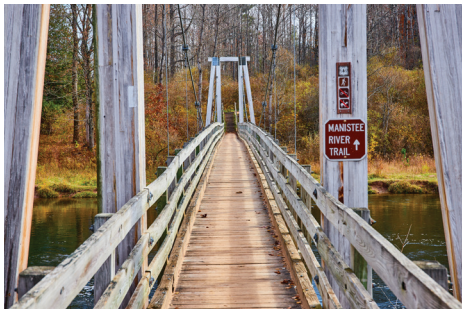
2025

READY TO HELP



Medicare Plus Blue℠ Group PPO

Evidence of Coverage

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

This document gives you the details about your Medicare health care coverage from January 1 – December 31, 2025. **This is an important legal document. Please keep it in a safe place.**

For questions about this document, please contact Customer Service at 1-800-422-9146. TTY users should call 711. Hours are 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday. 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 "your plan," it means Michigan Public Schools Employees' Retirement System's Medicare Plus Blue Group PPO.)

Benefits, premium, coinsurance, copayments and/or deductible may change on January 1, 2026.

The provider network may change at any time. You will receive notice when necessary.

We will notify affected enrollees about changes at least 30 days in advance.

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

- Your plan premium and cost sharing;
- Your medical benefits;
- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us if you need further assistance; and,
- Other protections required by Medicare law.

Michigan Public School Employees' Retirement System

bcbsm.com/mpsers

OMB Approval 0938-1051
(Expires: August 31, 2026)

H9572_MPSERS25MA EOC_C FVNR 1024

Form Approved
OMB# 0938-1421

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-422-9146. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-422-9146. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-800-422-9146。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-422-9146。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-422-9146. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-422-9146. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-422-9146 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-422-9146. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-422-9146 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-422-9146. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-422-9146. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-422-9146 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-422-9146. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-422-9146. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-422-9146. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-422-9146. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-422-9146 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Discrimination is against the law

Blue Cross Blue Shield of Michigan and Blue Care Network 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 and Blue Care Network 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 and Blue Care Network:

- 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 or Blue Care Network 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 and 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 Avenue, SW, Room 509F, HHH Building
Washington, D.C. 20201
Phone: 1-800-368-1019, TTD 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 **https://www.hhs.gov/civil-rights/filing-a-complaint/index.html.**

This notice is available at Blue Cross Blue Shield of Michigan and Blue Care Network's website: https://www.bcbsm.com/Important-Information/policies-practices/nondiscrimination-notice/.

2025 Evidence of Coverage

Table of Contents

CHAPTER 1:
Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in Medicare Plus Blue Group PPO, which is a Medicare PPO

You are covered by Medicare, and you have chosen to get your Medicare healthcare coverage through the Michigan Public School Employees' Retirement System's Medicare Plus Blue Group PPO plan. We are required to cover all Part A and Part B services. However, cost sharing and provider access in this plan differs from Original Medicare.

There are different types of Medicare health plans. Medicare Plus Blue Group PPO is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). The plan is approved by Medicare and administered by Blue Cross Blue Shield of Michigan. This plan does not include Part D prescription drug coverage. Your retirement system offers a prescription drug plan administered by Optum Rx.

Coverage under this Plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at: **irs.gov/Affordable-Care-Act/Individuals-and-Families** for more information.

Section 1.2 What is the *Evidence of Coverage* document about?

This *Evidence of Coverage* document explains how your Medicare and Michigan Public School Employees' Retirement System benefits are combined into one plan. This document explains your rights and responsibilities, what is covered, and what you pay as a member of this plan, and how to file a complaint if you are not satisfied with a decision or treatment.

The words *coverage* and *covered services* refer to the medical care and services available to you as a member of the Michigan Public School Employees' Retirement System Medicare Plus Blue Group PPO.

It's important for you to learn what the plan's rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* document.

If you are confused or concerned or just have a question, please contact Blue Cross Customer Service.

Section 1.3 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 receive 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 months in which you are enrolled in Medicare Plus Blue Group PPO between January 1, 2025, and December 31, 2025.

Each calendar year, Medicare allows changes to the plans that we offer. This means we can change the costs and benefits of Medicare Plus Blue Group PPO after December 31, 2025. We can also choose to stop offering the plan in your service area after December 31, 2025.

Medicare (the Centers for Medicare & Medicaid Services) must approve Medicare Plus Blue Group PPO each year. You can continue each year to get Medicare coverage as a member of this plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

You are eligible for membership in this plan as long as you:

- Meet the eligibility requirements for the Michigan Public School Employees' Retirement System.
    - Please contact the Michigan Office of Retirement Services (ORS) at 1-800-381-5111, Monday through Friday, 8:30 a.m. to 5 p.m. Eastern time, for more information. You can also visit **michigan.gov/orsmiaccount** and use the online Message Board for secure access to a representative.
- Have both Medicare Part A and Medicare Part B.
- Live in our geographic service area (Section 2.2 describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- Are a U.S. citizen or are lawfully present in the U.S.

You are not eligible for membership in this plan if you enroll in another Medicare Advantage Plan.

Section 2.2 Here is the service area for Medicare Plus Blue Group PPO plan

Medicare Plus Blue Group PPO is only available to individuals eligible for the Michigan Public School Employees' Retirement System health plan and who live in our service area. Our service area is the U.S. and its territories. You need a physical address within our service area, on file with ORS, to be enrolled in this plan.

