? Or by Blue Cross Customer Service or other staff at the plan?<ul style="list-style-type: none">○ Examples include waiting too long on the phone, in the waiting or exam room.
Cleanliness	<ul style="list-style-type: none">• Are you unhappy with the cleanliness or condition of a clinic, hospital or doctor's office?
Information you get from us	<ul style="list-style-type: none">• Did we fail to give you a required notice?• Is our written information hard to understand?
Timeliness (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals.)	<p>If you asked for a coverage decision or made an appeal, and you think we're not responding quickly enough, you can make a complaint about our slowness. Here are examples:</p> <ul style="list-style-type: none">• You asked us for a <i>fast coverage decision</i> or a <i>fast appeal</i>, and we said no; you can make a complaint.• You believe we're not meeting the deadlines for coverage decisions or appeals; you can make a complaint.• You believe we're not meeting deadlines for covering or reimbursing you for certain medical services that were approved; you can make a complaint.• You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 9.2 How to make a complaint

Legal Terms

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

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

- **Calling Blue Cross Customer Service at 1-800-422-9146 (TTY: 711) is usually the first step.** If there's anything else you need to do, Customer Service will let you know.
- **If you do not want to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing.
- You or someone you name can file the grievance. You should mail it to:

Blue Cross Blue Shield of Michigan
Grievances and Appeals Department
P.O. Box 2627
Detroit, MI 48231-2627

You may also fax it to us at 1-877-348-2251.

We must address your grievance as quickly as your health status requires, but no later than 30 days after the receipt date of the oral or written grievance. **However, we 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. If we decide to take extra days, we'll tell you in writing. In certain cases, you have the right to ask for a fast grievance, meaning we'll answer your grievance within 24 hours. There are only two reasons under which we'll grant a request for a fast grievance.

- If you've asked Blue Cross Blue Shield of Michigan to give you a fast decision about a service you haven't yet received and we have refused.
- If you do not agree with our request for a 14-day extension to respond to your standard grievance, organization determination or pre-service appeal.

- The deadline for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

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

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

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

When your complaint is about quality of care, you have two extra options:

- **You can make your complaint directly to the QIO.** The QIO is a group of practicing doctors and other healthcare experts paid by the federal government to check on and improve the care given to Medicare patients. *Chapter 2* and *Exhibit 1* of the **Appendix** have contact information.

Or

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

Section 9.4 You can also tell Medicare about your complaint

You can submit a complaint about Medicare Plus Blue Group PPO directly to Medicare. To submit a complaint to Medicare, go to [medicare.gov/my/medicare-complaint](https://www.medicare.gov/my/medicare-complaint). You can also call **1-800-MEDICARE (1-800-633-4227)**. TTY/TDD: **1-877-486-2048**.

CHAPTER 8: Ending membership in the plan

SECTION 1 Ending your membership in the plan

Ending your membership in Medicare Plus Blue Group PPO may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave the plan because you decide you *want* to leave.
 - You can disenroll from Medicare Plus Blue Group PPO at any time.
 - If you decide you want to disenroll from Medicare Plus Blue Group PPO, contact ORS at **1-800-381-5111** from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday.
- There are also limited situations where we're required to end your membership. *Section 4* tells you about situations when we must end your membership.

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

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

Section 2.1 You can end your membership at any time

You can end your membership in Medicare Plus Blue Group PPO at any time. Please contact ORS at **1-800-381-5111** from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday, if you would like to disenroll from this plan. ORS will contact us, and we'll take the necessary steps to cancel your membership. ORS can explain your options, implications of leaving this plan and the correct process to follow to disenroll.

If you're enrolled in Medicare drug coverage through the retirement system, disenrolling from Medicare Plus Blue Group PPO will disenroll you from your drug plan as well.

If you decide to disenroll from this plan and enroll in an individual Medicare Advantage Plan, or another employer, union or retiree sponsored Medicare Advantage Plan, you should first contact the plan you wish to enroll in to verify your disenrollment from this plan aligns with the time frame for enrolling in the new plan. This will help you avoid a lapse in healthcare coverage.

You can voluntarily cancel your medical plan 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 have the premium subsidy benefit and 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. If you have the Personal Healthcare Fund and disenroll from the plan, you will not be able to reenroll.

SECTION 3 Until your membership ends, you must keep getting your medical items and services through this plan

Until your membership ends, you're still a member of this plan. If you leave Medicare Plus Blue Group PPO, it may take time before your membership ends and your new Medicare coverage starts. Go to *Section 2* for information on when your new coverage begins. During this time, you must continue to get your medical items and services through this plan.

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

SECTION 4 Medicare Plus Blue Group PPO must end your plan membership in certain situations

Medicare Plus Blue Group PPO must end your membership in the plan if any of the following happen:

- You no longer have both Medicare Part A and Part B.
- You move out of the U.S. or its territories for more than 12 months.
- You become incarcerated (go to prison).
- You're not a U.S. citizen or lawfully present in the U.S.
- You lie about or withhold information about other insurance you have that provides medical or prescription drug coverage.
- You intentionally gave incorrect information when you enrolled in the plan and that information affects your eligibility for the plan. (We cannot end your coverage for this reason unless we get permission from Medicare first.)
- You continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of the plan. (We cannot end your coverage for this reason unless we get permission from Medicare first.)
- You let someone else use your member ID card to get medical care. (We cannot end your coverage for this reason unless we get permission from Medicare first.)
 - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

- You no longer meet the Michigan Public School Employees' Retirement System's eligibility requirements.

If you have questions or would like to know more information about disenrolling from this plan, contact ORS. ORS can explain your options, implications of leaving this plan and the correct process to follow.

Section 4.1 We cannot ask you to leave the plan for any health-related reason

Medicare Plus Blue Group PPO is not allowed to ask you to leave the plan for any health-related reason.

What should you do if this happens?

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

Section 4.2 You have the right to make a complaint if we end your membership in the plan

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

CHAPTER 9: Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services (CMS). In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws are not included or explained in this document.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability or geographic location within the service area. All organizations that provide Medicare Advantage Plans, like this plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get federal funding and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, call the U.S. Department of Health and Human Services' Office for Civil Rights at **1-800-368-1019** (TTY: **1-800-537-7697**) or your local Office for Civil Rights. You can also review information from the U.S. Department of Health and Human Services' Office for Civil Rights at **[HHS.gov/ocr/index.html](https://www.hhs.gov/ocr/index.html)**.

If you have a disability and need help with access to care, please call us at Customer Service. If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Medicare Plus Blue Group PPO, as a Medicare Advantage Organization, will exercise the same rights of recovery that the secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

SECTION 4 Additional Notice about Subrogation and Third-Party Recovery

Legal Term

Subrogation is the substitution of one claim for another, especially the transfer of the right to receive payment of a debt to somebody other than the original creditor.

Subrogation

If we make any payment to you or on your behalf for covered services, we're entitled to be fully subrogated to any and all rights you have against any person, entity or insurer that may be responsible for payment of medical expenses and/or benefits related to your injury, illness or condition.

Once we have made a payment for covered services, we shall have a lien on the proceeds of any judgment, settlement or other award or recovery you receive (our recovery shall not be limited by the terms and conditions of any such settlement, award or judgment), including but not limited to the following:

- Any award, settlement, benefits or other amounts paid under any workers' compensation law or award;
- Any and all payments made directly by or on behalf of a third-party tortfeasor or person, entity or insurer responsible for indemnifying the third-party tortfeasor;
- Any arbitration awards, payments, settlements, structured settlements or other benefits or amounts paid under an uninsured or under insured motorist coverage policy; or
- Any other payments designated, earmarked or otherwise intended to be paid to you as compensation, restitution or remuneration for your injury, illness or condition suffered as a result of the negligence or liability of a third party.

Legal Term

Tortfeasor is a person responsible for damages.

Legal Term

Indemnifying means providing someone with insurance protection against injury or loss.

