

**READY
TO HELP**



Medicare Plus BlueSM Group PPO **UAW Trust**

Evidence of Coverage for 2026

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

This document gives the details of your Medicare health coverage from January 1 – December 31, 2026. **This is an important legal document. Keep it in a safe place.**

For questions about this document, call Customer Service at 1-888-322-5616.
(TTY users call 711.) Hours are Monday through Friday, 8:00 am – 7:00 pm Eastern time. 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 “our plan,” it means Medicare Plus Blue Group PPO.)

This information is available for free in alternate formats, including large print and audio CD. Please call UAW Trust Medicare Advantage Service Center at the phone numbers printed on the back cover of this booklet if you need plan information in another format.

Benefits, deductibles and/or copayments may change on January 1, 2027.



Our provider network may change at any time. You'll get notice about any changes that may affect you at least 30 days in advance.

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

- Our cost sharing
- Our medical benefits
- How to file a complaint if you are not satisfied with a service or treatment
- How to contact us
- Other protections required by Medicare law

Discrimination is against the law

Blue Cross Blue Shield of Michigan, Blue Care Network and our vendors 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, Blue Care Network and our vendors 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, Blue Care Network and our vendors:

- 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 aren't 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, Blue Care Network or our vendors 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 & 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 Ave, SW, Room 509F, HHH Building
Washington, D.C. 20201
Phone: 1-800-368-1019, TDD: 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 <http://www.hhs.gov/ocr/office/file/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/>.

Notice of Availability

English: Call 1-888-322-5616 to connect with a complimentary interpreter who speaks English or to receive additional support you may need.

Spanish: Llame al 1-888-322-5616 para conectarse de forma gratuita con un intérprete que hable español o para recibir apoyo adicional que pueda necesitar.

Arabic: اتصل على 1-888-322-5616 للتواصل مع مترجم مجاني يتحدث اللغة العربية أو لتلقي المزيد من الدعم الذي قد تحتاجه.

Chinese Mandarin: 拨打1-888-322-5616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 1-888-322-5616 për t'u lidhur me një interpret pa pagesë që flet shqip ose për të marrë mbështetje shitesë që mund t'ju nevojitet.

German: Rufen Sie 1-888-322-5616 an, um einen kostenlosen Dolmetscher zu finden, der Deutsch spricht, oder um weitere Unterstützung zu erhalten.

Amharic: ኦማርኛ ከማናገር ነጻ ተርጓሚ ጋር ለመገናኘት ወይም ሊያስፈልግዎ የሚችል ተጨማሪ ድጋፍ ለማግኘት 1-888-322-5616 ላይ ይደውሉ።

Bengali: বিনামূল্যে বাংলা ভাষায় কথা বলতে পারেন এমন একজন সহায়ক দোভাষীর সাথে যোগাযোগ করতে অথবা আপনার প্রয়োজনীয় অতিরিক্ত সহায়তা পেতে 1-888-322-5616 নম্বরে কল করুন।

French: Appelez le 1-888-322-5616 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) दुभाषिए से संपर्क करने के लिए जो हिंदी बोलता हो या ऐसी अतिरिक्त सहायता प्राप्त करने के लिए जिसकी आपको आवश्यकता हो सकती है, 1-888-322-5616 पर कॉल करें।

Korean: 한국어 무료 통역사와 연결하시거나 필요한 추가 지원을 받으시려면 1-888-322-5616로 전화해 주십시오.

Polish: Zadzwoń pod numer 1-888-322-5616, 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 1-888-322-5616 కు కాల్ చేయండి.

Vietnamese: Xin gọi 1-888-322-5616 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 1-888-322-5616 fer schwetze mit en Interpreter as Deitsch schwetzt odder fer ennichi Hilf griege as du brauchsch. Des zellt dich nix koschde.

Tagalog: Tumawag sa 1-888-322-5616 upang kumonekta sa isang walang bayad na interpreter na nagsasalita ng Tagalog o upang makatanggap ng karagdagang suporta na maaaring kailanganin mo.

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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 chose to get your Medicare health care through our plan, Medicare Plus Blue Group PPO. Our plan covers all Part A and Part B services. However, cost sharing and provider access in this plan are different from Original Medicare.

Medicare Plus Blue Group PPO is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company. This plan doesn't include Part D prescription drug coverage.

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 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 in which you're enrolled in Medicare Plus Blue Group PPO between January 1, 2026 and December 31, 2026.

Medicare allows us to make changes to plans we offer each calendar year. This means we can change the costs and benefits of Medicare Plus Blue Group PPO after December 31, 2026. We can also choose to stop offering the plan in your service area, after December 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 our plan as long as we choose to continue offering our plan and Medicare renews approval of our plan.

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

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

- You're a UAW Retiree Medical Benefits Trust member.
- You have both Medicare Part A and Medicare Part B.
- You live in our geographic service area (described in Section 2.2). People who are incarcerated aren't considered to be in the geographic service area even if they're physically located in it.
- You're a United States citizen or lawfully present in the United States.

Section 2.2 Plan service area for Medicare Plus Blue Group PPO

Medicare Plus Blue Group PPO is only available to people who live in one of these states: Alabama, Florida, Indiana, and Michigan. To stay a member of our plan, you must continue to live in one of these states.

If you move out of our plan's service area, you can't stay a member of this plan. Please contact **Retiree Health Care Connect** at 1-866-637-7555, Monday through Friday 8:30 am to 4:30 pm Eastern time, to see if we have a plan in your new area. When you move, you'll have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Trust-sponsored Medicare health or drug plan in your new location.

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 users call 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 United States to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify Medicare Plus Blue Group PPO if you're not eligible to remain a member on this basis. Medicare Plus Blue Group PPO must disenroll you if you don't meet this requirement.

SECTION 3 Important membership materials you'll get

Section 3.1 Our plan membership card

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

 Blue Cross Blue Shield of Michigan Medicare PLUS Blue SM Group PPO	UAW RETIREE Medical Benefits Trust
Enrollee Name VALUED CUSTOMER	Plan # 572 897
Enrollee ID X3L918888888	Par B Drugs
Health Plan (B0840) 9101003777	RxBIN 610011
Group Number 007034213	RxPCN CTRXMEDD
	RxGrp BCBSMAN
	Issued 01/2026
	

Members: bcbsm.com/UAWTrust		Providers: bcbsm.com/provider/ma	
			
Blue Cross Blue Shield of Michigan A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association		Member Services: 888-322-5616	
Use of this card is subject to terms of applicable contracts, conditions and user agreements. Medicare limiting charges apply. Out-of-state providers, see with your local plan.		TTY/TDD: 711	
Customer Service Inquiry Dept. Mail Code X521 600 E. Lafayette Blvd. Detroit, MI 48226-2998		Misuse may result in prosecution. If you suspect fraud, call: 888-650-8136	
		Provider Inquiries: 800-676-BLUE	
		Facility Precertification Fax: 866-464-8223	
		Behavioral Health: 888-803-4960	
		Outpatient Authorizations: 800-728-8008	
Forms are available online at: bcbsm.com/provider/ma			

DON'T 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 membership 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 hospital services, hospice services, or participate in Medicare approved clinical research studies also called clinical trials.

If our plan membership card is damaged, lost, or stolen, call Customer Service at 1-888-322-5616 (TTY users call 711), Monday through Friday, 8 am – 7 pm Eastern time right away and we'll send you a new card.

Section 3.2 Provider Locator

The *Provider Locator* shows you how to find current network providers.

Network providers are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full.

As a member of our plan, you can choose to get care from out-of-network providers. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and medically necessary. However, if you use an out-of-network provider, your share of the costs for your covered services may be higher. Go to Chapter 3 for more specific information.

The most recent list of providers is also available on our website at **www.bcbsm.com/uawtrust**.

SECTION 4 Summary of important costs

	Your Costs in 2026
Monthly plan premium	\$0
Deductible	\$0 In-network \$490 out-of-network
Maximum out-of-pocket amount This is the most you'll pay out-of-pocket for covered Part A and Part B services (Go to Chapter 4 Section 1 for details).	\$0 in-network \$1,395 out-of-network
Out-of-pocket maximum for medical copay-based services	\$1,500
Primary care office visits	\$0 in-network 50% coinsurance out-of-network after deductible
Specialist office visits	\$10 in-network 50% coinsurance out-of-network after deductible Protected members: \$0 in-network, 50% coinsurance out-of-network after deductible
Inpatient hospital stays	\$0 in-network 30% coinsurance out-of-network

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)

Section 4.1 How much is your plan premium?

You don't pay a separate monthly plan premium for Medicare Plus Blue Group PPO.

Your coverage is provided through a contract with the UAW Retiree Medical Benefits Trust.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

You must continue to pay your Medicare Part B premium to stay a member of our plan. You may also pay a premium for Part A if you aren't eligible for premium-free Part A.

SECTION 5 Keep your plan membership information 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 our plan's network **use your membership information to know what services are covered and your cost-sharing amounts**. Because of this, it's very important that you to help us keep your information up to date.

If you have any of these changes, please contact Retiree Health Care Connect:

- Changes to your name, address, or phone number.

Contact **Retiree Health Care Connect** at 1-866-637-7555, Monday through Friday 8:30 am to 4:30 pm Eastern time. TTY users, call 711.

If you have any of these changes, please contact Blue Cross Blue Shield of Michigan Customer Service at 1-888-322-5616 (TTY users call 711), Monday through Friday, 8 am – 7 pm Eastern time:

- Any liability claims, such as claims from an automobile accident
- 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
- If you participate in a clinical research study. (**Note:** You're not required to tell our plan about clinical research studies you intend to participate in, but we encourage you to do so)

If any of this information changes, let us know by calling Customer Service at 1-888-322-5616 (TTY users call 711), Monday through Friday, 8 am – 7 pm Eastern time.

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 users call 1-800-325-0778).

SECTION 6 How other insurance works with our plan

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

Once a year, we'll send you a letter that lists any other medical or drug coverage we know about. Read this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that isn't listed, call Customer Service at 1-888-322-5616 (TTY users call 711), Monday through Friday, 8 am – 7 pm Eastern time. You may need to give our plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

When you have other insurance (like employer group health coverage), Medicare rules decide whether our plan or your other insurance pays first. The insurance that pays first (the "primary payer") pays up to the limits of its coverage. The one that pays second (the "secondary payer") only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all uncovered costs. If you have other insurance, tell your doctor, hospital, and pharmacy.

These rules apply for employer or union group health plan coverage:

- As a member of the UAW Retiree Medical Benefits Trust, Medicare Advantage pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
 - If you're under 65 and disabled and you (or your family member) are still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
 - If you're over 65 and you (or your spouse or domestic partner) are still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will be the primary payer.

These types of coverage usually pay first for services related to each type:

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

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

CHAPTER 2:

Phone numbers and resources

SECTION 1 Medicare Plus Blue Group PPO contacts

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

Customer Service – Contact Information

Call	1-888-322-5616 Calls to this number are free. Available from 8 am to 7 pm Eastern time, Monday through Friday. Customer Service also has free language interpreter services available for non-English speakers.
TTY	711. Calls to this number are free. Available from 8 am to 7 pm Monday through Friday, Eastern time.
FAX	1-866-467-1262
Write	Blue Cross Blue Shield of Michigan Medicare Plus Blue Group PPO Customer Service Inquiry Department – Mail Code X521 600 E. Lafayette Blvd Detroit, MI 48226-2998
Website	www.bcbsm.com/uawtrust

Davis Vision (Go to *Vision Care* in Chapter 4) – Contact Information

Call	1-888-234-5164 Available from 8 am to 11 pm Monday through Friday, Eastern time. Available from 9 am to 4 pm Saturday, Eastern time. Available from 12 pm to 4 pm Sunday, Eastern time.
TTY	1-800-523-2847 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.