To remain a member of this plan, you must continue to reside in our service area. If you move out of the service area, you will be disenrolled from this plan. If you plan to move out of the service area, you must contact ORS. Address and other demographic updates can be made online at **michigan.gov/orsmiaccount**.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

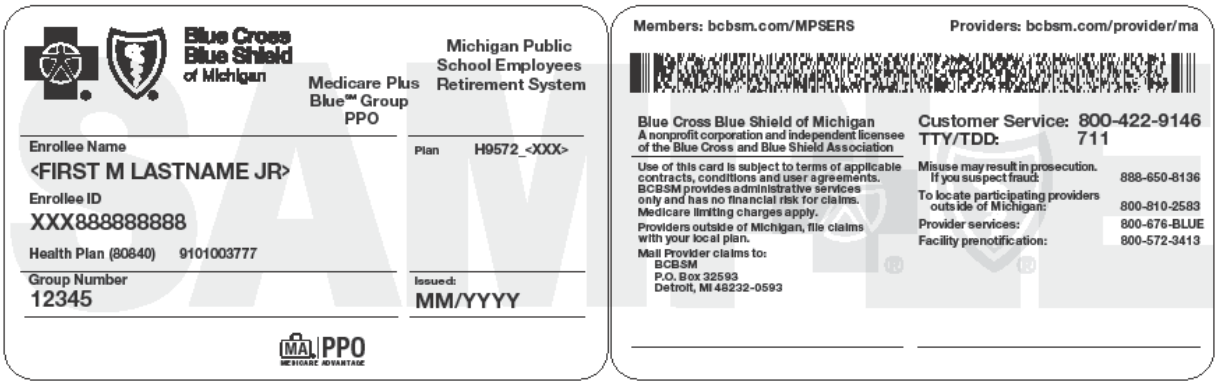
Section 2.3 U.S. Citizen or Lawful Presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the U.S. Medicare (the Centers for Medicare & Medicaid Services) will notify Blue Cross if you are not eligible to remain a member on this basis. We must disenroll you if you do not meet this requirement.

SECTION 3 Important membership materials you will receive

Section 3.1 Your membership identification (ID) card – Use it to get all covered care

While you are a member of this plan, you must use your membership ID card whenever you get services covered by this plan. You should also show the provider your Medicaid card, if applicable. Here's a sample membership card to show you what yours will look like:



Do NOT use your red, white, and blue Medicare card for covered medical services while you are 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 hospice services or participate in Medicare-approved clinical research studies, also called clinical trials.

If your plan membership card is damaged, lost, or stolen, call Blue Cross Customer Service right away and we will send you a new card.

Section 3.2 Provider Directory

The *Provider Directory* lists our current network providers and durable medical equipment suppliers.

Network providers are the doctors and other healthcare professionals, medical groups, durable medical equipment suppliers, hospitals, and other healthcare facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full. We have arranged for these providers to deliver covered services to members in this plan.

You can use our *Find a Doctor* tool at **bcbsm.com/mpsers** or contact Blue Cross Customer Service to locate network providers. Both Blue Cross Customer Service and the website can give you the most up-to-date information about changes in our network. You may ask Blue Cross Customer Service for more information about our network providers, including their qualifications.

You may also call providers to verify their participation or refer to your copy of the *Provider Directory*. If you don't have your copy of the *Provider Directory*, you can request a copy from Blue Cross Customer Service. A directory will be mailed to you within three days of the request.

Members living outside Michigan may use the *Provider Locator* to locate network providers.

To locate network providers for your routine hearing exams and hearing aids, refer to the Routine Hearing Care section located in Chapter 4, Section 2.2.

SECTION 4 Your monthly costs for Medicare Plus Blue Group PPO

Your costs may include the following:

- Plan premium (Section 4.1).
- Monthly Medicare Part B premium (Section 4.1).

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums, review your copy of the *Medicare & You 2025* handbook. Refer to the section called *How much does Part B coverage cost?*. If you need a copy, you can download it from the Medicare website **(medicare.gov)**.

Section 4.1 Plan premium

Your retirement system charges a premium for Medicare Plus Blue Group PPO coverage in 2025. Contact ORS at 1-800-381-5111 if you have questions about your premium.

Many members are required to pay other Medicare premiums.

In addition to paying the monthly plan premium, you must continue paying your Medicare premiums to remain a member of the plan.

SECTION 5 Keeping your plan membership record up to date

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

The doctors, hospitals, and other providers in our network need to have correct information about you. **These network providers use your membership record to know what services are covered and the cost-sharing amounts for you**. Because of this, it is very important that you help us keep your information up to date.

You must contact ORS to update the following information:

- Changes to your name, your physical and/or mailing address, your email address, or your phone number. You can go online to **michigan.gov/orsmiaccount** or call ORS at 1-800-381-5111.
- Corrections to your date of birth or other demographic information.

Please contact Blue Cross Blue Shield of Michigan Customer Service about these changes:

- If you have any liability claims, such as claims from an automobile accident.
- If you have been admitted to a nursing home.
- If you receive care in an out-of-area or out-of-network hospital or emergency room.
- If your designated responsible party (such as a caregiver) changes.
  - This must also be reported to ORS at 1-800-381-5111.
- If you are participating in a clinical research study. (**Note:** You are not required to tell your plan about the clinical research studies you intend to participate in, but we encourage you to do so.)

Remember to also report any changes to your personal information to Social Security. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

SECTION 6 How other insurance works with the plan

Other insurance

Medicare requires that we collect information about any other medical insurance coverage that you have.

You are not eligible for coverage for any services under the Medicare Plus Blue Group PPO plan if you have other Medicare Advantage group health coverage or if you enroll in another Medicare Advantage Plan.

If you have other group health insurance that is not a Medicare Advantage Plan from an employer or another retiree group, Blue Cross will coordinate with the other health insurance plan to determine which plan pays first and ensure your claims are paid correctly.

If you have other insurance, tell your doctor, hospital, and pharmacy.

If you have Medicare because of end-stage renal disease, and you also have commercial health coverage with another group, the other group commercial health plan will pay first for the first 30 months, starting when you became eligible for Medicare.

The following types of coverage are not group health coverage and usually pay first. You must call Blue Cross Customer Service if you have claims involving any of the following types of coverage:

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

Some people with Medicare are also eligible for Medicaid or TRICARE. Medicaid and TRICARE are not group health coverage and never pay first for Medicare-covered services. If you have Medicaid or TRICARE, your Medicare Plus Blue Group PPO plan pays first.

CHAPTER 2

Important phone numbers and resources

SECTION 1 Blue Cross Medicare Plus Blue Group PPO contacts (How to contact us, including how to reach Customer Service)

How to contact Blue Cross Customer Service

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

Method	Customer Service – Contact Information
CALL	1-800-422-9146 Calls to this number are free. Available from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday. Customer Service also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. Available from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday.
FAX	1-866-458-9342
WRITE	Blue Cross Blue Shield of Michigan MPSERS-Medicare Plus Blue Group PPO Customer Service Inquiry Department P.O. Box 441790 600 E. Lafayette Blvd. Detroit, MI 48226-1790
WEBSITE	**bcbsm.com/mpsers**

How to contact us when you are asking 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 will pay for your medical services. An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on asking for coverage decisions or appeals about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints*)).