Liability insurance claims are often not settled promptly. We may, at our discretion, make conditional payments while the liability claim is pending. We may also receive a claim and not know that a liability or other claim is pending. In those situations, our payments are conditional. Conditional payments must be refunded to us upon receipt of the insurance liability payment including medical payments or settlement.

Legal Term

<p><u>Liability insurance claims</u> consider who is legally responsible for causing damage or paying.</p>
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You agree to cooperate with us and any of our agents and/or representatives and to take any and all actions or steps necessary to secure our lien, including but not limited to:

- Responding to requests for information about any accidents or injuries;
- Responding to our requests for information and providing any relevant information that we have requested; and
- Participating in all phases of any legal action we commence in order to protect our rights, including, but not limited to, participating in discovery, attending depositions and appearing and testifying at trial.

In addition, you agree not to do anything to prejudice our rights, including, but not limited to, assigning any rights or causes of action that you may have against any person or entity relating to your injury, illness, or condition without our prior express written consent. Your failure to cooperate shall be deemed a breach of your obligations, and we may institute a legal action against you to protect our rights.

We're also entitled to be fully reimbursed for any and all benefit payments we make to you or on your behalf that are the responsibility of any person, organization or insurer. Our right of reimbursement is separate and apart from our subrogation right and is limited only by the amount of actual benefits paid under the plan. You must immediately pay to us any amounts you recover by judgment, settlement, award, recovery or otherwise from any liable third party, his or her insurer, to the extent that we paid out or provided benefits for your injury, illness or condition during your enrollment in this plan.

We're not obligated to pursue subrogation or reimbursement either for our own benefit or on your behalf. Our rights under Medicare laws and/or regulations and this *Evidence of Coverage* shall not be affected, reduced or eliminated by our failure to intervene in any legal action you commence relating to your injury, illness or condition.

CHAPTER 10: Definitions of important words

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

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

Approved Amount (or Allowed Amount) — The dollar amount Blue Cross Blue Shield of Michigan has agreed to pay for healthcare services covered by your plan. It may be more or less than the actual amount a doctor or supplier charges. Any required coinsurance, copayments and deductibles are subtracted from this amount before payment is made.

Balance Billing — When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of Medicare Plus Blue Group PPO, you only have to pay the plan's cost-sharing amounts when you get services covered by this plan. We do not allow providers to balance bill or otherwise charge you more than the amount of cost sharing the plan says you must pay.

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

Coinsurance — A percentage you pay for most covered medical services (for example, 10%) after you have met your deductible.

Colonoscopy — An examination of the colon by way of a scope inserted into the rectum. Members are advised to have a routine or screening colonoscopy.

- **Routine or screening colonoscopy** is an examination of a healthy colon when there's no sign, symptom or disease present.
- **Diagnostic colonoscopy** is performed to diagnose and, consequently, establish treatment if the colon is unhealthy (there's a sign, symptom or disease present). Diagnostic colonoscopies are often prescribed when there are colon health concerns such as certain symptoms or medical history.

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

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

Copayment (or copay) — A flat dollar amount you pay for specific services.

Cost Sharing — Cost sharing refers to amounts that a member has to pay when services are received. This is in addition to the plan's monthly premium. Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose on covered services before the plan begins to pay; (2) any coinsurance amount, a percentage of the approved amount for a service that the plan requires when a specific service is received; or (3) any flat dollar copayment amount that the plan requires when a specific service is received.

Coverage Decisions — A decision by your medical plan about whether a service is a benefit.

Covered Services — The term we use to mean all the healthcare services and supplies that are covered by this plan.

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

Customer Service — A department within Blue Cross responsible for answering your questions about your membership, benefits, grievances and appeals.

Deductible — The amount you must pay for covered services before the retirement system begins to pay.

Diagnostic Procedure — Testing to rule out or to confirm a suspected diagnosis because there's a sign or symptom of disease. When a screening procedure uncovers a symptom of disease, such as a polyp found during a colonoscopy, it is considered a diagnostic procedure. (See Screenings.)

Disenroll or Disenrollment — The process of ending your membership in the plan.

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

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

Emergency — A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain or a medical condition that is quickly getting worse.

Emergency Care — Covered services that are: 1) provided by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate or stabilize an emergency medical condition, mental health condition and/or substance use disorder.

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

Grievance — A type of complaint you make about the plan or providers including a complaint concerning the quality of your care. This does not involve coverage or payment disputes.

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

Home Infusion Therapy — Home infusion is an alternative method of delivering medication directly into the body, other than orally, in lieu of receiving the same treatment in a hospital setting. Types of infusion include, but are not limited to chemotherapy, hydration, pain management and antibiotic therapy.

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

Hospice Care — A special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital or a nursing home. Care from a hospice is meant to help patients in the last months of life by giving comfort and relief from pain. The focus is on care, not cure.

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

Mammography (Mammograms) — A screening mammogram is an X-ray of the breast used to detect breast changes in women who have no signs or symptoms of breast cancer. Mammograms make it possible to detect tumors that cannot be felt. A diagnostic mammogram is an X-ray of the breast that is used to check for breast cancer after a lump or other sign or symptom of breast cancer has been found.

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

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

Medicare — The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage (MA) Plan — Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be: i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage Plan can also be a Special Needs Plan (SNP). Medicare Plus Blue Group PPO is a Medicare Advantage Plan administered by Blue Cross Blue Shield of Michigan.

Medicare-Covered Services — Services covered by Medicare Part A and Part B. All Medicare health plans must cover all the services that are covered by Medicare Part A and Part B. The term Medicare-covered services does not include the extra benefits, such as hearing, that a Medicare Advantage Plan may offer.

Medicare Health Plan — A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans and Demonstration/Pilot Programs.

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

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

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

Original Medicare — Original Medicare is offered by the government, and not a private health plan such as Medicare Advantage Plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals and other healthcare providers payment amounts established by Congress. You can see any doctor, hospital or other healthcare provider that accepts Medicare. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance) and is available everywhere in the U.S.

Out-of-Network Provider — A provider or facility that does not have a contract with us to coordinate or provide covered services to members of this plan. Out-of-network providers are providers that are not employed, owned or operated by the plan.

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

Out-of-Pocket Maximum — This is the most you will pay in a calendar year for all services, excluding routine hearing care, from both network providers and out-of-network providers. See *Chapter 4, Section 1.2* for information about your maximum out-of-pocket amount.

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

Preferred Provider Organization (PPO) Plan — A PPO plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they're received from network or out-of-network providers.

Premium — The periodic payments you make to Medicare and your retirement system for health coverage.

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

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

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

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

Referral — A written order from your primary care provider for you to visit a specialist or get certain medical services.

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

Screenings — Preventive tests performed when no specific sign, symptom or diagnosis is present. Screenings test for disease or disease precursors so that early detection and treatment can be provided for those who test positive for disease. Covered screenings have no coinsurance, copayment or deductible. However, when a sign or symptom is discovered during a screening, the testing may transition into a diagnostic procedure. (See diagnostic procedure.)

Service Area — The geographic area in which you must reside to be eligible for coverage in this plan. Our service area is the U.S. and its territories.

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

Step Therapy — A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Urgently Needed Services — 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're temporarily outside your plan's service area, or even if you're inside the service area of the plan and unable to get 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. Medically necessary routine provider visits (like annual checkups) are not considered urgently needed even if you're outside your plan's service area or your plan network is temporarily unavailable.

Virtual Care — Meeting with a healthcare provider through electronic forms of communication.