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'll 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	1-888-322-5616 Calls to this number are free. Available from 8 am to 7 pm Monday through Friday, Eastern time.
TTY	711. Calls to this number are free. Available from 8 am to 7 pm Monday through Friday, Eastern time.
FAX	1-877-348-2251
Write	Blue Cross Blue Shield of Michigan Grievances and Appeals Department PO Box 44200 Detroit, MI 48244 Mail code A01C
Medicare Website	You can submit a complaint about Medicare Plus Blue Group PPO directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx .

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 doesn't 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	1-888-322-5616 Calls to this number are free. Available from 8 am to 7 pm Monday through Friday, Eastern time.
TTY	711. Calls to this number are free. Available from 8 am to 7 pm Monday through Friday, Eastern time.
FAX	1-877-348-2251
Write	Blue Cross Blue Shield of Michigan Grievances and Appeals Department PO Box 44200 Detroit, MI 48244 Mail code A01C
Medicare website	You can submit a complaint about Medicare Plus Blue Group PPO directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx .

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

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 provider bill, go to Chapter 5.

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	1-888-322-5616 Calls to this number are free. Available from 8 am to 7 pm Monday through Friday, Eastern time.
TTY	711. Calls to this number are free. Available from 8 am to 7 pm Monday through Friday, Eastern time.
FAX	1-866-624-1090
Write	Blue Cross Blue Shield of Michigan Medicare Plus Blue Group PPO Customer Service Inquiry Department – Mail Code X521 600 E. Lafayette Blvd. Detroit, MI 48226-2998

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 or 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.
Website	<u>www.Medicare.gov</u> • 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 health care 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 <u>www.Medicare.gov</u> to tell Medicare about any complaints you have about Medicare Plus Blue Group PPO. To submit a complaint to Medicare, go to <u>www.Medicare.gov/my/medicare-complaint</u>. 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.

SHIPs are independent state programs (not connected with any insurance company or health plan) that get money from the federal government to give free local health insurance counseling to people with Medicare.

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

Alabama Members:

Alabama Department of Senior Services – Contact Information	
Call	Toll-free 1-800-243-5463 Available from 8 am to 5 pm Central time, Monday through Friday.
TTY	711. Calls to this number are free. Available from 8 am to 5 pm Monday through Friday, Eastern time.
Write	Alabama Department of Senior Services 201 Monroe Street Suite 350 Montgomery, AL 36104
Website	<u>www.alabamaageline.gov</u>

Florida Members:

Florida Department of Elder Affairs – SHINE Program – Contact Information	
Call	Toll-free 1-800-963-5337 Available from 8 am to 5 pm Eastern time, Monday through Friday
TTY	1-800-955-8770 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Write	Department of Elder Affairs SHINE Program 4040 Esplanade Way Ste 270 Tallahassee, FL 32399-7000
Website	<u>www.FloridaShine.org</u>

Indiana Members:

SHIP – Contact Information	
Call	Toll-free 1-800-452-4800
TTY	1-866-846-0139 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Write	SHIP 311 W. Washington Street Ste. 300 Indianapolis, IN 46204
Website	www.medicare.in.gov

Michigan Members:

Michigan Medicare Assistance Program – Contact Information	
Call	Toll-free 1-800-803-7174
TTY	Available from 8 am to 8 pm Monday through Friday, Eastern time. 711. Calls to this number are free. Available from 8 am to 5 pm Monday through Friday, Eastern time.
Write	MMAP, Inc. 6015 W. St. Joe Highway Suite 103 Lansing, MI 48917
Website	www.michigan.gov/MDHHSMIOptions

SECTION 4 Quality Improvement Organization

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state.

QIOs have groups of doctors and other health care professionals paid by Medicare to check on and help improve the quality of care for people with Medicare. QIOs are independent organizations. They're not connected with our plan.

Contact the appropriate QIO below in any of these situations:

- You have a complaint about the quality of care you got. Examples of quality-of-care concerns include getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

Alabama Members:

Acentra Health – Contact Information	
Call	Toll free 1-888-317-0751 Weekdays: 9 am to 5 pm local time; Weekends and holidays: 10 am to 4 pm local time
TTY	711. Calls to this number are free. Weekdays: Available from 9 am to 5 pm Monday through Friday, local time; Weekends and holidays: 10 am to 4 pm, local time
Write	Acentra Health 5201 W Kennedy Blvd Suite 900 Tampa, FL 33609
Website	www.acentraqio.com

Florida Members:

Commence Health – Contact Information	
Call	Toll free 1-888-524-9900 Weekdays: 9 am to 5 pm local time. 24-hour voicemail service is available.
TTY	711. Calls to this number are free.
Write	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23450
Website	www.livantaqio.com

Indiana Members:

Commence Health – Contact Information	
Call	Toll free 1-888-524-9900 Weekdays: 9 am to 5 pm local time. 24-hour voicemail service is available.
TTY	711. Calls to this number are free.
Write	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23450
Website	www.livantaqio.com

Michigan Members:

Commence Health – Contact Information	
Call	Toll free 1-888-524-9900 Weekdays: 9 am to 5 pm local time.
TTY	711. Calls to this number are free.
Write	Commence Health BFCC-QIO Program P.O. Box 2678 Virginia Beach, VA 23450
FAX	1-855-236-2423
Website	www.livantaqio.cms.gov/en/States/Michigan

SECTION 5 Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment.

If you move or change your mailing address, contact Social Security to let them know.

Social Security – Contact Information

Call	1-800-772-1213 Calls to this number are free. Available 8 am to 7 pm, 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 am to 7 pm, Monday through Friday.
Website	www.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.
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums.
- **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 Medicare Savings Programs, contact the appropriate agency below.

Alabama Members:

Alabama Medicaid Agency – Contact Information	
Call	1-800-362-1504
TTY	711. Calls to this number are free. Available from 8 am to 7 pm, Monday through Friday, Eastern time.
Write	Alabama Medicaid Agency P.O. Box 5624 Montgomery, AL 36103
Website	www.medicaid.alabama.gov

Florida Members:

Florida Medicaid Program – Contact Information	
Call	Toll free 1- 850-300-4323 Agents available 7 am to 6 pm Monday through Friday.
TTY	1-800-955-8771 or call 711. Calls to this number are free. Available from 7 am to 6 pm, Monday through Friday, Eastern time.
Write	ACCESS Central Mail Center P.O. Box 1770 Ocala, FL 34478
Website	www.myflfamilies.com/services/public-assistance

Indiana Members:

Indiana Medicaid Program – Contact Information	
Call	1-800-403-0864
TTY	711. Calls to this number are free. Available from 8 am to 4:30 pm, Monday through Friday, Eastern time.
Write	Family & Social Services Administration (FSSA) Document Center P.O. Box 1810 Marion, IN 46952
Website	www.in.gov/medicaid/

Michigan Members:

Michigan Medicaid Program – Contact Information	
Call	Michigan Enrollees: 1-800-975-7630 Available 8 am to 5 pm, Monday through Friday. Beneficiary Helpline: 1-800-642-3195
TTY	1-800-263-5897 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Write	Michigan Department of Health & Human Services 333 S. Grand Ave. PO Box 30195 Lansing, MI 48909
Website	www.michigan.gov/mdhhs/assistance-programs/medicaid

CHAPTER 3:

Using our plan for your medical services

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

This chapter explains what you need to know about using our plan to get your medical care covered. For details on what medical care our 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 health care professionals licensed by the state to provide medical services and care. The term also includes hospitals and other health care facilities.
- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our 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, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the Medical Benefits Chart in Chapter 4.

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.

Medicare Plus Blue Group PPO will generally cover your medical care as long as:

- **The care you get is included in our plan's Medical Benefits Chart in Chapter 4.**
- **The care you get is considered medically necessary.** Medically necessary means that the services, supplies, equipment, or 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 our plan, you can get your care from either a

network provider or an out-of-network provider (go to Section 2 for more information).

- You can locate network providers using the *Provider Locator* on our website **www.bcbsm.com/uawtrust** or by calling Customer Service at 1-888-322-5616 (TTY users call 711), Monday through Friday, 8 am – 7 pm Eastern time.
- 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 can't pay a provider who isn't eligible to participate in Medicare. If you go to a provider who isn't 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.

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 health care 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.

Medicare Plus Blue Group PPO members don't need a referral to see a specialist. See the Medical Benefits Chart in Chapter 4 for services which may require prior authorization.

When a specialist or another network provider leaves our plan

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

- 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 plan so that you have time to choose a new provider.

- We'll make a good faith effort to provide you with 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We'll help you choose a new qualified in-network provider for continued care.
- If you're currently undergoing medical treatment or therapies with your current provider, you have the right to we'll ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- When an in-network provider is unavailable or inadequate to meet your medical needs, we'll arrange for any medically necessary covered benefit outside of our provider network at in-network cost sharing..
- If you find out your doctor or specialist is leaving our plan, 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 isn't being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality-of-care grievance to our plan, or both (go to Chapter 7).

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

As a member of our plan, you can choose to get care from out-of-network providers. However, providers that don't contract with us are under no obligation to treat you, except in emergency situations. Our plan will cover 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 your covered services may be higher.** Here are more 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 can't pay a provider who isn't eligible to participate in Medicare. If you get care from a provider who isn't 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 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 get 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, and if our plan later determines that the services aren't covered or weren't medically necessary, our plan may deny coverage and you'll be responsible for the entire cost. If we say we won't cover

the services you got, you have the right to appeal our decision not to cover your care (go to Chapter 7).

- It's best to ask an out-of-network provider to bill our plan first. But, if you've already paid for the covered services, we'll reimburse you for our 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 (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 (go to Section 3).

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

Section 3.1 Get if you have a medical emergency

A **medical emergency** is when you 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's quickly getting worse.

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 don't need to use a network doctor. You can get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they're not part of our network.

Covered services in a medical emergency

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency.

The doctors 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 doctors will continue to treat you until your doctors contact us and make plans for additional care.

If you get your follow-up care from out-of-network providers, you'll pay the higher out-of-network cost sharing.

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 wasn't an emergency, as long as you reasonably thought your health was in serious danger, we'll cover your care.

However, after the doctor says it wasn't an emergency, the amount of cost sharing that you pay will depend on whether you get the care from network providers or out-of-network providers. If you get the care from network providers, your share of the costs will usually be lower than if you get the care from out-of-network providers.

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 the service area or our plan network is temporarily unavailable.

Our plan covers worldwide emergency and urgent care outside the United States. You may be responsible for the difference between the approved amount and the provider's charge. Go to *Worldwide Coverage* in Chapter 4 for more information.

Section 3.3 Get care during a disaster

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

Visit **www.bcbsm.com/medicare** for information on how to get care during a disaster. You may also call Customer Service at 1-888-322-5616 (TTY users call 711), Monday through Friday, 8 am – 7 pm Eastern time to get more.

If you can't use a network provider during a disaster, our plan will allow you to get care from out-of-network providers at in-network cost sharing.

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

If you paid more than our plan 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 aren't covered by our 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 that aren't covered by our plan, you're responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you use up your benefit for that type of covered service. Once your benefit limitation has been reached, these additional services won't be applied toward your out-of-pocket maximum.

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 for volunteers to participate in the study.

When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (the care that isn't related to the study) through our plan.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you get as part of the study. If you tell us you are 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 don't need to tell us or get approval from us. The providers that deliver your care as part of the clinical research study don't need to be part of our plan's network. (This doesn't apply to covered benefits that require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational device

exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.

