January 1 – December 31, 2027

University of Michigan
Evidence of Coverage for 2027:

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, 2027. **This is an important legal document. Keep it in a safe place.**

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

- Your plan premium and cost sharing
- Your medical benefits
- How to file a complaint if you're not satisfied with a service or treatment
- How to contact us
- Other protections required by Medicare law

For questions about this document, call Customer Service at 1-855-669-8040 (TTY users call 711). Hours are 8 a.m. to 5:30 p.m. Eastern time, Monday through Friday. From October 1 through March 31, hours are from 8 a.m. to 8 p.m. Eastern time, seven days a week. 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 a different format, including large print, CD and audio. Please call Customer Service at the phone number printed on the back cover of this booklet if you need plan information in an alternate format.

Benefits, premiums, and/or copayments/coinsurance may change on January 1, 2028.

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.

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OMB Approval 0938-1051 (Expires: July 31, 2029)

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

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://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://bcbsm.com/important-information/policies-practices/nondiscrimination-notice/.**

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Notice of Availability

English: Call 1-855-669-8040 (TTY:711) to connect with a complimentary interpreter who speaks English or to receive additional support you may need.

Spanish: Llame al 1-855-669-8040 (TTY:711) para conectarse de forma gratuita con un intérprete que hable español o para recibir apoyo adicional que pueda necesitar.

Arabic: اتصل على 855-669-8040 (TTY:711)-1 للتواصل مع مترجم مجاني يتحدث اللغة العربية أو لتلقي المزيد من الدعم الذي قد تحتاجه.

Chinese Mandarin: 拨打1-855-669-8040 (TTY:711) 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 1-855-669-8040 (TTY:711) për t'u lidhur me një interpret pa pagesë që flet shqip ose për të marrë mbështetje shtesë që mund t'ju nevojitet.

German: Rufen Sie 1-855-669-8040 (TTY:711) an, um einen kostenlosen Dolmetscher zu finden, der Deutsch spricht, oder um weitere Unterstützung zu erhalten.

Amharic: አማርኛ ከሚናገር ነጻ ተርጓሚ ጋር ለመገናኘት ወይም ሊያስፈልግዎ የሚችል ተጨማሪ ድጋፍ ለማግኘት 1-855-669-8040 ((TTY:711)ላይ ይደውሉ።

Bengali: বিনামূল্যে বাংলা ভাষায় কথা বলতে পারেন এমন একজন সহায়ক দোভাষীর সাথে যোগাযোগ করতে অথবা আপনার প্রয়োজনীয় অতিরিক্ত সহায়তা পেতে 1-855-669-8040 (TTY:711) নম্বরে কল করুন।

French: Appelez le 1-855-669-8040 (TTY:711) 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, 1-855-669-8040 (TTY:711) पर कॉल करें।

Korean: 한국어 무료 통역사와 연결하시거나 필요한 추가 지원을 받으시려면 1-855-669-8040 (TTY:711) 로 전화해 주십시오.

Polish: Zadzwoń pod numer 1-855-669-8040 (TTY:711), aby połączyć się z nieodpłatnym tłumaczem posługującym się językiem polskim lub aby – w razie potrzeby – uzyskać dodatkową pomoc.

Telugu: తెలుగు మాట్లాడే ఉచిత ఇంటర్‌ప్రెటేటర్‌తో కనెక్ట్ కావడానికి లేదా మీకు అవసరం కాగల అదనపు మద్దతును పొందడానికి 1-855-669-8040 (TTY:711) కు కాల్ చేయండి.

Vietnamese: Xin gọi 1-855-669-8040 (TTY:711) 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 1-855-669-8040 (TTY:711) fer schwetze mit en Interpreter as Deitsch schwetzt odder fer ennichi Hilf griege as du brauchscht. Des zellt dich nix koschde.

Tagalog: Tumawag sa 1-855-669-8040 (TTY:711) 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 coverage 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 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 your enrollment form and any notices you get from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called riders or amendments.

The contract is in effect for the months you're enrolled in Medicare Plus Blue Group PPO between January 1, 2027, and December 31, 2027.

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, 2027. We can also choose to stop offering our plan in your service area, after December 31, 2027.

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 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 national, or an eligible noncitizen.

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 our plan service area. To stay a member of our plan, you must continue to live in our plan service area. The service area is described.

Our service area includes all 50 states and U.S. territories.

If you move out of our plan's service area, you can't stay a member of this plan. Call Customer Service at 1-855-669-8040 (TTY users call 711) to see if we have a plan in your new area. When you move, you'll have a Special Enrollment Period to either switch to Original Medicare or enroll in a 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 national, or an eligible noncitizen

You must be a U.S. citizen or national, or an eligible noncitizen 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 stay a member of our plan on this basis. Medicare Plus Blue Group PPO must disenroll you if you don't meet this requirement.

SECTION 3 Important membership materials

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:



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 1-855-669-8040 (TTY users call 711) right away and we'll send you a new card.

Section 3.2 Provider Directory

The *Provider Directory* **bcbsm.com/providersmedicare** lists our 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.

If you don't have a *Provider Directory*, you can ask for a copy (electronically or in paper form) from Customer Service at 1-855-669-8040 (TTY users call 711). Requested paper *Provider Directories* will be mailed to you within 3 business days.

SECTION 4 Summary of Important Costs

	Your Costs in 2027
Monthly plan premium As a member of our plan, you may pay a monthly plan premium to the University of Michigan.	**Your coverage is provided through a contract with University of Michigan. Please contact the University of Michigan for information about your plan premium**
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.)	**From in-network and out-of-network providers combined: $3,000 per individual**
Primary care office visits	**$10 copay per visit**
Specialist office visits	**$10 copay per visit**
Inpatient hospital stays	**Covered at 100% of the approved amount.**

Your costs may include the following:

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

Section 4.1 Plan premium

As a member of our plan, you pay a monthly plan premium.

Your coverage is provided through a contract with the University of Michigan. Contact the University of Michigan's benefits administrator for information about our plan premium.

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums, check your copy of *Medicare & You 2027* handbook in the section called *2027*

Medicare Costs. Download a copy from the Medicare website (Medicare.gov/medicare-and-you) or order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

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

SECTION 5 More information about your monthly premium

Section 5.1 Your monthly plan premium won't change during the year

We're not allowed to change our plan's monthly plan premium amount during the year. If the monthly plan premium changes for next year, we'll tell you in September and the new premium will take effect on January 1.

SECTION 6 Keep your plan membership record up to date

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

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

If you have any of these changes, let us know:

- Changes to your name, address, or phone number
- Changes in any other health coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation, or Medicaid)
- Any liability claims, such as claims from an automobile accident
- If you're admitted to a nursing home
- If you get care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes

- 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 1-855-669-8040 (TTY users call 711).

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

SECTION 7 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 is not listed, call Customer Service at 1-855-669-8040 (TTY users call 711). 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:

- If you have retiree coverage, Medicare 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 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 has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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 or 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	1-855-669-8040 Calls to this number are free. Available from 8 a.m. to 8 p.m. Eastern Time, seven days a week from October 1 - March 31. Available from 8 a.m. to 5:30 p.m. Eastern Time, Monday through Friday from April 1 - September 30. Customer Service 1-855-669-8040 (TTY users call 711) also has free language interpreter services for non-English speakers.
TTY	711 Calls to this number are free. Available from 8 a.m. to 8 p.m. Eastern Time, seven days a week from October 1 - March 31. Available from 8 a.m. to 5:30 p.m. Eastern Time, Monday through Friday from April 1 - September 30.
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
Website	**bcbsm.com/umichmaplans**

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

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

Coverage Decisions and Appeals for Medical Care – Contact Information	
Call	1-855-669-8040 Calls to this number are free. Available from 8 a.m. to 8 p.m. Eastern Time, seven days a week from October 1 - March 31. Available from 8 a.m. to 5:30 p.m. Eastern Time, Monday through Friday from April 1 - September 30.
TTY	711 Calls to this number are free. Available from 8 a.m. to 8 p.m. Eastern Time, seven days a week from October 1 - March 31. Available from 8 a.m. to 5:30 p.m. Eastern Time, Monday through Friday from April 1 - September 30.
Fax	1-877-348-2251
Write	Blue Cross Blue Shield of Michigan Grievances and Appeals Department P.O. Box 2627 Detroit, MI 48231-2627
Website	You can submit a complaint about Medicare Plus Blue Group PPO directly to Medicare. To submit an online complaint to Medicare, go to **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	1-855-669-8040

	Calls to this number are free. Available from 8 a.m. to 8 p.m. Eastern Time, seven days a week from October 1 - March 31. Available from 8 a.m. to 5:30 p.m. Eastern Time, Monday through Friday from April 1 - September 30.
TTY	711 Calls to this number are free. Available from 8 a.m. to 8 p.m. Eastern Time, seven days a week from October 1 - March 31. Available from 8 a.m. to 5:30 p.m. Eastern Time, Monday through Friday from April 1 - September 30.
Write	Blue Cross Blue Shield of Michigan Grievances and Appeals Department P.O. Box 2627 Detroit, MI 48231-2627
Medicare website	To submit a complaint about Medicare Plus Blue Group PPO directly to Medicare, go to **Medicare.gov/my/medicare-complaint**.

How to ask us to pay our share of the cost for medical care you 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 for more information.

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

Payment Requests – Contact Information	
Call	1-855-669-8040 Calls to this number are free. Available from 8 a.m. to 8 p.m. Eastern Time, seven days a week from October 1 - March 31. Available from 8 a.m. to 5:30 p.m. Eastern Time, Monday through Friday from April 1 - September 30.
TTY	711 Calls to this number are free.

	Available from 8 a.m. to 8 p.m. Eastern Time, seven days a week from October 1 - March 31. Available from 8 a.m. to 5:30 p.m. Eastern Time, Monday through Friday from April 1 - September 30.
Write	Blue Cross Blue Shield of Michigan Imaging and Support Services P.O. Box 32593 Detroit, MI 48232-0593
Website	**bcbsm.com/content/dam/microsites/medicare/documents/medical-claim-form-ppo.pdf**

SECTION 2 Get help from Medicare

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

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

Medicare – Contact Information	
Call	1-800-MEDICARE (1-800-633-4227) Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free.
Chat Live	Chat live at **Medicare.gov/talk-to-someone**.
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044
Website	**Medicare.gov** • 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 **Medicare.gov** to tell Medicare about any complaints you have about Medicare Plus Blue Group PPO.

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

SECTION 3 State Health Insurance Assistance Program (SHIP)

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

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

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

MI Options – Contact Information	
Call	1-800-803-7174
TTY	711
Write	MDHHS - Health Services Aging and Community Services Division Capitol Commons Center 400 South Pine Street, 6th Floor Lansing, MI 48933
Website	**michigan.gov/MDHHSMIOptions**

SECTION 4 Quality Improvement Organization (QIO)

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

Commence Health has a group of doctors and other health care professionals paid by Medicare to check on and help improve the quality of care for people with Medicare. Commence Health is an independent organization. It's not connected with our plan.

Contact Commence Health 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 is ending too soon.

Commence Health (Michigan's Quality Improvement Organization) – Contact Information	
Call	1-888-524-9900 Monday – Friday: 9 a.m. – 5 p.m. Saturday – Sunday: 10 a.m. – 4 p.m. 24-hour voicemail service is available
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Write	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23450
Website	**https://www.commencehealthqio.cms.gov/en**

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	**SSA.gov**

SECTION 6 Medicaid

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

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualifying Individual (QI):** Helps pay Part B premiums
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums

To find out more about Medicaid and Medicare Savings Programs, contact Michigan Department of Community Health Medical Services Administration.

Michigan Department of Community Health Medical Services Administration – Contact Information	
Call	1-800-642-3195 Monday through Friday 8 a.m.-5 p.m., Eastern time.
TTY	1-800-263-5897

Write	Michigan Department of Health and Human Services 333 S. Grand Ave. P.O. Box 30195 Lansing, MI 48909
Website	**michigan.gov/mdhhs**

SECTION 7 Railroad Retirement Board (RRB)

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

Railroad Retirement Board (RRB) – Contact Information	
Call	1-877-772-5772 Calls to this number are free. Press "3" to speak with an RRB representative from 9 a.m. to 3:00 p.m., Eastern time, Monday – Friday. Press "1" to access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number aren't free.
Website	**https://RRB.gov**

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

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner's) employer or retiree group as part of this plan, call the employer/union benefits administrator or Customer Service at 1-855-669-8040 (TTY users call 711) with any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Customer Service are printed on the back cover of this document.) You can call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2048.

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 "providers" 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 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 care from either a network provider or an out-of-network provider (go to Section 2 for more information).

- The providers in our network are listed in the Provider Directory **bcbsm.com/providersmedicare**.
- 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 is not eligible to participate in Medicare. If you go to a provider who is not eligible to participate in Medicare, you'll be responsible for the full cost of the services you receive. Check with your provider before getting services to confirm that they're eligible to participate in Medicare.

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

It's important to know what Medicare will or won't cover. Be sure to ask your provider if a service is covered. Providers should let you know when something isn't covered. Providers should give you a written notice or tell you verbally when Medicare does not cover the service. Medicare Plus Blue Group PPO members don't need prior authorization 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.
    - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past 3 years.

    - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past 3 months.
- We'll help you choose a new qualified in-network provider for continued care.
- If you're undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- When an in-network provider or benefit 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. Prior authorization may be necessary.
- 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 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 were not 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 to learn how to make an appeal).

- 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 care if you have a medical emergency

A **medical emergency** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that'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 get approval or a referral first from your PCP. 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. Your follow-up care will be covered by our plan.

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 our plan's service area or our plan network is temporarily unavailable.

This care can be received at urgent care centers, provider offices or hospitals. For information on accessing in-network urgently needed services, contact Customer Service. You may also refer to our plan's website at **bcbsm.com/umichmaplans**.

Our plan covers worldwide emergency and urgent care services outside the United States under the following circumstances:

Urgently needed services - services you require to avoid the likely onset of an emergency medical condition.

Emergency care - treatment needed immediately because of any delay would mean risk of permanent damage to your health.

Emergency transportation - transportation needed immediately because a delay would mean risk of permanent damage to your health.

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 **bcbsm.com/important-information/notices-about-plans/medicare/** for information on how to get needed care during a disaster.

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 that are not emergency or urgently needed services, 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 will not 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 is not related to the study) through our plan.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for covered services you get as part of the study. If you tell us you're in a qualified clinical trial, you're only responsible for the in-network cost sharing for the services in that trial. If you paid more—for example, if you already paid the Original Medicare cost-sharing amount—we'll reimburse the difference between what you paid and the in-network cost sharing. You'll need to provide documentation to show us how much you paid.