Method	Coverage Decisions and Appeals for Medical Care – Contact Information
CALL	1-800-422-9146 Calls to this number are free. Available from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday.
TTY	711 Calls to this number are free. Available from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday.
FAX	1-877-348-2251 – all appeals and complaints
WRITE	Blue Cross Blue Shield of Michigan Grievances and Appeals Department P.O. Box 2627 Detroit, MI 48231-2627

How to contact us when you are making 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 does not involve coverage or payment disputes. For more information on making a complaint about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Complaints about Medical Care – Contact Information
CALL	1-800-422-9146 Calls to this number are free. Available from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday.
TTY	711 Calls to this number are free. Available from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday.
FAX	1-877-348-2251 – all appeals and complaints

Method	Complaints about Medical Care – Contact Information
WRITE	Blue Cross Blue Shield of Michigan Grievances and Appeals Department P.O. Box 2627 Detroit, MI 48231-2627
MEDICARE WEBSITE	You can submit a complaint about Medicare Plus Blue Group PPO directly to Medicare. To submit an online complaint to Medicare, go to: **medicare.gov/MedicareComplaintForm/home.aspx**

Where to send a request asking us to pay for the plan's share of the cost for medical care you have received

If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the bill. See Chapter 5 (*Asking us to pay the plan's share of a bill you have received for covered medical services*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 7 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* for more information.

Method	Payment Requests – Contact Information
CALL	1-800-422-9146 Calls to this number are free. Available 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday.
TTY	711 Calls to this number are free. Available 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday.
FAX	1-866-507-5262
WRITE	Blue Cross Blue Shield of Michigan Imaging and Support Services P.O. Box 32593 Detroit, MI 48232-0593
WEBSITE	**http://www.bcbsm.com/content/dam/microsites/medicare/documents/medical-claim-form-ppo.pdf**

SECTION 2 Medicare
(How to get help and information directly from the federal Medicare program)

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 us.

Method	Medicare – Contact Information
CALL	1-800-MEDICARE or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	**medicare.gov** This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an estimate of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about Medicare Plus Blue Group PPO. • **Tell Medicare about your complaint:** You can submit a complaint about Medicare Plus Blue Group PPO directly to

Method	Medicare – Contact Information
	Medicare. To submit a complaint to Medicare, go to **medicare.gov/MedicareComplaintForm/home.aspx**. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 3 State Health Insurance Assistance Program (Free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Michigan, the SHIP is called Michigan Medicare Assistance Program.

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

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

Method	Michigan Medicare Assistance Program – Contact Information
CALL	1-800-803-7174
TTY	711
WRITE	Michigan Medicare Assistance Program 6105 W. St. Joseph Hwy., Suite 103 Lansing, MI 48917-4850

Method	Michigan Medicare Assistance Program – Contact Information
WEBSITE	**mmapinc.org**

METHOD TO ACCESS SHIP and OTHER RESOURCES:
• Visit **shiphelp.org.** (Click SHIP LOCATOR in middle of page.) • Select your **STATE** from the list. This will take you to a page with phone numbers and resources specific to your state.

State Health Insurance Assistance Programs in other states are listed in *Exhibit 1* of the Appendix. Contact information may change throughout the year.

SECTION 4 Quality Improvement Organization

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For Michigan, the Quality Improvement Organization is called Livanta.

Livanta has a group of doctors and other healthcare professionals who are paid by Medicare to check on and help improve the quality of care for people with Medicare. Livanta is an independent organization. It is not connected with Blue Cross.

You should contact Livanta in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home healthcare, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

Method	Livanta – Contact Information
CALL	1-888-524-9900 Monday through Friday: 9 a.m. to 5 p.m. (local time) Saturday and Sunday: 10 a.m. to 4 p.m. (local time) 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. Monday through Friday: 9 a.m. to 5 p.m. (local time) Saturday and Sunday: 10 a.m. to 4 p.m. (local time) 24-hour voicemail service is available
WRITE	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701
WEBSITE	**livantaqio.com**

Quality Improvement Organizations in other states are listed in Exhibit 2 of the Appendix. Contact information is subject to change throughout the year.

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or end-stage renal disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

If you move or change your mailing address, it is important that you contact Social Security, in addition to ORS, to let them know.

Method	Social Security – Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 8 a.m. to 7 p.m. (local time) Monday through Friday. You can 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 a.m. to 7 p.m. (local time) 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.

The programs offered through Medicaid 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 coinsurance, copayments and deductible). 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 its programs, contact the Michigan Department of Health and Human Services.

Method	Michigan Department of Health and Human Services – Contact Information
CALL	1-800-642-3195
WRITE	Michigan Department of Health and Human Services 333 S. Grand Ave. P.O. Box 30195 Lansing, MI 48909
WEBSITE	**michigan.gov/medicaid**

Medicaid programs in other states are listed in Exhibit 3 of the Appendix. Contact information may change throughout the year.

SECTION 7 How to contact the Railroad Retirement Board

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 receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

Method	Railroad Retirement Board – Contact Information
CALL	1-877-772-5772 Calls to this number are free. If you press "4," you may speak with an RRB representative from 9 a.m. to 3 p.m., Monday through Friday. If you press "1," you may access the automated RRB HelpLine and 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 with hearing or speaking. Calls to this number are *not* free.
WEBSITE	**rrb.gov**

SECTION 8 “Group insurance” or other health insurance from an employer

If you (or your spouse or domestic partner) are enrolled in other group health insurance from an employer or another retiree group, Blue Cross will coordinate with the other health insurance plan to determine which plan pays first and ensure your claims are paid correctly.

CHAPTER 3

Using the plan for your medical services

SECTION 1 Things to know about getting your medical care covered as a member of this plan

This chapter explains what you need to know about using the plan to get your medical care covered. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, equipment, medical plan prescription drugs and other medical care that is covered by the plan.