While you don't need to get our plan's permission to be in a clinical research study, we encourage you to notify us in advance. This includes participation in Medicare-qualified clinical trials.

If you participate in a study not approved by Medicare, you'll be responsible for paying all costs for your participation in the study.

Section 5.2 Who pays for services in a clinical research study

Once you join a Medicare-approved clinical research study, Original Medicare covers 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, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our 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 our 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.

When you're in a clinical research study, **neither Medicare nor our 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 health care. For example, Medicare won't pay for monthly CT scans done as part of a 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:

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 users should call 1-877-486-2048.

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

Section 6.1 A religious non-medical health care institution

A religious non-medical health care 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 a member's religious beliefs, we'll instead cover care in a religious non-medical health care institution. This benefit's provided only for Part A inpatient services (non-medical health care services).

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

To get care from a religious non-medical health care 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's *voluntary* and *not required* by any federal, state, or local law.
- **Excepted** medical treatment is medical care or treatment you get that's *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.
- Our plan only covers non-religious aspects of care.
- If you get services from this institution provided to you in a facility, the following conditions apply:
 - 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 our plan before you're admitted to the facility, or your stay won't be covered.

Medicare Inpatient Hospital coverage limits apply. For more information, see the Medical Benefits Chart in Chapter 4 of this document.

SECTION 7 Rules for ownership of durable medical equipment

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

Durable medical equipment (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. Other types of DME you must rent.

You will be offered the option to acquire ownership of certain items after 10 months (wheelchairs may be purchased at the time the equipment is first provided). If you choose to own the item, Medicare pays up to 13 months, then you own the device. If you don't purchase the equipment, Medicare pays up to 15 months. After 15 months, ownership remains with the DME supplier. However, you may use the item for as long as you need it. Call Customer Service at 1-888-322-5616 (TTY users call 711), Monday through Friday, 8 am – 7 pm Eastern time for more information.

What happens to payments you made for durable medical equipment if you switch to Original Medicare?

If you didn't get ownership of the DME item while in our plan, you'll have to make 13 new consecutive payments after you switch to Original Medicare to own the DME item unless you acquire a new item from a Medicare accepting provider. The payments you made while enrolled in our plan don't count toward these 13 payments.

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare don't count.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You didn't get ownership of the item while in our plan. You then go back to Original Medicare. You'll have to make 13 consecutive new payments to own the item once you rejoin Original Medicare. Any payments you already made (whether to our plan or to Original Medicare) don't count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

If you qualify for Medicare oxygen equipment coverage, Medicare Plus Blue Group PPO will cover the following at 100%:

- 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 and no longer medically require oxygen equipment, the oxygen equipment must be returned.

What happens if you leave our plan and return to Original Medicare?

Original Medicare requires an oxygen supplier to provide you services for 5 years. During the first 36 months, you rent the equipment. For the remaining 24 months, the supplier provides the equipment and maintenance (you're still responsible for the copayment for oxygen). After 5 years, you can choose to stay with the same company or go to another company. At this point, the 5-year cycle starts over again, even if you stay with the same company, and you're again required to pay copayments for the first 36 months. If you join or leave our plan, the 5-year cycle starts over.

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 Medicare Plus Blue Group PPO. This section also gives information about medical services that aren't covered and explains limits on certain services.

Section 1.1 Out-of-pocket costs you may pay for covered services

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

- **Deductible:** the amount you must pay for medical services before our plan begins to pay its share.
- **Copayment:** a fixed amount you pay each time you get certain medical services. You pay a copayment at the time you get the medical service.
- **Coinsurance:** a percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service.

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program don't 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, if applicable.

Section 1.2 Our plan deductible, out-of-pocket maximums and other limits

Type of Maximum	
Annual deductible per member per year	\$0 in-network
	\$490 out-of-network
Out-of-pocket maximum for deductible and coinsurance amounts for Medicare-covered medical services per member per year	\$0 in-network
	\$1,395 out-of-network
Out-of-pocket maximum for medical copay-based services	\$1,500

Your Deductible

Your **deductible** is \$0 for in-network services and \$490 for out-of-network services.

Your Out-of-Pocket Maximums

Under our plan, there are limits on what you pay for out-of-pocket covered medical services:

For **in-network services** there's no out-of-pocket maximum. This means that the plan pays 100% for covered medical services **in-network**.

For **Medicare Part B drugs**, a \$500 out-of-pocket maximum applies to retail and mail order pharmacy. Protected members have a \$0 out-of-pocket maximum for Medicare Part B drugs.

Your **out-of-network, out-of-pocket maximum amount** is \$1,395. This is the most you pay during the calendar year for covered services received from out-of-network providers. The amounts you pay for deductibles and coinsurance for covered services count toward this maximum out-of-pocket amount. If you've paid \$1,395 for covered services, you'll have 100% coverage and won't have any out-of-pocket costs for the rest of the year for covered out-of-network services (not including medical copay-based services). However, you must continue

to pay the Medicare Part B premium (unless your Part B premium is paid by Medicaid or another third party).

Other Limits

The plan has a maximum out-of-pocket amount of \$1,500 for medical copay-based medical services. Once you've paid \$1,500 out-of-pocket in copayments, the plan will cover these services at no cost to you for the rest of the calendar year.

Section 1.3 Contracted network providers aren't 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 our plan. Contracted network providers can't 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's how protection from balance billing works:

If your cost sharing is a copayment (a set amount of dollars, for example, \$15 for urgent care or \$50 for emergency room), you pay only that amount for any covered services from a network provider. You'll generally have higher coinsurance when you obtain care from out-of-network providers.

If you think a provider has balance billed you, call Customer Service at 1-888-322-5616 (TTY users call 711), Monday through Friday, 8 am – 7 pm Eastern time.

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

The Medical Benefits Chart on the next 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 these requirements are met:

- Your Medicare-covered services must be provided according to Medicare guidelines.
- Your services (including medical care, services, supplies, equipment, and Part B drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA 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 require prior authorization. Covered services that need approval in advance to be covered are marked by an asterisk (*) in the Medical Benefits Chart.
- 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.

Medical Benefits Chart



This apple shows preventive services in the Medical Benefits Chart.

Protected members are all retirees who retired before October 1, 1990, and all surviving spouses of retirees who retired before October 1, 1999.

Covered Service	What you pay
 Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	In-network and Out-of-network: Plan pays 100% of the approved amount

Covered Service	What you pay
Acupuncture for chronic low back pain only Covered services include: Up to 12 visits in 90 days are covered under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, disease, etc.) • not associated with surgery; and • not associated with pregnancy. An additional 8 sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient isn't improving or is regressing. <u>Provider Requirements:</u> Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. 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:	In-network and Out-of-network: • \$20 copayment per visit • Services apply to the annual copayment out-of-pocket maximum • Protected members: Plan pays 100% of the approved amount

Covered Service	What you pay
• 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 (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. 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.	

Covered Service	What you pay
Allergy injections & testing Covered services include: • Allergy shots • Allergy shot administration • Allergy testing	In-network: <u>In an office</u> • Plan pays 100% of the approved amount • Office visit copay may apply <u>In a facility</u> • Plan pays 100% of the approved amount Out-of-network: • 30% coinsurance of the approved amount after deductible • Services apply to the annual out-of-pocket maximum

Covered Service	What you pay
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. If the covered ambulance services aren't for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. We cover ambulance services even if you're not transported to a facility, if you're stabilized by medical staff at your home or other location. This service isn't covered outside of the U.S. or its territories.	In-network and Out-of-network: Plan pays 100% of the approved amount

Covered Service	What you pay
 Annual physical exam An examination performed by a primary care physician or other provider that collects health information. This is an annual medical exam and is more comprehensive than an annual wellness visit. It is covered once per year. Services include: • A physical examination, including vital signs and measurements • Guidance, counseling, and risk factor interventions • Administration or ordering of immunizations or diagnostic procedures • Covered only in the following locations: a provider's office, outpatient hospital or a member's home	In-network and Out-of-network: • Plan pays 100% of the approved amount

Covered Service	What you pay
 Annual wellness visit A visit with your health care provider to develop or update a personalized prevention plan based on your specific health and risk factors. This isn't a physical exam. The annual wellness visit can occur anytime throughout the calendar year, regardless of the date of your previous annual wellness visit.	In-network and Out-of-network: Plan pays 100% of the approved amount

Covered Service	What you pay
Blood Coverage of whole blood and packed red cells begins with the first pint. There is no limit to the number of pints. Includes storage and administration.	In-network - Plan pays 100% of the approved amount Out-of-network 30% coinsurance of the approved amount, after deductible - Services apply to the annual out-of-pocket maximum

Covered Service	What you pay
 Bone mass measurement For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered once every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	In-network: - Plan pays 100% of the approved amount Out-of-network: 30% coinsurance of the approved amount, after deductible - Services apply to the annual out-of-pocket maximum

Covered Service	What you pay
 Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women aged 40 and older • Clinical breast exams once every 24 months • 3-D mammograms are covered when medically necessary See Chapter 12 (Glossary) in the <i>Evidence of Coverage</i> for a definition of a mammogram screening.	In-network and Out-of-network: • Plan pays 100% of the approved amount

Covered Service	What you pay
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. Phase III cardiac rehabilitation programs aren't covered. They are considered maintenance programs, don't require physician supervision and monitoring, and aren't considered medically necessary. Please see the Exclusions Chart in Chapter 4, Section 3 of this <i>Evidence of Coverage</i>.	In-network: • Plan pays 100% of the approved amount Out-of-network: • 30% coinsurance of the approved amount after deductible • Services apply to the annual out-of-pocket maximum

Covered Service	What you pay
 Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	In-network and Out-of-network: Plan pays 100% of the approved amount

Covered Service	What you pay
 Cardiovascular disease screening tests Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	In-network and Out-of-network: Plan pays 100% of the approved amount

Covered Service	What you pay
 Cervical and vaginal cancer screening Covered services include: - For all women: Pap tests and pelvic exams are covered once every 24 months. - If you're at high risk of cervical or vaginal cancer or you're of childbearing age and have had an abnormal Pap test within the past three years: one Pap test every 12 months.	In-network and Out-of-network: Plan pays 100% of the approved amount

Covered Service	What you pay
Chiropractic services Covered services include: We cover only manual manipulation of the spine to correct subluxation. X-rays for chiropractic services are not covered by our plan.	In-network: • \$20 copayment • Services apply to the annual copayment out-of-pocket maximum • Protected members: Plan pays 100% of approved amount Out-of-network: • 50% coinsurance of the approved amount after deductible • Services apply to the annual out-of-pocket maximum

Covered Service	What you pay
Chronic pain management and treatment services Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning.	Cost sharing for this service will vary depending on services provided under the course of treatment. In-network and Out-of-network: <u>Office Visits</u> • \$0 copayment for primary care provider • \$10 copayment for specialty care provider • Services apply to the annual copayment out-of-pocket maximum • Protected members: plan pays 100% of approved amount <u>In a facility</u> • Plan pays 100% of the approved amount

Covered Service	What you pay
 Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every calendar year, preventive or diagnostic. • Computed tomography colonography for patients 45 year and older who aren't at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.	<u>Colonoscopy</u> In-network and Out-of-network: • Plan pays 100% of the approved amount <u>All other colorectal screening</u> In-network: • Plan pays 100% of the approved amount Out-of-network: • 30% coinsurance of the approved amount after deductible • Services apply to the annual out-of-pocket maximum

Covered Service	What you pay
- Colorectal cancer screening tests include a follow-up screening colonoscopy after a Medicare-covered non-invasive stool-based colorectal cancer screening test returns a positive result. - Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.	

