Blue Cross Blue Shield Blue Care Network of Michigan

Confidence comes with every card.®

Understanding your Explanation of Benefits statement

Michigan Public School Employees' Retirement System

Medicare members

"EOB" stands for Explanation of Benefits

As a Blue Cross Blue Shield of Michigan member, you'll receive an explanation of benefits (EOB) statement in the mail or email notification each month you receive health care services. Your EOB will show you:

- What services you received and what the provider billed
- What your retirement system health plan paid and any Blue Cross discounts that were applied
- The amount you may owe through coinsurance, copays and deductible
- Any services that were not covered by your retirement system medical plan

Reviewing your EOB statement is a good way to keep track of your medical care and out-of-pocket costs.

EOB statement details

1. Totals summarize the cost of the services you received. Here, you can see the amount your provider billed Blue Cross, total cost (amount the plan has approved), the amount your plan paid and your share of the cost.
2. Your annual deductible and annual out-of-pocket maximum amounts and how much you've paid toward them for the current calendar year. Copays for routine hearing exams and hearing aids are not included in the annual out-of-pocket maximum.

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TOTALS for medical and hospital claims	Amount providers have billed the plan	Total cost (amount the plan has approved)	**Plan's share**	**Your share**
Totals for this month (for claims processed from MM/DD/YYYY to MM/DD/YYYY)	$1,300.00	$1,000.00	$900.00	$100.00
Totals for YYYY (all claims processed through MM/DD/YYYY)	$2,300.00	$1,500.00	$1,350.00	$150.00

2

DEDUCTIBLE:

For most covered services, the plan pays its share of the cost only after you have paid your yearly plan deductible.

As of **MM/DD/YYYY**, you have paid **$150.00** of your **$800.00** yearly plan deductible

YEARLY LIMIT – this limit gives you financial protection

This limit tells the most you will have to pay in **YYYY** in "out-of-pocket" costs (copays, coinsurance, and your deductible) for medical and hospital services covered by the plan

This yearly limit is called your "out-of-pocket maximum " It puts a limit on how much you have to pay, but it does not put a limit on how much care you can get

Your out-of-pocket spending for most services will count toward your yearly out-of-pocket maximum

This means:

- Once you have reached your limit in out-of-pocket costs, you stop paying out of pocket for most services.
- You keep getting your covered medical and hospital services as usual, and the plan will pay the full approved amount for the rest of the year. Your out-of-pocket spending for services that are not covered by Medicare does not count toward your out-of-pocket maximum

Combined (in-network + out-of-network) limit

In **YYYY, $1,700** is the most you will have to pay for covered services you get from all providers (in-network providers + out-of-network providers combined).

As of **MM/DD/YYYY**, you have had **$150 in out-of-pocket costs** that count toward your **$1,700** combined out-of-pocket maximum for covered services.

EOB statement details *(continued)*

3 Detailed information about the services Blue Cross was billed for during the previous month. We'll tell you the information your provider puts on the claim to identify the medical service you received, the unique number Blue Cross assigns to a claim, what your health care providers billed us, what Blue Cross paid, and what your share is.

4 If Blue Cross denies payment for all or part of your claim, we'll provide an explanation why.

3

MI Health Center Claim Number: 00000000 (In-network provider)	Date of service	Amount the provider billed the plan	Total cost (amount the plan approved)	**Plan's share**	**Your share**
Air and bone conduction assessment of speech recognition (billing code 92557)	M/DD/YY	$1,300.00	$1,000.00	$900.00 You pay 10% of the total amount for services from an in-network provider.	$100.00

4

Things to know about your denied claim:

- *Denial code 09, Provider ID does not exist*
- We have denied all or part of this claim and **you have the right to appeal.** Making an appeal is a formal way of asking us to *change the decision* we made to deny your claim. If we agree to change our decision, it means we will approve the claim rather than deny it, and we will pay our share.
- **The provider can also make an appeal, and if this happens, you may not have to pay.** You may wish to contact the provider to find out if they will ask us for an appeal. If the provider properly asks for an appeal, you will not be responsible for payment, except for the normal cost-sharing amount, and you don't need to make an appeal yourself.
- **When we deny part or all of a claim, we send you a letter** ("Notice of Denial of Payment") explaining why the service or item is not covered. This letter also tells what to do if you want to appeal our decision and have us reconsider.
- **IMPORTANT**: If you do not have this letter, call us at Member Services (phone numbers are in a box on page 1).
- **If you have questions or need help with your appeal, you can contact:**
  - Our Member Services (phone numbers are in a box on page 1)
  - 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.)]

Online EOBs

Log in at **www.bcbsm.com/mpsers** or the BCBSM mobile app if you want to view recent claims, how much you've paid in deductibles or coinsurance and other information. It's easy:

1. Go to **www.bcbsm.com/mpsers** or the BCBSM mobile app and follow steps to create an online Blue Cross member account.
2. After logging in, select ***Claims***.
3. Click on ***Explanation of Benefits (EOB)*** statements.

Help us prevent fraud

Checking to make sure you actually received services as shown on the EOB helps us prevent error and fraud. If you have questions about a claim or your EOB, call Customer Service at 1-800-422-9146 Monday through Friday from 8:30 a.m. to 5 p.m. Eastern time. TTY users should call 711.

Key terms

Coinsurance — The percentage you pay for the costs of covered medical services. The amount of your coinsurance is based on the Medicare Plus Blue℠ Group PPO approved amount for covered services. You pay 10 percent coinsurance for most covered services and your retirement system pays the remaining 90 percent.

Copay or copayment — A flat dollar amount that you pay when you receive certain medical services.

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

Deductible — A fixed dollar amount you must pay during each calendar year before covered services and supplies are paid by your retirement system. The deductible is applied after the coinsurance.

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

Blue Cross Blue Shield of Michigan

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Medicare Plus Blue℠ Group PPO is a PPO plan with a Medicare contract. Enrollment in Medicare Plus Blue depends on contract renewal.

Refer to your Evidence of Coverage *for a complete description of your benefits and applicable cost sharing amounts. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copays, coinsurance and restrictions may apply. Benefits and/or copays/coinsurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium.*

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