For the details on what medical care is covered by this plan and how much you pay when you get this care, use the benefits chart in the next chapter, Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*).

Section 1.1 What are network providers and covered services?

- Providers are doctors and other healthcare professionals licensed by the state to provide medical services and care. The term “providers” also includes hospitals and other healthcare facilities.
- Network providers are the doctors and other healthcare professionals, medical groups, hospitals, and other healthcare facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in this 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, healthcare services, supplies, and equipment that are covered by this plan. Your covered services for medical care are listed in the benefits chart in Chapter 4.

To locate network providers for your routine hearing exams and hearing aids, refer to the Routine Hearing Care section located in Chapter 4, Section 2.2.

Section 1.2 Basic rules for getting your medical care covered by the plan

As a Medicare health plan, Medicare Plus Blue Group PPO must cover all services covered by Original Medicare and must follow Original Medicare’s coverage rules.

The plan will generally cover your medical care as long as:

- **The care you receive is included in the Medical Benefits Chart** (this chart is in Chapter 4 of this document).
- **The care you receive is considered medically necessary**. “Medically necessary” means that the services, supplies, equipment or prescription drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- **You receive your care from a provider who is eligible to provide services under Original Medicare.** As a member of this plan, you can receive your care from either a network provider or an out-of-network provider (for more about this, see Section 2 in this chapter).
    - The providers in our network are listed in the *Provider Directory*.
    - 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 cannot 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 will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.
    - Although Original Medicare does not cover routine hearing exams and hearing aids, these services are covered by your retirement system plan. To locate network providers for your routine hearing exams and hearing aids, refer to the Routine Hearing Care section located in Chapter 4, Section 2.2.

SECTION 2 Using network and out-of-network providers to get your medical care

Section 2.1 How to get care from specialists and other network providers

A specialist is a doctor who provides healthcare services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart conditions.
- Orthopedists care for patients with certain bone, joint, or muscle conditions.

You don’t need to get a referral when you get care from in-network providers.

What if a specialist or another provider leaves our network?

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of this plan during the year. If your doctor or specialist leaves the network, you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, we will furnish you with uninterrupted access to qualified doctors and specialists.

- We will notify you that your provider is leaving our network so that you have time to select a new provider.
    - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.
    - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.
- We will assist you in selecting a new qualified in-network provider that you may access for continued healthcare.
- If you are currently undergoing medical treatment or therapies with your current provider, you have the right to request, and we will work with you to ensure, that the medically necessary treatment or therapies you are receiving continue.
- If you find out your doctor or specialist is leaving our network, please contact us so we can assist you in finding a new provider to manage your care.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file a quality of care complaint to the QIO, a quality of care grievance to the plan, or both. Please see Chapter 7.

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

As a member of this plan, you can choose to receive most of your care from out-of-network providers. However, your routine hearing exams and hearing aids are not covered unless you call TruHearing at **1-855-205-6305** (TTY **711**) and follow the instructions you are given. You have no routine hearing care benefits if you see a non-TruHearing provider.

Please note providers that do not contract with us are under no obligation to treat you, except in emergency situations. Your plan will cover most services from either in-network or out-of-network providers, as long as the services are covered benefits and are medically necessary. However, **if you use an out-of-network provider, your share of the costs for your covered services may be higher.**

Here are other 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 cannot pay a provider who is not eligible to participate in Medicare. If you receive care from a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.
- You don’t need to get a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers you may want to ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary. (See Chapter 7, Section 4 for information about asking for coverage decisions.) This is important because:

- Without a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 7 *(What to do if you have a problem or complaint)* to learn how to make an appeal.

- It is best to ask an out-of-network provider to bill the plan first. But, if you have already paid for the covered services, we will reimburse you for the plan's share of the cost for covered services. Or, if an out-of-network provider sends you a bill that you think we should pay, you can send it to us for payment. See Chapter 5 (*Asking us to pay the plan's share of a bill you have received for covered medical services*) for information about what to do if you receive a bill or if you need to ask for reimbursement.
- If you are 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. See Section 3 for more information about these situations.

SECTION 3 How to get services when you have an emergency or urgent need for care or during a disaster

Section 3.1 Getting care if you have a medical emergency

What is a medical emergency and what should you do if you have one?

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 your loss of life (and, if you are 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 is 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 do *not* need to get approval or a referral first from your Primary Care Provider (PCP).

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the U.S. or its territories. Your plan covers ambulance services in situations when getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency.

The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over, you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by the plan.

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 was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

Section 3.2 Getting care when you have an urgent need for services

What are urgently needed services?

Urgently needed services are covered services that require immediate medical attention but are not considered emergencies. These services are covered by your plan even when you are temporarily outside the service area of the plan, or even if you are inside the service area of the plan and unable to obtain the service from network providers due to time, location or circumstances. 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, are not considered urgently needed services.

Section 3.3 Getting care during a disaster

If the governor of your state, the U.S. Secretary of Health and Human Services, or the President of the U.S. declares a state of disaster or emergency in your geographic area, you are still entitled to care from your plan.

Please visit the following website **bcbsm.com/medicare** for information on how to obtain needed care during a disaster.

SECTION 4 What if you are billed directly for the full cost of your services?

Section 4.1 You can ask us to pay the plan's share of the cost of covered services

If you have paid more than your plan cost sharing for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 5 (*Asking us to pay the plan's share of a bill you have received for covered medical services*) for information about what to do.

Section 4.2 If services are not covered by the 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 of this document. If you receive services not covered by our plan, you are responsible for paying the full cost of services.

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service.

SECTION 5 How are your medical services covered when you are 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 request volunteers to participate in the study.

Once Medicare approves the study, someone who works on the study will contact you to explain more about the study. If you express interest, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study, *and* you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. If you tell us that you are in a qualified clinical trial, then you are only responsible for the in-network cost sharing for the services in that trial. If you already paid the Original Medicare cost-sharing amount, and it was more, we will reimburse the difference between what you paid and the in-network cost sharing. However, you will need to provide documentation to show us how much you paid.

When you are in a clinical research study, you may stay enrolled in this plan and continue to get the rest of your care (the care that is not related to the study) through this plan.