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Exhibit 1 State Health Insurance Assistance Programs

State:	Alabama	State:	Arkansas
Local:	1-334-242-5743	Local:	1-501-371-2782
Toll-free:	1-800-243-5463	Toll-free:	1-800-224-6330
Website:	www.alabamaageline.gov	Website:	https://insurance.arkansas.gov/consumer-services/senior-health/
Address:	RSA Tower 201 Monroe Street Suite 350 Montgomery, AL 36104	Address:	Arkansas Insurance Department 1 Commerce Way Suite 102 Little Rock, AR 72202

State:	Alaska	State:	California
Local:	1-907-269-3666	Local:	1-916-419-7500
Toll-free:	1-800-478-9996	Toll-free:	1-800-510-2020
Website:	dhss.alaska.gov/dsds/pages/medicare/default.aspx	TTY:	1-800-735-2929
Address:	Senior and Disability Services 3601 C Street Suite 902 Anchorage, AK 99503	Website:	www.aging.ca.gov/HICAP/
		Address:	California Department of Aging 2880 Gateway Oaks Drive Suite 200 Sacramento, CA 95833

State:	Arizona	State:	Colorado
Local:	1-602-542-4446	Local:	1-303-894-7499
Toll-free:	1-800-432-4040	Toll-free:	1-800-930-3745
Website:	des.az.gov/medicare-assistance	Website:	doi.colorado.gov
Address:	DES Division of Aging and Adult Services Site Code 950A 1789 W. Jefferson Street Mail Drop 6271 Phoenix, AZ 85007	Address:	Colorado Division of Insurance 1560 Broadway Suite 850 Denver, CO 80202

Exhibit 1 State Health Insurance Assistance Programs

State:	Connecticut	State:	Florida
Local:	1-860-424-5055	Local:	1-800-963-5337
Toll-free:	1-866-218-6631	TDD/TTY:	1-800-955-8770
TTY:	portal.ct.gov/aginganddisability	Website:	www.floridashine.org
Website:	Aging and Disability Services	Address:	Department of Elder Affairs SHINE Program 4040 Esplanade Way Suite 270 Tallahassee, FL 32399
Address:	55 Farmington Avenue, 12 th floor Hartford, CT 06105		
State:	Delaware	State:	Georgia
Local:	1-302-674-7364	Toll-free:	1-866-552-4464
TTY:	1-800-336-9500	TTY:	1-404-657-1929
Website:	https://insurance.delaware.gov/divisions/dmab/	Website:	aging.georgia.gov/georgia-ship
Address:	Insurance Commissioner 1351 West North Street Suite 101 Dover, DE 19904	Address:	Georgia SHIP 47 Trinity Ave. SW Atlanta, GA 30334
State:	District of Columbia	State:	Guam
Local:	1-202-727-8370	Local:	1-671-735-7421
TTY:	711	TTY:	1-671-735-7415
Website:	dacl.dc.gov/service/health-insurance-counseling	Website:	http://dphss.guam.gov/division-of-senior-citizens-2/
Address:	Department of Aging and Community Living 500 K Street, NE Washington, DC 20002	Address:	Department of Public Health and Social Services 123 Chalan Kareta Mangilao, Guam 96913

Exhibit 1 State Health Insurance Assistance Programs

State: Hawaii
Toll-free: 1-888-875-9229
Oahu: 1-808-586-7299
TTY: 1-866-810-4379
Website: www.hawaiiiship.org
Address: Executive Office on Aging
No. 1 Capitol District
250 South Hotel Street
Suite 406
Honolulu, HI 96813

State: Indiana
Local: 1-800-452-4800
TTY: 1-866-846-0139
Website: www.medicare.in.gov
Address: SHIP
311 W. Washington Street
Suite 300
Indianapolis, IN 46204

State: Idaho
Local: 1-208-334-4250
Toll-free: 1-800-247-4422
Website: doi.idaho.gov/shiba/
Address: Idaho Department of Insurance
700 W. State Street
3rd Floor
P.O. Box 83720
Boise, ID 83720

State: Iowa
Local: 1-800-351-4664
TTY: 1-800-735-2942
Website: shiip.iowa.gov/
Address: Iowa Insurance Division
1963 Bell Avenue
Suite 100
Des Moines, IA 50315

State: Illinois
Local: 1-800-252-8966
TTY: 711
Website: ilaging.illinois.gov/ship.html
Address: Illinois Department on Aging
One Natural Resources Way
Suite 100
Springfield, IL 62702

State: Kansas
Local: 1-785-296-4986
Toll-free: 1-800-432-3535
TTY: 1-785-291-3167
Website: <https://www.kdads.ks.gov/services-programs/long-term-services-supports>
Address: Kansas Department for Aging
and Disability Services
503 S. Kansas Ave.
Topeka, KS 66603

Exhibit 1 State Health Insurance Assistance Programs

State: Kentucky
Local: 1-502-564-6930
Toll-free: 1-877-293-7447 (option 2)
Website: [Chfs.ky.gov/agencies/dail/Pages/ship.aspx](https://chfs.ky.gov/agencies/dail/Pages/ship.aspx)
Address: State Health Insurance Assistance Program
275 E. Main Street 3E-E
Frankfort, KY 40601

State: Maryland
Local: 1-410-767-1100
Toll-free: 1-800-243-3425
TTY: 711
Website: <https://aging.maryland.gov/Pages/default.aspx>
Address: Maryland Department of Aging
36 S. Charles St.
12th Floor
Baltimore, MD 21201

State: Louisiana
Local: 1-225-342-5900
Toll-free: 1-800-259-5300 or
1-800-259-5301
Website: www.lds.la.gov/consumers/senior-health-shiip
Address: Louisiana Dept. of Insurance
P.O. Box 94214
Baton Rouge, LA 70804

State: Massachusetts
Toll-free: 1-800-243-4636
Website: <https://www.mass.gov/orgs/executive-office-of-elder-affairs>
Address: Executive Office of Elder Affairs
One Ashburn Place,
10th floor
Boston MA 02108

State: Maine
Local: 1-207-287-9200
Toll-free: 1-800-262-2232
TTY: 711
Website: <https://www.maine.gov/dhhs/oads>
Address: Office of Aging and Disability
11 State House Station
41 Anthony Ave.
Augusta, ME 04333

State: Michigan
Toll-free: 1-800-803-7174
TTY: 711
Website: www.michigan.gov/MDHHSMIOptions
Address: MI Options
6015 W. St. Joesph Hwy
Suite 103
Lansing, MI 48917

Exhibit 1 State Health Insurance Assistance Programs

State: Minnesota
Local: 1-651-431-2500
TTY: 1-800-627-3529
Website: <https://mn.gov/board-on-aging/connect-to-services/healthy-aging/>
Address: Minnesota Board on Aging
P.O. Box 64976
St. Paul, MN 55164

State: Montana
Local: 1-406-444-4077
Toll-free: 1-800-551-3191
Website: dphhs.mt.gov/sltc/aging/SHIP
Address: Senior and Long-Term Care
Division
PO Box 4210
Helena, MT 59604

State: Mississippi
Toll-free: 1-844-822-4622
Website: www.mississippiaccess.tocare.org
Address: Mississippi Dept. of Human
Services
Division of Aging and
Adult Services
1170 Lakeland Dr.
Jackson MS 39216

State: Nebraska
Toll-free: 1-800-234-7119
Local: 1-402-471-2841
TTY: 711
Website: <https://doi.nebraska.gov/ship-smp>
Address: SHIP
1526 K Street
Suite 201
Lincoln, NE 68508

State: Missouri
Toll-free: 1-800-390-3330
TTY: 711
Website: www.missouriship.org
Address: MO SHIP
601 N Nifong Blvd
Suite 3A
Columbia, MO 65203

State: Nevada
Local: 1-775-687-4210
Toll-free: 1-888-729-0571
Website: <https://adsd.nv.gov/>
Address: Nevada Aging and Disability
Services Division
1550 E. College Parkway
Carson City, NV 89706

Exhibit 1 State Health Insurance Assistance Programs

State: New Hampshire
Local: 1-603-271-9203
Toll-free: 1-800-351-1888
Website: www.dhhs.nh.gov/programs-services/adult-aging-care/servicelink
Address: New Hampshire Department of Health and Human Services
105 Pleasant Street
Concord, NH 03301

State: New York
Local: 1-800-701-0501
Toll-free: 1-800-342-9871
Website: <https://aging.ny.gov/programs/medicare-and-health-insurance>
Address: Office for the Aging
2 Empire State Plaza,
5th Floor
Albany, NY 12223

