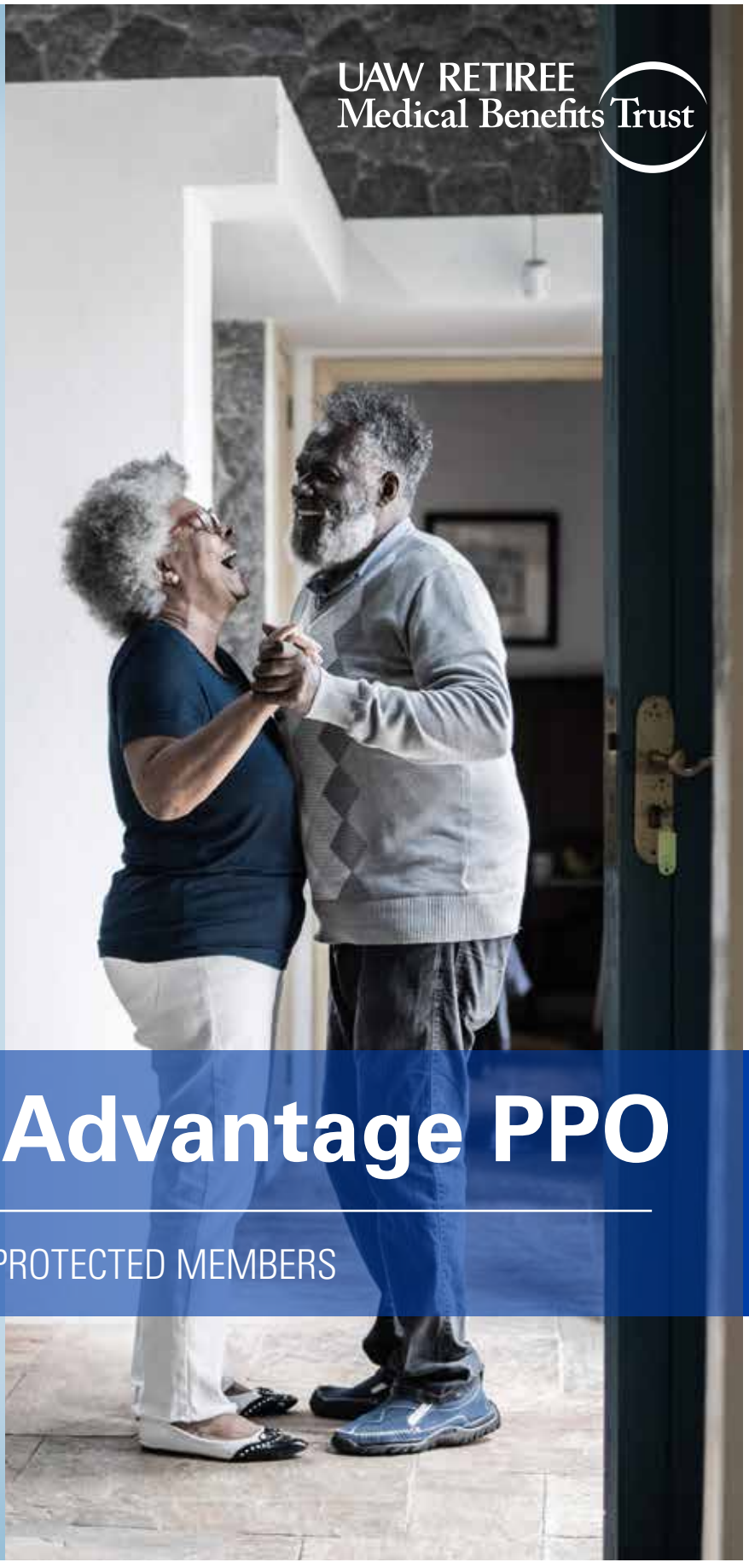


2023
guide to
understanding your
explanation of benefits
statements and
out-of-pocket costs