If you want to participate in any Medicare-approved clinical research study, you 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 our plan's permission to be in a clinical research study, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

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 the routine items and services you get as part of the study, including:

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

After Medicare pays its share of the cost for these services, 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.

> *Example of cost sharing in a clinical trial:* Let's say you have a lab test that costs $100 as part of the research study. Your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan. In this case, Original Medicare would pay $80 for the test, and you would pay the $20 copay required under Original Medicare. You would then notify our plan that you got a qualified clinical trial service

and submit documentation (like a provider bill) to our plan. Our plan would then directly pay you $10. This makes your net payment for the test $10, the same amount you'd pay under our plan's benefits.

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 Medicare.gov/coverage/clinical-research-studies. You can also call 1-800-MEDICARE (1-800-633-4227). TTY users 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 is 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.

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.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. **As a member of Medicare Plus Blue Group PPO, you usually won't get ownership of rented DME items no matter how many copayments you make for the item while a member of our plan.** You won't get ownership even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under some limited circumstances we'll transfer ownership of the DME item to you. Call Customer Service at 1-855-669-8040 (TTY users call 711) 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. 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:

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

If you leave Medicare Plus Blue Group PPO or no longer medically require oxygen equipment, 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 with 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 applicable cost sharing 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 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. You can find a list of durable medical equipment coverage limitations, which shows continuous diabetic blood glucose monitors and traditional blood glucose monitors and test strips in the Addendum in the back of this document.

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. **You have no deductible under your Medicare Plus Blue Group PPO coverage.**
- **Copayment:** the fixed amount you pay each time you get certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart tells you more about your copayments.)
- **Coinsurance:** the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart tells you more about your coinsurance.)

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.

Section 1.2 What's the most you'll pay covered medical services?

Under our plan, there are 2 different limits on what you pay out-of-pocket for covered medical services:

- Your **in-network maximum out-of-pocket amount (MOOP)** is $3,000. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from network providers. The amounts you pay for copayments, and coinsurance for covered services from network providers count toward this in-network maximum out-of-pocket amount. (The amounts you pay for plan premiums and services from out-of-network providers don't count toward your in-network maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your in-network maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart.) If you pay $3,000 for covered Part A and Part B services from network providers, you won't have any out-of-pocket costs for the rest of the year when you see our network providers. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).
- Your **combined maximum out-of-pocket amount** is $3,000. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from both in-network and out-of-network providers. The amounts you pay for copayments and coinsurance for covered services count toward this combined maximum out-of-pocket amount. If you pay $3,000 for covered Medicare Part A and Part B services that count toward the combined maximum out-of-pocket amount, you won't have additional cost sharing for those covered services for the rest of the calendar year. However, you must continue to pay our plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 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. 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, $10.00), you pay only that amount for any covered services from a network provider. You'll generally have higher copayments when you get care from out-of-network providers.
- If you think a provider has balance billed you, call Customer Service at 1-855-669-8040 (TTY users call 711).

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 coverage 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 can't require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- Some services listed in the Medical Benefits Chart are covered as in-network services *only* if your doctor or other network provider gets approval from us in advance (sometimes called prior authorization).
    - Covered services that need approval in advance to be covered as in-network services are marked by an asterisk in the Medical Benefits Chart.

  - You never need approval in advance for out-of-network services from out-of-network providers.
  - While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.

- If your coordinated care plan provides approval of a prior authorization request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, your medical history, and the treating provider's recommendation.
- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less.* (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You 2027* handbook. View it online at **Medicare.gov** or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.)

- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you're also treated or monitored for an existing medical condition during the visit when you get the preventive service, a copayment will apply for the care you got for the existing medical condition.
- If Medicare adds coverage for any new services during 2027, either Medicare or our plan will cover those services.

 This apple shows preventive services in the Medical Benefits Chart.

Medical Benefits Chart

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 (PA), nurse practitioner (NP), or clinical nurse specialist (CNS).	**In-network and Out-of-network:** There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for chronic low back pain 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 • Not associated with pregnancy An additional 8 sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. **Provider Requirements:** Physicians may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNS`s), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • A master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the	**In-network and Out-of-network:** You pay a $10 copay for acupuncture for chronic low back pain services.

Covered Service	What you pay
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.	
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 if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our 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. **Note:** Your plan includes additional ambulance services. See **Enhanced Benefits** for a description and cost sharing.	**In-network and Out-of-network:** Ambulance services are covered at 100% of the approved amount.
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. The annual wellness visit is enhanced so it can occur anytime throughout the calendar year, regardless of the date of the member's previous year's annual wellness visit. **Note**: Your first annual wellness visit can't take place within 12 months of your *Welcome to Medicare* preventive visit. However, you don't need to have had a *Welcome to Medicare* visit to be covered for annual wellness visits after you've had Part B for 12 months.	**In-network and Out-of-network:** There is no coinsurance, copayment, or deductible for the annual wellness visit.

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 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 and Out-of-network:** There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.
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 calendar year. • 3D mammograms are covered when medically necessary • Additional breast cancer screening covered based on medical necessity	**In-network and Out-of-network:** There is no coinsurance, copayment, or deductible for covered screening mammograms. If you have a medical condition, a follow-up (second) mammogram and/or biopsy on a separate day from the screening, the procedure is considered diagnostic and your contractual cost sharing for Medicare-covered services will apply. If you receive other services during the visit, out-of-pocket costs may apply.
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. The plan covers these comprehensive programs if you've had at least one of these conditions: • Heart attack in the last 12 months	**In-network and Out-of-network:** Cardiac rehabilitation services are covered at 100% of the approved amount.

Covered Service	What you pay
• Coronary artery bypass surgery • Stable angina pectoris (chest pain) • Heart valve repair or replacement • Coronary angioplasty (a medical procedure used to open a blocked artery) or coronary stenting (a procedure used to keep an artery open) • Heart or heart and lung transplant • Stable chronic heart failure You can get up to 36 cardiac rehabilitation sessions. You can have 2 sessions per day (each lasting 1 hour), and the program can last up to 36 weeks. If you qualify, you may be able to get 36 more sessions that can be spread out over a longer time period.	
*Cardiac rehabilitation services may require prior authorization; your plan provider will arrange for this authorization, if needed. Please see the **Exclusions Chart** in Chapter 4, Section 3 of your *Evidence of Coverage.*	
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:** There is no coinsurance or copayment for the intensive behavioral therapy cardiovascular disease preventive benefit. If you receive other services during the visit, out-of-pocket costs may apply.
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).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.

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 12 months • One pap test every 12 months if at high risk of cervical or vaginal cancer or if of childbearing age and have had an abnormal pap test within the past 3 years • Additional pap smears and pelvic exams are covered based on medical necessity	**In-network and Out-of-network:** There is no coinsurance or copayment for Medicare-covered cervical and vaginal cancer screening. If you receive other services during the visit, out-of-pocket costs may apply.
Chiropractic services Covered services include: Manual manipulation of the spine to correct subluxation for acute/corrective treatment Your plan includes additional chiropractic services. See **Enhanced Benefits** for a description and cost sharing.	**In-network and Out-of-network:** You pay a $10 copay for chiropractic services.

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 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 years and older who are not 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	**In-network and Out-of-network:** There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam, however, you won't be charged additional out-of-pocket costs. If you receive other services during the visit, out-of-pocket costs may apply.

Covered Service	What you pay
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. • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patient not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. • Colorectal cancer screening tests include a follow-on 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.	
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental X-rays) are not covered by Original Medicare. However, Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation.	**In-network and Out-of-network:** Original Medicare covers very limited medically necessary dental services. Medicare Plus Blue Group PPO will cover those same medically necessary services. The cost sharing for those services (e.g., surgery, office visits,

Covered Service	What you pay
See the **Physician/Practitioner Services, including doctor's office visits benefit** for examples of Medicare-covered dental services.	X-rays) is referenced in other areas of this benefit chart. For more information, contact Customer Service.
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/or referrals.	**In-network and Out-of-network:** There is no coinsurance or copayment for an annual depression screening visit. If you receive other services during the visit, out-of-pocket costs may apply.
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:** There is no coinsurance or copayment for the Medicare- covered diabetes screening tests. If you receive other services during the visit, out-of-pocket costs may apply.

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: • Supplies to monitor your blood glucose: blood glucose monitor, 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: one pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts, or one pair of depth shoes and 3 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. • Diabetic insulin pumps Northwood is our preferred network provider. To coordinate your DME contact them at 1-800-667-8496, 8:30 a.m. to 5 p.m. Monday through Friday. TTY users call 711. To use another supplier not listed, call Customer Service. **Note**: For all people who have diabetes and use insulin, covered services include – approved continuous glucose monitors and supply allowance for the continuous glucose monitoring as covered by Original Medicare. **Continuous glucose monitors must be obtained from a network pharmacy.** To find a network pharmacy, visit our website **(bcbsm.com/pharmaciesmedicare).**	**In-network and Out-of-network:** Covered at 100% of the approved amount for diabetes self-management training, diabetic services and supplies. If you receive other services during the visit, out-of-pocket costs may apply.

Covered Service	What you pay
At the back of this *Evidence of Coverage* document, we include an addendum which tells you the brands and manufacturers of continuous diabetic blood glucose monitors and traditional blood glucose monitors and test strips that we will cover. * Diabetic services and supplies may require prior authorization; your plan provider will arrange for this authorization, if needed.	Continuous glucose monitors are only covered at in-network pharmacies. * All brands must be filled at a BCBSM network pharmacy and billed under Medicare Part B BIN: 262400 PCN: RXBCMA * You will have no copay. * Covered for insulin-dependent diabetics. * Non-insulin-diabetics require prior authorization approval. * A new prescription is required. * As a member, you may call Customer Service on the number back of your member ID card to ask specifically about getting a CGM.
Durable medical equipment (DME) and related supplies* (For a definition of durable medical equipment, go to Chapter 10 and Chapter 3)	**In-network and Out-of-network**:

Covered Service	What you pay
Durable medical equipment (DME) and related supplies* (continued) 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, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME 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. The most recent list of suppliers is available on our website at **bcbsm.com/providersmedicare.** **Note:** You must have a prescription from your provider to obtain Durable Medical Equipment (DME) items and services. *Durable medical equipment and related supplies may require prior authorization; your plan provider will arrange for this authorization, if needed.	DME items required under the preventive benefit provisions of CMS are covered at 100% of the approved amount with no in-network cost-sharing when rendered by an in-network provider. For a list of preventive DME items that CMS requires to be covered at 100%, call Customer Service. Member must obtain DME from BCBSM DME supplier, Northwood at 1-800-667-8496, 8:30 a.m. to 5 p.m. Monday through Friday. TTY users call 711. When outside of Michigan contact Customer Service
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services • Needed to evaluate or stabilize an emergency medical condition	**In-network and Out-of-network:** You pay a $65 copay for Medicare-covered emergency room visits,

Covered Service	What you pay
A medical emergency is a sudden medical condition, illness, or injury that is so severe that the absence of immediate medical attention could result in a serious threat to life, serious impairment to bodily functions, or serious dysfunction of any body part. Cost sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network.	(waived if admitted within three days). **Outside the U.S.:** You may be responsible for the difference between the approved amount and the provider's charge. You have BCBS Global Core Coverage (foreign travel) for worldwide emergency, urgent and non-emergency care.
Health and wellness education programs Medicare Plus Blue Group PPO offers 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 assistance 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 **join.personifyhealth.com/bluecrossmedicarerewards** Phone support and hours of operation are **1-888-573-3113**, Monday through Thursday: 8 a.m. through 11 p.m. Eastern time; Friday: 8 a.m. through 7 p.m. Eastern time; Saturday: 9 a.m. through 3 p.m. Eastern time. TTY users call 711.	**In-network and Out-of-network:** There is no coinsurance or copayment for health and wellness education programs. If you receive other services during the visit, out-of-pocket costs may apply.
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. Diagnostic hearing exam – 1 per year.	**In-network and Out-of-network:** For diagnostic hearing office visits, you pay a:
Diagnostic testing covered once every 36 months. **Note:** Your plan includes additional hearing and hearing aid services. See **Enhanced Benefits** for a description and cost sharing.	$10 copay with a primary care provider or a specialist.

Covered Service	What you pay
HIV screening For people who ask for an HIV screening test or 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:** There's no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening. If you receive other services during the visit, out-of-pocket costs may apply.
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 (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies *Home health agency care services may require prior authorization. Your plan provider will arrange for this authorization, if needed.	**In-network and Out-of-network:** Home health agency care is covered at 100% of the approved amount. Medical supplies ordered by physicians, such as durable medical equipment are not covered under home health agency care. See Durable Medical Equipment for more information. **Note:** Custodial care is not the same as home health agency care. For information, see Custodial Care in the exclusion list in Chapter 4, Section 3 of your Evidence of Coverage.

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 stay in our plan; if you stay in our plan you must continue to pay plan premiums. **For hospice services and services 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 Original Medicare pays for. You'll be billed Original Medicare cost sharing. **For services covered by Medicare Part A or B not related to your terminal prognosis:** If you need non-emergency, non-urgently needed services 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 services • If you get the covered services from an out-of-network provider, your share of the costs for covered services may be higher	**In-network and Out-of-network:** When you enroll in a Medicare-certified hospice program, your hospice services are covered by Original Medicare, not Medicare Plus Blue Group PPO

Covered Service	What you pay
For services covered by Medicare Plus Blue Group PPO but not 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. Your plan includes additional hospice 5th level coverage, see **Enhanced Benefits** for a description and out-of-pocket costs. You may be asked to provide your Original Medicare beneficiary identifier number off your red, white and blue Medicare card.	
Immunizations Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or 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've never received a complete series, you don't know your vaccination history, or you have any other condition that puts you at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you're at risk and they meet Medicare Part B coverage rules Additional immunizations NOT covered by the plan include but are not limited to shingles (Shingrix) RSV, and routine Tdap. Contact your prescription drug manager for information on immunizations not covered by your medical plan.	**In-network and Out-of-network:** There is no coinsurance or copayment for the pneumonia, flu/influenza, Hepatitis B and COVID-19 vaccines. Flu, pneumonia, COVID-19 and other vaccines are also available at retail network pharmacies. If you receive other services during the visit, out-of-pocket costs may apply
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. Covered services include but aren't limited to:	**In-network and Out-of-network:** Inpatient hospital care is covered at 100% of the approved amount. You have an unlimited number of medically necessary inpatient hospital days.

Covered Service	What you pay
• 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 • Lab tests • 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 disorder services • 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 will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. 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 obtain transplants at this distant location, we will arrange or 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. • Blood - including storage and administration. Coverage of whole blood, packed red cells and all other components of blood begins with the first pint used. • Physician services **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	If you get authorized inpatient care at an out-of-network hospital after your emergency condition has stabilized, your cost is the cost sharing you would pay at a network hospital, if applicable.