State: New Jersey
Local: 1-800-792-8820
TTY: 711
Website: <https://www.nj.gov/human-services/doas/>
Address: Division of Aging Services
New Jersey Department of Human Services
P.O. Box 715
Trenton, NJ 08625

State: North Carolina
Local: 1-855-408-1212
Website: www.ncdoi.com/SHIIP
Address: NC Department of Insurance
1201 Mail Service Center
Raleigh NC 27699

State: New Mexico
Local: 1-505-476-4799
Toll-free: 1-800-432-2080
TTY: 1-505-476-4937
Website: <https://aging.nm.gov/>
Address: New Mexico Aging and Long-Term Services Department
2550 Cerrillos Road
Santa Fe, NM 87505

State: North Dakota
Local: 1-701-328-2440
Toll-free: 1-888-575-6611
Website: <https://www.insurance.nd.gov/consumers/medicare>
Address: North Dakota Insurance Department
600 E. Boulevard Ave
Bismack, ND 58505

Exhibit 1 State Health Insurance Assistance Programs

State: Ohio
Local: 1-614-644-2658
Toll-free: 1-800-686-1578
Website: Insurance.ohio.gov/consumers
Address: Ohio Department of Insurance
50 W. Town Street
3rd Floor - Suite 300
Columbus, OH 43215

State: Pennsylvania
Local: 1-717-783-1550
Website: www.aging.pa.gov
Address: Pennsylvania Department
of Aging
555 Walnut Street
5th Floor
Harrisburg, PA 17101

State: Oklahoma
Local: 1-405-521-2828
Toll-free: 1-800-522-0071
Website: www.oid.ok.gov/consumers/information-for-seniors/senior-health-insurance-counseling-program-ship/
Address: Oklahoma Insurance
Department
400 NE 50th Street
Oklahoma City, OK 73105

State: Puerto Rico
Local: 1-787-721-6121
Website: <https://www.oppea.pr.gov/>
Address: Office of the Procurator for
the Elderly Central Office –
San Juan
P.O. Box 191179
San Juan, PR 00919

State: Oregon
Toll-free: 1-800-722-4134
TTY: 711
Website: shiba.oregon.gov/Pages/index.aspx
Address: Oregon SHIBA
350 Winter Street, NE
Room 330
Salem OR 97309

State: Rhode Island
Local: 1-888-884-8721
Toll-free: 1-401-462-3000
TTY: 1-401-462-0740
Website: oha.ri.gov
Address: Office of Healthy Aging
25 Howard Ave
Building 57
Cranston, RI 02920

Exhibit 1 State Health Insurance Assistance Programs

State:	South Carolina	State:	South Dakota Western
Local:	1-803-734-9900	Toll-free:	1-877-286-9072
TTY:	1-800-868-9095	Website:	https://dhs.sd.gov/en
Website:	www.aging.sc.gov/Pages/default.aspx	Address:	South Dakota Department of Human Services
Address:	South Carolina Department on Aging 1301 Gervais Street Suite 350 Columbia, SC 29201		3800 E. Highway 34 – Hillsview Plaza c/o 500 East Capitol Ave Pierre, SD 57501

State:	South Dakota Eastern	State:	Tennessee
Local:	1-605-773-5990	Local:	1-615-862-8828
Toll-free:	1-800-265-9684	Toll-free:	1-877-801-0044
Website:	https://dhs.sd.gov/en	Website:	https://www.tn.gov/disability-and-aging/councils-and-commissions/commission-on-aging-and-disability.html
Address:	South Dakota Department of Human Services 3800 E Highway 34 Hillsview Plaza c/o 500 East Capitol Ave. Pierre, SD 57501	Address:	Tennessee Commission on Aging And Disability 315 Deadrick St. Nashville, TN 37243

State:	South Dakota Central	State:	Texas
Toll-free:	1-877-331-4834	Local:	1-512-424-6500
Website:	https://dhs.sd.gov/en	TTY:	1-512-424-6597
Address:	South Dakota Department of Human Services 3800 East Highway 34 Hillsview Plaza c/o 500 East Capitol Ave Pierre, SD 57501	Website:	hhs.texas.gov/services/health/medicare
		Address:	North Austin Complex 4601 W. Guadalupe St. Austin, TX 78751

Exhibit 1 State Health Insurance Assistance Programs

State: Utah
Local: 1-801-538-3910
Toll-free: 1-877-424-4640
Website: www.daas.utah.gov/
Address: Utah Department of Health
and Human Services Aging
and Adult Services
288 North 1460 West
Salt Lake City, UT 84116

State: Virgin Islands
St. Croix: 1-340-773-6449
Website: ltg.gov.vi/department/vi-ship-medicare/
Address: VI State Health Insurance
Plan/Medicare
1131 King Street
Suite 101
Christiansted, St. Croix, VI 00820

State: Virgin Islands
St. Thomas: 1-340-774-2991
Website: ltg.gov.vi/department/vi-ship-medicare
Address: VI State Health Insurance
Program/Medicare
5049 Kongens Gade
St. Thomas, VI 00802

State: Virginia
Local: 1-804-662-9333
Toll-free: 1-800-552-3402
TTY: 1-800-552-3402
Website: www.vda.virginia.gov/vicap.htm
Address: Division for Community Living
Office for Aging Services
1610 Forest Avenue
Suite 100
Henrico, VA 23229

State: Vermont
Local: 1-802-241-0294
Toll-free: 1-800-642-5119
TTY: 711
Website: www.asd.vermont.gov/services/ship
Address: Department of Disabilities,
Aging and Independent Living
Adult Services Division
280 State Drive, HC2 South
Waterbury, VT 05671

State: Washington
Toll-free: 1-800-562-6900
TDD: 1-360-586-0241
Website: www.insurance.wa.gov/statewide-health-insurance-benefits-advisors-shiba
Address: Office of the Insurance
Commissioner
P.O. Box 40255
Olympia, WA 98504

Exhibit 1 State Health Insurance Assistance Programs

State: West Virginia
Local: 1-304-558-3317
Toll-free: 1-877-987-3646
Website: www.wvship.org
Address: West Virginia SHIP / SMP
1900 Kanawha Blvd. East
Charleston, WV 25305

State: Wisconsin
Toll-free: 1-800-242-1060
TTY: 711
Website: <https://longtermcare.wi.gov/Pages/Home.aspx>
Address: Board on Aging & Long-Term
Care
1402 Pankratz Street,
Suite 111
Madison, WI 53704

State: Wyoming
Local: 1-307-856-6880
Toll-free: 1-800-856-4398
Website: <https://www.wyomingseniors.com/services/wyoming-state-health-insurance-information-program>
Address: Wyoming Senior Citizens, Inc.
106 West Adams Ave
Riverton, WY 82501

Exhibit 2 Quality Improvement Organizations

State: Alabama
Organization: Acentra Health
Toll-free: 1-888-317-0751
TTY: 711
Website: www.acentraqio.com
Address: Acentra Health
5201 W. Kennedy Blvd
Suite 900
Tampa, FL 33609

State: Arkansas
Organization: Acentra Health
Toll-free: 1-888-315-0636
TTY: 711
Website: www.acentraqio.com
Address: Acentra Health
5201 W. Kennedy Blvd
Suite 900
Tampa, FL 33609

State: Alaska
Organization: Acentra Health
Toll-free: 1-888-305-6759
TTY: 711
Website: www.acentraqio.com
Address: Acentra Health
5201 W. Kennedy Blvd
Suite 900
Tampa, FL 33609

State: California
Organization: Commence Health
Toll-free: 1-877-588-1123
TTY: 711
Website: www.livantaqio.cms.gov/en
Address: BFCC-QIO Program
Commence Health
PO Box 2687
Virginia Beach, VA 23450

State: Arizona
Organization: Commence Health
Local: 1-877-588-1123
TTY: 711
Website: www.livantaqio.cms.gov/en
Address: BFCC-QIO Program
Commence Health
PO Box 2687
Virginia Beach, VA 23450