Medicare Advantage PPO

FOR PROTECTED MEMBERS

“EOB” stands for explanation of benefits

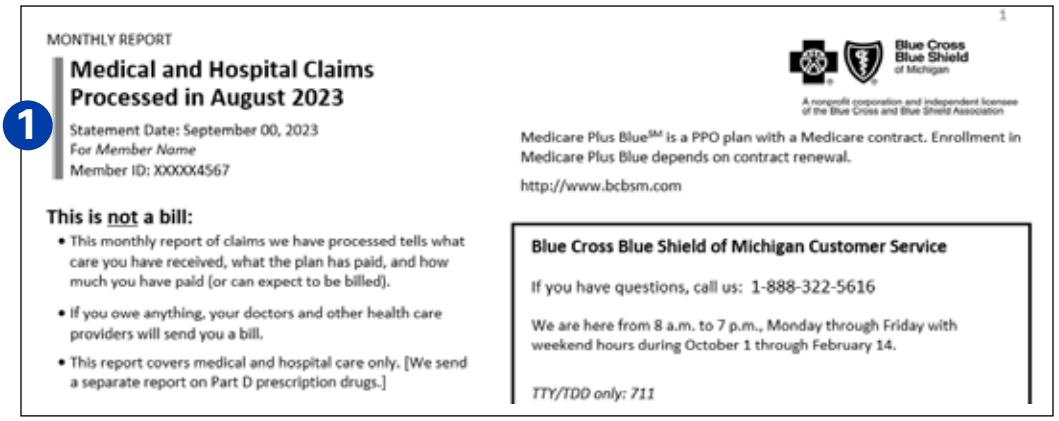
As a member of the Medicare Plus Blue℠ Group PPO plan, after you have a medical service, you’ll receive an explanation of benefits, or EOB. The EOB will show you:

- What services you had, the date of service, and what the provider billed
- What your plan paid
- Your possible out-of-pocket costs (ex: deductibles, coinsurance or copayments)
- 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 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 2023

Statement Date: September 00, 2023
For Member Name
Member ID: XXXXX4567

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.]

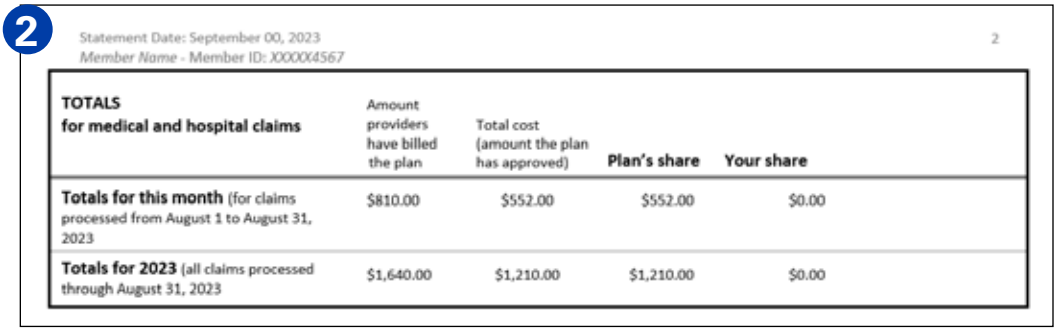
Blue Cross Blue Shield of Michigan Customer Service

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

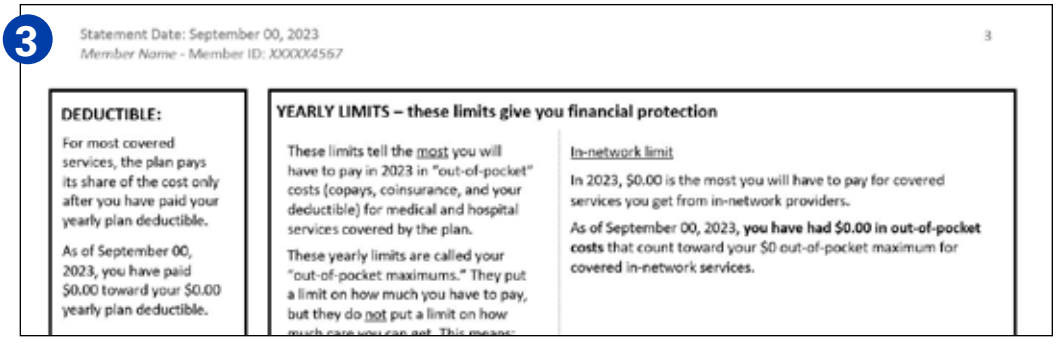
2 Summarizes the totals of services processed during the time period listed on the EOB



Statement Date: September 00, 2023
Member Name - Member ID: *XXXXX4567*

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, 2023	$810.00	$552.00	$552.00	$0.00
Totals for 2023 (all claims processed through August 31, 2023	$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



Statement Date: September 00, 2023
Member Name - Member ID: *XXXXX4567*

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, 2023, 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 2023 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

In-network limit

In 2023, $0.00 is the most you will have to pay for covered services you get from in-network providers.