Covered Service	What you pay
outpatient. If you're not sure if you're an inpatient or an outpatient, ask the hospital staff. Get more information from the Medicare fact sheet Medicare Hospital Benefits available at **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.	
Inpatient services in a psychiatric hospital* Covered services include mental health care services that require a hospital stay. You have unlimited days of inpatient services in a psychiatric hospital. * Inpatient mental health/behavioral health services may require prior authorization; your plan provider will arrange for this authorization, if needed**.**	**In-network and Out-of-network:** Inpatient services in a psychiatric hospital are covered at 100% of the approved amount.
Inpatient stay: Covered services you get in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay If you've used up your inpatient benefits or if the inpatient stay isn't reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you get while you're in the hospital or the skilled nursing facility (SNF). Covered services include, but aren't limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and	**In-network and Out-of-network:** Covered services received in a hospital or SNF during a non-covered stay are covered at 100% of the approved amount. Additional out-of-pocket costs may apply for professional services. We will cover medical services; however, we do not cover SNF facility charges unless there is an approved authorization on file.
replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	

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 kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during the first year you get medical nutrition therapy services under 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 their order yearly if your treatment is needed into the next calendar year.	**In-network and Out-of-network:** There is no coinsurance or copayment for members eligible for Medicare-covered medical nutrition therapy services. If you receive other services during the visit, out-of-pocket costs may apply
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 for long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle. For more information on this program, contact Customer Service at **1-855-669-8040.**	**In-network and Out-of-network:** There is no coinsurance or copayment for the MDPP services. If you receive other services during the visit, out-of-pocket costs may apply.
Medicare Part B drugs * **These drugs are covered under Part B of Original Medicare. Members of our plan get 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)	**In-network and Out-of-network:** Approved Medicare Part B drugs are covered at 100%, including drugs used in certain oral anti-cancer and anti-nausea drugs, and certain immunosuppressive drugs

Covered Service	What you pay
• Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan • The Alzheimer's drug, Leqembi®, (generic name lecanemab) is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor 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 of the covered transplant, and you must have Part B 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 • 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 covered under Medicare Part B • Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv® and the oral medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal	following a Medicare-covered transplant. This plan only covers Medicare Part B prescription drugs. You will pay no more than $35 for one-month's supply of insulin. Medicare Part B drugs may require step therapy. See the link at the bottom of this benefit for more information. The following link will take you to a list of Part B Drugs that may be subject to step therapy: **http://bcbsm.com/amslibs/content/dam/public/providers/documents/ma-ppo-bcna-medical-drugs-prior-authorization.pdf**

Covered Service	What you pay
Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa, Mircera®, or Methoxy polyethylene glycol-epoetin beta) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) We also cover some vaccines under our Part B drug benefit.	
Mobile Crisis and Crisis Stabilization for Behavioral Health Mobile Mental Health Crisis Solutions will improve care for people that are in crisis, ideally to prevent higher levels of care. Services include onsite services, mobile crisis intervention by telehealth or face to face, along with crisis stabilization. Services also include crisis stabilization centers, where clinicians provide assessment, diagnosis, treatment planning, initiation of treatment, lab exams and other interventions similar to medical/surgical observation services. Mobile intervention is provided by a crisis intervention team led by social workers who can obtain consultations from psychologists, or consulting psychiatrists. Mobile crisis services onsite in the field can include assessment, diagnosis, short term crisis psychotherapy intervention either face to face or via telehealth, medication consultation, and triage to the appropriate level of care. For more information or to find a provider near you, visit **bcbsm.com/mentalhealth** or contact your Medicare Advantage plan's customer service.	**In-network and Out-of-network:** Services are covered at 100% of the approved amount for mobile crisis and crisis stabilization for behavioral health.

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:** There is no coinsurance or copayment for preventive obesity screening and therapy. If you receive other services during the visit, out-of-pocket costs may apply.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an 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:** Services are covered at 100% of the approved amount for opioid treatment program services.

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
• Laboratory tests
• Blood - including storage and administration. Coverage of whole blood, packed red cells and all other components of blood begins with the first pint used.
• Diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem
  • Other outpatient diagnostic tests, including sleep studies
  • High-tech radiology services (e.g., CT scans, echocardiography, MRAs, MRIs, PET scans, or nuclear medicine)
 	
*Outpatient diagnostic tests and therapeutic services and supplies may require prior authorization; your plan provider will arrange for this authorization, if needed.
	In-network and Out-of-network:
	
	Outpatient diagnostic tests and services are covered at 100% of the approved amount.

Covered Service	What you pay
Outpatient hospital observation* Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. If you receive a bill for self-administered medications while in observation, contact the health plan to discuss your options. **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 your stay may be considered outpatient, referred to as an observation stay. In these instances all services provided during the stay are billed as an outpatient and associated copays may apply. If you aren't sure if you're an outpatient, ask the hospital staff. If you receive a bill for self-administered medications while in observation, contact the health plan to discuss your options. Get more information in the Medicare fact sheet *Medicare Hospital Benefits*. This fact sheet is available at **Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf** or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.	**In-network and Out-of-network:** Outpatient hospital observation is covered at 100% of the approved amount.
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 emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital	**In-network and Out-of-network:** Outpatient hospital services are covered at 100% of the approved amount. Emergency room physician services are covered at

Covered Service	What you pay
• Mental 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 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, ask the hospital staff. * Outpatient hospital services may require prior authorization; your plan provider will arrange for this authorization, if needed.	100% of the approved amount.
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker (CSW), clinical nurse specialist (CNS), licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.	**In-network and Out-of-network:** You pay a $10 copay for an outpatient mental health office visit with your primary care provider or with a specialist. Outpatient mental health services rendered at a mental health facility are covered at 100% of the approved amount. You pay a $10 copay for a telehealth mental health visit with your primary care provider or with a specialist.
Outpatient rehabilitation services Covered services include physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments,	**In-network and Out-of-network:**

Covered Service	What you pay
independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	$10 copay for outpatient physical, speech and occupational therapy Other outpatient rehabilitation services are covered at 100% of the approved amount.
Outpatient substance use disorder services Coverage under Medicare Part B is available for treatment services provided in the outpatient department of a hospital. A coverage example is a patient who has been discharged from an inpatient stay for the treatment of substance use disorder or who requires additional treatment but does not require services found only in the inpatient hospital setting. The coverage available for these services is subject to the same rules generally applicable to the coverage of outpatient hospital services. Outpatient substance use disorder visits include counseling, detoxification, medical testing and diagnostic evaluation.	**In-network and Out-of-network:** Outpatient substance use disorder treatment services at approved facilities are covered at 100% of the approved amount.
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 services, 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 and Out-of-network:** Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers are covered at 100% of the approved amount. Outpatient clinics owned and operated by hospitals (known as hospital-based practices) may cost you more.

Covered Service	What you pay
Partial hospitalization services and Intensive outpatient services* *Partial hospitalization* is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental 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. *Intensive outpatient service* is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally Qualified Health Center, or a rural health clinic that'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 but less intense than partial hospitalization. * Partial hospitalization services and Intensive outpatient services may require prior authorization; your plan provider will arrange for this authorization, if needed.	**In-network and Out-of-network:** Partial hospitalization and intensive outpatient services are covered at 100% of the approved amount.
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically necessary medical care or surgery services you get 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, if your doctor orders it to see if you need medical treatment o Certain telehealth services, including: primary care physician services and individual sessions for mental health specialty services. o 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.	**In-network and Out-of-network:** **Office visits** You pay a $10 copay for an office visit with a primary care provider or with a specialist. **Telehealth (online visit)** You pay a $10 copay for a telehealth visit with a primary care provider or with a specialist. Surgical services performed in an office are covered at 100% of the approved amount.

Covered Service	What you pay
• As part of your Medicare Advantage plan, we offer safe and secure Virtual Care. Virtual Care gives you urgent care 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 and our plan-approved vendor.* This service is separate from any virtual care your personal doctor might offer. • You can also use Teladoc Health™ to access telehealth services. Visit **bcbsm.com/virtualcare** for more information or 1-800-835-2362, available 24 hours a day, 7 days a week, 365 days a year. TTY users call 1-855-636-1578. • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: • You're not a new patient **and**	After the first 12 months of Part B coverage, an annual routine physical exam is covered at 100% of the approved amount. If a surgical or diagnostic procedure is performed during an office visit, these procedures are considered diagnostic and you will be responsible for the Medicare-covered surgical service out-of-pocket costs in addition to your office visit copay.

Covered Service	What you pay
• The check-in isn't related to an office visit in the past 7 days **and** • The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**: • You're not a new patient **and** • The evaluation isn't related to an office visit in the past 7 days **and** • The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician). Teladoc Health™ is an independent company that provides Virtual Care Solutions for Blue Cross Blue Shield of Michigan and Blue Care Network.	
Podiatry services* Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs * Podiatry services may require prior authorization; your plan provider will arrange for this authorization, if needed.	**In-network and Out-of-network:** Podiatry services in an office are covered at 100% of the approved amount. Some medically necessary foot care services other than office visits are covered at 100% of the approved amount.
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	**In-network and Out-of-network:**

Covered Service	What you pay
cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication including the fee for injecting the drug, if applicable • 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	There is no coinsurance, copayment, or deductible for the PrEP benefit.
Prostate cancer screening exams For men aged 50 and older, covered services include the following once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test • Additional prostate cancer screening covered based on medical necessity	**In-network and Out-of-network:** There is no coinsurance, copayment, or deductible for an annual PSA test.
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 *Vision Care* later in this table for more detail. Prosthetics and orthotics coverage is limited to basic equipment. Deluxe or upgraded equipment must be medically necessary and requires prior authorization for coverage. Custom styles, colors and materials are not covered.	**In-network and Out-of-network:** Medicare-approved prosthetic and orthotic devices and related supplies are covered at 100% of the approved amount.

Covered Service	What you pay
You must obtain prosthetics and orthotics from BCBSM's P&O supplier, Northwood at **1-800-667-8496**, 8:30 a.m. to 5 p.m. Monday through Friday. TTY users call **711**. When outside of the plan's service area, members must contact Northwood. To use another supplier, contact Customer Service. **Note:** You must have a prescription from your provider to obtain 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.	
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and *an order* for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	**In-network and Out-of-network:** Pulmonary rehabilitation services are covered at 100% of the approved amount.
Retail health clinic services We cover visits to plan-contracted walk-in health clinics (located in a pharmacy setting) for minor health issues that require attention fast, but are non-emergency conditions such as sore throat, earaches, sunburn, sprains and strains, and suture removal.	**In-network and Out-of-network:** You pay a $10 copay for retail health clinic services.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults (including pregnant women) 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:** There is no coinsurance or copayment for Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit. If you receive other services during the visit, out-of-pocket costs may apply.

Covered Service	What you pay
Screening for lung cancer with low dose computed tomography (LDCT) For qualified people, an LDCT is covered every 12 months. **Eligible members are** people age 50 – 77 who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and 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. *For LDCT lung cancer screenings after the initial LDCT screening:* 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:** There is no coinsurance or copayment for Medicare-covered counseling and shared decision-making visit or for the LDCT. If you receive other services during the visit, out-of-pocket costs may apply. **Note:** If the provider finds a diagnosis, the screening would no longer be considered preventative, and a cost-share may apply.
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 cover 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:** There is no coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus.
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs	**In-network and Out-of-network:**

Covered Service	What you pay
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 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.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
Services to treat kidney disease Kidney disease and dialysis 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 6 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 (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, go to **Medicare Part B drugs** in this table**.**	**In-network and Out-of-network:** Kidney disease education services are covered at 100% of the approved amount. Dialysis services are covered at 100% of the approved amount. Professional charges are covered at 100% of the approved amount.
Skilled nursing facility (SNF) care* (For a definition of skilled nursing facility care, go to Chapter 10. Skilled nursing facilities are sometimes called SNFs.)	**In-network and Out-of-network:**

Covered Service	What you pay
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 (this includes substances naturally present in the body, such as blood clotting factors) • Blood - including storage and administration. Coverage of whole blood, packed red cells and all other components of blood begins with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you get SNF care from network facilities. Under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • 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 *Skilled nursing facility care may require prior authorization; your plan provider will arrange for this authorization, if needed.	Skilled nursing facility care is covered at 100% of the approved amount. 120 days are covered per benefit period. No prior hospitalization is required. A benefit period begins the day you are admitted to a SNF and ends after you have not been received skilled care in a SNF for 60 consecutive days. Once the benefit period ends, a new benefit period begins when you have an admission to a SNF. New benefit periods do not begin due to a change in diagnosis, condition, or calendar year.
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: • Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • Are competent and alert during counseling	**In-network and Out-of-network:** There is no coinsurance or copayment for Medicare-covered smoking and tobacco use cessation preventive benefits.

Covered Service	What you pay
• A qualified physician or other Medicare-recognized practitioner provides counseling We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.) Call Personify Health at **1-888-573-3113** for enrollment assistance. TTY users, call **711**.	If you receive other services during the visit, out-of-pocket costs may apply.
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 (PA), or nurse practitioner (NP)/clinical nurse specialist (CNS) 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 and Out-of-network:** Supervised exercise therapy is covered up to 100% of the approved amount.
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, even if you're inside our plan's service area, 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	**In-network and Out-of-network:** For urgent care visits, you pay a $10 copay. **Outside the U.S.** You may be responsible for the difference between the approved amount and the provider's charge.

Covered Service	What you pay
urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable. 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. You have BCBS Global Core Coverage (foreign travel) for worldwide emergency, urgent and non-emergency care.	Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network.
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. • For people who are at high risk for glaucoma, we cover one glaucoma screening each year People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older and Hispanic Americans who are 65 or older. • 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 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery. • Prescription lenses/frames (and replacements) needed after a cataract surgery; the surgery can be for any disease of the eye or to replace a missing organic lens. Routine eye exams are covered. See **Enhanced Benefits** for additional information and out-of-pocket costs.	**In-network and Out-of-network:** Vision care is covered at 100% of the approved amount. If you receive other services during the visit, out-of-pocket costs may apply.
Note: Medically necessary contacts (not elective contacts) require provider approval and must meet criteria of "medically necessary."	