State: Colorado
Organization: Acentra Health
Toll-free: 1-888-317-0891
TTY: 711
Website: www.acentraqio.com
Address: Acentra Health
5201 W. Kennedy Blvd
Suite 900
Tampa, FL 33609

Exhibit 2 Quality Improvement Organizations

State: Connecticut
Organization: Acentra Health
Toll-free: 1-888-319-8452
TTY: 711
Website: www.acentraqio.com
Address: Acentra Health
5201 W. Kennedy Blvd
Suite 900
Tampa, FL 33609

State: Florida
Organization: Acentra Health
Toll-free: 1-888-317-0751
TTY: 711
Website: www.acentraqio.com
Address: Acentra Health
5201 W. Kennedy Blvd
Suite 900
Tampa, FL 33609

State: Delaware
Organization: Commence Health
Toll-free: 1-888-396-4646
TTY: 711
Website: www.livantaqio.cms.gov/en
Address: BFCC-QIO Program
Commence Health
PO Box 2687
Virginia Beach, VA 23450

State: Georgia
Organization: Acentra Health
Toll-free: 1-888-317-0751
TTY: 711
Website: www.acentraqio.com
Address: Acentra Health
5201 W. Kennedy Blvd
Suite 900
Tampa, FL 33609

State: District of Columbia
Organization: Commence Health
Toll-free: 1-888-396-4646
TTY: 711
Website: www.livantaqio.cms.gov/en
Address: BFCC-QIO Program
Commence Health
PO Box 2687
Virginia Beach, VA 23450

State: Hawaii
Organization: Commence Health
Toll-free: 1-877-588-1123
TTY: 711
Website: www.livantaqio.cms.gov/en
Address: BFCC-QIO Program
Commence Health
PO Box 2687
Virginia Beach, VA 23450

Exhibit 2 Quality Improvement Organizations

State: Idaho
Organization: Acentra Health
Toll-free: 1-888-305-6759
TTY: 711
Website: www.acentraqio.com
Address: Acentra Health
5201 W. Kennedy Blvd
Suite 900
Tampa, FL 33609

State: Iowa
Organization: Commence Health
Toll-free: 1-888-755-5580
TTY: 711
Website: www.livantaqio.cms.gov/en
Address: BFCC-QIO Program
Commence Health
PO Box 2687
Virginia Beach, VA 23450

State: Illinois
Organization: Commence Health
Toll-free: 1-888-524-9900
TTY: 711
Website: www.livantaqio.cms.gov/en
Address: BFCC-QIO Program
Commence Health
PO Box 2687
Virginia Beach, VA 23450

State: Kansas
Organization: Commence Health
Toll-free: 1-888-755-5580
TTY: 711
Website: www.livantaqio.cms.gov/en
Address: BFCC-QIO Program
Commence Health
PO Box 2687
Virginia Beach, VA 23450

State: Indiana
Organization: Commence Health
Toll-free: 1-888-524-9900
TTY: 711
Website: www.livantaqio.cms.gov/en
Address: BFCC-QIO Program
Commence Health
PO Box 2687
Virginia Beach, VA 23450

State: Kentucky
Organization: Acentra Health
Toll-free: 1-888-317-0751
TTY: 711
Website: www.acentraqio.com
Address: Acentra Health
5201 W. Kennedy Blvd.
Suite 900
Tampa, FL 33609

Exhibit 2 Quality Improvement Organizations

State: Louisiana
Organization: Acentra Health
Toll-free: 1-888-315-0636
TTY: 711
Website: www.acentraqio.com
Address: Acentra Health
5201 W. Kennedy Blvd.
Suite 900
Tampa, FL 33609

State: Massachusetts
Organization: Acentra Health
Toll-free: 1-888-319-8452
TTY: 711
Website: www.acentraqio.com
Address: Acentra Health
5201 W. Kennedy Blvd
Suite 900
Tampa, FL 33609

State: Maine
Organization: Acentra Health
Toll-free: 1-888-319-8452
TTY: 711
Website: www.acentraqio.com
Address: Acentra Health
5201 W. Kennedy Blvd
Suite 900
Tampa, FL 33609

State: Michigan
Organization: Commence Health
Toll-free: 1-888-524-9900
TTY: 711
Website: www.livantaqio.cms.gov/en
Address: BFCC-QIO Program
Commence Health
PO Box 2687
Virginia Beach, VA 23450

State: Maryland
Organization: Commence Health
Toll-free: 1-888-396-4646
TTY: 711
Website: www.livantaqio.cms.gov/en
Address: BFCC-QIO Program
Commence Health
PO Box 2687
Virginia Beach, VA 23450

State: Minnesota
Organization: Commence Health
Toll-free: 1-888-524-9900
TTY: 711
Website: www.livantaqio.cms.gov/en
Address: BFCC-QIO Program
Commence Health
PO Box 2687
Virginia Beach, VA 23450

Exhibit 2 Quality Improvement Organizations

State: Mississippi
Organization: Acentra Health
Toll-free: 1-888-317-0751
TTY: 711
Website: www.acentraqio.com
Address: Acentra Health
5201 W. Kennedy Blvd.
Suite 900
Tampa, FL 33609

State: Nebraska
Organization: Commence Health
Toll-free: 1-888-755-5580
TTY: 711
Website: www.livantaqio.cms.gov/en
Address: BFCC-QIO Program
Commence Health
PO Box 2687
Virginia Beach, VA 23450

State: Missouri
Organization: Commence Health
Toll-free: 1-888-755-5580
TTY: 711
Website: www.livantaqio.cms.gov/en
Address: BFCC-QIO Program
Commence Health
PO Box 2687
Virginia Beach, VA 23450

State: Nevada
Organization: Commence Health
Toll-free: 1-877-588-1123
TTY: 711
Website: www.livantaqio.cms.gov/en
Address: BFCC-QIO Program
Commence Health
PO Box 2687
Virginia Beach, VA 23450

State: Montana
Organization: Acentra Health
Toll-free: 1-888-317-0891
TTY: 711
Website: www.acentraqio.com
Address: Acentra Health
5201 W. Kennedy Blvd
Suite 900
Tampa, FL 33609

State: New Hampshire
Organization: Acentra Health
Toll-free: 1-888-319-8452
TTY: 711
Website: www.acentraqio.com
Address: Acentra Health
5201 W. Kennedy Blvd
Suite 900
Tampa, FL 33609

Exhibit 2 Quality Improvement Organizations

State: New Jersey
Organization: Commence Health
Toll-free: 1-866-815-5440
TTY: 711
Website: www.livantaqio.com
Address: BFCC-QIO Program
Livanta LLC
PO Box 2687
Virginia Beach, VA 23450

State: North Carolina
Organization: Acentra Health
Toll-free: 1-888-317-0751
TTY: 711
Website: www.acentraqio.com
Address: Acentra Health
5201 W. Kennedy Blvd
Suite 900
Tampa, FL 33609

State: New Mexico
Organization: Acentra Health
Toll-free: 1-888-315-0636
TTY: 711
Website: www.acentraqio.com
Address: Acentra Health
5201 W. Kennedy Blvd.
Suite 900
Tampa, FL 33609

State: North Dakota
Organization: Acentra Health
Toll-free: 1-888-317-0891
TTY: 711
Website: www.acentraqio.com
Address: Acentra Health
5201 W. Kennedy Blvd
Suite 900
Tampa, FL 33609

State: New York
Organization: Commence Health
Toll-free: 1-866-815-5440
TTY: 711
Website: www.livantaqio.cms.gov/en
Address: BFCC-QIO Program
Commence Health
PO Box 2687
Virginia Beach, VA 23450

State: Ohio
Organization: Commence Health
Toll-free: 1-888-524-9900
TTY: 711
Website: www.livantaqio.cms.gov/en
Address: BFCC-QIO Program
Commence Health
PO Box 2687
Virginia Beach, VA 23450

