UAW RETIREE Medical Benefits Trust

2022

guide to understanding your explanation of benefits statements and cost sharing

Medicare Advantage PPO

FOR PROTECTED MEMBERS

“EOB” stands for explanation of benefits

As a member of the Medicare Plus Blue℠ Group PPO plan, after you have a medical service, you will receive an explanation of benefits, or EOB. The EOB will show you:

- What services you had, the date of service, and what the provider billed
- What your plan paid
- The amount you may owe through deductibles, coinsurance or copayments (also known as your cost sharing)
- Any services that were not covered by your plan

Reviewing your EOB statements is a good way to keep track of your medical care.

EOB statement details

1 Identifies who this EOB statement is for and includes Customer Service information if you have questions about something on your statement.

MONTHLY REPORT

Medical and Hospital Claims Processed in August 2022

Statement Date: September 00, 2022
For *Member Name*
Member ID: XXXXX4567

1

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

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

http://www.bcbsm.com

This is not a bill:

- This monthly report of claims we have processed tells what care you have received, what the plan has paid, and how much you have paid (or can expect to be billed).
- If you owe anything, your doctors and other health care providers will send you a bill.
- This report covers medical and hospital care only. [We send a separate report on Part D prescription drugs.]

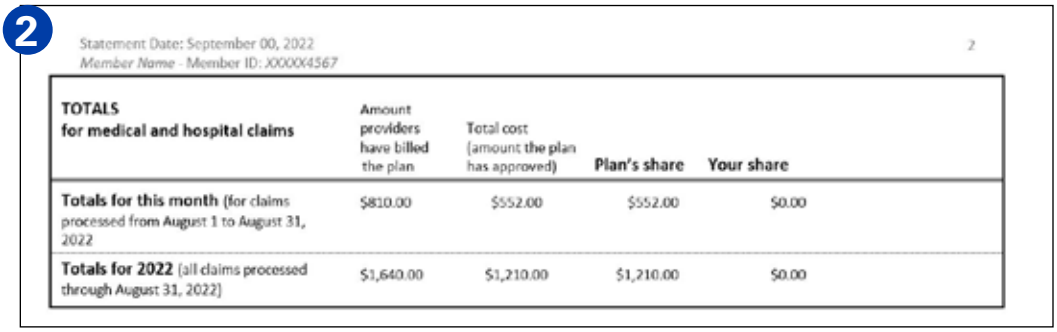
Blue Cross Blue Shield of Michigan Customer Service

If you have questions, call us: 1-888-322-5616

We are here from 8 a.m. to 7 p.m., Monday through Friday with weekend hours during October 1 through February 14.

TTY/TDD only: 711

2 Summarizes the totals of services processed during the time period listed on the EOB.

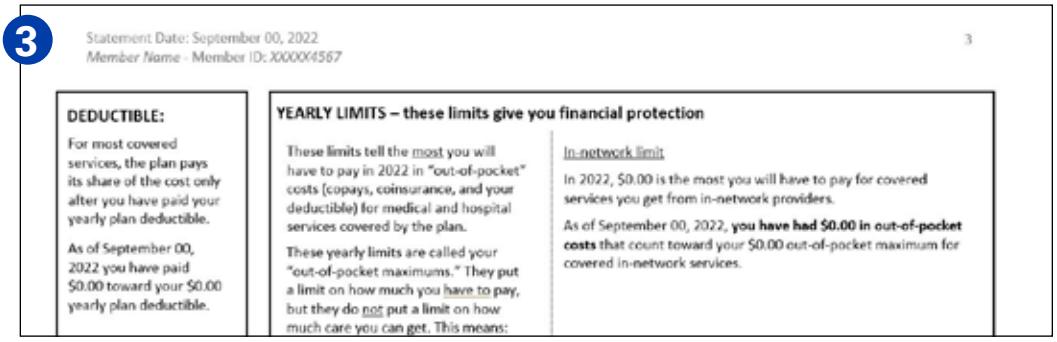


Statement Date: September 00, 2022
Member Name - Member ID: *XXXXX4567*

2

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 August 1 to August 31, 2022	$810.00	$552.00	$552.00	$0.00
Totals for 2022 (all claims processed through August 31, 2022)	$1,640.00	$1,210.00	$1,210.00	$0.00

3 Shows the balances to date for deductibles and out-of-pocket maximums for your current benefit period.



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DEDUCTIBLE:

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

As of September 00, 2022 you have paid $0.00 toward your $0.00 yearly plan deductible.

YEARLY LIMITS – these limits give you financial protection

These limits tell the most you will have to pay in 2022 in "out-of-pocket" costs (copays, coinsurance, and your deductible) for medical and hospital services covered by the plan.