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 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 only 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:** There is no coinsurance or copayment for the *Welcome to Medicare* preventive visit. Out-of-pocket costs may apply if a covered service (e.g., diagnostic test) is outside the scope of the *Welcome to Medicare* preventive visit.
Worldwide emergency coverage If you need care when you're outside of the United States and its territories, you have coverage for emergency services, urgently needed services, and emergency transportation only. In general, health care you get while traveling outside the United States and its territories is limited to: • Urgently needed services (services you require in order to avoid the likely onset of an emergency medical condition) • Emergency care (treatment needed immediately because any delay would mean risk of permanent damage to your health) • You have coverage for worldwide emergency transportation (transportation needed immediately because a delay would mean risk of permanent damage to your health) **Services not covered while traveling outside the United States and its territories** • By federal law, Medicare Plus Blue Group PPO can't cover prescription drugs you purchase outside the United States and its territories • Maintenance dialysis	**In-network and Out-of-network:** There is no coinsurance, copayment, or deductible for worldwide emergency coverage. There is a combined $50,000 lifetime limit that applies to both urgent and emergent medical care and emergency transportation outside of the United States and its territories. Medicare Plus Blue Group PPO has limited coverage for healthcare services outside the United States and its territories. You may choose to buy a travel insurance policy to get more coverage.
Enhanced Benefits	

Covered Service	What you pay
Adult briefs and incontinence liners We cover adult diapers and incontinence liners to provide effective bladder control protection. **Wipes are not covered.** You must obtain durable medical equipment (DME) from BCBSM's supplier, Northwood, at **1-800-667-8496**, 8:30 a.m. to 5 p.m. Monday through Friday. TTY users call 711.	**In-network and Out-of-network:** Adult briefs and incontinence liners are covered at 100% of the approved amount when deemed medically necessary and ordered through Northwood.
Ambulance Services / Non-Transport We cover ambulance services, even if you are not transported to a facility, if you are stabilized at your home or another location. This service is not covered outside of the U.S. or its territories.	**In-network and Out-of-network:** Services are covered at 100% of the approved amount.
Annual physical exam Covered services include: One yearly routine physical exam (an annual preventive medical exam that is more comprehensive than an annual wellness visit) • An examination performed by a primary care provider that collects health information. Services include: o An age and gender appropriate physical exam, including vital signs and measurements. o Guidance, counseling and risk factor reduction interventions. o Administration or ordering of immunizations, lab tests or diagnostic procedures.	**In-network and Out-of-network:** Services are covered up to 100% of the approved amount. Out-of-pocket costs may apply if a covered service (e.g., diagnostic test) is outside the scope of the annual physical exam.
o Covered only in the following locations: provider's office, outpatient hospital or a member's home.	

Covered Service	What you pay
Autism Spectrum Disorder Services (No age limit) • Applied behavioral analysis (ABA) treatment - when rendered by an approved board-certified behavioral analyst. Subject to prior authorization. • Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder • Other covered services, including mental health services, for autism spectrum disorder	**In-network and Out-of-network:** Applied behavioral analysis treatment is covered at 100% of the approved amount when rendered by an approved board-certified behavioral analyst. You pay a $10 copay for outpatient physical therapy, speech therapy, occupational therapy, and a $10 copay for other covered services including mental health services for autism spectrum disorder
BCBS Global Core Coverage (foreign travel) Your plan provides coverage outside the United States for medical care that is emergency room, urgent care, and non-emergency care services.	**In-network and Out-of-network:** For services covered under BCBS Global Core Coverage (foreign travel), you pay the same cost sharing as you would for corresponding covered services provided in the United States.
Enhanced chiropractic services Covered services include: • Maintenance therapy • X-rays (one per year) and chiropractic radiology services • Evaluation and management services Chiropractic physical therapy visits	**In-network and Out-of-network:** You pay a $10 copay for enhanced chiropractic services.

Covered Service	What you pay
Contraceptive devices and injections Contraception (i.e., birth control, prevention of pregnancy) is the means by which an individual uses means that will prevent pregnancy. Methods of contraception include barrier methods, non-hormonal contraception, hormonal contraception, and injections performed by a licensed provider.	**In-network and Out-of-network:** Contraceptive devices and injections are covered at 100% of the approved amount.
Determination of refractive state Eye exam for determination of refractive state is necessary for obtaining glasses and is covered under these circumstances: • A provider must identify your refractive state to determine an injury, illness or disease • An ophthalmologist or an optometrist must determine the refractive state for corrective lenses • Your refractive state is determined as part of a surgical procedure.	**In-network and Out-of-network:** Determination of refractive state is covered at 100% of the approved amount.
Gender reassignment and gender affirming procedures* Certain gender affirming services are payable by participating providers for members over the age of 18. These services may be covered when medically necessary and when Medicare-approved criteria are met. Subject to prior authorization. Please see our plan's policy for further information.	**In-network and Out-of-network:** Gender reassignment and gender affirming procedures are covered at 100% of the approved amount.
	Must meet approved medical criteria.
Gradient compression stockings* We cover gradient compression stockings that squeeze the leg to reduce and prevent swelling as well as improve blood flow. Also including mastectomy sleeves, two per 12 months. *Gradient compression stockings may require prior authorization; your plan provider will arrange for this authorization, if needed.	**In-network and Out-of-network:** Gradient compression stockings are covered at 100% of the approved amount.

Covered Service	What you pay
Hearing aids and services Hearing aids must be prescribed by a provider, audiologist, or hearing aid dealer based on the most recent audiometric examination and hearing aid evaluation test. Audiometric exam - one every 36 months Hearing aid evaluation - one every 36 months Ordering and fitting the hearing aid (monaural or binaural hearing aid) - one every 36 months Hearing aid conformity test - one every 36 months **Note:** Hearing aid evaluation may be performed sooner if medically necessary.	**In-network and Out-of-network:** The $10 copay applies to specialist office visits, not these exams. **Hearing aids binaural (both ears) or monaural (one ear)** Covered up to the maximum allowance every 36 months, including applicable dispensing fees: $1,500 for monaural (one ear) hearing aids or $2,500 for binaural (both ears) hearing aids. **Ordering and fitting the hearing aid** Covered at 100% of allowed amount once every 36 months. **Hearing aid conformity test** Covered 100% of the allowed amount once every 36 months.

Covered Service	What you pay
Hearing services – routine exam A medical evaluation to find the cause of the hearing loss and determine if it can be improved with a hearing aid is covered as an office visit when furnished by a provider, audiologist, or other qualified provider. The following test is covered as an office visit under the hearing services benefit when furnished by a physician, audiologist or other qualified provider: An annual routine exam to measure hearing ability	**In-network and Out-of-network:** Hearing services are covered at 100% of the approved amount.
Home infusion therapy* Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual 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 are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring	**In-network and Out-of-network:** Home infusion therapy enhanced benefits are covered at 100% of the approved amount.

Covered Service	What you pay
• Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier Home infusion therapy: • Must be medically necessary • Must be given by a participating Home Infusion Therapy (HIT) provider or in a participating freestanding Ambulatory Infusion Center (AIC) • May use drugs that require prior authorization, consult with your provider The additional Medicare Plus Blue home infusion therapy benefit provides coverage for the in-home administration of infusion therapy services when the Original Medicare coverage criteria are not met. Coverage is available when the infusion therapy is: • Prescribed by a physician to: • Manage a chronic condition • Treat a condition that requires acute care if it can be managed safely at home • Certified by the physician as medically necessary for the treatment of the condition • Appropriate for use in the patient's home • Medical IV therapy, injectable therapy or total parenteral nutrition therapy • Chelation therapy, performed in the patient's home or a nursing home Components of care available regardless of whether the patient is confined to the home: • Nursing visits • Durable medical equipment, medical supplies and solutions • Catheter care • Injectable therapy • Drugs *Home infusion therapy services may require prior authorization. Your plan provider will arrange for this authorization, if needed.	

Covered Service	What you pay
Hospice room and board (5th Level) The 5th level hospice care benefit covers inpatient room and board hospice care in a skilled nursing or hospice facility. This coverage doesn't apply when hospice care is received in the home. Original Medicare covers expenses related to hospice care in the home.	**In-network and Out-of-network:** Hospice room and board (5th Level) services are covered at 100% of the approved amount. Limited to 45 days per lifetime.
Human organ transplants* • Bone marrow and hematopoietic stem cell transplants when required for the following conditions: • Allogeneic (from a donor) transplants for: o Osteopetrosis o Renal cell cancer o Primary amyloidosis • Autologous (from the patient) transplants for: o Renal cell cancer o Germ cell tumors of ovary, testis, mediastinum, retroperitoneum o Neuroblastoma (stage III or IV) o Primitive neuroectodermal tumors o Ewing's sarcoma o Medulloblastoma o Wilms' tumor • A second bone marrow transplant for multiple myeloma after a failed first bone marrow transplant. When directly related to a covered transplant, we cover immunosuppressive drugs and other transplant– related prescription drugs, during and after the benefit period. For non–covered transplants, your prescription drug plan is responsible for immunosuppressive drugs and other transplant–related prescription drugs. There is no lifetime maximum for non-Medicare covered organs. Human organ transplant services may require prior authorization. Your plan provider will arrange for this authorization, if needed	**In-network and Out-of-network:** Human Organ Transplants are covered up to 100% of the approved amount. Medicare covers medically necessary solid organ transplants including heart, lung, kidney, pancreas, intestine, multivisceral, liver, along with certain cornea and stem cell/bone marrow transplants. Your plan includes additional coverage for certain human organ transplants not covered by Original Medicare, including Bone Marrow, Oncology, Kidney, Cornea and Skin.

Covered Service	What you pay
In vitro fertilization (IVF) Eligible conditions for the diagnosis and treatment of infertility are: • Encounter for assisted reproductive fertility procedure cycle and/or encounter for fertility preservation (the retrieval of mature eggs and/or sperm for the creation of embryos that are frozen for future use) • Iatrogenic infertility (impairment of fertility by surgery, radiation, chemotherapy, or medical treatment affecting the ability to produce sperm or eggs) Age restrictions: IVF is payable for women up to the age of 43 with the following guidelines. • Ages up to and including 35 single embryo transfer only • Ages between 36 and 43 double embryo transfer • Iatrogenic infertility covered for female members up to age 43 • Members with a genetic condition that will result in early menopause or impaired sperm production in later years are covered up to age 26 Fertility preservation procedures are available for both women and men. Must meet approved guidelines. Covered infertility diagnosis, treatment, assisted reproduction, artificial conception and fertility preservation procedures are payable when rendered only by the UMHS Center for Reproductive Medicine. A lifetime plan maximum of $20,000 applies to covered infertility diagnosis, treatment, assisted reproduction, artificial conception and fertility preservation procedures. Subject to medical criteria.	**In-network and Out-of-network:** In vitro fertilization assessment services are covered at 100% of the approved amount. All other in vitro fertilization services are covered at 20% of the approved amount.

Covered Service	What you pay
Nutritional counseling Must be related to approved medical conditions such as: • Diabetes • Chronic renal disease • Kidney transplant • Eating disorders Must be medically necessary and meet approved criteria	**In-network and Out-of-network:** Nutritional counseling related to approved medical conditions is covered at 100% of the approved amount.
Postnatal care visits (applies to member only) The postnatal period begins after childbirth and is typically considered to end within six weeks. Postnatal care is the care that the mother receives after delivery. It includes counseling and health education on recognition of danger signs and appropriate care seeking. Postnatal care can be provided in a health facility or at home, depending on the needs of the mother. Postnatal care is to be provided by your Primary Care provider or participating OB/GYN, or participating certified nurse midwife.	**In-network and Out-of-network:** Postnatal care visits are covered at 100% of the approved amount**.**
Pregnancy terminations Medically necessary or voluntary.	**In-network and Out-of-network:** Pregnancy terminations are covered at 100% of the approved amount.
Private duty nursing We provide nursing to individuals who need skilled care and require individualized continuous 24-hour nursing care that's more intense than what is available under other benefits when ordered by a physician (M.D. or D.O.) who is involved with your ongoing care. • At least two trained caregivers (a family member, a friend, etc.) must be trained and competent to give	**In-network and Out-of-network:** Private duty nursing is covered at 70% of the approved amount.

Covered Service	What you pay
care when the nurse is not in attendance. • The family or caregivers must provide at least 8 hours of skilled care per day. • Generally, more than 16 hours per day of Private Duty Nursing will not be approved. ○ However, up to 16 hours per day may be approved for up to 30 days while you are being transitioned from an inpatient setting to home. Private duty nursing does not cover services provided by, or within the scope of practice of, medical assistants, nurse's aides, home health aides, or other non-nurse level caregivers. This benefit is not intended to supplement the care-giving responsibility of the family, guardian or other responsible parties.	These services **do not apply** toward your annual out-of-pocket maximum.
Routine eye exam Routine eye exams are covered once per calendar year. Glasses, lenses, frames and contact lenses are not covered.	**In-network and Out-of-network:** Routine eye exams are covered at 100% of the approved amount.
Health fitness program 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	**In-network and Out-of-network:** There is no copay or coinsurance for SilverSneakers. Fitness services must be provided at SilverSneakers® participating locations. You can find a location or request information at **silversneakers.com** or 1-866-584-7352, 8 a.m. to 8 p.m. Eastern time, Monday through Friday. TTY users call 711.

Covered Service	What you pay
• 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 Members can also choose one kit per year (four options to choose from). Each kit includes a quick start guide. The at-home kits available include: • Walking: includes a pedometer • Toning: includes a SilverSneakers ball • Strength: includes a resistance band • Yoga: includes a yoga strap Go to **silversneakers.com** to learn more or call 1-866-584-7352, 8 a.m. to 8 p.m. Eastern time, Monday through Friday. TTY users call 711. SilverSneakers is a registered trademark of Tivity Health, Inc. © 2026 Tivity Health, Inc. All rights reserved.	
Temporomandibular joint dysfunction (TMJ) treatment Temporomandibular joint (TMJ) dysfunction may be the result of congenital or developmental anomalies; fractures or dislocations resulting from trauma, internal derangement or ankylosis (stiffening or fixation of a joint); arthritic diseases or neoplastic diseases. Following services are covered to treat TMJ: • Surgery directly related to the temporomandibular joint (jaw joint) and related anesthesia services • Arthrocentesis performed for the treatment of temporomandibular joint (jaw joint) dysfunction) • Diagnostic X-rays (including MRIs) • Trigger point injections • Physical therapy (See physical therapy services) • Reversible appliance therapy (mandibular orthotic repositioning device such as a bite splint)	**In-network and Out-of-network:** You pay a $10 copay for temporomandibular joint dysfunction treatment office visit with your primary care provider. Other temporomandibular joint dysfunction (TMJ) treatment is covered at 100% of the approved amount.