Exhibit 2 Quality Improvement Organizations

State: Oklahoma
Organization: Acentra Health
Toll-free: 1-888-315-0636
TTY: 711
Website: www.acentraqio.com
Address: Acentra Health
5201 W. Kennedy Blvd.
Suite 900
Tampa, FL 33609

State: Puerto Rico
Organization: Commence Health
Toll-free: 1-866-815-5440
Local: 1-787-520-5743
TTY: 711
Website: www.livantaqio.cms.gov/en
Address: BFCC-QIO Program
Commence Health
PO Box 2687
Virginia Beach, VA 23450

State: Oregon
Organization: Acentra Health
Toll-free: 1-888-305-6759
TTY: 711
Website: www.acentraqio.com
Address: Acentra Health
5201 W. Kennedy Blvd
Suite 900
Tampa, FL 33609

State: Rhode Island
Organization: Acentra Health
Toll-free: 1-888-319-8452
TTY: 711
Website: www.acentraqio.com
Address: Acentra Health
5201 W. Kennedy Blvd
Suite 900
Tampa, FL 33609

State: Pennsylvania
Organization: Commence Health
Toll-free: 1-888-396-4646
TTY: 711
Website: www.livantaqio.cms.gov/en
Address: BFCC-QIO Program
Commence Health
PO Box 2687
Virginia Beach, VA 23450

State: South Carolina
Organization: Acentra Health
Toll-free: 1-888-317-0751
TTY: 711
Website: www.acentraqio.com
Address: Acentra Health
5201 W. Kennedy Blvd.
Suite 900
Tampa, FL 33609

Exhibit 2 Quality Improvement Organizations

State: South Dakota
Organization: Acentra Health
Toll-free: 1-888-317-0891
TTY: 711
Website: www.acentraqio.com
Address: Acentra Health
5201 W. Kennedy Blvd
Suite 900
Tampa, FL 33609

State: Utah
Organization: Acentra Health
Toll-free: 1-888-317-0891
TTY: 711
Website: www.acentraqio.com
Address: Acentra Health
5201 W. Kennedy Blvd
Suite 900
Tampa, FL 33609

State: Tennessee
Organization: Acentra Health
Toll-free: 1-888-317-0751
TTY: 711
Website: www.acentraqio.com
Address: Acentra Health
5201 W. Kennedy Blvd.
Suite 900
Tampa, FL 33609

State: Vermont
Organization: Acentra Health
Toll-free: 1-888-319-8452
TTY: 711
Website: www.acentraqio.com
Address: Acentra Health
5201 W. Kennedy Blvd
Suite 900
Tampa, FL 33609

State: Texas
Organization: Acentra Health
Toll-free: 1-888-315-0636
TTY: 711
Website: www.acentraqio.com
Address: Acentra Health
5201 W. Kennedy Blvd.
Suite 900
Tampa, FL 33609

State: Virgin Islands
Organization: Commence Health
Toll-free: 1-866-815-5440
Local: 1-340-773-6334
TTY: 711
Website: www.livantaqio.cms.gov/en
Address: BFCC-QIO Program
Commence Health
PO Box 2687
Virginia Beach, VA 23450

Exhibit 2 Quality Improvement Organizations

State: Virginia
Organization: Commence Health
Toll-free: 1-888-396-4646
TTY: 711
Website: www.livantaqio.cms.gov/en
Address: BFCC-QIO Program
Commence Health
PO Box 2687
Virginia Beach, VA 23450

State: Wisconsin
Organization: Commence Health
Toll-free: 1-888-524-9900
TTY: 711
Website: www.livantaqio.cms.gov/en
Address: BFCC-QIO Program
Commence Health
PO Box 2687
Virginia Beach, VA 23450

State: Washington
Organization: Acentra Health
Toll-free: 1-888-305-6759
TTY: 711
Website: www.acentraqio.com
Address: Acentra Health
5201 W. Kennedy Blvd
Suite 900
Tampa, FL 33609

State: Wyoming
Organization: Acentra Health
Toll-free: 1-888-317-0891
TTY: 711
Website: www.acentraqio.com
Address: Acentra Health
5201 W. Kennedy Blvd
Suite 900
Tampa, FL 33609

State: West Virginia
Organization: Commence Health
Toll-free: 1-888-396-4646
TTY: 711
Website: www.livantaqio.cms.gov/en
Address: BFCC-QIO Program
Commence Health
PO Box 2687
Virginia Beach, VA 23450

Exhibit 3 State Medicaid Agencies

Information on Medicaid by state is available at this website:

<https://www.medicaid.gov/about-us/contact-us/contact-state-page.html>

State:	Alabama	State:	Arkansas
Agency:	Alabama Medicaid Agency	Agency:	Arkansas Medicaid Program
Local:	1-334-242-5000	Local:	1-501-682-1001
Website:	https://medicaid.alabama.gov/	Toll-free:	1-800-482-8988
Address:	Alabama Medicaid Agency P.O. Box 5624 Montgomery, AL 36103	Website:	humanservices.arkansas.gov/ divisions-shared-services/ medical-services/
		Address:	Division of Medical Services P.O. Box 1437, Slot S401 Little Rock, AR 72203
State:	Alaska	State:	California
Agency:	Alaska Medicaid Program	Agency:	Medi-Cal
Toll-free:	1-800-478-7778	Toll-free:	1-800-541-5555
TDD:	711	Website:	https://www.dhcs.ca.gov/ services/medi-cal/Pages/ Medi-Cal_EHB_Benefits.aspx
Website:	health.alaska.gov/dpa/pages/ medicaid/default.aspx	Address:	Medi-Cal Eligibility Division P.O. Box 997417 MS 4607 Sacramento, CA 95899
Address:	Division of Public Assistance Senior Benefits 3601 C Street, Suite 404 Juneau, AK 99811		
State:	Arizona	State:	Colorado
Agency:	Arizona Health Care Cost Containment System (AHCCCS)	Agency:	Health First Colorado
Local:	1-602-417-4000	Toll-free:	1-800-221-3943
Toll-free:	1-800-654-8713	TTY:	711
Website:	www.azahcccs.gov	Website:	www.healthfirstcolorado.com
Address:	AHCCCS 801 E. Jefferson St Phoenix, AZ 85034	Address:	Department of Health Care Policy & Financing 303 E. 17 th Avenue Suite 1100 Denver, CO 80203

Exhibit 3 State Medicaid Agencies

State:	Connecticut	State:	Florida
Agency:	Husky Health Connecticut	Agency:	Florida Medicaid Program
Local:	1-855-805-4325	Local:	1-850-300-4323
Toll-free:	1-855-789-2428	TTY:	711 / 1-800-955-8771
Website:	https://health.ct.gov/elderly-longterm-are?language=en_US	Website:	https://www.myflfamilies.com/services/public-assistance
Address:	Husky Health Program c/o Department of Social Services 55 Farmington Avenue Hartford, CT 06105	Address:	ACCESS Central Mail Center PO Box 1770 Ocala, FL 34478
<hr/>			
State:	Delaware	State:	Georgia
Agency:	Delaware Medicaid Program	Agency:	Georgia Dept. of Community Health Georgia Medicaid Program
Local:	1-302-255-9040	Local:	1-877-423-4746
Website:	dhss.delaware.gov/dmma	Toll-free:	1-404-657-5468
Address:	Delaware Health and Social Services 1901 N. Dupont Highway New Castle, DE 19720	Website:	medicaid.georgia.gov/
		Address:	Georgia Dept. of Community Health 2 M.L.K Jr. Dr. SE, Atlanta, GA 30334
<hr/>			
State:	District of Columbia	State:	Guam
Agency:	D.C. Medicaid Program	Agency:	Medicaid Assistance Program
Local:	1-202-671-4200	Local:	1-671-635-7429
TTY:	711	TTY:	1-671-635-7432
Website:	dhs.dc.gov/page/apply-recertify-benefits	Website:	dphss.guam.gov/division-of-public-welfare/
Address:	Department of Human Services 64 th New York Ave, NE 6 th floor Washington, DC 20002	Address:	Department of Public Health and Social Services 123 Chalan Kareta Mangilao, GY 96913