These yearly limits are called your "out-of-pocket maximums." They put a limit on how much you have to pay, but they do not put a limit on how much care you can get. This means:

In-network limit

In 2022, $0.00 is the most you will have to pay for covered services you get from in-network providers.

As of September 00, 2022, **you have had $0.00 in out-of-pocket costs** that count toward your $0.00 out-of-pocket maximum for covered in-network services.

4 Provides detailed information about the claim we processed:

A This is the unique number Blue Cross assigns to a claim. You can reference this number if you need to call us about this claim. This section also provides information that indicates if the provider you received services from was an in-network or out-of-network provider.

B This is information your provider puts on the claim to identify the medical service you received.

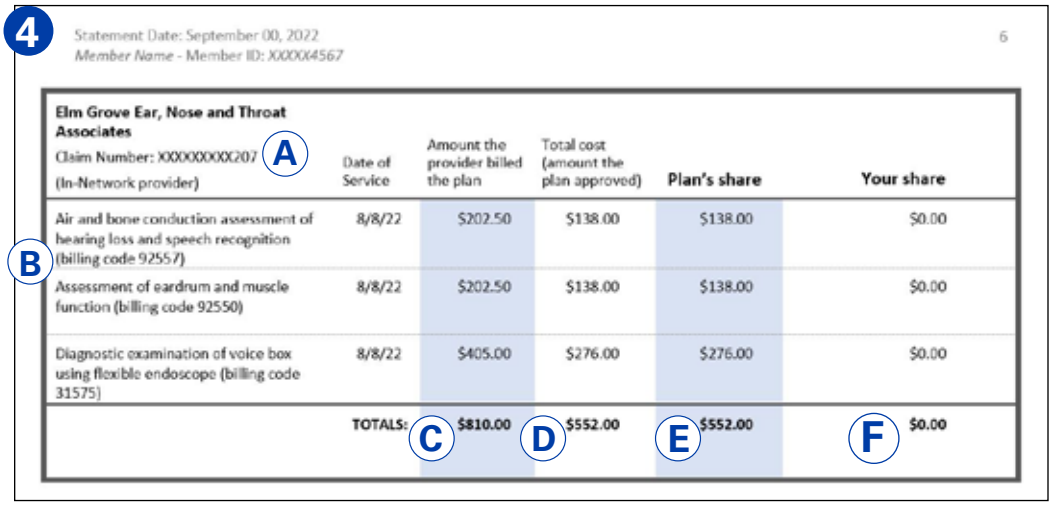
C This is the amount submitted to Blue Cross on the claim.

D This is the amount approved by Blue Cross for your services.

E This is what Blue Cross paid.

F This is what you pay. You may have already paid or may still owe this amount. You should never be asked to pay more than this amount.

5 This section provides detailed information about all services that were denied.



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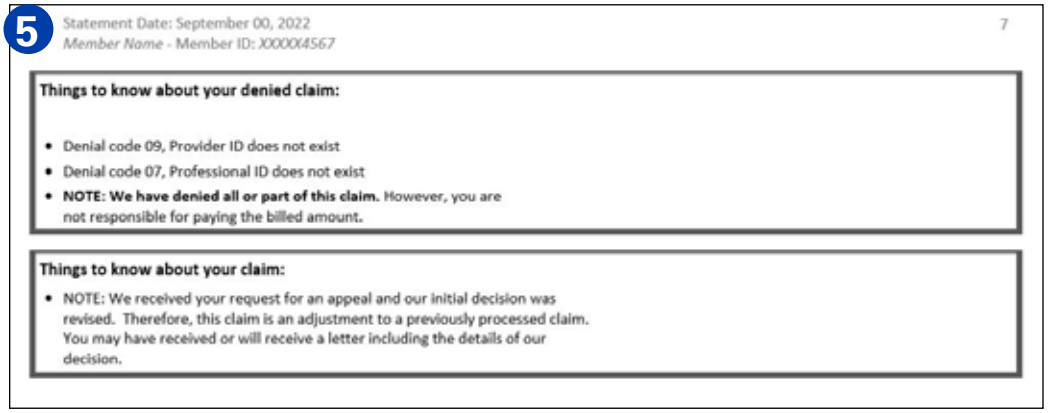
Member Name - Member ID: XXXXX4567

Elm Grove Ear, Nose and Throat Associates Claim Number: XXXXXXXXX207 **A** (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 hearing loss and speech recognition (billing code 92557) **B**	8/8/22	$202.50	$138.00	$138.00	$0.00
Assessment of eardrum and muscle function (billing code 92550)	8/8/22	$202.50	$138.00	$138.00	$0.00
Diagnostic examination of voice box using flexible endoscope (billing code 31575)	8/8/22	$405.00	$276.00	$276.00	$0.00
	TOTALS:	**$810.00** **C**	**$552.00** **D**	**$552.00** **E**	**$0.00** **F**

The last page of your statement provides information on what you can do if you disagree with any of the benefit decisions made for a claim, including your appeal rights. You can also find definitions for terms used on the statement.