If you want to participate in any Medicare-approved clinical research study, you are not required to tell Blue Cross or get approval from Blue Cross. The providers that deliver your care as part of the clinical research study do *not* need to be part of the Blue Cross network of providers. Please note that clinical research studies do not include benefits for which the plan is responsible, that includes, as a component, a clinical trial or registry to assess the benefit. The plan includes certain benefits specified under national coverage determinations requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDEs) studies and may be subject to prior authorization and other plan rules.

Although you do not need to get our permission to be in a clinical research study, which is covered by Original Medicare for Medicare Advantage enrollees, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

Section 5.2 When you participate in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you receive 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 is part of the research study.
- Treatment of side effects and complications of the new care.

After Medicare has paid its share of the cost for these services, this plan will pay the difference between the cost sharing in Original Medicare and your cost sharing as a member of this plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from this plan. However, you are required to submit documentation showing how much cost sharing you paid. Please see Chapter 5 for more information for submitting requests for payments.

> *Here's an example of how the cost sharing works:* Let's say that you have a lab test that costs $100 as part of the research study. Let's also say that your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan's benefits. 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 received a qualified clinical trial service and submit documentation, such as a provider bill, to the plan. The plan would then pay you $10 directly, which is the same amount you would pay under our plan's benefits. Please note that in order to receive payment from our plan, you must submit documentation to our plan such as a provider bill.

When you are part of a clinical research study, **neither Medicare nor this plan will pay for any of the following**:

- Generally, Medicare will *not* pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.
- Items or services provided only to collect data, and not used in your direct healthcare. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.
- Items and services customarily provided by the research sponsors free-of-charge for any enrollee in the trial.

Do you want to know more?

You can get more information about joining a clinical research study by visiting the Medicare website to read or download the publication *Medicare and Clinical Research Studies*. The publication is available at: medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf.

You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

Section 6.1 What is a religious non-medical healthcare institution?

A religious non-medical healthcare 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 your religious beliefs, you have coverage for inpatient non-medical services provided by religious non-medical healthcare institutions. This benefit is provided only for Part A inpatient services (non-medical healthcare services).

Section 6.2 Receiving care from a religious non-medical healthcare institution

To get care from a religious non-medical healthcare institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is non-excepted.

- Non-excepted medical care or treatment is any medical care or treatment that is *voluntary* and *not required* by any federal, state, or local law.
- Excepted medical treatment is medical care or treatment that you get that is *not* voluntary or *is required* under federal, state, or local law.

The religious non-medical healthcare institution must be certified by Medicare and the following conditions apply:

- You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
- You must get approval in advance from us before you are admitted to the facility or your stay will not be covered.

For more information, see the Medical Benefits Chart in Chapter 4.

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 Will you own the durable medical equipment after making a certain number of payments under the plan?

Durable medical equipment (DME) includes items such as 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 use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 consecutive months. However, as a member of Medicare Plus Blue Group PPO, you usually will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of this plan, even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined this plan. Under certain limited circumstances we will transfer ownership of the DME item to you. Call Blue Cross Customer Service for more information.

What happens to payments you made for durable medical equipment if you switch between this plan and Original Medicare?

If you did not acquire ownership of the DME item while in this plan, in order to own the item, you will have to make 13 new consecutive payments after you switch to Original Medicare. The payments made while enrolled in the plan do not count.

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined this plan. The payments you made in Original Medicare do not count. You will have to make 13 payments to the plan before owning the item (if you are eligible to acquire ownership of the DME item).

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined the plan. You were in the plan but did not obtain ownership while in the plan. You then go back to Original Medicare. You will have to make 13 consecutive new

payments to own the item once you join Original Medicare again. All previous payments (whether to this plan or to Original Medicare) do not count.

SECTION 8 Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?

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, then the oxygen equipment must be returned.

CHAPTER 4

Medical Benefits Chart (what is covered and what you pay)

SECTION 1 Understanding your out-of-pocket costs for covered services

This chapter provides a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of your retirement system's Medicare Plus Blue Group PPO plan. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

Section 1.1 Types of out-of-pocket costs you may pay for your covered services

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- The deductible is the amount you must pay for medical services before your retirement system begins to pay its share. Section 1.2 tells you more about your out-of-pocket costs, including deductible.
- Coinsurance is a percentage you pay of the total cost of certain medical services after you have met your deductible. You pay a coinsurance at the time you get the medical service (for example, 10%). The Medical Benefits Chart in Section 2 tells you more about your coinsurance.
- A copayment (copay) is a flat dollar amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service and your retirement system pays the rest. The Medical Benefits Chart in Section 2 tells you more about your copayments.

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments, or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable.

Section 1.2 What is the most you will pay for Medicare Part A and Part B covered medical services?

This plan limits how much you have to pay out of pocket each year for certain covered medical services. This is called your annual out-of-pocket maximum. Your annual out-of-pocket maximum includes your deductible, coinsurance, and your emergency room and urgent care copays. It does not include your copays for routine hearing exams and hearing aids. Once you reach your out-of-pocket maximum, with the exception of routine hearing exams and hearing aids, you will not have to pay any out-of-pocket costs for the remainder of the year. You will continue to pay your premium as required by the retirement system.

Section 1.3 We do not allow providers to balance bill you

As a member of Medicare Plus Blue Group PPO, an important protection for you is that you only have to pay your cost-sharing amount when you get services covered by this plan. Providers may not add 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 is a dispute and we don't pay certain provider charges.

Here is how this protection works:

- If your cost sharing is a copayment (a set amount of dollars, for example, $65), then you pay only that amount for the covered service.
- If your cost sharing is a coinsurance (a percentage of the approved amount), then you never pay more than that percentage plus your deductible. For both quality of care and cost savings, we encourage you to use network providers because your cost depends on the approved amount for the type of provider you see:
    - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by our reimbursement rate (as determined in the contract between the provider and Blue Cross).
    - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
    - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- If you believe a provider has balance billed you, call Blue Cross Customer Service.