Covered Service	What you pay
Travel and lodging for covered transplants and clinical trials • The benefit period begins five days prior to the initial transplant and extends through the patient's transplant episode of care. The transplant surgery must be performed at a Medicare-approved transplant facility at least 100 miles from home. • Travel and lodging benefits are also payable during covered clinical trials and begin with the first service date of the clinical trials and end 180 days after that date. • Coverage includes expenses for the patient and one other person eligible to accompany the patient and two persons if the patient is a child under age 18 or if the transplant involves a living donor. • Benefits are payable up to a combined maximum of $150 per day for the covered duration. The maximum amount payable for travel and lodging services related to the initial solid organ transplant is $10,000. The maximum amount payable for services related to an approved clinical trial or bone marrow transplant is $5,000.	**In-network and Out-of-network:** Travel and lodging for covered transplants and clinical trials are covered at 100% of the approved amount.
Voluntary sterilization Sterilization is accomplished by surgical removal of testes or ovaries or inactivation by irradiation or by tying off or removing a portion of reproductive ducts.	**In-network and Out-of-network:** Voluntary sterilization services are covered at 100% of the approved amount.
Weight reduction/bariatric surgery* We cover weight reduction procedures and surgery when Medically Necessary based on Blue Cross's medical criteria and established guidelines related to the procedure. Your provider approves the service and must notify Blue Cross prior to the procedure taking place. Must meet approved criteria. *Weight reduction/Bariatric procedures and surgery may require prior authorization; your plan provider will arrange for this authorization, if needed.	**In-network and Out-of-network:** Weight reduction/bariatric surgery is covered up to 100% of the approved amount.

Covered Service	What you pay
Well-woman visits/Gynecological exam • Gynecological exam, one per calendar year, at least 11 months after the most recent well-woman visit/gynecological exam. • Additional well-women visits may be allowed based on medical necessity.	**In-network and Out-of-network:** Well-woman visits/Gynecological exam is covered at 100% of the approved amount, one per member per calendar year.
Wigs (including stands and adhesive)* Wigs must be prescribed by a physician and require an approved medical condition. *Wigs may require prior authorization; your plan provider will arrange for this authorization, if needed.	**In-network and Out-of-network:** Wigs are covered at 100% of the approved amount.

SECTION 3 Services that aren't covered by our plan (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 get 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 made not to cover a medical service, go to Chapter 7, Section 5.3.)

Services not covered by Medicare	Covered only under specific conditions
Acupuncture	Available for people with chronic low back pain under certain circumstances
Cardiac rehabilitation, Phase III programs (For information on other cardiac rehabilitation programs, see Chapter 4, Section 2, and Chapter 10, Definitions of important words.)	Not covered under any condition
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 bathing or dressing	Not covered under any condition
Experimental medical and surgical procedures, equipment, and medications Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community	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)
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
Home-delivered meals	Not covered under any condition
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
Routine chiropractic care	Manual manipulation of the spine to correct a subluxation is covered
Routine dental care, such as cleanings, fillings, or dentures	Not covered under any condition
Eyeglasses, 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 foot care	Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes)
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, 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 is not part of our network, you're only responsible for paying your share of the cost. (Your share of the cost may be higher for an out-of-network provider than for a network provider.) Ask the provider to bill our 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, 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 is not eligible to participate in Medicare. If the provider is not 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 feel you paid too much, send us the bill along with documentation of any payment you made and ask us to pay you back the difference between the amount you paid and the amount you owed under 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. The enrollment date may even have occurred last year.

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

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

- You don't have to use the form, but it'll help us process the information faster.
- Download a copy of the form from our website (**bcbsm.com/medicare**) or call Customer Service at **1-855-669-8040 (**TTY users call *711*) 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 is *not* covered, or you did *not* follow all the rules, we 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 and consistent with your cultural sensitivities (in languages other than English, 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 materials 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's accessible and appropriate for you. To get information from us in a way that works for you, call Customer Service at 1-855-669-8040 (TTY users call 711).

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 our 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 our 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 at 1- 855-669-8040 (TTY: 711). 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 aren't getting your medical care within a reasonable amount of time, Chapter 7 tells what you can do.

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

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

- Your personal health information includes the personal information you 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 you 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 our 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, call Customer Service at 1-855-669-8040 (TTY users call 711).

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 polices (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 will allow it to be used and given out ("disclosed"). We must follow the privacy practices described in this notice while it is in effect. This notice takes effect September 30, 2016, and will remain in effect until we replace or modify it.

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

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

Our uses and disclosures of protected health information

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

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

These communications may include information about the 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 will have a written contract with that third party designed to protect the privacy of your PHI. For example, we may share your information with business associates who process claims or conduct disease management programs on our behalf.
- **To group health plans and plan sponsors:** We participate in an organized 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 are 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 will not 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 will not be made without a signed authorization except where permitted by law.
- **Sale of PHI:** We will not 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 will not 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, will not be made without your signed authorization.

Disclosures you may request

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

Individual rights

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

- **Access**: With certain exceptions, you have the right to look at or receive a copy of your PHI contained in the group of records that are used by or for us to make decisions about you, including our enrollment, payment, claims adjudication, and case or medical management notes. We reserve the right to charge a reasonable cost- based fee for copying and postage. You may request that these materials be provided to you in written form or, in certain circumstances, electronic form. If you request an alternative

format, such as a summary, we may charge a cost-based fee for preparing the summary. If we deny your request for access, we will tell you the basis for our decision and whether you have a right to further review.

- **Disclosure accounting:** You have the right to an accounting of disclosures we, or our business associates, have made of your PHI in the six years prior to the date of your request. We are not required to account for disclosures we made before April 14, 2003, or disclosures to you, your personal representative or in accordance with your authorization or informal permission; for treatment, payment, and 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 are 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 are not required to agree to these additional restrictions; but if we do, we will abide by them (except as needed for emergency treatment or as required by law) unless we notify you that we are terminating our agreement.
- **Amendment:** You have the right to request that we amend your PHI in the set of records we described above under Access. If we deny your request, we will provide you with a written explanation. If you disagree, you may have a statement of your disagreement placed in our records. If we accept your request to amend the information, we will make reasonable efforts to inform others, including individuals you name, of the amendment.
- **Confidential communication:** We communicate decisions related to payment and benefits, which may contain PHI, to the subscriber. Individual members who believe that this practice may endanger them may request that we communicate with them using a reasonable alternative means or location. For example, an individual member may request that we send an Explanation of Benefits to a post office box instead of to the subscriber's address. To request confidential communications, call the customer service number on the back of your membership ID card or 1-313-225-9000.
- **Breach notification:** In the event of a breach of your unsecured PHI, we will provide you with notification of such a breach as required by law or where we otherwise deem appropriate.

Questions and complaints

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

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

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

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

You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with their address to file your complaint upon request. We support your right to protect the privacy of your PHI. We will not 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 1-855-669-8040 (TTY users call 711):

- **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 is not covered and what you can do about it.** Chapter 7 provides information on asking for a written explanation on why a medical service 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 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 treatment options recommended for your condition, no matter what they cost or whether they're 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 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 1-855-669-8040 (TTY users call 711) 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 can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

- The hospital will ask whether you signed an advance directive form and whether you have it with you.

- If you 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 the Michigan Department of Licensing and Regulatory Affairs for your situation in Michigan. Outside of Michigan, contact your state department of health agency or State Health Insurance Assistance Program (SHIP) for assistance.

Visit: michigan.gov/lara and click on: *File a complaint*

To file a complaint against a hospital or other health care facility contact:

Department of Licensing and Regulatory Affairs
Bureau of Survey & Certification
PO Box 30838
Lansing, MI 48909

Call: 1-800-882-6006, 8 a.m. to 5 p.m. Monday through Friday. TTY users call 711.
Email: BCHS-Complaints@michigan.gov
Fax: 1-517-763-0219

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

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

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

Email: BPL-Complaints@michigan.gov

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

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

If you have any problems, concerns, or complaints and need to ask for coverage, or make an appeal, Chapter 7 of this document tells what you can do. Whatever you do —ask for a coverage decision, make an appeal, or make a complaint — **we're required to treat you fairly**.

Section 1.7 If you believe you're being treated unfairly, or your rights 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 1-855-669-8040 (TTY users call 711)**
- **Call your local SHIP** at 1-800-803-7174.
- **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 1-855-669-8040 (TTY users call 711)**
- **Call your local SHIP** at 1-800-803-7174.
- **Contact Medicare**
  - Visit **Medicare.gov** to read the publication Medicare Rights & Protections (available at **Medicare Rights & Protections**)
  - Call 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, call Customer Service at 1-855-669-8040 (TTY users call 711).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverag*e 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.** Chapter 1 tells you about coordinating these benefits.
- **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 premiums 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 record 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 move, tell Social Security (or the Railroad Retirement Board).**

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

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

This chapter explains 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 to do.

Section 1.1 Legal terms

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

However, it's sometimes important to know the correct legal terms. To help you know which terms to use to get the right help or information, we include these legal terms when we give 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 1-855-669-8040 (TTY users call 711) 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 is not connected with us or with any insurance company or health plan. The counselors at this program can help

you understand which process you should use to handle a problem you're having. They can also answer questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers and website URLs in Chapter 2, Section 3 of this document.

Medicare

You can also contact Medicare for help:

- Call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.
- Visit Medicare.gov

SECTION 3 Which process to use for your problem

Is your problem or concern about your benefits or coverage?

This includes problems about whether medical care (medical items, services and/or 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 may 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, if our plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either you or your network doctor can show 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 incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We make a coverage decision whenever we decide what'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 complete the review, we give you our decision.

In limited circumstances a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we'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 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 1-855-669-8040 (TTY users call 711)**
- **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 need to be appointed as your representative. Call Customer Service at 1-855-669-8040 (TTY users call 711) and ask for the Appointment of Representative form. (The form is also available **at CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf**).
    - For medical care or 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 1-855-669-8040 (TTY users call 711) and ask for the Appointment of Representative form. (The form is also available at **CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf** This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.
    - We can accept an appeal request from a representative without the form, but we 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 you 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 1-855-669-8040 (TTY users call 711). 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 Chart. 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 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

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 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 to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage we agreed to within 72 hours after we 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 will notify you in writing when it gets your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a 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 of this chapter 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. The independent review organization will notify you in writing when it gets your 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 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 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. If they take extra days, they will notify you in writing.

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

- For the standard appeal*,* if your request is for a medical item or service, the independent review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it gets your appeal. If your request is for a Part B drug, the

independent 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. If they take extra days, they will notify you in writing.

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 Part B 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 get the decision from the independent review organization**.**
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care 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 the 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 got for medical care

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

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you're asking for a coverage decision. To make this coverage decision, we'll check to see if the medical care you paid for is covered. 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 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 is not covered, or you did not follow all the rules, we won't send payment. Instead, we'll send you a letter that says we won't pay for the medical care and the reasons why.

If you 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 all covered hospital services necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day you leave the hospital. They'll 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, call Customer Service at 1-855-669-8040 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:
   - Your right to get Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay.
   - Where to report any concerns, you have about the quality of your hospital care.
   - Your right to **request an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date, so we'll cover your hospital care for a longer time.

2. **You'll be asked to sign the written notice to show that you got it and understand your rights.**
   - You or someone who is acting on your behalf will be asked to sign the notice.
   - Signing the notice shows *only* that you got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date.

3. **Keep your copy** of the notice so you'll have the information about making an appeal (or reporting a concern about quality of care) if you need it.
   - If you sign the notice more than 2 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, call Customer Service at 1-855-669-8040 (TTY users call 711) or 1-800 MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can also get the notice online at CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

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

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

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it**. If you have questions or need help, call Customer Service at 1-855-669-8040 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. Use the Appendix at the end of this document to find the SHIP for your state. SHIP contact information is available in 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 1-855-669-8040 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227). (TTY users call 1-877-486-2048.) Or you can get a sample notice online at **CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.**

Step 2: The 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 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, **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 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 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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

When you're getting covered **home 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 these 3 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 <u>doesn't</u> 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, call Customer Service at 1-855-669-8040 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. Use the Appendix at the end of this document to find the SHIP for your state. SHIP contact information is available in 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 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, **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 all the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your appeal request, reviewers will decide on your appeal and tell you 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 is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 Taking your appeal to Levels 3, 4, and 5

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 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 not respect 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?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it?

Complaint	Example
	• 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 about the *timeliness* of our actions related to coverage decisions and appeals)	If you 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.

- **Calling Customer Service at 1-855-669-8040 (TTY users call 711) is usually 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.
- **You or someone you name can file the grievance.** You should mail it to:
  Blue Cross Blue Shield of Michigan
  Grievance and Appeals Department
  P.O. Box 2627
  Detroit, MI 48231-2627
  You may also fax it to us at 1-877-348-2251
- 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 **Medicare.gov/my/medicare-complaint**. You can also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users 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 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.

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

Section 2.1 You can end your membership during the Open Enrollment Period

You can end your membership in our plan during the **Open Enrollment Period** each year. During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- **The Open Enrollment Period** is from **October 12 through October 23**.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of coverage:**
    - Another Medicare health plan, with or without drug coverage,
    - Original Medicare *with* a separate Medicare drug plan,
    - Original Medicare *without* a separate Medicare drug plan.
- **Your membership will end in our plan** when your new plan's coverage starts on January 1.

Section 2.2 You can end your membership during the Medicare Advantage Open Enrollment Period

You can make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period** each year.

- **The Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and also for new Medicare enrollees who are enrolled in an MA plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.
- **During the Medicare Advantage Open Enrollment Period** you can:
    - Switch to another Medicare Advantage Plan with or without drug coverage.
    - Disenroll from our plan and get coverage through Original Medicare. If you switch to Original Medicare during this period, you can also join a separate Medicare drug plan at the same time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan, or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare drug plan, your membership in the drug plan will start the first day of the month after the drug plan gets your enrollment request.

Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of Medicare Plus Blue Group PPO may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply to you. These are just examples. For the full list you can contact our plan, call Medicare, or visit Medicare.gov.

- Usually, when you move
- If you have Medicaid
- If we violate our contract with you
- If you're getting care in an institution, such as a nursing home or long-term care (LTC) hospital
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE)

Enrollment time periods vary depending on your situation.

To find out if you're eligible for a Special Enrollment Period, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. If you're eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and drug coverage. You can choose:

- Another Medicare health plan with or without drug coverage.
- Original Medicare *with* a separate Medicare drug plan.
- Original Medicare *without* a separate Medicare drug plan.

Your membership will usually end on the first day of the month after we get your request to change our plan.

Section 2.4 Get more information about when you can end your membership

If you have questions about ending your membership you can:

- **Call Customer Service at 1-855-669-8040 (TTY users call 711)**
- Find the information in the Medicare & You 2027 handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227) TTY users call 1-877-486-2048.

SECTION 3 How to end your membership in our plan

The table below explains how you can end your membership in our plan.