Covered Service	What you pay
Dental services Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. We'll cover those same medically necessary services. Some examples include: • Reconstruction of the jaw following fracture or injury • Tooth extractions done in preparation for radiation treatment for cancer involving the jaw • Oral exams preceding kidney transplantation In general, preventive dental services (such as cleaning, routine dental exams, and dental X-rays) are covered by your UAW Trust dental carrier.	In-network and Out-of-network: • \$20 copayment • Services apply to the annual copayment out-of-pocket maximum • Protected members: Plan pays 100% of approved amount

Covered Service	What you pay
 Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and referrals.	In-network and Out-of-network: Plan pays 100% of the approved amount

Covered Service	What you pay
 Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of these risk factors: • High blood pressure (hypertension) • History of abnormal cholesterol and triglyceride levels (dyslipidemia) • Obesity, or a history of high blood sugar (glucose) Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test.	In-network and Out-of-network: • Plan pays 100% of the approved amount

Covered Service	What you pay
Diabetes self-management training, diabetic services and supplies* For all people who have diabetes (insulin and non-insulin users). Covered services include: • Approved continuous glucose monitors and supply allowance as covered by Original Medicare. Supplies to monitor your blood glucose: Blood glucose monitor, continuous glucose monitor (CGM), blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • For people with diabetes who have severe diabetic foot disease: ○ 2 pairs of therapeutic custom-molded shoes per calendar year (including inserts provided with such shoes) and four additional pairs of inserts -or- ○ 2 pairs of depth shoes and six pairs of inserts (not including the non-customized removable inserts provided with such shoes) ○ Coverage includes fitting • Diabetes self-management training is covered under certain conditions • For DME supplies, diabetic supplies and prosthetic devices, please contact 1-888-322-5616, 8 am to 7 pm Eastern time, Monday through Friday. TTY users call 711.	In-network and Out-of-network: • Plan pays 100% of the approved amount

Covered Service	What you pay
* Diabetes self-management training, diabetic services and supplies may require prior authorization; your plan provider will arrange for this authorization, if needed.	

Covered Service	What you pay
Durable medical equipment and related supplies* (For a definition of durable medical equipment, go to Chapter 10 and Chapter 3) Covered items include, but aren't limited to, wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, orthotics, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary durable medical equipment covered by Original Medicare. If our supplier in your area doesn't carry a particular brand or manufacturer, you can ask them if they can special order it for you. You must have a prescription or a Certificate of Medical Necessity from your provider to obtain Durable Medical Equipment (DME). For DME supplies, diabetic supplies and prosthetic devices, please contact 1-888-322-5616, 8 am to 7 pm, Eastern time, Monday through Friday. TTY users call 711. * Durable medical equipment and related supplies may require prior authorization; Our plan provider will arrange for this authorization, if needed.	In-network and Out-of-network: • Plan pays 100% of the approved amount

Covered Service	What you pay
Emergency care Emergency care refers to services that are: - Furnished by a provider qualified to furnish emergency services, and - Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you 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's quickly getting worse. For information about emergent or urgently needed medical items and services furnished outside of the United States and its territories, see <i>Worldwide Coverage</i>.	In-network and Out-of-network: \$50 copayment - Waived if admitted to the hospital within 24 hours - Copayment is applied to the copayment out-of-pocket maximum

Covered Service	What you pay
Gradient compression stockings We cover gradient compression stockings that squeeze the leg to reduce and prevent swelling as well as improve blood flow. • There is no limit to the number of pairs per year • Limited to a compression gradient of 18 mmHg and above	In-network and Out-of-network: • Plan pays 100% of the approved amount

Covered Service	What you pay
 Health and Wellness education programs We offer health and wellness education programs that include: • 24-Hour Nurse Advice Line ○ Speak to a registered nurse 24 hours a day, 7 days a week for help with health-related questions. You can reach the nurse line by calling 1-855-624-5214. TTY users, call 711. • Tobacco Cessation Coaching ○ Our Tobacco Cessation Coaching program is a yearly program offered as a self-guided experience with 24/7 access via web or mobile, or live coaching with enrollment online or over phone and available via telephonic or platform chat. Online access is https://join.personifyhealth.com/bluecrossmedicarerewards. Phone support and hours of operation are 1-888-573-3113 ▪ Monday through Thursday, 8 am to 11 pm Eastern time. TTY users call 711. ▪ Friday, 8 am to 7 pm Eastern time. TTY users call 711. ▪ Saturday, 9 am to 3 pm Eastern time. TTY users call 711. • SilverSneakers® fitness program (go to SilverSneakers in this table).	In-network and Out-of-network: • Plan pays 100% of the approved amount

Covered Service	What you pay
 HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months • If you are pregnant, we cover up to 3 screening exams during a pregnancy	In-network and Out-of-network: • Plan pays 100% of the approved amount

Covered Service	What you pay
Home health agency care* Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but aren't limited to: • Part-time or intermittent skilled nursing and home health aide services. No visit limitations. • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies * Home health agency care may require prior authorization; your plan provider will arrange for this authorization, if needed. Medical supplies ordered by a physician such as DME equipment are covered under <i>Durable Medical Equipment</i>. Please Note: Custodial care isn't the same as home health agency care. For information, see <i>Custodial Care</i> in the exclusion list in Chapter 4, Section 3 of this <i>Evidence of Coverage</i>.	In-network and Out-of-network: • Plan pays 100% of the approved amount

Covered Service	What you pay
Home infusion therapy* 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). Covered services include, but aren't limited to: • Professional services, including nursing services, furnished in accordance with our 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 * Home infusion therapy may require prior authorization; your plan provider will arrange for this authorization, if needed.	In-network and Out-of-network: • Plan pays 100% of the approved amount

Covered Service	What you pay
Hospice care You're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you're admitted to a hospice you have the right to remain in your plan. For hospice services and for services that are covered by Medicare Part A or B that are related to your terminal prognosis: Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost sharing.	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.

Covered Service	What you pay
For services covered by Medicare Part A or B aren't related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B that aren't related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (like if there's a requirement to get prior authorization): • If you get the covered services from a network provider and follow plan rules for getting service, you pay only our plan cost sharing amount for in-network service. • If you get the covered services from an out-of-network provider, you pay the cost sharing under Original Medicare. For services covered by Medicare Plus Blue Group PPO but aren't covered by Medicare Part A or B: Medicare Plus Blue Group PPO will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our plan cost sharing amount for these services. Note: If you need non-hospice care (care that's not related to your terminal prognosis), contact us to arrange the services.	

Covered Service	What you pay
Hospice support in a Skilled Nursing Facility or Hospice Facility (5th level hospice) Covers inpatient room and board in a Skilled Nursing Facility or Hospice Facility for members who are medically stable but unable to return home. The benefit doesn't apply when getting hospice care in the home. For patients who can't be transported, this benefit covers hospice service in an inpatient hospital setting. Lifetime maximum of 210 days of coverage for 5th level hospice.	In-network and Out-of-network: • Plan pays 100% of the approved amount

Covered Service	What you pay
Human Organ Transplant Program* Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If Medicare Plus Blue Group PPO provides transplant services at a location outside the pattern of care for transplants in your community, and you choose to get transplants at this distant location, we'll arrange and pay for appropriate lodging and transportation costs for you and a companion. Coverage is up to \$10,000; travel and lodging is covered for only one year after the initial transplant (includes up to five additional days prior to the initial transplant). Outside of the service area is defined as 100 miles or more, one-way to the facility, from your home address. * Human organ transplants may require prior authorization; your plan provider will arrange for this authorization, if needed.	In-network: • Plan pays 100% of the approved amount Out-of-network: • 30% coinsurance of the approved amount after deductible • Services apply to the annual out-of-pocket maximum

Covered Service	What you pay
 Immunizations/vaccinations United States Preventive Services Task Force vaccines are covered in office and facility settings with no place-of-service restrictions. Covered Medicare Part B services include: • Pneumonia vaccines. • Flu/influenza shots (vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary. • Hepatitis B vaccines if you are at high or intermediate risk of getting Hepatitis B. • COVID-19 vaccines. • Other vaccines if you are at risk and they meet Medicare Part B coverage rules.	In-network and Out-of-network: • Plan pays 100% of the approved amount • When administered in an office setting, out-of-pocket costs may apply.

Covered Service	What you pay
Inpatient hospital care* Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. 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. Unlimited days for medically necessary inpatient hospital stays. Covered services include but aren't limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications (not including self-administered drugs) • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • Physician services	In-network: • Plan pays 100% of the approved amount Out-of-network: • 30% coinsurance of the approved amount, after deductible • Services apply to the annual out-of-pocket maximum

Covered Service	What you pay
* Inpatient hospital care may require prior authorization; your plan provider will arrange for this authorization, if needed. Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you’re not sure if you’re an inpatient or an outpatient, ask the hospital staff. Get more information in the Medicare fact sheet <i>Medical Hospital Benefits</i> This fact sheet is available at www.Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	

Covered Service	What you pay
Inpatient services in a psychiatric hospital* Covered services include behavioral health care services that require a hospital stay. Our plan covers 90 days for a benefit period. A benefit period starts the day you go into an inpatient psychiatric hospital. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into an inpatient psychiatric hospital after one benefit period has ended, a new benefit period begins. You must pay the Inpatient Behavioral Health Care copays for each benefit period. There's no limit to the number of benefit periods. You have additional lifetime reserve days. If your hospital stay is longer than 90 days, you can use your lifetime reserve days, subject to the Medicare lifetime limit of 190 days. * Inpatient behavioral health care may require prior authorization; your plan provider will arrange for this authorization, if needed.	In-network: - Plan pays 100% of the approved amount Out-of-network: 30% coinsurance of the approved amount, after deductible - Services apply to the annual out-of-pocket maximum

Covered Service	What you pay
Laboratory and pathology tests Includes laboratory and pathology testing in all places of service.	In-network and Out-of-network: Plan pays 100% of the approved amount

Covered Service	What you pay
 Lung cancer screening with low dose computed tomography (LDCT) For qualified people, a LDCT is covered every 12 months. Eligible enrollees are: people age 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years (an average of one pack a day for 20 years) or who currently smoke or have quit smoking within the last 15 years, who get an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. <i>For LDCT lung cancer screenings after the initial LDCT screening:</i> the members must get 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 later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	In-network and Out-of-network: Plan pays 100% of the approved amount

Covered Service	What you pay
 Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during the first year that you get medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a physician's order. A physician must prescribe these services and renew the order yearly if your treatment is needed into the next calendar year.	In-network and Out-of-network: Plan pays 100% of the approved amount

Covered Service	What you pay
 Medicare Diabetes Prevention Program (MDPP) MDPP services are covered for eligible people under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	In-network and Out-of-network: • Plan pays 100% of the approved amount

Covered Service	What you pay
Medicare Part B drugs* These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you get 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. • The Alzheimer's drugs Leqembi® (generic name lecanemab) and Kinsula™ (generic name Donanemab-azbt), which are 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 about what scans and tests you may need as part of your treatment • Clotting factors you give yourself by injection if you have hemophilia • Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time you get immunosuppressive drugs. • Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug	<i>For Medicare Part B drugs administered at an outpatient facility:</i> In-network: • Plan pays 100% of the approved amount Out-of-network: • 10% coinsurance of the approved amount for each Medicare covered Part B drug and chemotherapy • Not subject to the deductible <i>For Medicare Part B drugs administered by a physician:</i> In-network: <u>In a physician's office</u> • \$0 copayment for primary care provider service • \$10 copayment for specialty care physician service • Services apply to the annual copayment out-of-pocket maximum • Protected members: Plan pays 100% of approved amount