Exhibit 3 State Medicaid Agencies

State: Hawaii
Agency: Hawaii Department of Human Services Med-Quest
Honolulu: 1-800-316-8005
TTY: 711
Website: medquest.hawaii.gov/
Address: Department of Human Services Directors Office
1350 S. King Street
Suite 200
Honolulu, HI 96814

State: Hawaii
Agency: Med-Quest
East Hawaii Section: 1-800-316-8005
Website: medquest.hawaii.gov/
Address: East Hawaii Section
1404 Kilauea Ave.
Hilo, HI 96720

State: Hawaii
Agency: Med-Quest
Waipahu Section: 1-800-316-8005
Website: medquest.hawaii.gov/
Address: Med-Quest Waipahu Section
94-275 Mokuola Street
Suite 301
Waipahu, HI 96797

State: Hawaii
Agency: Med-Quest
West Hawaii Section: 1-800-316-8005
Website: medquest.hawaii.gov/
Address: Med-Quest - West Hawaii Section Lanihau Professional Center
75-5591 Palani Road
Suite 3004
Kailua-Kona, HI 96740

State: Hawaii
Agency: Med-Quest
Kapolei Unit: 1-800-316-8005
Website: medquest.hawaii.gov/
Address: Kakuhihewa State Office Bld.
Kapolei Unit
601 Kamokila Blvd.
Room 415
Kapolei, HI 96707

State: Hawaii
Agency: Med-Quest
Lanai Unit: 1-800-316-8005
Website: medquest.hawaii.gov/
Address: Med-Quest - Lanai Unit
730 Lanai Ave.
Lanai City, HI 96763

Exhibit 3 State Medicaid Agencies

State: Hawaii
Agency: Med-Quest
Maui Section: 1-800-316-8005
Website: medquest.hawaii.gov/
Address: Med-Quest - Maui Section
Millyard Plaza
210 Imi Kala Street
Suite 101
Wailuku, HI 96793

State: Idaho
Agency: Idaho Medicaid Program
Local: 1-877-456-1233
Website: [healthandwelfare.idaho.gov/
services-programs/medicaid-
health/about-medicaid-
elderly-or-adults-disabilities](http://healthandwelfare.idaho.gov/services-programs/medicaid-health/about-medicaid-elderly-or-adults-disabilities)
Address: Self Reliance Programs
P.O. Box 83720
Boise, ID 83720

State: Hawaii
Agency: Med-Quest
Molokai Unit: 1-808-553-1758
Website: medquest.hawaii.gov/
Address: Med-Quest - Molokai Unit
State Civic Center
65 Makaena Street
Room 110
Kaunakakai, HI 96748

State: Illinois – Chicago Office
Agency: Illinois Medicaid Program
Local: 1-800-843-6154
TTY: 711
Website: [www.dhs.state.il.us/page.aspx
?item=33698](http://www.dhs.state.il.us/page.aspx?item=33698)
Address: Department of Human
Services – EEO/AA Office
401 S. Clinton Street
7th floor
Chicago, IL 60607

State: Hawaii
Agency: Med-Quest
Kauai Unit: 1-800-316-8005
Website: medquest.hawaii.gov/
Address: Med-Quest - Kauai Unit
Dynasty Court
4473 Pahee Street
Suite A
Lihue, HI 96766

State: Illinois – Springfield Office
Agency: Illinois Medicaid Program
Local: 1-800-843-6154
TTY: 711
Website: [www.illinois.gov/hfs/Pages/
default.aspx](http://www.illinois.gov/hfs/Pages/default.aspx)
Address: Department of Human
Services – Springfield Office
201 S. Grand Avenue, East
Springfield, IL 62704

Exhibit 3 State Medicaid Agencies

State: Indiana
Agency: Indiana Medicaid Program
Toll-free: 1-800-403-0864
Website: www.in.gov/medicaid/
Address: FSSA Document Center
P.O. Box 1810
Marion, IN 46952

State: Kentucky
Agency: Kentucky Medicaid Program
Local: 1-502-564-5497
Toll-free: 1-800-372-2973
Website: chfs.ky.gov/agencies/dms/Pages/default.aspx
Address: Department for Medicaid Services
275 E. Main St.
Frankfort, KY 40621

State: Iowa
Agency: Iowa Medicaid Program
IA Health Link
Local: 1-877-347-5678
Toll-free: 1-800-972-2017
TTY: 1-800-735-2942
Website: dhs.iowa.gov/
Address: Department of Human Services
Member Services
321 E. 12th Street
Des Moines, Iowa 50319

State: Louisiana
Agency: Louisiana Medicaid Program
Local: 1-225-342-9500
Website: ldh.la.gov
Address: Louisiana Department of Health
P.O. Box 629
Baton Rouge, LA 70821

State: Kansas
Agency: KanCare Medicaid for
Kansas
Local: 1-800-792-4884
TTY: 1-800-792-4292
Website: www.kancare.ks.gov
Address: KanCare Clearinghouse
P.O. Box 3599
Topeka, KS 66601

State: Maine
Agency: MaineCare
Local: 1-207-287-3707
TTY: 711
Website: www.maine.gov/dhhs/oms
Address: Dept. of Health and Human Services
109 Capitol Street
11 State House Station
Augusta, ME 04333

Exhibit 3 State Medicaid Agencies

<p>State: Maryland Agency: Maryland Medical Assistance Program Local: 1-410-767-6500 Toll-free: 1-877-463-3464 Website: mmcp.health.maryland.gov/Pages/home.aspx Address: Maryland Department of Health 201 W. Preston St Baltimore, MD 21201</p>	<p>State: Minnesota Organization: Minnesota Medicaid Program Local: 1-651-431-2700 Toll-free: 1-800-366-5411 Website: mn.gov/dhs/ Address: Minnesota Health Care Programs Member and Provider Services P.O. Box 64993 St. Paul, MN 55164</p>
<p>State: Massachusetts Agency: MassHealth Local: 1-800-841-2900 TTY: 711 Website: www.mass.gov/topics/masshealth Address: Health Insurance Processing Center P.O. Box 4405 Taunton, MA 02780</p>	<p>State: Mississippi Agency: Mississippi Medicaid Program Local: 1-601-359-6050 Toll-free: 1-800-421-2408 TDD: 1-228-206-6062 Website: www.medicaid.ms.gov Address: Mississippi Division of Medicaid 550 High Street Suite 1000 Jackson, MS 39201</p>
<p>State: Michigan Agency: Michigan Medicaid Program MI Enrolls: 1-800-975-7630 Helpline: 1-800-642-3195 TTY: 1-800-263-5897 Website: www.michigan.gov/mdhhs/assistance-programs/medicaid Address: Michigan Department of Health & Human Services 333 S. Grand Ave P.O. Box 30195 Lansing, MI 48909</p>	<p>State: Missouri Agency: MO HealthNet Division Local: 1-573-751-3425 TTY: 711 Website: https://mydss.mo.gov/mhd Address: Family Support Division P.O. Box 2700 Jefferson City, MO 65102</p>

Exhibit 3 State Medicaid Agencies

State: Montana
Agency: Montana Medicaid Program
Toll-free: 1-406-444-0273
TTY: 1-888-706-1535
Website: <https://dphhs.mt.gov/MontanaHealthcarePrograms/MemberServices>
Address: Montana Dept. of Public Health and Human Services
P.O. Box 202951
1400 Broadway
Helena, MT 59620

State: Nevada
Agency: Nevada Medicaid Program
Local: 1-877-638-3472
TTY: 711
Website: dwss.nv.gov
Address: Nevada Medicaid Customer Service
P.O. Box 30042
Reno, NV 89520

State: Nebraska
Agency: Nebraska Medicaid Program
Local: 1-402-471-3121
TDD: 1-800-833-7352
Website: dhhs.ne.gov/Pages/Medicaid-Clients.aspx
Address: Nebraska Department of Health & Human Services
P.O. Box 95026
Lincoln, NE 68509