To switch from our plan to:	Here's what to do:
Another Medicare health plan	• Enroll in the new Medicare health plan. • You'll automatically be disenrolled from Medicare Plus Blue Group PPO when your new plan's coverage starts.
Original Medicare *with* a separate Medicare drug plan	• Enroll in the new Medicare drug plan. • You'll automatically be disenrolled from Medicare Plus Blue Group PPO *w*hen your new plan's coverage starts.
Original Medicare *without* a separate Medicare drug plan	• **Send us a written request to disenroll.** Contact Customer Service at 1-855-669-8040 (TTY users call 711) if you need more information on how to do this. • You can also contact **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users call 1-877-486-2048. • You'll be disenrolled from Medicare Plus Blue Group PPO when your coverage in Original Medicare starts.

Note: If you have other creditable drug coverage and disenroll from that coverage, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later after going without creditable drug coverage for 63 days or more in a row.

SECTION 4 Until your membership ends, and your new Medicare coverage starts, 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 5 Medicare Plus Blue Group PPO must end our plan membership 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 away from our service area for more than 6 months
  - If you move or take a long trip, call Customer Service at 1-855-669-8040 (TTY users call 711) 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 national, or an eligible noncitizen
- 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 1-855-669-8040 (TTY users call 711).

Section 5.1 We can't ask you to leave our plan for any health-related reason

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 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 1-877-486-2048.

Section 5.2 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* 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 **HHS.gov/ocr/index.html**.

If you have a disability and need help with access to care, call Customer Service at 1-855-669-8040 (TTY users call 711). If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Medicare Plus Blue Group PPO, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in

subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

SECTION 4 Additional Notice Subrogation and Third-Party Recovery

If we make any payment to you or on your behalf for covered services, we are 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 award, settlement, benefits, or other amounts paid under any automobile insurance

policy law or award, including no-fault;

3. 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;

4. Any arbitration awards, payments, settlements, structured settlements, or other benefits

or amounts paid under an uninsured or under insured motorist coverage policy; or

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

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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 already 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 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 measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you have not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Cardiac rehabilitation, Phase III - Phase III cardiac rehabilitation programs are considered maintenance programs, do not require physician supervision and monitoring, and are not considered medically necessary. See Chapter 4, Section 2.1 for more information about cardiac rehabilitation.

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

Chronic-Care Special Needs Plan - C-SNPs are SNPs that restrict enrollment to MA eligible people who have specific severe and chronic diseases.

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

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. Go to Chapter 4, Section 1 for information about your combined maximum out-of-pocket amount.

Complaint – The formal name for making a complaint is **filing a grievance**. The complaint process is used *only* for certain types of problems. This includes problems about quality of care, waiting times, and the customer service you get. It also includes complaints if our plan 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, or a prescription. 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 gotten. 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 the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

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.

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.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll people who are entitled to both Medicare (Title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (Title XIX). States cover some Medicare costs, depending on the state and person's eligibility.

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

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

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

Emergency Care – Covered services that are: 1) provided by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

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

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

Global Core – A Blue Cross and Blue Shield Association program that allows members to receive urgent and emergent care from providers who participate with Blues plans when traveling outside of the United States and its territories. You will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

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 body other than orally in lieu of receiving the same treatment in a hospital setting. Types of infusion include, but are not limited to: chemotherapy, hydration, pain management, and antibiotic therapy.

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. Our plan must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you're still a member of 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 have a terminal prognosis 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-Based Practice – Many provider offices, health centers or hospital-based outpatient clinics owned and operated by hospitals may charge an additional hospital usage fee when you see any provider in the office, health center or clinic. These hospital-based outpatient facilities conveniently offer a variety of providers and services integrated within one complex. From a Medicare perspective, you are being treated within the hospital system rather than a physician's office and can be subject to a hospital-based usage fee. Even medical centers and provider offices located a long distance from the main hospital campus can be considered part of the hospital. When you use these hospital-based practices – also known as "provider-based" in Medicare terms – they bill a single service in two parts: one bill for the physician's care and another bill for the hospital/facility fees. This can result in higher out-of-pocket costs for you. To find out if your providers are part of a hospital-based or provider-based practice, ask your provider. For more information, see "Outpatient Hospital Services" in Chapter 4, Section 2 Medical Benefits chart.

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.

Initial Enrollment Period – When you're first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

In-Network Maximum Out-of-Pocket Amount – The most you'll pay for covered Part A and Part B services gotten from network (preferred) 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.

Low Income Subsidy (LIS) –Go to Extra Help.

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

Maximum Charge – The maximum charge is the maximum cost that Medicare Plus Blue Group PPO will pay a provider for a particular medical service. The maximum charge includes the amount that Medicare Plus Blue Group PPO pays the provider as well as the amount that you pay (your copay or coinsurance). Our providers are not allowed to balance bill you for the remaining amount.

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for in-network covered Part A and Part B services. Amounts you pay for your plan premiums, Medicare Part A and Part B premiums do not count toward the maximum out-of-pocket amount. See your maximum out-of-pocket Rider for your maximum out-of-pocket amount.

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 Open Enrollment Period – The time period from January 1 to March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan or get coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after a person is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage 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 must cover all the services that are covered by Medicare Part A and B. The term Medicare-Covered Services doesn't include the extra benefits, such as vision, dental, or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in 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.

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill *gaps* in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

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 – A network is a group of providers or pharmacies that are under contract or arrangement with our organization to deliver the benefit package approved by CMS. See Chapter 1, SECTION 6 Keeping your plan membership record up to date.

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**.

Observation (Outpatient Hospital Observation) – An observation stay is an outpatient hospital stay in which you receive medically necessary Medicare-covered services while a decision is being made about whether further treatment requires you to be admitted as an inpatient or if you are well enough to be discharged to your home. You may stay more than one day during an observation stay. Observation services may be given in the emergency department or another area of the hospital. (Also see *Hospital Inpatient Stay*).

Open Enrollment Period – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

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 2 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 gotten is also referred to as the member's out-of-pocket cost requirement.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans get both their Medicare and Medicaid benefits through our plan.

Part A – Generally helps cover services furnished by institutional providers such as hospitals (for inpatient services), skilled nursing facilities, or home health agencies.

Part B – Covers most of the medical services not covered by Part A (such as physician's services and other outpatient services) and certain items (such as durable medical equipment and supplies).

Part B Drugs – Typically an injectable or infusible drug that is not usually self- administered and that is furnished and administered as part of a physician service. If the injection is usually self-administered (e.g., migraine medicines that are injected such as Imitrex) or is not furnished and administered as part of a physician service, it is not covered by Part B. Medicare Part B also covers a limited number of other types of drugs such as nebulizer solutions (albuterol), immunosuppressants, oral anti-cancer medicines, oral anti-nausea medicines, erythropoietins, and some prophylactic vaccines (flu and pneumonia).

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

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Physical Therapy – Includes treatment given by licensed health care professionals to improve the movement and strength of an area of the body, and training on how to use special equipment, such as how to use a walker or get in and out of a wheelchair.

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 in-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 services that help you stay healthy, detect health problems early, determine the most effective treatments, and prevent certain diseases. Preventive services include exams, shots, lab tests, and screenings. They also include programs for health monitoring, and counseling and education to help you take care of your own health.

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 do not need prior authorization to obtain out-of-network services. However, you may want to check with the plan before obtaining services from out-of-network providers to confirm that the service is covered by your plan and what your cost-sharing responsibility is. Covered services that need prior authorization are marked in the 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.

Referral – A written order from your primary care doctor for you to visit a specialist or get certain medical services. Without a referral, our plan may not pay for services from a specialist.

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

Screenings – Preventive tests performed when no specific sign, symptom, or diagnosis is present. Screenings check for disease or signs of disease so that early detection and treatment can be provided for those who test positive for disease. A screening is not the same as a diagnostic procedure. (Also see Diagnostic Procedure).

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 live in a nursing home, or who have certain chronic medical conditions.

Speech Therapy – Includes exercises given by licensed health care professionals to regain and strengthen speech and/or swallowing skills.

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.

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 get 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.

Addendum

Durable medical equipment coverage limitations

The list below includes the plan's preferred brands or models of diabetic supplies.

Continuous Diabetic Blood Glucose Monitors (only available at a network pharmacy):

- FreeStyle Libre
- Dexcom G Series

ALL non-preferred Continuous Diabetic Blood Glucose Monitors will incur non-preferred coinsurance.

Insulin Pumps:

- Tandem t:slim
- BetaBionics
- Medtronic MiniMed (will incur non-preferred coinsurance for Continuous Diabetic Blood Glucose Monitor, if this pump is selected)

Insulin Pump Supplies:

- Medtronic MiniMed (standard 72-hour wear only)
- Tandem t:slim
- BetaBionics

Preferred Traditional Blood Glucose Monitors and Test Strips (available at a network pharmacy):

- Accu-Chek
- Contour

Non-Preferred Traditional Blood Glucose Monitors and Test Strips (available at a network pharmacy), will incur non-preferred coinsurance:

- OneTouch
- FreeStyle
- Glucocard
- Foracare
- EasyMax
- Prodigy

Appendix

Exhibit 1 State Health Insurance Assistance Programs

State:	Alabama
Local:	1-334-242-5743
Toll-free:	1-800-243-5463
Website:	**www.alabamaageline.gov**
Address:	RSA Tower 201 Monroe Street Suite 350 Montgomery, AL 36104

State:	Arkansas
Local:	1-501-371-2600
Toll-free:	1-800-282-9134
Website:	**https://insurance.arkansas.gov/consumer-services/senior-health/**
Address:	Arkansas Insurance Department 1 Commerce Way Little Rock, AR 72202

State:	Alaska
Local:	1-907-269-3666
Website:	**dhss.alaska.gov/dsds/pages/medicare/default.aspx**
Address:	Senior and Disability Services 3601 C Street Suite 902 Anchorage, AK 99503

State:	California
Local:	1-916-419-7500
TTY:	1-800-735-2929
Website:	**www.aging.ca.gov/HICAP/**
Address:	California Department of Aging 2880 Gateway Oaks Drive Suite 200 Sacramento, CA 95833

State:	Arizona
Local:	1-602-542-4791
Toll-free:	1-800-432-4040
Website:	**des.az.gov/medicare-assistance**
Address:	DES Division of Aging and Adult Services Site Code 950A 1789 W. Jefferson Street Mail Drop 6271 Phoenix, AZ 85007

State:	Colorado
Local:	1-303-894-7499
Toll-free:	1-800-930-3745
Website:	**doi.colorado.gov**
Address:	Colorado Division of Insurance 1560 Broadway Suite 850 Denver, CO 80202

Exhibit 1 State Health Insurance Assistance Programs

State:	Connecticut
Local:	1-860-424-5055
Toll-free:	1-866-218-6631
Website:	**portal.ct.gov/aginganddisability**
Address:	Aging and Disability Services 55 Farmington Avenue, 12th floor Hartford, CT 06105

State:	Florida
Local:	1-800-963-5337
TDD/TTY:	1-800-955-8770
Website:	**www.floridashine.org**
Address:	Department of Elder Affairs SHINE Program 4040 Esplanade Way Suite 270 Tallahassee, FL 32399

State:	Delaware
Local:	1-302-674-7300
Toll-free:	1-800-282-8611
Website:	**https://insurance.delaware.gov/divisions/dmab/**
Address:	Insurance Commissioner 1351 West North Street Suite 101 Dover, DE 19904

State:	Georgia
Toll-free:	1-866-552-4464
Website:	**aging.georgia.gov/georgia-ship**
Address:	Georgia SHIP 47 Trinity Ave. S.W. Atlanta, GA 30334

State:	District of Columbia
Local:	1-202-727-8370
TTY:	711
Website:	**dacl.dc.gov/service/health-insurance-counseling**
Address:	Department of Aging and Community Living 250 E Street SW Washington, DC 20024

State:	Guam
Local:	1-671-735-7421
TTY:	1-671-735-7415
Website:	**https://dphss.guam.gov/**
Address:	Division of Senior Citizens 130 University Drive, Suite 8 University Castle Mall Mangilao, Guam 96913

Exhibit 1 State Health Insurance Assistance Programs

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

State:	Indiana
Local:	1-800-452-4800
TTY:	1-888-311-1846
Website:	**www.medicare.in.gov**
Address:	SHIP 311 W. Washington Street Suite 300 Indianapolis, IN 46204

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

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

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

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

Exhibit 1 State Health Insurance Assistance Programs

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

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

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

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

State:	Maine
Local	1-207-287-3707
Toll-free:	1-800-262-2232
TTY:	711
Website:	**https://www.maine.gov/dhhs/oads**
Address:	Department of Health and Human Services 109 Capitol Street 11 State House Station Augusta, Maine 04333

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

Exhibit 1 State Health Insurance Assistance Programs

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

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

State:	Mississippi
Local:	1-601-359-4915
Toll-free:	1-844-822-4622
Website:	**www.mississippiaccesstocare.org**
Address:	Mississippi Dept. of Human Services Division of Aging and Adult Services 1170 Lakeland Dr. Jackson MS 39216

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

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

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

Exhibit 1 State Health Insurance Assistance Programs

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

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

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

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

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

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

Exhibit 1 State Health Insurance Assistance Programs

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

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

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

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

State:	Oregon
Toll-free:	1-800-722-4134
TTY:	711
Website:	**shiba.oregon.gov/Pages/index.aspx**
Address:	Oregon SHIBA 500 Summer St NE, E-12, Salem, OR 97309

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

Exhibit 1 State Health Insurance Assistance Programs

State:	South Carolina
Local:	1-803-734-9900
TTY:	1-800-868-9095
Website:	**www.aging.sc.gov/Pages/default.aspx**
Address:	South Carolina Department on Aging 1301 Gervais Street Suite 350 Columbia, SC 29201

State:	South Dakota Western
Local:	1-605-773-5990
Toll-free:	1-800-265-9684
Website:	**https://dhs.sd.gov/en**
Address:	South Dakota Department of Human Services 3800 E. Highway 34 – Hillsview Plaza c/o 500 East Capitol Ave Pierre, SD 57501

State:	South Dakota Eastern
Local:	1-605-773-5990
Toll-free:	1-800-265-9684
Website:	**https://dhs.sd.gov/en**
Address:	South Dakota Department of Human Services 3800 E Highway 34 Hillsview Plaza c/o 500 East Capitol Ave. Pierre, SD 57501

State:	Tennessee
Toll-free:	1-877-801-0044 / 1-800-535-9725
Website:	**https://www.tn.gov/disability-and-aging/councils-and-commissions/commission-on-aging-and-disability.html**
Address:	Tennessee Commission on Aging And Disability 315 Deaderick St. Nashville, TN 37243

State:	South Dakota Central
Local:	1-605-773-5990
Toll-free:	1-800-265-9684
Website:	**https://dhs.sd.gov/en**
Address:	South Dakota Department of Human Services 3800 East Highway 34 Hillsview Plaza c/o 500 East Capitol Ave Pierre, SD 57501