Covered Service	What you pay
- 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 oral End-Stage Renal Disease (ESRD) drugs - Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiy[®] 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 End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen[®], Procrit[®], Epoetin Alfa, Aranesp[®] or Darbepoetin Alfa). - Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases	Out-of-network: <u>In a physician's office</u> 30% coinsurance of the approved amount, after you have met your deductible, for primary care or specialty care provider service - Services apply to the annual out-of-pocket maximum <i>For Medicare Part B prescription drugs administered in other settings:</i> In-network: - Plan covers certain drugs at 100% of the approved amount: - Oral anti-cancer drugs - Anti-nausea drugs - Immunosuppressive drugs following a Medicare covered transplant <u>In the home</u> - Plan pays 100% of the approved amount

Covered Service	What you pay												
Parenteral and enteral nutrition (intravenous and tube feeding) * Medicare Part B drugs may require prior authorization and/or step therapy; your plan provider will arrange for this authorization, if needed.	<u>At a retail pharmacy</u> <table><tr><th>Tier</th><th>1–31 day supply</th><th>32–62 day supply</th><th>63–90 day supply</th></tr><tr><td>Tier 1</td><td>\$0</td><td>\$0</td><td>\$0</td></tr><tr><td>Tier 2</td><td>10% up to max of \$33</td><td>10% up to max of \$66</td><td>10% up to max of \$99</td></tr></table> Protected members: Plan pays 100% of the approved amount Note: There is a \$500 out-of-pocket maximum for Medicare Part B drugs obtained at pharmacies. Protected members have a \$0 out-of-pocket maximum for Medicare Part B drugs. Out-of-network: 10% coinsurance of the approved amount for each Medicare covered Part B drug and chemotherapy - Services apply to the annual out-of-pocket maximum - Plan covers certain drugs at 100%: - Oral anti-cancer drugs - Anti-nausea drugs - Immunosuppressive drugs following a Medicare covered transplant <u>In the home</u> - Plan pays 100% of the approved amount	Tier	1–31 day supply	32–62 day supply	63–90 day supply	Tier 1	\$0	\$0	\$0	Tier 2	10% up to max of \$33	10% up to max of \$66	10% up to max of \$99
Tier	1–31 day supply	32–62 day supply	63–90 day supply										
Tier 1	\$0	\$0	\$0										
Tier 2	10% up to max of \$33	10% up to max of \$66	10% up to max of \$99										

Covered Service	What you pay
	Note: You won’t pay more than \$35 for one month’s supply of insulin, and \$105 for a three-month supply of insulin.

Covered Service	What you pay
 Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. 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 doctor or practitioner to find out more.	In-network and Out-of-network: • Plan pays 100% of the approved amount

Covered Service	What you pay
Online visits through Teladoc Health™ As part of your Medicare Advantage plan, we offer safe and secure Virtual Care. Virtual Care gives you medical, urgent, and behavioral health care through your phone, tablet, or computer from anywhere in the United States. Virtual urgent care visits from U.S. board-certified doctors are available 24/7, without an appointment. Virtual behavioral health visits are available by appointment from licensed behavioral health providers such as therapists, counselors, and U.S. board-certified psychiatrists. Virtual Care is available through Teladoc Health™, an independent company. This service is separate from any virtual care your doctor might offer. You can use Teladoc Health™ to access telehealth services. Visit www.bcbsm.com/virtualcare for more information or call 1-800-835-2362, available 24 hours a day, 7 days a week, 365 days a year. TTY users call 1-855-636-1578. Urgent general medical appointments available 24 hours a day, 7 days a week, 365 days a year (e.g., sore throat, fever, etc.) Mental health appointment availability is 7 days a week, 7 am to 9 pm local time. Providers will contact member directly. Appointments aren't conducted through the 800 number above.	For online medical and behavioral health services: • Plan pays 100% of the approved amount • Services must be received through Teladoc Health

Covered Service	What you pay
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through a Medicare-enrolled Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	In-network and Out-of-network: • Plan pays 100% of the approved amount

Covered Service	What you pay
Outpatient behavioral health care* Covered services include: Behavioral health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified behavioral health care professional as allowed under applicable state laws. * Outpatient behavioral health care may require prior authorization; your plan provider will arrange for this authorization, if needed.	In-network and Out-of-network: • Plan pays 100% of the approved amount • Unlimited visits

Covered Service	What you pay
Outpatient diagnostic tests and therapeutic services and supplies* Covered services include, but aren't limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies* • Surgical supplies, such as dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Non-radiological diagnostic procedures/tests (including but not limited to EKGs, pulmonary function tests, sleep studies, treadmill stress tests and other non-radiological tests) • High-tech radiology services (e.g., CAT scans, MRAs, MRIs, PET scans, echocardiography, or nuclear medicine) rendered by plan providers require prior authorization. * Outpatient diagnostic tests and therapeutic services and supplies may require prior authorization; your plan provider will arrange for this authorization, if needed.	In-network: • Plan pays 100% of the approved amount Out-of-network: • 30% coinsurance of the approved amount, after deductible • Services apply to the annual out-of-pocket maximum

Covered Service	What you pay
Outpatient hospital services* We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but aren't limited to: • Services in an outpatient clinic, such as observation services or outpatient surgery • Diagnostic tests billed by the hospital • Behavioral health care, 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 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 aren't sure if you're an outpatient, you should ask the hospital staff. * Outpatient hospital services may require prior authorization; your plan provider will arrange for this authorization, if needed.	In-network: • Plan pays 100% of the approved amount Out-of-network: • 30% coinsurance of the approved amount, after deductible • Services apply to the annual out-of-pocket maximum

Covered Service	What you pay
Outpatient rehabilitation services Covered services include: • Outpatient physical and speech therapy (at home or facility) • Outpatient occupational therapy (in a facility) Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	In-network: • Plan pays 100% of the approved amount Out-of-network: • 30% coinsurance of the approved amount, after deductible • Services apply to the annual out-of-pocket amount

Covered Service	What you pay
Outpatient substance use disorder services* Outpatient substance use disorder visits include counseling, detoxification, medical testing, and diagnostic evaluation. * Outpatient substance use disorder services may require prior authorization; your plan provider will arrange for this authorization, if needed.	In-network and Out-of-network: • Plan pays 100% of the approved amount • Unlimited days

Covered Service	What you pay
Outpatient surgery*, including services provided at hospital outpatient facilities and ambulatory surgical centers 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. * Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers, may require prior authorization; your plan provider will arrange for this authorization, if needed.	In-network: • Plan pays 100% of the approved amount Out-of-network: • 30% coinsurance of the approved amount, after deductible • Services apply to the annual out-of-pocket amount

Covered Service	What you pay
Partial hospitalization services and intensive outpatient services* <i>Partial hospitalization</i> is a structured program of active psychiatric treatment provided as a hospital outpatient service, or by a community behavioral health center, that's more intense than 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. <i>Intensive outpatient service</i> 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's 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. * Partial hospitalization services may require prior authorization; your plan provider will arrange for this authorization, if needed.	In-network and Out-of-network: • Plan pays 100% of the approved amount • Unlimited visits

Covered Service	What you pay
Physician/Practitioner services, including virtual visits with your own doctor A primary care practitioner can refer to a physician, nurse practitioner, clinical nurse specialist, or physician assistant. You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment • Consultation your doctor has with other doctors by telephone, internet, or electronic health record • Second opinion prior to surgery • Total body skin examination performed by a trained health care professional, usually a dermatologist, to search for any unusual or suspicious lesions or conditions on the skin's surface, including hands and arms, legs and feet, torso, scalp, inside of the mouth and external genital area. Covered once in a lifetime.	In-network: <u>Office Visits</u> • \$0 copayment for primary care provider • \$10 copayment for specialty care provider • Services apply to the annual out-of-pocket maximum • Protected members: Plan pays 100% of the approved amount <u>Rural health clinic</u> • Plan pays 100% of approved amount <u>Behavioral Health and Substance Use Disorder services</u> • Plan pays 100% of the approved amount Out-of-network: <u>Office Visits</u> • 50% coinsurance of the approved amount, after deductible for primary care and specialty care provider • Services apply to the annual out-of-pocket maximum

Covered Service	What you pay
Note: Provider offices or outpatient clinics owned and operated by hospitals (known as hospital-based practices) may cost you more.	<u>Rural health clinic:</u> • 50% coinsurance of the approved amount, after deductible • Services apply to the annual out-of-pocket maximum <u>Behavioral Health and Substance Use Disorder services</u> • Plan pays 100% of the approved amount

Covered Service	What you pay
Podiatry services* Covered services include: • Routine foot care for members with certain medical conditions affecting the lower limbs • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet • Conditions covered include, but aren't limited to, hammer toes, bunion deformities, heel spurs • Other services include preventive treatment of the foot, removal of corns and calluses, trimming, cutting, and clipping of nails and wart care, up to 6 visits per year * Podiatry services may require prior authorization; your plan provider will arrange for this authorization, if needed.	In-network: • \$10 copayment • Services apply to the annual copayment out-of-pocket maximum • Protected members: Plan pays 100% of approved amount Out-of-network: • 30% coinsurance of the approved amount for surgical services, after deductible • 50% coinsurance of the approved amount after deductible for evaluation and management services • Services apply to the annual out-of-pocket maximum

Covered Service	What you pay
 Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug. • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to 8 HIV screenings every 12 months. A one-time hepatitis B virus screening.	In-network and Out-of-network: • Plan pays 100% of the approved amount

Covered Service	What you pay
 Prostate cancer screening exams For aged 50 and older, covered services include the following - once every 12 months: - Digital rectal exam - Prostate Specific Antigen (PSA) test	In-network: - Plan pays 100% of the approved amount Out-of-network: <u>Digital rectal exam</u> 30% coinsurance of the approved amount - Not subject to the deductible - Services apply to the out-of-pocket maximum <u>Prostate specific antigen (PSA) test</u> - Plan pays 100% of the approved amount

Covered Service	What you pay
Prosthetic and orthotic devices and related supplies* Devices (other than dental) that replace all or part of a body part or function. These include but aren't limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery. Go to <i>Vision Care</i> later in this table for more details. Note: 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. * Prosthetic devices and related supplies may require prior authorization; your plan provider will arrange for this authorization, if needed.	In-network and Out-of-network: Plan pays 100% of the approved amount

Covered Service	What you pay
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) or chronic respiratory disease and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	In-network: • Plan pays 100% of the approved amount Out-of-network: • 30% coinsurance of the approved amount, after deductible • Services apply to the annual out-of-pocket maximum

Covered Service	What you pay
 Screening and counseling to reduce alcohol misuse We cover 1 alcohol misuse screening for adults who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	In-network and Out-of-network: • Plan pays 100% of the approved amount

Covered Service	What you pay
 Screening for Hepatitis C virus infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. If you were born between 1945-1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	In-network and Out-of-network: • Plan pays 100% of the approved amount

Covered Service	What you pay
 Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (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. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30-minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We'll only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	In-network and Out-of-network: Plan pays 100% of the approved amount

Covered Service	What you pay
Services to treat kidney disease* Covered services include: • 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, we cover 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 Chapter 3, 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 • Certain home support services when necessary (such as visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B drugs, go to <i>Medicare Part B drugs</i> in this table. * Services to treat kidney disease may require prior authorization; your plan provider will arrange for this authorization, if needed.	In-network and Out-of-network: <u>Dialysis</u> • Plan pays 100% of the approved amount, after deductible <u>Home dialysis equipment and kidney disease education services</u> • Plan pays 100% of the approved amount • Not subject to deductible

Covered Service	What you pay
SilverSneakers® 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. Benefits include: • 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 • SilverSneakers Community gives you options to get active outside of traditional gyms (like recreation centers, malls, and parks) • Online fitness tips and healthy eating information • Social connections through events such as shared meals, holiday celebrations, and class socials	Included in the plan at participating facilities

Covered Service	What you pay
Fitness services must be provided at SilverSneakers participating locations. You can find a location or request information at www.silversneakers.com to learn more or call 1-866-584-7352, 8 am to 8 pm Eastern time, Monday through Friday. TTY users call 711. SilverSneakers is a registered trademark of Tivity Health, Inc. © 2025 Tivity Health, Inc. All rights reserved.	