As of September 00, 2023, **you have had $0.00 in out-of-pocket costs** that count toward your $0 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, and if the provider you've seen is in network or out of network

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

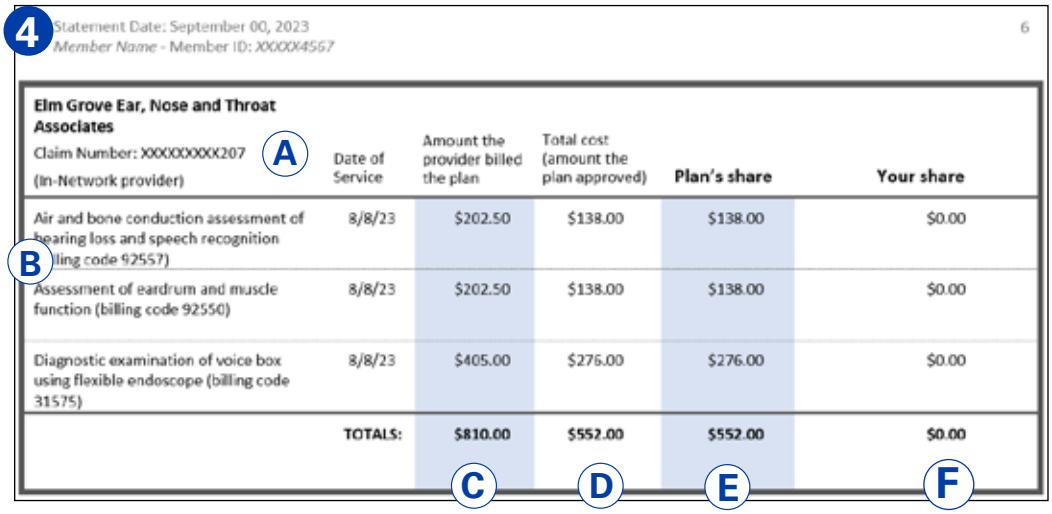
C This is the amount submitted to Blue Cross on the claim

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

E This is what Blue Cross paid

F This displays your out-of-pocket costs. You should never be asked to pay more the amount shown to be your out-of-pocket cost on your EOB statement

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

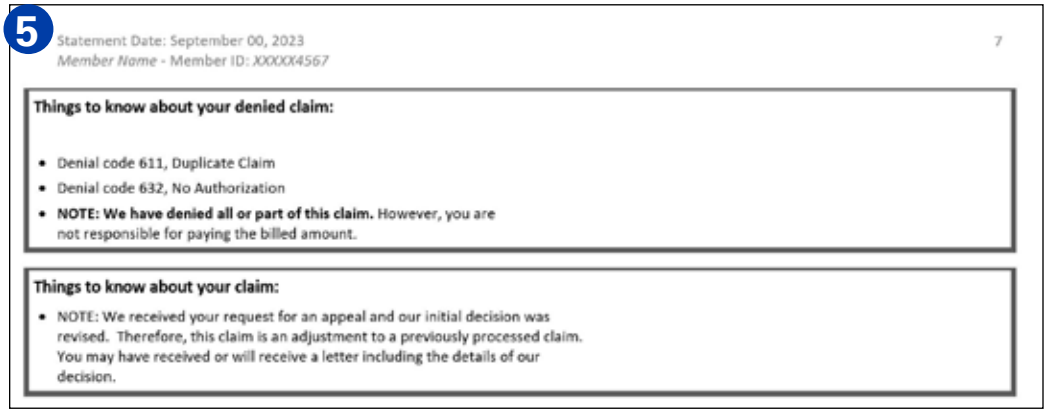


4

Statement Date: September 00, 2023 6
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 (B) lling code 92557)	8/8/23	$202.50	$138.00	$138.00	$0.00
Assessment of eardrum and muscle function (billing code 92550)	8/8/23	$202.50	$138.00	$138.00	$0.00
Diagnostic examination of voice box using flexible endoscope (billing code 31575)	8/8/23	$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.



5

Statement Date: September 00, 2023 7
Member Name - Member ID: *XXXXX4567*

Things to know about your denied claim:

- Denial code 611, Duplicate Claim
- Denial code 632, No Authorization
- **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 **www.bcbsm.com/protectedplan** if you want to view recent claims, deductibles, coinsurance balances and other information. It's easy:

1. Go to **www.bcbsm.com/protectedplan** 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've questions about a claim or EOB, call the Fraud Hotline at **800-482-3787**, Monday through Friday from 8:00 a.m. to 7:00 p.m., Eastern Time. TTY users, call **711**.

Claim questions and appeals

1

To confirm you're 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 the out-of-pocket cost stated on your EOB statement and file the EOB for your records.