SECTION 2 Use the Medical Benefits Chart to find out what is covered and how much you will pay

Section 2.1 Your medical benefits and costs as a member of this plan

The Medical Benefits Chart on the following 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 the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, equipment, and medical plan prescription drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or prescription drugs are needed for the prevention,

diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- For new enrollees, your Medicare Advantage coordinated care plan must provide a minimum 90-day transition period, during which time the new Medicare Advantage plan may not require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- Some of the services listed in the Medical Benefits Chart are covered as in-network services *only* if your doctor or other network provider gets approval in advance (sometimes called prior authorization) from Blue Cross.
    - 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, your medical plan covers everything that Original Medicare covers. We also cover everything your retirement system covered before you had Medicare. For most services, you pay less in this plan than you would in Original Medicare. For others you may pay more. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2025* handbook. View it online at **medicare.gov** or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- Most preventive services are covered at no cost to you. See the Medical Benefits Chart for a complete list of covered preventive services. If you are also treated or monitored for an existing medical condition during the visit when you receive the preventive services, cost sharing will apply for the care received for the existing medical condition.
- If Medicare adds coverage for any new services during 2025, either Medicare or this plan will cover those services.

Deductible and limits on how much you pay for covered services	
Annual deductible for covered medical services	$800
Coinsurance/copay maximum Note: Copayments for routine hearing exams and hearing aids are NOT included in the coinsurance/copay maximum.	$900
Maximum out of pocket for member cost sharing Note: Copayments for routine hearing exams and hearing aids are NOT included in the maximum out-of-pocket amount.	$1,700

Medical Benefits Chart

- Services with * may require prior authorization. Your network provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to lack of prior authorization.

 You will see this apple next to the preventive services in the benefits chart.

Services that are covered for you	What you must pay when you get these services
Inpatient Care	
Hospice care Your hospice services are paid for by Original Medicare, not Medicare Plus Blue Group PPO. You must use your red, white, and blue Medicare membership card to get hospice services. You can get a one-time only hospice consultation with a hospice medical director or hospice doctor to discuss your care options, pain, and management of your symptoms. You can get this one-time consultation even if you decide not to get hospice care. To qualify for hospice care, a hospice doctor and your doctor (if you have one) must certify that you're terminally ill, meaning you have a life expectancy of six months or less. If you're already getting hospice care, a hospice doctor or nurse practitioner will need to see you about six months after your hospice care started to certify that you're still terminally ill. Coverage includes: • All items and services needed for pain relief and symptom management. • Medical, nursing, and social services. • Drugs. • Certain durable medical equipment.	You pay nothing for hospice services. When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services **related** to your terminal prognosis are paid for by Original Medicare, not Medicare Plus Blue Group PPO. **Note:** If you need non-hospice care (care that is **not related** to your terminal condition), you should contact us to arrange the services. Getting your non-hospice care through our network providers will lower your share of the costs for the services.

Services that are covered for you	What you must pay when you get these services
Hospice care, *continued* • Aide and homemaker services. • Other covered services, as well as services Medicare usually doesn't cover, like spiritual and grief counseling. • Inpatient respite care in a Medicare-approved facility so that your usual caregiver can rest (you can stay up to five days each time you get respite care). A Medicare-approved hospice usually gives hospice care in your home or other facility where you live, like a nursing home. Hospice care doesn't include your stay in a facility (room and board) unless the hospice medical team determines that you need short-term inpatient stays for pain and symptom management that can't be addressed at home. These stays must be in a Medicare-approved facility, like a hospice facility, hospital, or skilled nursing facility that contracts with the hospice. You can continue to get hospice care as long as the hospice medical director or hospice doctor re-certifies that you're terminally ill.	
Inpatient hospital care* Hospital care includes the care you get in acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, and long-term care hospitals. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. Covered services include: • Semiprivate room (or private room if medically necessary). • Meals, including special diets. • Physician services. • Regular nursing services.	**In-network and Out-of-network:** Your coinsurance is 10% of the approved amount, after deductible. The deductible and coinsurance apply to the annual out-of-pocket maximum. You pay nothing for clinical lab services. You have unlimited days for inpatient care.

Services that are covered for you	What you must pay when you get these services
Inpatient hospital care,* *continued* • Costs of special care units (such as intensive care or coronary care units). • Operating and recovery room costs. • Drugs and medications. • Lab tests. • X-rays, CAT scans, MRIs, PET scans and other radiology services. • Anesthesia, including administration, cost of equipment, supplies and the services of a hospital anesthesiologist when billed as a hospital service. • Blood used for each condition or diagnosis, including storage for blood before surgery. • Diagnostic tests, such as EEGs, EKGs, ECGs, and EMGs. • Chemotherapy and radiation therapy. • Customary, standard and medically accepted artificial prosthetic devices when permanently implanted internally, such as heart valves and hip joints. • Oxygen and other gas therapy. • Necessary surgical and medical supplies. • Use of appliances and equipment, such as wheelchairs. • Physical, occupational, and speech language therapy for the treatment of the condition for which you are hospitalized. • Routine nursery care of a newborn during the mother's eligible stay. • Substance use disorder services. *Inpatient hospital services rendered by plan providers will require prior authorization. Your plan provider will arrange for this authorization. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process.	

Services that are covered for you	What you must pay when you get these services
Inpatient hospital care,* *continued* You will not be held responsible for the charge if the denial is due to a lack of prior authorization. **Transplants** Under certain conditions, the following types of transplants are covered: • Bone marrow/stem cell. • Corneal. • Duodenum. • Heart. • Heart-lung. • Intestine. • Kidney. • Liver. • Lung. • Lobar lung. • Pancreas and/or intestinal/multivisceral. • Pancreas, liver, intestine and pancreatic tissue. • Stomach. Reasonable travel and lodging may be provided for certain transplants when the transplant is not available locally and we send you to a transplant center outside the normal community patterns of care. Coverage for travel and lodging expenses is very limited for most transplants. However, if you have a Medicare-covered organ transplant, you have coverage for reasonable and necessary travel and lodging up to a $10,000 maximum for you and one companion (two companions if you're under age 18 or the transplant involves a living donor related to you).	Deductible and coinsurance do not apply to travel and lodging associated with Medicare-covered transplants.