Covered Service	What you pay
Skilled nursing facility (SNF) care* No prior hospital stay or renewal period is required. Covered services include, but aren't limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of our plan of care, including substances that are naturally present in the body, such as blood clotting factors (does not include self-administered drugs) • Medical and surgical supplies ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services • Generally, you'll 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 our plan's amounts for payment.	In-network: • Plan pays 100% of the approved amount • Unlimited days Out-of-network: • 30% coinsurance of the approved amount, after deductible • Services apply to the annual out-of-pocket maximum • Unlimited days

Covered Service	What you pay
○ 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. For a definition of skilled nursing facility care, go to Chapter 10. Skilled nursing facilities are sometimes called SNFs. * Skilled nursing care may require prior authorization; your plan provider will arrange for this authorization, if needed.	

Covered Service	What you pay
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD). Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or 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 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 health care provider.	In-network: • Plan pays 100% of the approved amount Out-of-network: • 30% coinsurance of the approved amount, after deductible • Services apply to the annual out-of-pocket maximum

Covered Service	What you pay
Urgent care, including retail health clinics A plan-covered service requiring immediate medical attention that’s not an emergency is an urgently needed service if either you’re temporarily outside our plans service area, or even if you’re inside the service area of the plan, it’s unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. 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 our plan’s service area or our plan network is temporarily unavailable. For information about emergent or urgently needed medical items and services furnished outside of the United States and its territories, see <i>Worldwide Coverage</i>.	In-network and Out-of-network: • \$15 copayment per visit • Services apply to the annual copayment out-of-pocket maximum

Covered Service

What you pay

Vision care

Your UAW Trust vision care services are provided through Davis Vision. For more information on your vision care coverage, contact Davis Vision at [1-888-234-5164](tel:1-888-234-5164) (TTY users call 1-800-523-2847)

Davis Vision is an independent company. It does not provide Blue Cross Blue Shield of Michigan products or services to Trust members.

Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts.

Services covered by Medicare Plus Blue Group include:

- One routine eye exam per 12 months through a VSP participating provider/location.
- Physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration.
- For people with diabetes, screening for diabetic retinopathy is covered once per year.
- One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you can't reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.)
- A 20% discount is included for the member to purchase frames/lenses at a VSP participating provider/location.

In-network:

Routine eye exams (covered by VSP)

- \$20 copayment
- Services apply to the annual copayment out-of-pocket maximum
- **Protected members:** Plan pays 100% of approved amount

Diabetic eye exams

- Plan pays 100% of the approved amount

Diagnosis and treatment of diseases/conditions of the eye

- \$10 copayment
- Services apply to the annual copayment out-of-pocket maximum
- **Protected members:** Plan pays 100% of the approved amount

Covered Service	What you pay
	<u>Corrective lenses following cataract surgery</u> - Plan pays 100% of the approved amount <u>Annual glaucoma screening</u> - Plan pays 100% of the approved amount Out-of-network: <u>Diabetic eye exams</u> - Plan pays 100% of the approved amount <u>Diagnosis and treatment of diseases/conditions of the eye</u> 50% coinsurance of the approved amount, after deductible - Services apply to the annual out-of-pocket maximum <u>Corrective lenses following cataract surgery</u> - Plan pays 100% of the approved amount <u>Annual glaucoma screening</u> - Plan pays 100% of the approved amount

Covered Service	What you pay
 Welcome to Medicare preventive visit Our plan covers the one-time Welcome to Medicare preventive visit. The visit 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. Important: We cover the Welcome to Medicare preventive visit within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you want to schedule your Welcome to Medicare preventive visit.	In-network and Out-of-network: • Plan pays 100% of the approved amount • An office visit copay may apply if the covered service (i.e., diagnostic test) is outside the scope of the Welcome to Medicare preventive visit.

Covered Service	What you pay
Worldwide Coverage Medicare Plus Blue Group PPO includes coverage of emergent or urgently needed medical items and services furnished outside of the United States and its territories. Blue Cross Blue Shield Global Core allows our members to find doctors, hospitals and resources outside of the U.S., Puerto Rico and the U.S. Virgin Islands. You may be responsible for the difference between the approved amount and the provider's charge. To register on the website, go to https://www.bcbsglobalcore.com To download the mobile app, go to https://www.bcbsglobalcore.com/Home/MobileApp/	Plan pays 80% of the approved amount up to the maximum annual benefit of \$25,000 or 60 consecutive days, whichever is reached first

Covered Service	What you pay
<i>Other Services</i>	
Wigs, wig stand, adhesive Wigs must be prescribed by a physician for hair loss resulting from any medical condition or treatment. Up to a \$250 annual maximum	In-network and Out-of-network: Plan pays 100% of the approved amount

SECTION 3 What services aren't covered by the plan?

Section 3.1 Services we don't cover (exclusions)

This section tells you what services are excluded from Medicare coverage and therefore, aren't covered by this plan.

The chart below lists services and items that either aren't 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 receive the excluded services at an emergency facility, the excluded services are still not covered, and our plan won't pay for them.

The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3 in this document).

Services not covered by Medicare	Covered only under specific conditions
Acupuncture	Available for people with chronic low back pain under certain circumstances.
Cosmetic surgery or procedures	Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Custodial care Custodial care is personal care that doesn't require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as cleaning, cooking, bathing, or dressing.	Not covered under any condition

Services not covered by Medicare	Covered only under specific conditions
Experimental medical and surgical procedures, equipment, and medications	May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (Go to Chapter 3, Section 5 for more information on clinical research studies)
Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.	
Fees charged for care by your immediate relatives or members of your household.	Not covered under any condition
Full-time nursing care in your home.	Not covered under any condition
Hearing aid batteries, repairs, adjustments or reconfigurations.	Not covered under any condition
Home-delivered meals	Available to members engaged with a Blue Cross Coordinated Care nurse, and discharged from a medical or surgical hospital or behavioral health admission within the past 30 days. This program offers 14 days of meals (28 meals). Observation stays, rehabilitation facilities or outpatient stays aren't eligible.
Homemaker services include basic household help, including light housekeeping or light meal preparation	Not covered under any condition
Naturopath services (uses natural or alternative treatments)	Not covered under any condition
Non-routine dental care	Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Orthopedic shoes or supportive devices for the feet	Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	Not covered under any condition
Private room in a hospital.	Covered only when medically necessary.
Reversal of sterilization procedures and or non-prescription contraceptive supplies	Not covered under any condition

Services not covered by Medicare	Covered only under specific conditions
Routine chiropractic care	Manual manipulation of the spine to correct a subluxation is covered.
Radial keratotomy, LASIK surgery, and other low vision aids	One pair of eyeglasses with standard frames (or one set of contact lenses) covered after each cataract surgery that implants an intraocular lens.
Routine dental care, such as cleanings, fillings, or dentures	Not covered under any condition
Routine foot care	Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes).
Routine hearing exams, hearing aids, or exams to fit hearing aids	Not covered under any condition
Services considered not reasonable and necessary, according to Original Medicare standards	Not covered under any condition

CHAPTER 5:

Asking us to pay our 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. Other times, you may pay more than you expected under the coverage rules of our plan or you may get a bill from a provider. In these cases, you can ask our plan to pay you back (reimburse you). It's your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services covered by our plan. There may be deadlines that you must meet to get paid back. 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 cost sharing. First refer to your Explanation of Benefits (EOB) and 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.

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

1. When you got medical care from a provider who isn't in our plan's network

When you get care from a provider who isn't 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 the plan for our 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, you need to ask us to pay you back for our 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 don't 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 our 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 can't pay a provider who isn't eligible to participate in Medicare. If the provider isn't eligible to participate in Medicare, you'll be responsible for the full cost of the services you got.

2. When a network provider sends you a bill you think you shouldn't pay

Network providers should always bill our plan 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 don't 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 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 you think is more than you should pay, send us the bill. We'll contact the provider directly and resolve the billing problem.
- If you already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under our plan.

3. If you're retroactively enrolled in our plan

Sometimes a person's enrollment in our plan is retroactive. (This means that the first day of their enrollment has already passed.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any covered services after your enrollment date, you can ask us to pay you back for our 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

You can ask us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

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'll help us process the information faster.
 - The following information is necessary to help us process your claim if you don't use the claim form:
 - Enrollee/member ID
 - Name of Patient
 - Date(s) of service
 - Who provided the service (doctor or facility name), phone number, Tax ID and National Provider Identifier (or NPI)
 - Amount charged for each service
 - Procedure code (the description of service) AND diagnosis code (the reason for the visit)
 - Proof of payment (i.e., an itemized statement from your provider that shows the amount paid. Cash register receipts and canceled checks are accepted as proof of payment in certain cases. Money orders and personal itemizations aren't accepted as proof of payment.)
- Download a copy of the form from our website ([**www.bcbsm.com/uawtrust**](http://www.bcbsm.com/uawtrust)) or call Customer Service at 1-888-322-5616 (TTY users call 711), Monday through Friday, 8 am – 7 pm Eastern time and ask for the form.

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

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

SECTION 3 We'll 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 for 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 isn't covered, or you did *not* follow all the rules, won't pay for our share of the cost. We'll send you a letter explaining the reasons why we aren't 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 Our plan must honor your rights and cultural sensitivities

Section 1.1 We must provide information in a way that works for you (in languages other than English, in large print, or other alternate formats, etc.)

Our 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 our plan may meet these accessibility requirements include, but aren't limited to: provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in 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, please call Customer Service at 1-888-322-5616 (TTY users call 711), Monday through Friday, 8 am – 7 pm Eastern time.

Our 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 health care services.

If providers in the plan's network for a specialty aren't available, it's our 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 our plan's network that cover a service you need, call the plan for information on where to go to get this service at in-network cost sharing.

If you have any trouble getting information from our plan 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 Medicare Plus Blue Group PPO Customer Service at 1-888-322-5616 (TTY users call 711), Monday through Friday, 8 am – 7 pm Eastern time. You can also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 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 in our plan's network. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral and still pay the in-network cost-sharing amount.

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 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 gave us 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, called a "Notice of Privacy Practice," 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 get written permission from you or someone you have given legal power to make decisions for you first*.
- There are certain exceptions that don't require us to get your written permission first. 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 our 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's been shared with others

You have the right to look at your medical records held by the 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 health care 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 aren't routine.

If you have questions or concerns about the privacy of your personal health information, please call Customer Service at 1-888-322-5616 (TTY users call 711), Monday through Friday, 8 am – 7 pm Eastern time.

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

NOTICE OF PRIVACY PRACTICES

FOR MEMBERS OF OUR NONGROUP AND UNDERWRITTEN GROUP PLANS INCLUDING MEDICARE ADVANTAGE AND PRESCRIPTION DRUG PLANS

**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 health care 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, race/ethnicity, language, gender identity and sexual orientation 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 health care 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'll allow it to be used and given out ("disclosed"). We must follow the privacy practices described in this notice while it's 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'll provide a revised notice to our subscribers.