State:	Texas
Local:	1-512-424-6500
TTY:	1-512-424-6597
Website:	**hhs.texas.gov/services/health/medicare**
Address:	North Austin Complex 4601 W. Guadalupe St. Austin, TX 78751

Exhibit 1 State Health Insurance Assistance Programs

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

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

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

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

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

State:	Washington
Toll-free:	1-800-562-6900
TDD:	1-360-586-0241
Website:	**www.insurance.wa.gov/statewide-health-insurance-benefits-advisors-shiba**
Address:	Office of the Insurance Commissioner 5000 Capitol Blvd SE, Tumwater, WA 98501

Exhibit 1 State Health Insurance Assistance Programs

State:	West Virginia
Local:	1-304-558-3317
Toll-free:	1-877-987-4463
Website:	**www.wvship.org**
Address:	West Virginia SHIP / SMP 1900 Kanawha Blvd. East Charleston, WV 25305

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

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

Appendix

Exhibit 2 Quality Improvement Organization

State:	Alabama
Organization:	Acentra Health
Toll-free:	1-888-317-0751
TTY:	711
Website:	**www.acentraqio.com**
Address:	Acentra Health 1650 Summit Lake Dr. Suite 102 Tallahassee, FL 32317

State:	Arkansas
Organization:	Acentra Health
Toll-free:	1-888-315-0636
TTY:	711
Website:	**www.acentraqio.com**
Address:	Acentra Health 1650 Summit Lake Dr. Suite 102 Tallahassee, FL 32317

State:	Alaska
Organization:	Acentra Health
Toll-free:	1-888-305-6759
TTY:	711
Website:	**www.acentraqio.com**
Address:	Acentra Health 1650 Summit Lake Dr. Suite 102 Tallahassee, FL 32317

State:	California
Organization:	Commence Health
Toll-free:	1-877-588-1123
TTY:	711
Website:	**www.livantaqio.cms.gov/en**
Address:	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23454

State:	Arizona
Organization:	Commence Health
Local:	1-877-588-1123
TTY:	711
Website:	**www.livantaqio.cms.gov/en**
Address:	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23454

State:	Colorado
Organization:	Acentra Health
Toll-free:	1-888-317-0891
TTY:	711
Website:	**www.acentraqio.com**
Address:	Acentra Health 1650 Summit Lake Dr. Suite 102 Tallahassee, FL 32317

Exhibit 2 Quality Improvement Organization

State:	Connecticut
Organization:	Acentra Health
Toll-free:	1-888-319-8452
TTY:	711
Website:	**www.acentraqio.com**
Address:	Acentra Health 1650 Summit Lake Dr. Suite 102 Tallahassee, FL 32317

State:	Florida
Organization:	Acentra Health
Toll-free:	1-888-317-0751
TTY:	711
Website:	**www.acentraqio.com**
Address:	Acentra Health 1650 Summit Lake Dr. Suite 102 Tallahassee, FL 32317

State:	Delaware
Organization:	Commence Health
Toll-free:	1-888-396-4646
TTY:	711
Website:	**www.livantaqio.cms.gov/en**
Address:	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23454

State:	Georgia
Organization:	Acentra Health
Toll-free:	1-888-317-0751
TTY:	711
Website:	**www.acentraqio.com**
Address:	Acentra Health 1650 Summit Lake Dr. Suite 102 Tallahassee, FL 32317

State:	District of Columbia
Organization:	Commence Health
Toll-free:	1-888-396-4646
TTY:	711
Website:	**www.livantaqio.cms.gov/en**
Address:	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23454

State:	Hawaii
Organization:	Commence Health
Toll-free:	1-877-588-1123
TTY:	711
Website:	**www.livantaqio.cms.gov/en**
Address:	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23454

Exhibit 2 Quality Improvement Organization

State:	Idaho
Organization:	Acentra Health
Toll-free:	1-888-305-6759
TTY:	711
Website:	**www.acentraqio.com**
Address:	Acentra Health 1650 Summit Lake Dr. Suite 102 Tallahassee, FL 32317

State:	Iowa
Organization:	Commence Health
Toll-free:	1-888-755-5580
TTY:	711
Website:	**www.livantaqio.cms.gov/en**
Address:	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23454

State:	Illinois
Organization:	Commence Health
Toll-free:	1-888-524-9900
TTY:	711
Website:	**www.livantaqio.cms.gov/en**
Address:	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23454

State:	Kansas
Organization:	Commence Health
Toll-free:	1-888-755-5580
TTY:	711
Website:	**www.livantaqio.cms.gov/en**
Address:	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23454

State:	Indiana
Organization:	Commence Health
Toll-free:	1-888-524-9900
TTY:	711
Website:	**www.livantaqio.cms.gov/en**
Address:	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23454

State:	Kentucky
Organization:	Acentra Health
Toll-free:	1-888-317-0751
TTY:	711
Website:	**www.acentraqio.com**
Address:	Acentra Health 1650 Summit Lake Dr. Suite 102 Tallahassee, FL 32317

Exhibit 2 Quality Improvement Organization

State:	Louisiana
Organization:	Acentra Health
Toll-free:	1-888-315-0636
TTY:	711
Website:	**www.acentraqio.com**
Address:	Acentra Health 1650 Summit Lake Dr. Suite 102 Tallahassee, FL 32317

State:	Massachusetts
Organization:	Acentra Health
Toll-free:	1-888-319-8452
TTY:	711
Website:	**www.acentraqio.com**
Address:	Acentra Health 1650 Summit Lake Dr. Suite 102 Tallahassee, FL 32317

State:	Maine
Organization:	Acentra Health
Toll-free:	1-888-319-8452
TTY:	711
Website:	**www.acentraqio.com**
Address:	Acentra Health 1650 Summit Lake Dr. Suite 102 Tallahassee, FL 32317

State:	Michigan
Organization:	Commence Health
Toll-free:	1-888-524-9900
TTY:	711
Website:	**www.livantaqio.cms.gov/en**
Address:	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23454

State:	Maryland
Organization:	Commence Health
Toll-free:	1-888-396-4646
TTY:	711
Website:	**www.livantaqio.cms.gov/en**
Address:	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23454

State:	Minnesota
Organization:	Commence Health
Toll-free:	1-888-524-9900
TTY:	711
Website:	**www.livantaqio.cms.gov/en**
Address:	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23454

Exhibit 2 Quality Improvement Organization

State:	Mississippi
Organization:	Acentra Health
Toll-free:	1-888-317-0751
TTY:	711
Website:	**www.acentraqio.com**
Address:	Acentra Health 1650 Summit Lake Dr. Suite 102 Tallahassee, FL 32317

State:	Nebraska
Organization:	Commence Health
Toll-free:	1-888-755-5580
TTY:	711
Website:	**www.livantaqio.cms.gov/en**
Address:	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23454

State:	Missouri
Organization:	Commence Health
Toll-free:	1-888-755-5580
TTY:	711
Website:	**www.livantaqio.cms.gov/en**
Address:	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23454

State:	Nevada
Organization:	Commence Health
Toll-free:	1-877-588-1123
TTY:	711
Website:	**www.livantaqio.cms.gov/en**
Address:	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23454

State:	Montana
Organization:	Acentra Health
Toll-free:	1-888-317-0891
TTY:	711
Website:	**www.acentraqio.com**
Address:	Acentra Health 1650 Summit Lake Dr. Suite 102 Tallahassee, FL 32317

State:	New Hampshire
Organization:	Acentra Health
Toll-free:	1-888-319-8452
TTY:	711
Website:	**www.acentraqio.com**
Address:	Acentra Health 1650 Summit Lake Dr. Suite 102 Tallahassee, FL 32317

Exhibit 2 Quality Improvement Organization

State:	New Jersey
Organization:	Commence Health
Toll-free:	1-866-815-5440
TTY:	711
Website:	**www.livantaqio.com**
Address:	BFCC-QIO Program Livanta LLC PO Box 2687 Virginia Beach, VA 23454

State:	North Carolina
Organization:	Acentra Health
Toll-free:	1-888-317-0751
TTY:	711
Website:	**www.acentraqio.com**
Address:	Acentra Health 1650 Summit Lake Dr. Suite 102 Tallahassee, FL 32317

State:	New Mexico
Organization:	Acentra Health
Toll-free:	1-888-315-0636
TTY:	711
Website:	**www.acentraqio.com**
Address:	Acentra Health 1650 Summit Lake Dr. Suite 102 Tallahassee, FL 32317

State:	North Dakota
Organization:	Acentra Health
Toll-free:	1-888-317-0891
TTY:	711
Website:	**www.acentraqio.com**
Address:	Acentra Health 1650 Summit Lake Dr. Suite 102 Tallahassee, FL 32317

State:	New York
Organization:	Commence Health
Toll-free:	1-866-815-5440
TTY:	711
Website:	**www.livantaqio.cms.gov/en**
Address:	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23454

State:	Ohio
Organization:	Commence Health
Toll-free:	1-888-524-9900
TTY:	711
Website:	**www.livantaqio.cms.gov/en**
Address:	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23454

Exhibit 2 Quality Improvement Organization

State:	Oklahoma
Organization:	Acentra Health
Toll-free:	1-888-315-0636
TTY:	711
Website:	**www.acentraqio.com**
Address:	Acentra Health 1650 Summit Lake Dr. Suite 102 Tallahassee, FL 32317

State:	Puerto Rico
Organization:	Commence Health
Toll-free:	1-866-815-5440
Local:	1-787-520-5743
TTY:	711
Website:	**www.livantaqio.cms.gov/en**
Address:	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23454

State:	Oregon
Organization:	Acentra Health
Toll-free:	1-888-305-6759
TTY:	711
Website:	**www.acentraqio.com**
Address:	Acentra Health 1650 Summit Lake Dr. Suite 102 Tallahassee, FL 32317

State:	Rhode Island
Organization:	Acentra Health
Toll-free:	1-888-319-8452
TTY:	711
Website:	**www.acentraqio.com**
Address:	Acentra Health 1650 Summit Lake Dr. Suite 102 Tallahassee, FL 32317

State:	Pennsylvania
Organization:	Commence Health
Toll-free:	1-888-396-4646
TTY:	711
Website:	**www.livantaqio.cms.gov/en**
Address:	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23454

State:	South Carolina
Organization:	Acentra Health
Toll-free:	1-888-317-0751
TTY:	711
Website:	**www.acentraqio.com**
Address:	Acentra Health 1650 Summit Lake Dr. Suite 102 Tallahassee, FL 32317

Exhibit 2 Quality Improvement Organization

State:	South Dakota
Organization:	Acentra Health
Toll-free:	1-888-317-0891
TTY:	711
Website:	**www.acentraqio.com**
Address:	Acentra Health 1650 Summit Lake Dr. Suite 102 Tallahassee, FL 32317

State:	Utah
Organization:	Acentra Health
Toll-free:	1-888-317-0891
TTY:	711
Website:	**www.acentraqio.com**
Address:	Acentra Health 1650 Summit Lake Dr. Suite 102 Tallahassee, FL 32317

State:	Tennessee
Organization:	Acentra Health
Toll-free:	1-888-317-0751
TTY:	711
Website:	**www.acentraqio.com**
Address:	Acentra Health 1650 Summit Lake Dr. Suite 102 Tallahassee, FL 32317

State:	Vermont
Organization:	Acentra Health
Toll-free:	1-888-319-8452
TTY:	711
Website:	**www.acentraqio.com**
Address:	Acentra Health 1650 Summit Lake Dr. Suite 102 Tallahassee, FL 32317

State:	Texas
Organization:	Acentra Health
Toll-free:	1-888-315-0636
TTY:	711
Website:	**www.acentraqio.com**
Address:	Acentra Health 1650 Summit Lake Dr. Suite 102 Tallahassee, FL 32317

State:	Virgin Islands
Organization:	Commence Health
Toll-free:	1-866-815-5440
Local:	1-340-773-6334
TTY:	711
Website:	**www.livantaqio.cms.gov/en**
Address:	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23454

Exhibit 2 Quality Improvement Organizations

State:	Virginia
Organization:	Commence Health
Toll-free:	1-888-396-4646
TTY:	711
Website:	**www.livantaqio.cms.gov/en**
Address:	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23454

State:	Wisconsin
Organization:	Commence Health
Toll-free:	1-888-524-9900
TTY:	711
Website:	**www.livantaqio.cms.gov/en**
Address:	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23454

State:	Washington
Organization:	Acentra Health
Toll-free:	1-888-305-6759
TTY:	711
Website:	**www.acentraqio.com**
Address:	Acentra Health 1650 Summit Lake Dr. Suite 102 Tallahassee, FL 32317

State:	Wyoming
Organization:	Acentra Health
Toll-free:	1-888-317-0891
TTY:	711
Website:	**www.acentraqio.com**
Address:	Acentra Health 1650 Summit Lake Dr. Suite 102 Tallahassee, FL 32317

State:	West Virginia
Organization:	Commence Health
Toll-free:	1-888-396-4646
TTY:	711
Website:	**www.livantaqio.cms.gov/en**
Address:	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23454

Exhibit 3 State Medicaid Agencies

lnformation on Medicaid by state is available at this website:
https://www.medicaid.gov/about-us/contact-us/contact-state page.html

State:	Alabama
Agency:	Alabama Medicaid Agency
Local:	1-334-242-5000
Website:	**https://medicaid.alabama.gov/**
Address:	Alabama Medicaid Agency P.O. Box 5624 Montgomery, AL 36103

State:	Arkansas
Agency:	Arkansas Medicaid Program
Local:	1-501-682-1001
Toll-free:	1-800-482-8988
Website:	**humanservices.arkansas.gov/divisions-shared-services/medical-services/**
Address:	Division of Medical Services P.O. Box 1437, Slot S401 Little Rock, AR 72203

State:	Alaska
Agency:	Alaska Medicaid Program
Toll-free:	1-800-478-7778
TDD:	711
Website:	**health.alaska.gov/dpa/pages/medicaid/default.aspx**
Address:	Division of Public Assistance Senior Benefits 3601 C Street, Suite 902 Anchorage, AK 99503

State:	California
Agency:	Medi-Cal
Toll-free:	1-800-541-5555
Website:	**https://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-Cal_EHB_Benefits.aspx**
Address:	Medi-Cal Eligibility Division P.O. Box 997413 MS 0000 Sacramento, CA 95899

State:	Arizona
Agency:	Arizona Health Care Cost Containment System (AHCCCS)
Local:	1-602-417-4000
Toll-free:	1-800-654-8713
Website:	**www.azahcccs.gov**
Address:	AHCCCS 150 N. 18th Ave. Phoenix, AZ 85007