State: New Hampshire
Agency: New Hampshire Medicaid Program
Toll-Free: 1-844-275-3447
TTY: 1-800-735-2964
Website: www.dhhs.nh.gov/programs-services/medicaid
Address: Division of Medicaid Services
NH Department of Health & Human Services
129 Pleasant Street
Concord, NH 03301

Exhibit 3 State Medicaid Agencies

State:	New Jersey	State:	North Carolina
Agency:	New Jersey Medicaid Program NJ Family Care	Agency:	North Carolina Medicaid Program
Local:	1-800-701-0710	Local:	1-888-245-0179
TTY:	1-800-701-0720	Website:	https://medicaid.ncdhhs.gov/
Website:	www.njfamilycare.org	Address:	North Carolina Division of Medical Assistance 2501 Mail Service Center Raleigh, NC 27699
Address:	NJ Department of Human Services Division of Medical Assistance & Health Services P.O. Box 712 Trenton, NJ 08625		
State:	New Mexico	State:	North Dakota
Agency:	New Mexico Medicaid Program Centennial Care	Agency:	North Dakota Medicaid Program
Local:	1-800-283-4465	Local:	1-701-328-7068
Website:	www.hsd.state.nm.us	Toll-free:	1-800-755-2604
Address:	NM Human Services Department P.O. Box 2348 Santa Fe, NM 87504	TTY:	711
		Website:	https://www.hhs.nd.gov/adults-and-aging
		Address:	North Dakota Health and Human Services 600 E. Boulevard Ave., Dept. 325 Bismarck, ND 58505
State:	New York	State:	Ohio
Agency:	New York Medicaid Program	Agency:	Ohio Department of Medicaid
Local:	1-800-541-2831	Local:	1-800-324-8680
TTY:	711	Website:	www.ohiomh.com
Website:	health.ny.gov/health_care/medicaid/	Address:	Ohio Department of Medicaid 505 South High Street Suite 200 Columbus, OH 43215
Address:	New York State Department of Health Corning Tower Empire Plaza, Corner Tower, State Street Albany, NY 12237		

Exhibit 3 State Medicaid Agencies

State: Oklahoma
Agency: SoonerCare
Local: 1-800-987-7767
TTY: 711
Website: www.okhca.org
Address: Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma, OK 73105

State: Puerto Rico
Agency: Puerto Rico Department of Health Medicaid Program
Local: 1-787-765-2929, Ext. 6700
TTY: 1-787-625-6955
Website: www.medicaid.pr.gov/
Address: Programa Medicaid
Departamento de Sauld
P.O. Box 70184
San Juan, PR 00936

State: Oregon
Agency: Oregon Health Plan
Local: 1-503-947-2340
TTY: 711
Website: <https://www.oregon.gov/oha/Pages/index.aspx>
Address: Oregon Health Authority
Director's Office
500 Summer Street NE, E-20
Salem OR 97301

State: Rhode Island
Agency: HealthSource RI
Local: 1-855-840-4774
TTY: 1-888-657-3173
Website: www.healthsourceri.com/medicaid
Address: HealthSource RI Walk-In Center
401 Wampanoag Trail East
Providence, RI 02915

State: Pennsylvania
Agency: Pennsylvania Medical Assistance Program
Local: 1-800-692-7462
TDD: 1-800-451-5886
Website: www.dhs.pa.gov
Address: Department of Human Services
P.O. Box 2675
Harrisburg, PA 17105

State: South Carolina
Agency: South Carolina Medicaid Program
Local: 1-888-549-0820
TTY: 1-888-842-3620
Website: www.scdhhs.gov
Address: SCDHHS
P.O. Box 8206
Columbia, SC 29202

Exhibit 3 State Medicaid Agencies

State: South Dakota
Agency: Healthy Connections
Local: 1-605-773-3165
Toll-free: 1-800-226-1033
TTY: 711
Website: dss.sd.gov/medicaid
Address: South Dakota Department
of Social Services
700 Governors Drive
Pierre, SD 57501

State: Utah
Agency: Utah Medicaid Program
Local: 1-801-538-6155
Toll-free: 1-800-662-9651
TTY: 711
Website: medicaid.utah.gov/
Address: Utah Dept. of Health and
Human Services
P.O. Box 143106
Salt Lake City, UT 84114

State: Tennessee
Agency: TennCare
Local: 1-855-259-0701
TTY: 1-877-779-3103
Website: www.tn.gov/tenncare.html
Address: TennCare Connect
P.O. Box 305240
Nashville TN 37230

State: Vermont
Agency: Green Mountain Care
Local: 1-802-879-5900
TTY: 711
Website: <https://dvha.vermont.gov/members>
Address: Department of Vermont
Health Access
280 State Dr. NOB 1 South
Waterbury, VT 05671

State: Texas
Agency: Texas Medicaid Program
Local: 1-512-424-6500
TTY: 1-800-735-2989 / 512-424-6597
Website: <https://www.hhs.texas.gov/services/health/medicaid-chip>
Address: Texas Health and Human Services
P.O. Box 13247
Austin, TX 78711

State: Virgin Islands – St. Thomas
Agency: Medical Assistance Program
St. Thomas: 1-340-774-0930
Website: <https://dhs.vi.gov/office-of-medicaid/>
Address: Department of Human Service –
St. Thomas
1303 Hospital Ground Knud
Hansen Complex Building A
St. Thomas, VI 00820

Exhibit 3 State Medicaid Agencies

State: Virgin Islands – St. Croix
Agency: Healthy Connections
St. Croix: 1-340-718-2980
Website: <https://dhs.vi.gov/office-of-medicaid/>
Address: Department of Human Services
3011 Golden Rock
Christiansted
St. Croix, VI 00820

State: West Virginia
Agency: Bureau for Medical Services
Local: 1-304-558-1700
Toll-free: 1-877-716-1212
TTY: 711
Website: dhhr.wv.gov/bms/pages/default.aspx
Address: West Virginia Bureau for Medical Services
350 Capitol St.
Room 251
Charleston, WV 25301

State: Virginia
Agency: Department of Medical Assistance Services (DMAS)
Toll-free: 1-800-643-2273
TTY: 1-800-817-6608
Website: www.dmas.virginia.gov
Address: Cover Virginia
600 East Broad Street
Richmond, VA 23219

State: Wisconsin
Agency: Wisconsin Medicaid Program
Local: 1-608-266-1865
TTY: 711 / 1-800-947-3529
Website: www.dhs.wisconsin.gov/medicaid/index.htm
Address: Department of Health Services
1 West Wilson Street
Madison, WI 53703

State: Washington
Agency: Apple Health
Local: 1-800-562-3022
TTY: 711
Website: <https://www.hca.wa.gov/>
Address: Washington State Health Care Authority
P.O. Box 45531
Olympia, WA 98504

State: Wyoming
Agency: EqualityCare
Local: 1-307-777-7531
TTY: 711
Website: health.wyo.gov/healthcarefin/medicaid/
Address: Wyoming Department of Health
122 W 25th St
4th Floor West
Cheyenne, WY 82001

Medicare Plus Blue Group PPO Customer Service

- Call** **1-800-422-9146**
Calls to this number are free. Available from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday. Customer Service also has free language interpreter services available for non-English speakers.
- TTY/TTD** **711**
Calls to this number are free. Available from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday.
- Fax** **1-866-458-9342**
- Write** **Blue Cross Blue Shield of Michigan**
MPSERS — Medicare Plus Blue Group PPO
Customer Service Inquiry Department – P.O. Box 441790
600 E. Lafayette Blvd.
Detroit, MI 48226-1790
- Website** bcbsm.com/mpsers

MI Options

MI Options is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

- Call** **1-800-803-7174**
Available from 8 a.m. to 8 p.m., Monday through Friday
- TTY/TTD** **711**
- Write** **MDHHS – Health Services**
Aging and Community Services Division
P. O. Box 30676
Lansing, MI 48909
- Website** www.michigan.gov/MDHHSMIOptions

Medicare PLUS BlueSM Group PPO



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