Where multiple state or federal laws protect the privacy of your PHI, we'll 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 health care providers (doctors, dentists, pharmacies, hospitals, and other caregivers) who request it in connection with your treatment. For example, we may disclose your PHI to health care 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 health care providers and other health plans, including:
 - Obtaining premium payments and determining eligibility for benefits
 - Paying claims for health care services that are covered by our health plan
 - Responding to inquiries, appeals and grievances
 - Coordinating benefits with other insurance you may have
- **For health care operations:** We may use and disclose your PHI for our health care 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 health care operations. For example, we may disclose your PHI for their quality assessment and improvement activities or for health care fraud and abuse detection.

Note: We will not 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 health care or payment for health care. 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'll use and disclose your PHI if we're required to do so by law. For example, we'll use and disclose your PHI in responding to court and administrative orders and subpoenas, and to comply with workers' compensation laws. We'll 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 health care 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'll 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 health care 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 BCBSM 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 www.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'll 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 aren't 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 health care 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 health care operations. We aren't required to agree to these additional restrictions; but if we do, we'll 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'll 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'll 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'll 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 [**www.bcbsm.com**](http://www.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 [**www.bcbsm.com**](http://www.bcbsm.com).

You also may submit a written complaint to the U.S. Department of Health and Human Services. We'll 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 Review 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, call Customer Service at 1-888-322-5616 (TTY users call 711), Monday through Friday, 8 am – 7 pm Eastern time:

- **Information about our 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.** Chapters 3 and 4 provide information regarding medical services.
- **Information about why something isn't covered and what you can do about it.** Chapter 7 provides information on asking for a written explanation on why a medical service isn't covered or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 We must support your right to make decisions about your care

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 health care 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 health care. 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 of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our 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's to be done if you can't make medical decisions for yourself

Sometimes people become unable to make health care 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.
- **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 of these situations are called **advance directives**. Documents like a **living will** and **power of attorney for health care** are examples of advance directives.

How to set up an advance directive to give your 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 call Customer Service at 1-888-322-5616 (TTY users call 711), Monday through Friday, 8 am – 7 pm Eastern time to ask for the forms.
- **Fill out the form and sign it.** No matter where you get this form, it's 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 makes 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 have signed an advance directive form and whether you have it with you.
- If you didn't sign 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 or not you signed an advance directive.

If your instructions aren't followed

If you sign an advance directive, and you believe that a doctor or hospital didn't follow the instructions in it, you can file a complaint with:

Alabama Members:

Alabama Department of Insurance – Contact Information	
Call	1- 334-269-3550
Write	P.O. Box 303351 Montgomery, AL 36130-3351
Website	www.aldoi.gov/ContactUs.aspx

Florida Members:

Florida Medical Quality Assurance (FMQA) – Contact Information	
Call	1-850-642-3195
Write	Department of Health 4052 Bald Cypress Way, Bin C75 Tallahassee, FL 32399-3260
FAX	1-850-488-0796
Website	www.floridahealth.gov/licensing-and-regulation/enforcement/report-unlicensed-activity/file-a-complaint.html

Indiana Members:

Indiana Department of Insurance – Contact Information	
Call	1-800-622-4461
Write	Indiana Department of Insurance Consumer Service Department 311 West Washington Street, Suite 300 Indianapolis, IN 46204-2787
FAX	1-317-234-2103
Website	www.in.gov/idoi/2547.htm

Michigan Members:

Michigan Department of Community Health – Contact Information	
Call	1-800-642-3195
Write	333 S. Grand Ave. P.O. Box 30195 Lansing, Michigan 48909
Website	www.michigan.gov/mdhhs

Section 1.6 You have the right to make complaints and ask us to reconsider decisions we have 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 aren’t 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 users call 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’re having from these places:

- **Call Customer Service at 1-888-322-5616 (TTY users call 711), Monday through Friday, 8 am – 7 pm Eastern time.**
- **Call your local SHIP** (For the SHIP in your state, go to Chapter 2, Section 3).
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048).

Section 1.8 How to get more information about your rights

Get more information about your rights from these places:

- **Call Customer Service at 1-888-322-5616 (TTY users call 711), Monday through Friday, 8 am – 7 pm Eastern time.**
- **Call your local SHIP** (For the SHIP in your state, go to Chapter 2, Section 3).
- **Contact Medicare.**
 - Visit www.Medicare.gov to read the publication *Medicare Rights & Protections* (available at <https://www.medicare.gov/publications/11534-medicare-rights-and-protections.pdf>) .
 - **Call Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048).

SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, please call Customer Service at 1-888-322-5616 (TTY users call 711), Monday through Friday, 8 am – 7 pm Eastern time..

- **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’s covered and the rules you need to follow to get covered services.
 - Chapters 3 and 4 give details about medical services.
- **If you have any other health coverage in addition to our plan, or separate drug coverage, you’re required to tell us.**
- **Tell your doctor and other health care providers that you’re enrolled in our plan.** Show our plan membership 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 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 continue to pay your Medicare Part B premium to stay a member of our plan.
 - For some of your medical services covered by our plan, you must pay your share of the cost when you get the service.
- **If you move *within* our plan service area, we need to know** so we can keep your membership information up to date and know how to contact you.
- **If you move *outside* of our plan service area, you can't stay a member of our plan.**
- **If you are considering moving outside of the plan service area, you must immediately contact Retiree Health Care Connect (RHCC) at 1-866-637-7555.**
- **If you move, tell Social Security.**

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 2 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 to do.

Section 1.2 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 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 Customer Service at 1-888-322-5616 (TTY users call 711), Monday through Friday, 8 am – 7 pm Eastern time, for help. In some situations, you may also want help or guidance from someone who isn't 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 isn't 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. You will find phone numbers and website URLs in Chapter 2, Section 3.

Medicare

You can also contact Medicare for help:

- Call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.
- Visit www.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 Part B drugs) are covered or not, the way they're covered, and problems related to payment for medical care.

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 (services, items and Part B drugs, including payment). To keep things

simple, we generally refer to medical items, services and Medicare Part B 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 you get services

If you want to know if we'll cover a 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, our plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either your network doctor can show that 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'll 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 invalid 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're making a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we might decide medical care isn't 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 aren't 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 have 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 invalid 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'll

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 don't need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we don't 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 aren't satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.1 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 Customer Service at 1-888-322-5616 (TTY users call 711), Monday through Friday, 8 am – 7 pm Eastern time.**
- **Get free help** from your State Health Insurance Assistance Program.
- **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 Customer Service at 1-888-322-5616 (TTY users call 711), Monday through Friday, 8 am – 7 pm Eastern time, and ask for the *Appointment of Representative* form. (The form is also available at www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf).
 - For medical care or Part B 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 Customer Service at 1-888-322-5616 (TTY users call 711), Monday through Friday, 8 am – 7 pm Eastern time, and ask for the *Appointment of Representative* form. (The form is also available at www.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 can't 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 aren't 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 3 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. 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 health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)*

If you're not sure which information applies to you, call Customer Service at 1-888-322-5616 (TTY users call 711), Monday through Friday, 8 am – 7 pm Eastern time. You can also get help or information from your SHIP.

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 our share of the cost of your care

Your benefits for medical care are described in Chapter 4 in the Medical Benefits. In some cases, different rules apply to ask for a Part B drug. In those cases, we'll explain how the rules for Part B 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 5 following situations:

1. You aren't getting certain medical care you want, and you believe that this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**
2. Our plan won't approve the medical care your doctor or other medical provider wants to give you, and you believe this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**
3. You got medical care that you believe should be covered by our plan, but we have said we won't pay for this care. **Make an Appeal. Section 5.3.**
4. You got and paid for medical care that you believe should be covered by our plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5.**
5. You're 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 health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, go to Sections 6 and 7 of this Chapter. Special rules apply to these types of care.

Section 5.2

How to ask for a coverage decision

(how to ask our plan to authorize or provide the medical care coverage you want)

Legal Terms:

A coverage decision that involves your medical care is called an **organization determination**.

A fast coverage decision is 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 7 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 Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. To get a fast coverage decision, you must meet 2 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'll decide whether your health requires that we give you a fast coverage decision.** If we don't 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 our plan to make a coverage decision or fast coverage decision.

- Start by calling, writing, or faxing our 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 7 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 receive get your request. If your request is for a Part B 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 Part B drug.
- If you believe we shouldn't 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 Part B 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 Part B drug.
- If you believe we *shouldn't* 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 our 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 7 calendar days for Part B 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 our plan for an appeal or a fast appeal

- **If you're asking for a standard appeal, submit your standard appeal in writing.** You may also ask for an appeal by calling us. 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 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 our 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 us to.
 - 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 Part B drug.
 - If we don't 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 provide within 72 hours after we get 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 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 Part B drug you didn't get yet,, we'll give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if your health condition requires us to.
 - 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 Part B drug.
 - If you believe we shouldn't 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 for information on complaints).
 - If we don't 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 7 calendar days** if your request is for a Part B drug.
- **If our 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 isn't connected with us and isn't 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 of the information related to your appeal.

If you had a fast appeal at Level 1, you'll 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 receives 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 Part B 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 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 Part B drug, the review organization must give you an answer to your Level 2 appeal **within 7 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 Part B 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 Medicare Part B prescription drug**, we must authorize or provide the Part B 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 receive the decision from the 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 shouldn't be approved. (This is called **upholding the decision** or **turning down your appeal**). In this case, the independent review organization will send you a letter:
 - 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 3 additional levels in the appeals process after Level 2 (for a total of 5 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 Level 3, 4, and 5 appeals processes.

Section 5.5 If you're asking us to pay you for our share of a bill you have received 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 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 all the rules, we'll send you the payment for the cost typically within 30 calendar days, but no later than 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 isn't 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 don't 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 have already received and paid for, you aren't 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 your covered hospital services necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff work with you to prepare for the day you leave the hospital. They'll 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'll get a written notice from Medicare that tells you about your rights

Within 2 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 don't 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 Customer Service at 1-888-322-5616 (TTY users call 711), Monday through Friday, 8 am – 7 pm Eastern time or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

1. Read this notice carefully and ask questions if you don't understand it. It tells you about:

- Your right to receive 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 that we'll cover your hospital care for a longer time.

2. You will be asked to sign the written notice to show that you received 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 have received 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 handy 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'll get another copy before you're scheduled to be discharged.
- To look at a copy of this notice in advance, you can call Customer Service at 1-888-322-5616 (TTY users call 711), Monday through Friday, 8 am – 7 pm Eastern time or 1-800-MEDICARE (1-800-633-4227. TTY users call 1-877-486-2048. You can also see the notice online at 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 covered 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 Customer Service at 1-888-322-5616 (TTY users call 711), Monday through Friday, 8 am

– 7 pm Eastern time. Or call your State Health Insurance Assistance Program, a government organization that provides personalized help (Go to Chapter 2, Section 3).

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

The **Quality Improvement Organization** is a group of doctors and other health care 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 aren't part of our plan.