Services that are covered for you	What you must pay when you get these services
Inpatient hospital care,* *continued* 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. Keep in mind, Medicare drug coverage (Part D) covers immunosuppressive drugs if Part B doesn't cover them. If you're entitled to Medicare only because of permanent kidney failure, your Medicare coverage will end 36 months after the month of your transplant. Medicare Plus Blue Group PPO will not pay for any services or items, including immunosuppressive drugs, for patients who are not entitled to Medicare. **Note:** To be an inpatient, your provider must write an order to admit you to the hospital. Even if you stay in the hospital overnight, you might still be considered an *outpatient*. If you are not sure if you are an inpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Medicare Hospital Benefits.* This fact sheet is available on the web 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. You can call these numbers for free, 24 hours a day, 7 days a week.	

Services that are covered for you	What you must pay when you get these services
Inpatient services in a psychiatric hospital* Covered services include mental healthcare services that require a hospital stay. *Inpatient mental health/behavioral health services rendered by plan providers require prior authorization. Your plan provider will arrange for this authorization. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	**In-network and Out-of-network:** Your coinsurance is 10% of the approved amount, after deductible. The deductible and coinsurance apply to the annual out-of-pocket maximum. You have unlimited days of inpatient care coverage.
Religious non-medical healthcare institution In these facilities, religious beliefs prohibit conventional and unconventional medical care. If you qualify for hospital or skilled nursing facility care, the plan will only cover the inpatient, non-religious, non-medical items and services. An example is room and board, or any items and services that don't require a doctor's order or prescription, like unmedicated wound dressings or use of a simple walker.	**In-network and Out-of-network:** In a Medicare-certified institution, your coinsurance is 10% of the approved amount, after deductible. The deductible and coinsurance apply to the annual out-of-pocket maximum.
Skilled nursing facility (SNF) care* (For a definition of skilled nursing facility care, see Chapter 10. Skilled nursing facilities are sometimes called SNFs.) To qualify for care in a skilled nursing facility, your doctor must certify that you need daily skilled care, like intravenous injections or physical therapy.	**In-network and Out-of-network:** Your coinsurance is 10% of the approved amount, after deductible. The deductible and coinsurance apply to the annual out-of-pocket maximum. The plan will cover up to 100 days of medically necessary care in a skilled nursing facility.

Services that are covered for you	What you must pay when you get these services
Skilled nursing facility (SNF) care*, *continued* Covered services include, but are not limited to: • Semiprivate room (or a private room if medically necessary). • Meals, including special diets. • General and skilled nursing care. • Physician/practitioner services. • Physical therapy, occupational therapy, and speech therapy. • Drugs administered to you as part of your plan of care (this includes substances that are naturally present in the body, such as blood clotting factors). • Blood, including storage and administration. • 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. *Skilled nursing facility care rendered by plan providers will require prior authorization. Your plan provider will arrange for this authorization. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	Your days renew after you've been out of a SNF or hospital for 60 consecutive days.