We'll send you one medical EOB and one prescription 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'll send you an EOB. In addition, you'll 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**, Monday through Friday, 8:00 a.m. to 7:00 p.m. TTY users, call **711**. A Blue Cross representative will be happy to review the EOB and answer your questions.

3

You have the right to appeal our decision. If we make a coverage decision 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've 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've reviewed your case.

Out-of-pocket costs — 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're 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% 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% 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 doesn't 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're responsible for any out-of-pocket costs (deductible, coinsurance or copay) that apply 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% of the allowed amount for covered services until January 1 of the following year, when a new coverage period begins.

Part D Explanation of Benefits "EOB"

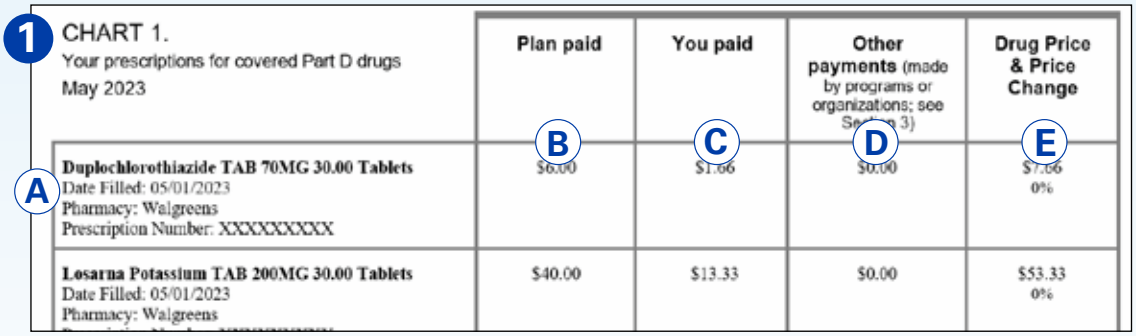
Your explanation of benefits statement, or EOB, will show you three types of costs we keep track of:

- Information for the month. This report gives the payment details about the prescriptions you've filled during the previous month. It shows the total drugs costs, what the plan paid, and what you and others on your behalf paid
- Drug price information. This information will display the total drug price, and information about price changes from the first fill for each prescription claim of the same quantity
- Available lower cost alternative prescriptions

EOB statement details

1 Lists your prescriptions, costs and payments for the previous month:

- **A** Identifies your prescribed medications
- **B** Identifies the costs covered by your plan
- **C** Identifies the costs you paid
- **D** Identifies payments made by outside programs and organizations
- **E** Shows changes in drug prices

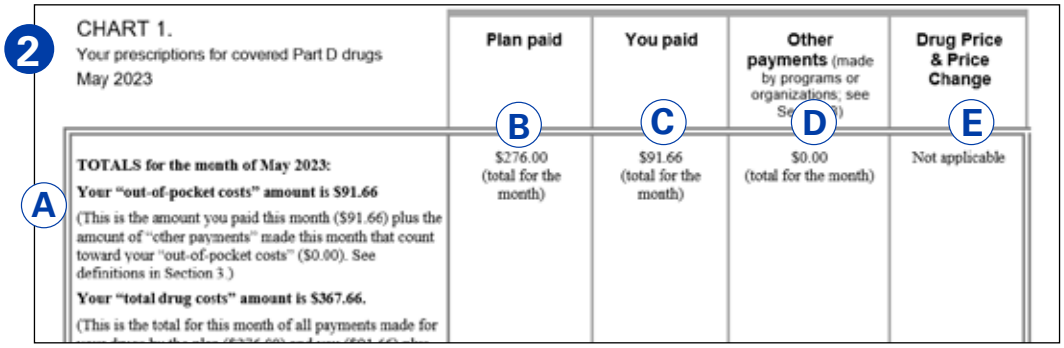


1 CHART 1.
Your prescriptions for covered Part D drugs
May 2023

	Plan paid (B)	You paid (C)	Other payments (made by programs or organizations; see Se...3) (D)	Drug Price & Price Change (E)
A **Duplochlorothiazide TAB 70MG 30.00 Tablets** Date Filled: 05/01/2023 Pharmacy: Walgreens Prescription Number: XXXXXXXXX	$6.00	$1.66	$0.00	$7.66 0%
Losarna Potassium TAB 200MG 30.00 Tablets Date Filled: 05/01/2023 Pharmacy: Walgreens	$40.00	$13.33	$0.00	$53.33 0%

2 Summarizes your totals for the previous month

- **A** Shows month-to-date-totals for out-of-pocket and total drug costs
- **B** Identifies the costs covered by your plan
- **C** Identifies the costs you paid
- **D** Identifies payments made by outside programs and organizations
- **E** Displays changes in drug and pricing