Step 1: Contact the Quality Improvement Organization 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 Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *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 Quality Improvement Organization.
 - **If you don't 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 hospital discharge the Quality Improvement Organization 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 Customer Service at 1-888-322-5616 (TTY users call 711), Monday through Friday, 8 am – 7 pm Eastern time or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048). Or you can see a sample notice online at www.cms.gov/Medicare/forms-notice/beneficiary-notice-initiative/ffs-ma-im.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

- Health professionals at the Quality Improvement Organization (“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 and we 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’s 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 Quality Improvement Organization 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 Quality Improvement Organization 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, then **you may have to pay the full cost** of hospital care you get after noon on the day after the Quality Improvement Organization 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 Quality Improvement Organization 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 Quality Improvement Organization to take another look at its decision on your first appeal. If the Quality Improvement Organization 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 Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization 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 Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization 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 have got since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **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 3 additional levels in the appeals process after Level 2 (for a total of 5 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 9 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 health 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 the three types of care for you, we're required to tell you in advance. When your coverage for that care ends, *we'll 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'll 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 2 calendar days before our plan is going to stop covering your care. The notice tells you:
 - The date when we'll 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 doesn't mean you agree** with our plan's decision to stop care.

Section 7.2 How to make a Level 1 appeal to have our 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 Customer Service at 1-888-322-5616 (TTY users call 711), Monday through Friday, 8 am – 7 pm Eastern time. Or call your State Health Insurance Assistance Program, a government organization that provides personalized help (Go to Chapter 2, Section 3).

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

The **Quality Improvement Organization** is a group of doctors and other health care 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 aren't part of our plan.

Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization 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 Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- You must contact the Quality Improvement Organization 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 Quality Improvement Organization using the contact information on the *Notice of Medicare Non-coverage*. The name, address, and phone number of the Quality Improvement Organization for your state may also be found in Chapter 2.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

Legal Term:

Detailed Explanation of Non-Coverage. Notice that gives details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization (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 our 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 its 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's 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 health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you'll 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 7.3 How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or 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 Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day when the Quality Improvement Organization 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 Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at 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 its 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's 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 3 additional levels of appeal after Level 2, for a total of 5 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 Level 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 can't 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 3 levels of appeal work in much the same way at the first 2 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's 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 don't 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 don't 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 the **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 customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you got (including care in the hospital)?
Respecting your privacy	• Did someone disrespect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Customer Service? • Do you feel you're being encouraged to leave our plan?

Complaint	Example
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Customer Service or other staff at our plan? ○ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• 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 <i>timeliness</i> of our actions about coverage decisions and appeals)	If you already asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a fast coverage decision or a fast appeal, and we said no; you can make a complaint. • You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we aren't meeting deadlines for covering or reimbursing you for certain medical items or services or drugs 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.

- **Usually, calling Customer Service at 1-888-322-5616 (TTY users call 711), Monday through Friday, 8 am – 7 pm Eastern time is the first step.** If there's anything else you need to do, Customer Service will let you know.
- **If you don't 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.
- 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 don't agree** with some or all of 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

When your complaint is about quality of care, you have 2 extra options:

- **You can make your complaint directly to the Quality Improvement Organization.**
- The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization 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 **www.Medicare.gov/my/medicare-complaint**. You can also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 8:

Ending membership in our plan

SECTION 1 Ending your membership in our 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 our plan because you decide that you *want* to leave. Sections 2 and 3 give information on ending your membership voluntarily.
- There are also limited situations where we're required to end your membership. Section 5 tells you about situations when we must end your membership.

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

You can end your membership in Medicare Plus Blue Group PPO at any time. Notify **Retiree Health Care Connect** at 1-866-637-7555, Monday through Friday 8:30 am to 4:30 pm Eastern time (TTY users, call 711), that you would like to disenroll from our plan. They will contact us and we'll take the necessary steps to cancel your membership.

If you decide to disenroll from our plan and enroll in an individual Medicare Advantage plan, Original Medicare, or another retiree medical benefits administrator-sponsored Medicare Advantage plan, you may want to verify that your disenrollment from our plan aligns with the timeframe for enrolling in the new plan. This will help you avoid a lapse in health care coverage.

SECTION 2 Until your membership ends, you must keep getting your medical items and services through our plan

Until your membership ends, and your new Medicare coverage starts, you must continue to get your medical items, services through our plan.

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

SECTION 3 Medicare Plus Blue Group PPO must end your membership in the plan in certain situations

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

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.
- If you're temporarily absent (out of the service area or out of the country) for more than 12 consecutive months and CMS receives notification.
- If you move or take a long trip, call Customer Service at 1-888-322-5616 (TTY users call 711), Monday through Friday, 8 am – 7 pm Eastern time to find out if the place you're moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you're no longer a United States citizen or lawfully present in the United States.
- If you intentionally give us incorrect information when you're enrolling in our plan and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first)
- If 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 our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first)
- If you let someone else use your membership card to get medical care. (We can't make you leave our plan 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.

If you have questions or want more information on when we can end your membership call Customer Service at 1-888-322-5616 (TTY users call 711), Monday through Friday, 8 am – 7 pm Eastern time.

Section 3.1 We can't ask you to leave our plan for any reason related to your health

Medicare Plus Blue Group PPO isn't allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

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

Section 3.2 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. 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* and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws aren't included or explained in this document. The principal law that applies to this 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 aren't 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 our 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 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 Department of Health and Human Services' Office for Civil Rights at www.HHS.gov/ocr/index.html.

If you have a disability and need help with access to care, please call Customer Service at 1-888-322-5616 (TTY users call 711), Monday through Friday, 8 am – 7 pm Eastern time. 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 isn't 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 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:

1. Any award, settlement, benefits, or other amounts paid under any workers' compensation law or award;
2. 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;
3. Any arbitration awards, payments, settlements, structured settlements, or other benefits or amounts paid under an uninsured or under insured motorist coverage policy; or
4. 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.

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.

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:

1. Responding to requests for information about any accidents or injuries;

2. Responding to our requests for information and providing any relevant information that we have requested; and
3. 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 our 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 our plan.

We aren't 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

Administration Fee – The cost associated with giving you an injection.

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 doesn't exceed 24 hours.

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

Approved Amount – The dollar amount Blue Cross Blue Shield of Michigan has agreed to pay for health care services covered by your plan. It may be more or less than the actual amount a doctor or supplier charges. Any required 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 our plan's allowed cost-sharing amount. As a member of Medicare Plus Blue Group PPO, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We don't allow providers to "balance bill" or otherwise charge you more than the amount of cost sharing our plan says you must pay.

Benefit Period – The way that both our plan and Original Medicare measure your use of skilled nursing facility (SNF) services. A benefit period begins the day you go into a skilled nursing facility. The benefit period ends when you haven't gotten any skilled care in a SNF for 60 days in a row. If you go into a skilled nursing facility after one benefit period has ended, a new benefit period begins. There's no limit to the number of benefit periods.

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

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services after you pay any deductibles.

Combined Maximum Out-of-Pocket Amount – This is the most you'll pay in a year for all Part A and Part B services from both network (preferred) providers and out-of-network (non-preferred) providers. See Chapter 4, Section 1 for information about your combined maximum out-of-pocket amount.

Complaint – The formal name for making a complain” is **filing a grievance**. The complaint process is used 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 doesn’t 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 and speech-language pathology services, and home environment evaluation services.

Copayment (or copay) – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor’s visit, hospital outpatient visit. A copayment is a set amount (for example \$10), rather than a percentage.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services are received. Cost sharing includes any combination of the following 3 types of payments: (1) any deductible amount a plan may impose before services are covered; (2) any fixed “copayment” amount that a plan requires when a specific service is gotten; or (3) any “coinsurance” amount, a percentage of the total amount paid for a service that a plan requires when a specific service is gotten.

Covered Services – The term we use to mean all of the health care services and supplies that are covered by our plan.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you don’t need skilled medical care or skilled nursing care. Custodial care provided by people who don’t 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. Medicare doesn’t pay for custodial care.

Customer Service – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 Section 1 for information about how to contact Customer Service.

Deductible – The amount you must pay for health care before our plan pays.

Disenroll or Disenrollment – The process of ending your membership in our plan.

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 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.

Evidence of Coverage (EOC) and Disclosure Information – This document 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 our plan.

Extra Help – A Medicare or a state program to help people with limited income and resources pay Medicare prescription drug program costs, such as deductibles and coinsurance.

Grievance – A type of complaint you make about our plan or providers, including a complaint concerning the quality of your care. This doesn't involve coverage or payment disputes.

Home Health Aide – A person who provides services that don't 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 bloodstream, rather than orally, in lieu of receiving the same treatment in a hospital setting. Types of infusion include, but aren't 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 6 months or less. Our plan must provide you with a list of hospices in your geographic area. If you elect hospice you're still a member of our plan. You can still get all medically necessary services as well as the supplemental benefits we offer.

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 Inpatient Stay – A hospital stay when you’ve 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.”

Maximum Out-of-Pocket – The most you’ll pay for covered Part A and Part B services gotten from providers. After you have reached this limit, you won’t have to pay anything when you get covered services from network providers for the rest of the contract year. However, until you reach your combined out-of-pocket amount, you must continue to pay your share of the costs when you seek care from an out-of-network (non-preferred) provider.

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 health care 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 an i) HMO, ii) PPO, iii) a Private Fee-for-Service (PFFS) plan, or a iv) Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called Medicare Advantage Plans with Prescription Drug Coverage.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all the services that are covered by Medicare Part A and Part B.

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 our plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Member (Member of our Plan, or Plan Member) – A person with Medicare who is eligible to get covered services, who has enrolled in our 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 health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. **Network providers** have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called “plan providers.”

Organization Determination – A decision our 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 (“Traditional Medicare” or “Fee-for-Service” Medicare) – Original Medicare is offered by the government, and not a private health plan such as Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. 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 United States.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that doesn’t have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that aren’t employed, owned, or operated by our 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 or drugs gotten is also referred to as the member’s “out-of-pocket” cost requirement.

Part C – Go to Medicare Advantage (MA) Plan

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization 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. Member cost sharing will generally be higher when plan benefits are gotten from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Preventive Services – Health care 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).

Primary Care Provider (PCP) – The doctor, nurse practitioner, clinical nurse specialist, physician assistant or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization – Approval in advance to get covered services. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other network provider gets “prior authorization” from our plan. In a PPO, you don't need prior authorization to get out-of-network services. However, you may want to check with our plan before getting services from out-of-network providers to confirm that the service is covered by our plan 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 health care experts paid by the federal government to check and improve the care given to Medicare patients.

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

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. Our plan must disenroll you if you permanently move out of our plan's service area.

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.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you move into a nursing home, or if we violate our contract with you.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits aren't the same as Social Security benefits.

Therapeutic Radiology – Therapeutic radiology (also called radiation oncology or radiation therapy) is the treatment of cancer and other diseases with radiation.

Therapy limits/thresholds – Outpatient rehabilitation services therapy limits/thresholds apply to certain outpatient provider settings including but not limited to outpatient hospital, critical access hospital settings and home health for certain therapy providers, such as privately practicing therapists and certain home health agencies for those members not under a home health plan of care. Both in and out-of-network deductibles and copayments count towards the therapy limits/thresholds. Therapy services may be extended beyond the therapy limits/thresholds if documented by the provider as medically necessary.

Urgently Needed Services – A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or it's unreasonable given your time, place, and circumstances to obtain this service from network providers. 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 our plan's service area or our plan network is temporarily unavailable.

Please contact our UAW Trust Medicare Advantage Service Center at 1-888-322-5616 for additional information. (TTY users should call 711) Hours are Monday through Friday, 8:00 a.m. – 7:00 p.m. Eastern time. Calls to this number are free.

UAW Trust Medicare Advantage Service Center also has free language interpreter services available for non-English speakers.

www.bcbsm.com/uawtrust

State Health Insurance Assistance Program

Please see Chapter 2 Section 3 of this document.

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