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Things to know about your denied claim:

- Denial code 09, Provider ID does not exist
- Denial code 07, Professional ID does not exist
- **NOTE: We have denied all or part of this claim.** However, you are not responsible for paying the billed amount.

Things to know about your claim:

- NOTE: We received your request for an appeal and our initial decision was revised. Therefore, this claim is an adjustment to a previously processed claim. You may have received or will receive a letter including the details of our decision.

Online EOBs

Log in at **bcbsm.com** if you want to view recent claims, deductibles, coinsurance balances and other information. It's easy:

1. Go to **bcbsm.com** and follow steps to create a member account.
2. After logging in, select *Claims* in the blue bar near the top.
3. Click on *Explanation of Benefits* 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 EOB, call Customer Service at **1-888-322-5616**, 8:00 a.m. to 7:00 p.m., Eastern time, Monday through Friday. TTY call **711**.

Claim questions and appeals

1

To confirm you are paying the right amount, compare the EOB and the provider bill side-by-side. Match the service dates and the amounts. If they match, pay the provider that amount and file the EOB for your records.

We'll only send you an EOB once a month, and only if you used your benefits. After your claims are submitted to Blue Cross by your health care providers, we will send you an EOB. In addition, you will most likely receive a billing statement from your provider, showing any outstanding balances you may owe.

2

If the amounts do not match, or if you have questions, call Customer Service at 1-888-322-5616, 8 a.m. to 7 p.m., Eastern time, Monday through Friday. TTY call 711. This number can be found on the back of your Blue Cross member ID. A Blue Cross representative will be happy to review the EOB statement and answer your questions.

3

You have the right to appeal our decision. If we make a coverage decision and you are not satisfied, you can can appeal the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

4

If your appeal is for payment of a service you've already received, we'll give you a written decision within **60 days**.

5

If you ask for an appeal and we continue to deny your request for payment of a service, we'll send you a written decision and automatically send your case to an independent reviewer. The independent reviewer will provide a written decision once they have reviewed your case

Cost-sharing — Your health care costs explained in 3 steps

STEP		You pay	
		In network	**Out of network**
1	Deductible – per calendar year	$0	$490 In network and out of network combined
2	Coinsurance	0%	30% coinsurance after deductible
3	Out-of-pocket maximum – per calendar year (combination of deductible and coinsurance)	$0	$1,395 In network and out of network combined

January 1
Beginning of coverage period

December 31
End of coverage period

Understanding important terms

Allowed amount — The maximum payment amount allowed by Blue Cross for health care services. For covered services, PPO providers accept the allowed amount as payment in full.

Deductible — The amount you pay every year for covered medical services before Blue Cross begins to pay.

Coinsurance — The percentage of the allowed amount you pay for covered services after you've paid your deductible. Blue Cross pays the remaining percentage of the allowed amount.

Copayment — A fixed dollar amount that you are responsible for paying for specific services. These services include office visits, emergency room visits and urgent care visits.

Out-of–pocket maximum — The total amount you pay for deductible and coinsurance in a calendar year. Once you reach your out-of-pocket maximum, Blue Cross pays 100 percent of the allowed amount for covered services.

Out-of-pocket maximum for copay-based services — The total amount you pay for copays in a calendar year. Once you reach your copay out-of-pocket maximum of $1,500, Blue Cross pays 100 percent of the allowed amount for covered services.

In-network provider — A health care provider that has a contract with our Medicare Advantage PPO network. Using a network provider helps keep your health care out-of-pocket costs to a minimum.

Out-of-network provider — A health care provider that does not have a contract with our Medicare Advantage PPO network. Services performed by an out-of-network provider typically cost you more than services performed by an in-network provider.

Coverage period — During this period (January 1 – December 31) you are responsible for any cost sharing (deductible, coinsurance or copay) that applies to covered services you receive until your out-of–pocket maximum is met. Once you reach your out-of-pocket maximum, Blue Cross pays 100 percent of the allowed amount for covered services until January 1 of the following year, when a new coverage period begins.

Contact information

Do you have questions about a claim?
Want to check if your provider is in our network?

Customer Service

1-888-322-5616

(TTY users should call 711)

Monday through Friday

from 8 a.m. to 7 p.m., Eastern time

www.bcbsm.com/UAWTrust

Medicare PLUS Blue℠ Group PPO

Blue Cross Blue Shield of Michigan

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UAW RETIREE Medical Benefits Trust

Blue Cross Blue Shield of Michigan is proudly represented by the UAW

Out-of-network (noncontracted) providers are under no obligation to treat Medicare Plus Blue Group PPO members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage *for more information, including the cost sharing that applies to out-of-network services.*