2019 Medicare PLUS BlueSM Group PPO

Guide to understanding your explanation of benefits statements and cost-sharing for UAW Trust members

This guide will help you understand the information on your EOB and how cost-sharing works with your plan. We encourage you to become more familiar with both of these important parts of your Medicare Plus Blue Group PPO plan.
As a member of the Medicare Plus Blue Group PPO plan, once we have received and processed a claim for medical services, you will receive an explanation of benefits, or EOB (also known as a monthly summary report), for claims processed in the previous month. The EOB will show you:

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

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

EOB statement details

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

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

3. Shows the balances to date for deductibles and out-of-pocket maximums for your current benefit period.
Detailed information about the claim we processed:

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

B. Information your provider puts on the claim to identify the medical service you received.

C. The amount submitted to Blue Cross on the claim.

D. The amount approved by Blue Cross for your services.

E. What Blue Cross paid.

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

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

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

Online EOBS

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

1. Go to bcbsm.com and follow steps to create a member account.

2. After logging in, select Claims in the blue bar near the top.

3. Click on Explanation of Benefits statements.

Help us prevent fraud

Checking to make sure you actually received services as shown on the EOB helps us prevent error and fraud. If you have questions about a claim or EOB, call Customer Service at 1-888-322-5616, 8:00 a.m. to 7:00 p.m., Eastern time, Monday through Friday.
Claim questions and appeals

To confirm you are paying the right amount, compare the EOB and the provider bill side-by-side. Match the service dates and the amounts. If they match, pay the provider that amount and file the EOB for your records.
We'll only send you an EOB once a month, and only if you used your benefits. After your claims are submitted to Blue Cross by your health care providers, we will send you an EOB. In addition, you will most likely receive a billing statement from your provider, showing any outstanding balances you may owe.

2

If the amounts do not match, or if you have questions, call Customer Service at 1-888-322-5616, 8:00 a.m. to 7:00 p.m., Eastern time, Monday through Friday. This number can be found on the back of your Blue Cross ID card. A Blue Cross representative will be happy to review the EOB statement and answer your questions.

3

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

4

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

5

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

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

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

**Copayment (copay)** — A fixed dollar amount that you are responsible for paying for specific services. These services include office visits, emergency room visits, urgent care visits and outpatient mental health visits.

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

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

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

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

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

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

---

**Medicare Plus Blue Group PPO cost-sharing for UAW Trust members**

Your health care costs explained in 3 steps.

<table>
<thead>
<tr>
<th>STEP</th>
<th>Description</th>
<th>In-network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Deductible — per calendar year</td>
<td>$245</td>
<td>$490 (In network and out of network combined)</td>
</tr>
<tr>
<td>2</td>
<td>Coinsurance</td>
<td>10% coinsurance after deductible</td>
<td>30% coinsurance after deductible</td>
</tr>
<tr>
<td>3</td>
<td>Out-of-pocket maximum — per calendar year (combination of deductible and coinsurance)</td>
<td>$630</td>
<td>$1,395 (In network and out of network combined)</td>
</tr>
</tbody>
</table>

---

January 1
Beginning of coverage period

December 31
End of coverage period

---

**January 1**
Beginning of coverage period

**December 31**
End of coverage period
Medicare Plus Blue Group PPO cost-sharing steps

**STEP 1** You haven’t met your deductible yet. You must pay your deductible before Blue Cross begins to pay health care benefits.

Example:
Cost of health care service: $130
Allowed amount: $100
You pay: $100
Blue Cross pays: $0

**STEP 2** You have now met your deductible; coinsurance begins. You pay a percentage of the allowed amount, while Blue Cross pays the remaining balance.

Example:
Cost of health care service: $130
Allowed amount: $100
You pay: $10 (which is 10 percent of the allowed amount)
Blue Cross pays: $90

**STEP 3** You have now met your out-of-pocket maximum. Blue Cross pays 100 percent of the allowed amount for health care benefits that are subject to deductible and coinsurance for the remainder of the calendar year.

Example:
Cost of health care service: $130
Allowed amount: $100
You pay: $0
Blue Cross pays: $100

**Copayments** do not apply toward your deductible and coinsurance out-of-pocket maximum. You are responsible for paying your copays for the entire calendar year until you satisfy the $1,500 out-of-pocket maximum for copay-based services. Common services covered by your plan that require a copay are office visits, chiropractic manipulations, emergency and urgent care. Refer to your Evidence of Coverage for full benefit information.
Contact information

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

**Customer Service**

1-888-322-5616

(TTY users should call 711)

Monday through Friday
from 8:00 a.m. to 7:00 p.m., Eastern time

[www.bcbsm.com/UAWTrust](http://www.bcbsm.com/UAWTrust)

Medicare PLUS Blue™ Group PPO

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

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