State:	Colorado
Agency:	Health First Colorado
Toll-free:	1-800-221-3943
TTY:	711
Website:	**www.healthfirstcolorado.com**
Address:	Department of Health Care Policy & Financing 303 E. 17th Avenue Suite 1100 Denver, CO 80203

Exhibit 3 State Medicaid Agencies

State:	Connecticut
Agency:	Husky Health Connecticut
Local:	1-855-805-4325
Toll-free:	1-855-789-2428
Website:	**https://health.ct.gov/elderly-longterm-are?language=en_US**
Address:	Husky Health Program P.O. Box 5005 Wallingford, CT 06492

State:	Florida
Agency:	Florida Medicaid Program
Local:	1-850-300-4323
TTY:	711 / 1-800-955-8771
Website:	**https://www.myflfamilies.com/services/public-assistance**
Address:	ACCESS Central Mail Center PO Box 1770 Ocala, FL 34478

State:	Delaware
Agency:	Delaware Medicaid Program
Local:	1-302-255-9040
Website:	**dhss.delaware.gov/dmma**
Address:	Delaware Health and Social Services 1901 N. Dupont Highway New Castle, DE 19720

State:	Georgia
Agency:	Georgia Dept. of Community Health Georgia Medicaid Program
Local:	1-404-657-5468
Toll-free:	1-877-423-4746
Website:	**medicaid.georgia.gov/**
Address:	Georgia Dept. of Community Health 2 M.L.K Jr. Dr. SE, East Tower Atlanta, GA 30334

State:	District of Columbia
Agency:	D.C. Medicaid Program
Local:	1-202-671-4200
TTY:	711
Website:	**dhs.dc.gov/page/apply-recertify-benefits**
Address:	Department of Human Services 64th New York Ave, NE 6th floor Washington, DC 20002

State:	Guam
Agency:	Medicaid Assistance Program
Local:	1-671-922-2510
Website:	**dphss.guam.gov/division-of-public-welfare/**
Address:	Department of Public Health and Social Services 155 Hesler Place Hagatna, Guam 96910

Exhibit 3 State Medicaid Agencies

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

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

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

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

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

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

Exhibit 3 State Medicaid Agencies

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

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

State:	Hawaii
Agency:	Med-Quest
Molokai Unit:	1-800-316-8005
Website:	**medquest.hawaii.gov/**
Address:	Med-Quest - Molokai Unit State Civic Center 65 Makaena Street Room 110 Kaunakakai, HI 96748

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

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

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

Exhibit 3 State Medicaid Agencies

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

State:	Kentucky
Agency:	Kentucky Medicaid Program
Local:	1-502-564-5497
Toll-free:	1-833-372-0004
Website:	**chfs.ky.gov/agencies/dms/Pages/default.aspx**
Address:	Department for Medicaid Services 275 E. Main St. Frankfort, KY 40621

State:	Iowa
Agency:	Iowa Medicaid Program IA Health Link
Local:	1-877-347-5678
Toll-free:	1-800-972-2017
TTY:	1-800-735-2942
Website:	**dhs.iowa.gov/**
Address:	Department of Human Services Member Services 321 E. 12th Street Des Moines, Iowa 50319

State:	Louisiana
Agency:	Louisiana Medicaid Program
Local:	1-225-342-9500
Website:	**ldh.la.gov**
Address:	Louisiana Department of Health P.O. Box 629 Baton Rouge, LA 70821

State:	Kansas
Agency:	KanCare Medicaid for Kansas
Local:	1-800-792-4884
TTY:	1-800-792-4292
Website:	**www.kancare.ks.gov**
Address:	KanCare Clearinghouse P.O. Box 3599 Topeka, KS 66601

State:	Maine
Agency:	MaineCare
Local:	1-207-287-3707
TTY:	711
Website:	**www.maine.gov/dhhs/oms**
Address:	Dept. of Health and Human Services 109 Capitol Street 11 State House Station Augusta, ME 04333

Exhibit 3 State Medicaid Agencies

State:	Maryland
Agency:	Maryland Medical Assistance Program
Local:	1-410-767-6500
Toll-free:	1-877-463-3464
Website:	**mmcp.health.maryland.gov/Pages/home.aspx**
Address:	Maryland Department of Health 201 W. Preston St Baltimore, MD 21201

State:	Minnesota
Organization:	Minnesota Medicaid Program
Local:	1-651-431-2700
Toll-free:	1-800-366-5411
Website:	**mn.gov/dhs/**
Address:	Minnesota Health Care Programs Member and Provider Services P.O. Box 64993 St. Paul, MN 55164

State:	Massachusetts
Agency:	MassHealth
Local:	1-800-841-2900
TTY:	711
Website:	**www.mass.gov/topics/masshealth**
Address:	Health Insurance Processing Center P.O. Box 4405 Taunton, MA 02780

State:	Mississippi
Agency:	Mississippi Medicaid Program
Local:	1-601-359-6050
Toll-free	1-800-421-2408
TDD:	1-228-206-6062
Website:	**www.medicaid.ms.gov**
Address:	Mississippi Division of Medicaid P.O. Box 2222 Jackson, Mississippi 39225

State:	Michigan
Agency:	Michigan Medicaid Program
MI Enrolls:	1-800-975-7630
Helpline:	1-800-642-3195
TTY:	1-888-263-5897
Website:	**www.michigan.gov/mdhhs/assistance-programs/medicaid**
Address:	Michigan Department of Health & Human Services 333 S. Grand Ave P.O. Box 30195 Lansing, MI 48909

State:	Missouri
Agency:	MO HealthNet Division
Local:	1-573-526-9400
TTY:	711
Website:	**https://mydss.mo.gov/mhd**
Address:	Family Support Division P.O. Box 2700 Jefferson City, MO 65102

Exhibit 3 State Medicaid Agencies

State:	Montana
Agency:	Montana Medicaid Program
Toll-free:	1-406-444-0273
TTY:	1-888-706-1535
Website:	**https://dphhs.mt.gov/MontanaHealthcarePrograms/MemberServices**
Address:	Montana Dept. of Public Health and Human Services P.O. Box 202951 1400 Broadway Helena, MT 59620

State:	Nevada
Agency:	Nevada Medicaid Program
Local:	1-877-638-3472
TTY:	711
Website:	**dwss.nv.gov**
Address:	Nevada Medicaid Customer Service P.O. Box 30042 Reno, NV 89520

State:	Nebraska
Agency:	Nebraska Medicaid Program
Local:	1-402-471-3121
TDD:	1-800-833-7352
Website:	**dhhs.ne.gov/Pages/Medicaid-Clients.aspx**
Address:	Nebraska Department of Health & Human Services P.O. Box 95026 Lincoln, NE 68509

State:	New Hampshire
Agency:	New Hampshire Medicaid Program
Toll-Free:	1-844-275-3447
TTY:	1-800-735-2964
Website:	**www.dhhs.nh.gov/programs-services/medicaid**
Address:	Division of Medicaid Services NH Department of Health & Human Services 129 Pleasant Street Concord, NH 03301

Exhibit 3 State Medicaid Agencies

State:	New Jersey
Agency:	New Jersey Medicaid Program NJ Family Care
Local:	1-800-701-0710
TTY:	711
Website:	**www.njfamilycare.org**
Address:	NJ Department of HumanServices Division of Medical Assistance & Health Services P.O. Box 712 Trenton, NJ 08625

State:	North Carolina
Agency:	North Carolina Medicaid Program
Local:	1-888-245-0179
Website:	**https://medicaid.ncdhhs.gov/**
Address:	North Carolina Division of Medical Assistance 2501 Mail Service Center Raleigh, NC 27699

State:	New Mexico
Agency:	New Mexico Medicaid Program Centennial Care
Local:	1-800-283-4465
Website:	**www.hsd.state.nm.us**
Address:	NM Human Services Department P.O. Box 2348 Santa Fe, NM 87504

State:	North Dakota
Agency:	North Dakota Medicaid Program
Local:	1-701-328-7068
Toll-free:	1-800-755-2604
TTY:	711
Website:	**https://www.hhs.nd.gov/adults-and-aging**
Address:	North Dakota Health and Human Services 600 E. Boulevard Ave., Dept. 325 Bismarck, ND 58505

State:	New York
Agency:	New York Medicaid Program
Local:	1-800-541-2831
TTY:	711
Website:	**health.ny.gov/health_care/medicaid/**
Address:	New York State Department of Health Corning Tower Empire State Plaza, Albany, NY 12237

State:	Ohio
Agency:	Ohio Department of Medicaid
Local:	1-800-324-8680
Website:	**www.ohiomh.com**
Address:	Ohio Department of Medicaid 505 South High Street Suite 200 Columbus, OH 43215

Exhibit 3 State Medicaid Agencies

State:	Oklahoma
Agency:	SoonerCare
Local:	1-800-987-7767
TTY:	711
Website:	**www.okhca.org**
Address:	Oklahoma Health Care Authority 4345 N. Lincoln Blvd. Oklahoma City, OK 73105

State:	Puerto Rico
Agency:	Puerto Rico Department of Health Medicaid Program
Local:	1-787-765-2929, Ext. 6700
TTY:	1-787-625-6955
Website:	**www.medicaid.pr.gov/**
Address:	Programa Medicaid Departamento de Salud P.O. Box 70184 San Juan, PR 00936

State:	Oregon
Agency:	Oregon Health Plan
Local:	1-503-947-2340
TTY:	711
Website:	**https://www.oregon.gov/oha/Pages/index.aspx**
Address:	Oregon Health Authority Director's Office 500 Summer Street NE, E-20 Salem, OR 97301

State:	Rhode Island
Agency:	HealthSource RI
Local:	1-855-840-4774
TTY:	1-888-657-3173
Website:	**www.healthsourceri.com/medicaid**
Address:	HealthSource RI Walk-In Center 401 Wampanoag Trail East Providence, RI 02915

State:	Pennsylvania
Agency:	Pennsylvania Medical Assistance Program
Local:	1-800-692-7462
TDD:	1-800-451-5886
Website:	**www.dhs.pa.gov**
Address:	Department of Human Services P.O. Box 2675 Harrisburg, PA 17105

State:	South Carolina
Agency:	South Carolina Medicaid Program
Local:	1-888-549-0820
TTY:	1-888-842-3620
Website:	**www.scdhhs.gov**
Address:	SCDHHS P.O. Box 8206 Columbia, SC 29202

Exhibit 3 State Medicaid Agencies

State:	South Dakota
Agency:	Healthy Connections
Local:	1-605-773-3165
TTY:	711
Website:	**dss.sd.gov/medicaid**
Address:	South Dakota Department of Social Services 700 Governors Drive Pierre, SD 57501

State:	Utah
Agency:	Utah Medicaid Program
Local:	1-801-538-6155
Toll-free:	1-800-662-9651
TTY:	711
Website:	**medicaid.utah.gov/**
Address:	Utah Dept. of Health and Human Services P.O. Box 143106 Salt Lake City, UT 84114

State:	Tennessee
Agency:	TennCare
Local:	1-855-259-0701
TTY:	1-877-779-3103
Website:	**www.tn.gov/tenncare.html**
Address:	TennCare Connect P.O. Box 305240 Nashville, TN 37230

State:	Vermont
Agency:	Green Mountain Care
Local:	1-802-879-5900
TTY:	711
Website:	**https://dvha.vermont.gov/members**
Address:	Department of Vermont Health Access 280 State Dr. NOB 1 South Waterbury, VT 05671

State:	Texas
Agency:	Texas Medicaid Program
Local:	1-512-424-6500
TTY:	1-800-735-2989 / 512-424-6597
Website:	**https://www.hhs.texas.gov/services/health/medicaid-chip**
Address:	Texas Health and Human Services P.O. Box 13247 Austin, TX 78711

State:	Virgin Islands – St. Thomas
Agency:	Medical Assistance Program
St. Thomas:	1-340-774-0930
Website:	**https://dhs.vi.gov/office-of-medicaid/**
Address:	Department of Human Service – St. Thomas 1303 Hospital Ground Knud Hansen Complex Building A St. Thomas, VI 00820

Exhibit 3 State Medicaid Agencies

State:	Virgin Islands – St. Croix
Agency:	Healthy Connections
St. Croix:	1-340-718-2980
Website:	**https://dhs.vi.gov/office-of-medicaid/**
Address:	Department of Human Services 3011 Golden Rock Christiansted St. Croix, VI 00820

State:	West Virginia
Agency:	Bureau for Medical Services
Local:	1-304-558-1700
Toll-free:	1-877-716-1212
TTY:	711
Website:	**dhhr.wv.gov/bms/pages/default.aspx**
Address:	West Virginia Bureau for Medical Services 350 Capitol St. Room 251 Charleston, WV 25301

State:	Virginia
Agency:	Department of Medical Assistance Services (DMAS)
Toll-free:	1-800-643-2273
TTY:	1-800-817-6608
Website:	**www.dmas.virginia.gov**
Address:	Cover Virginia 600 East Broad Street Richmond, VA 23219

State:	Wisconsin
Agency:	Wisconsin Medicaid Program
Local:	1-608-266-1865
TTY:	711 / 1-800-947-3529
Website:	**www.dhs.wisconsin.gov/medicaid/index.htm**
Address:	Department of Health Services 1 West Wilson Street Madison, WI 53703

State:	Washington
Agency:	Apple Health
Local:	1-800-562-3022
TTY:	711
Website:	**https://www.hca.wa.gov/**
Address:	Washington State Health Care Authority P.O. Box 45531 Olympia, WA 98504

State:	Wyoming
Agency:	EqualityCare
Local:	1-307-777-7656
Toll-free:	1-866-571-0944
TTY:	711
Website:	**health.wyo.gov/healthcarefin/medicaid/**
Address:	Wyoming Department of Health 122 W 25th St 4th Floor West Cheyenne, WY 82001

Medicare Plus Blue Group PPO Customer Service

Call	**1-855-669-8040** Calls to this number are free. Available from 8 a.m. to 5:30 p.m. Eastern time, Monday through Friday. From October 1 through March 31, hours are from 8 a.m. to 8 p.m. Eastern time, seven days a week. Customer Service also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. Available from 8 a.m. to 5:30 p.m. Eastern time, Monday through Friday. From October 1 through March 31, hours are from 8 a.m. to 8 p.m. seven days a week.
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
Website	**bcbsm.com/umichmaplans**

MI Options

MI Options is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

Call	**1-800-803-7174** Available from 9 a.m. to 4:30 p.m. Eastern time, Monday through Friday.
TTY	**711**
Write	Michigan Medicare and Medicaid Assistance Program 6105 West St. Joseph Hwy., Suite 204 Lansing, MI 48917-4850
Website	**michigan.gov/MDHHSMIOptions**

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.