2 CHART 1.
Your prescriptions for covered Part D drugs
May 2023

	Plan paid (B)	You paid (C)	Other payments (made by programs or organizations; see Se...) (D)	Drug Price & Price Change (E)
A **TOTALS for the month of May 2023:** **Your "out-of-pocket costs" amount is $91.66** (This is the amount you paid this month ($91.66) plus the amount of "other payments" made this month that count toward your "out-of-pocket costs" ($0.00). See definitions in Section 3.) **Your "total drug costs" amount is $367.66.** (This is the total for this month of all payments made for	$276.00 (total for the month)	$91.66 (total for the month)	$0.00 (total for the month)	Not applicable

3 Summarizes your year-to-date totals for out-of-pocket costs and total drug costs:

A Shows your year-to-date-totals paid by your plan

B Shows the total amount you paid for the year

C Shows payments made by outside programs and organizations

Year-to-date totals 01/01/2023 through 05/30/2023	Plan paid (A)	You paid (B)	Other payments (made by programs or organizations; see Section 3) (C)
Your year-to-date amount for "out-of-pocket costs" is $458.30 **Your year-to-date amount for "total drug costs" is $1838.00.** For more about "out-of-pocket costs" and "total drug costs," see Section 3.	$1,380.00 (year-to-date total)	$1,099.92 (year-to-date total)	$0.00 (year-to-date total)

4 Shows the Standard Medicare Part D stages and how they apply to you under the plan. During all coverage stages, your share of the cost of a covered drug will never be more than your copayment. If the full cost of a covered drug is less than your copayment, you will pay for the cost of the drug.

A Because there is no deductible for your plan, this stage does not apply to you

B The Initial Coverage stage begins after your first prescription is filled. During this stage, you will pay the lesser of your copayment or the full cost of the drug and the plan will pay their share of the costs for Tier 1, Tier 2, and Tier 3 prescription drugs. Once you and the plan have paid $4,660.00, you will move to the Coverage Gap

C Once you reach $4,660.00 in total drug cost, you enter the Coverage Gap stage. Your share of the cost of a covered drug will never be more than your copayment

D Once your out-of-pocket total reaches $7,400, the Catastrophic Coverage Stage begins. The plan continues to pay most of the cost of your drugs. You will be responsible for your copayment

SECTION 2. Which "drug payment stage" are you in?

As shown below, your Part D prescription drug coverage has "drug payment stages." How much you pay for a covered Part D prescription depends on which payment stage you are in when you fill it. During the calendar year, whether you move from one payment stage to the next depends on how much is spent for your drugs.

STAGE 1 (A) **Yearly Deductible**	STAGE 2 (B) **Initial Coverage**	STAGE 3 (C) **Coverage Gap**	You are in this stage: (D) STAGE 4 **Catastrophic Coverage**
(Because there is no deductible for the plan, this payment stage does not apply to you.	• You begin in this payment stage when you fill your first prescription of the plan year. During this payment	• During this payment stage, you (or others on your behalf) receive a 70% manufacturer's discount on covered brand	• During this payment stage, the plan pays most of the cost for your covered drugs.

5 Shows your out-of-pocket and total drug costs:

A This shows your monthly and year-to-date payment details

B This is the explanation of "out-of-pocket cost"

C This shows your "total drug costs" for the year

D This is the explanation of "total drug costs"

SECTION 3. Your "out-of-pocket costs" and "total drug costs" (amounts and definitions)

We're including this section to help you keep track of your "out-of-pocket costs" and "total drug costs" because these costs determine which drug payment stage you are in. As explained in Section 2, the payment stage you are in determines how much you pay for your prescriptions.

Your "out-of-pocket costs" (A)	Your "total drug costs" (C)
$91.66, month of May 2023 **$1,099.92 year-to-date** (since January 2023)	**$275.00, month of May 2023** **$1,380.00 year-to-date** (since January 2023)
DEFINITION: **"Out-of-pocket costs" includes:** (B) • What you pay when you fill or refill a prescription for a covered Part D drug. (This includes payments for your drugs, if any, that are made by family or friends.) • Payments made for your drugs by any of the following programs or organizations: "Extra Help" from Medicare; Medicare's Coverage Gap Discount Program; Indian Health Service; AIDS drug assistance programs; most charities; and most State Pharmaceutical Assistance Programs (SPAPs)	**DEFINITION:** **"Total drug costs" is the total of all payments made for your covered Part D drugs. It includes:** (D) • What the plan pays. • What you pay. • What others (programs or organizations) pay for your drugs.

NOTES

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.

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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.*