Services that are covered for you	What you must pay when you get these services
Services covered when you exhaust your skilled nursing facility (SNF) days or when you are not inpatient (Inpatient services covered during a non-covered inpatient stay) If you remain in a skilled nursing facility (SNF) after you've exhausted your SNF benefits, or you are not admitted to a SNF because the stay is not reasonable and necessary, but you live in a nursing facility, you still have coverage under this plan. Covered services that are provided by doctors and other medical care suppliers include, but are not 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. • Durable medical equipment. • Physical therapy, speech therapy, and occupational therapy.	**In-network and Out-of-network:** Your cost share depends on the service provided. Refer to the description of the service elsewhere in this Medical Benefits Chart for cost-share information.
Outpatient Services	
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist. **Note:** If you have a family history of abdominal aortic aneurysms, or you're a man aged 65-75 and you've smoked at least 100 cigarettes in your lifetime, you're considered at risk.	**In-network and Out-of-network:** Covered at 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Acupuncture for chronic low back pain Up to 12 visits in 90 days are covered for chronic low back pain, defined as: • lasting 12 weeks or longer; • nonspecific, in that it has no known cause (not related to cancer that has spread, inflammatory or infectious disease); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered if you are demonstrating an improvement. No more than 20 acupuncture treatments will be covered annually. Treatment is not covered if you are not improving or are regressing. You must get acupuncture from a doctor, or by another healthcare provider (like a nurse practitioner or physician assistant) who has both of these: • A master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine. • A current, full, active, and unrestricted license to practice acupuncture in the state where care is being provided.	**In-network and Out-of-network:** Your coinsurance is 10% of the approved amount, after deductible. The deductible and coinsurance apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Alcohol misuse screening and counseling The plan covers one alcohol misuse screening per calendar year for adults who use alcohol but don't meet the medical criteria for alcohol dependency. If your primary care doctor or other primary care provider determines you're misusing alcohol, you can get up to four brief face-to-face counseling sessions per year (if you're competent and alert during counseling). A qualified primary care doctor or other primary care provider must provide the counseling in a primary care setting (like a doctor's office).	**In-network and Out-of-network:** Covered at 100% of the approved amount.
Ambulance services The plan covers ground ambulance transportation when you need to be transported to a hospital, critical access hospital, or skilled nursing facility for medically necessary services, and transportation in any other vehicle could endanger your health. The plan may pay for emergency ambulance transportation in an airplane or helicopter to a hospital if you need immediate and rapid ambulance transportation that ground transportation can't provide. In some cases, the plan may pay for limited, medically necessary, non-emergency ambulance transportation if you have a written order from your doctor stating that ambulance transportation is necessary due to your medical condition. The plan will only cover ambulance services to the nearest appropriate medical facility that's able to give you the care you need. Ambulance services without transportation are also covered.	**In-network and Out-of-network:** Your coinsurance is 10% of the approved amount, after deductible. The deductible and coinsurance apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Annual routine physical An annual routine physical is comprised of updating your health history, checking vital signs, a visual exam and a physical exam.	**In-network and Out-of-network:** Covered at 100% of the approved amount.
Annual standard, routine laboratory tests Laboratory tests performed as a result of, or during, an annual routine physical and are not diagnostic in nature.	**In-network and Out-of-network:** Covered at 100% of the approved amount when done in conjunction with an annual routine physical exam.
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. The annual wellness visit can occur anytime throughout the year, regardless of the date of your previous annual wellness visit. Advance care planning is also covered as part of the annual wellness visit. This is planning for care you would want to get if you become unable to speak for yourself. Your provider may also perform a cognitive assessment to look for signs of dementia, including Alzheimer's disease. If you have a current prescription for opioids, your provider will review your potential risk factors for opioid use disorder, evaluate your severity of pain and current treatment plan, provide information on non-opioid treatment options, and may refer you to a specialist, if appropriate. Your doctor or healthcare provider may also use a questionnaire to better understand your social needs and refer you for appropriate services and support. This is called a "social determinants of health risk assessment," and it's free when you get it as part of your yearly wellness visit.	**In-network and Out-of-network:** Covered at 100% of the approved amount. **Note:** If advance care planning is done outside the annual wellness visit, your coinsurance is 10% of the approved amount, after deductible. You may also be charged cost sharing if a service performed (e.g., diagnostic test) is outside the scope of the annual wellness visit. The deductible and coinsurance apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Annual wellness visit, *continued* **Note:** Your first annual wellness visit can't take place within 12 months of your Welcome to Medicare exam. However, you don't need to have had a Welcome to Medicare exam to be covered for annual wellness visits after you've had Part B for 12 months.	
Bone mass measurement This test helps to see if you're at risk for broken bones. It's covered once every 24 months (more often if medically necessary) for people who have certain medical conditions or meet certain criteria. Qualified individuals are people at risk of losing bone mass or at risk of osteoporosis. Coverage includes procedures to identify bone mass, detect bone mass, or determine bone quality, including a physician's interpretation of the results.	**In-network and Out-of-network:** Covered at 100% of the approved amount.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39. • One routine, screening mammogram (breast X-ray) every calendar year. • Clinical breast exam once every 24 months. • Clinical breast exam once every 12 months for those at high risk. • 3-D mammograms when medically necessary. • Diagnostic mammograms more frequently than once a year when medically necessary.	**In-network and Out-of-network:** Covered at 100% of the approved amount. **Note:** If a diagnostic test is performed, your coinsurance is 10% of the approved amount, after deductible. The deductible and coinsurance apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Cardiac rehabilitation services The plan covers comprehensive programs that include exercise, education, and counseling for patients who meet these conditions: • A heart attack in the last 12 months. • Coronary artery bypass surgery. • Current stable angina pectoris (chest pain). • A heart valve repair or replacement. • A coronary angioplasty (a medical procedure used to open a blocked artery) or coronary stenting (a procedure used to keep an artery open). • A heart or heart-lung transplant. • Stable, chronic heart failure. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than regular cardiac rehabilitation programs. Services are covered in a doctor's office or hospital outpatient setting.	**In-network and Out-of-network:** Your coinsurance is 10% of the approved amount, after deductible. The deductible and coinsurance apply to the annual out-of-pocket maximum.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) The plan covers one visit per year with your primary care provider to help lower your risk for cardiovascular disease. During your visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you are eating well.	**In-network and Out-of-network:** Covered at 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Cardiovascular disease screenings These screenings include blood tests that help detect conditions that may lead to a heart attack or stroke. The plan covers these screening tests once every five years to test your cholesterol, lipid, lipoprotein, and triglyceride levels.	**In-network and Out-of-network:** Covered at 100% of the approved amount.
Caregiver training resources Training that helps your caregiver learn and develop skills to care for you (like giving medications, personalized care, and more) as part of your treatment plan. If your healthcare provider determines that caregiver training is appropriate for your treatment plan, your caregiver can get individual or group training sessions from your provider without requiring you to be present. Training must focus on your health goals, and your treatment must require a caregiver's help to succeed.	**In-network and Out-of-network:** Your coinsurance is 10% of the approved amount, after deductible. The deductible and coinsurance apply to the annual out-of-pocket maximum.
Cervical and vaginal cancer screening Pap tests and pelvic exams are covered once every calendar year.	**In-network and Out-of-network:** Covered at 100% of the approved amount.
Chemotherapy The medical plan covers chemotherapy in a doctor's office, freestanding clinic, or hospital outpatient setting for people with cancer.	**In-network and Out-of-network:** Your coinsurance is 10% of the approved amount, after deductible. The deductible and coinsurance apply to the annual out-of-pocket maximum.
Chiropractic services Covered services are limited to: • Manual manipulation of the spine to correct subluxation. • Spine X-rays and chiropractic radiology services.	**In-network and Out-of-network:** Your coinsurance is 10% of the approved amount, after deductible. The deductible and coinsurance apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Clinical research studies Clinical research studies test how well different types of medical care work and if they're safe. Most costs for clinical research studies are paid for by Original Medicare, not Medicare Plus Blue Group PPO. You must use your red, white, and blue Medicare membership card to get services. The plan covers some costs in qualifying clinical research studies. Refer to Chapter 3 for additional information.	Original Medicare covers most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost, this plan will pay the difference between Original Medicare's cost sharing and the cost sharing under Medicare Plus Blue Group PPO.
Colorectal cancer screening The plan covers these screenings to help find precancerous growths or find cancer early, when treatment is most effective. One or more of these tests may be covered: • Fecal occult blood test - This test is covered once every calendar year if you're 45 or older. • Flexible sigmoidoscopy - This test is generally covered once every 48 months if you're 45 or older, or 120 months after a previous screening colonoscopy for those not at high risk. • Colonoscopy - This test is generally covered once every 120 months (high risk every 24 months) or 48 months after a previous flexible sigmoidoscopy. There's no minimum age. If you initially have a non-invasive stool-based screening test and receive a positive result, the plan also covers a follow-up colonoscopy as a screening test. • Barium enema - This test is generally covered once every 48 months if you're 45 or older (high risk, every 24 months) when used instead of a sigmoidoscopy or colonoscopy.	**In-network and Out-of-network:** Covered at 100% of the approved amount. **Note:** If a polyp or other tissue is found and removed during the colonoscopy, your coinsurance is 10% of the approved amount. The coinsurance applies to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Colorectal cancer screening, *continued* • Multi-target stool DNA and blood-based biomarker tests - These lab tests are generally covered once every three years if you meet all these conditions: - Are between ages 45-85. - Show no signs or symptoms of colorectal disease including, but not limited to, lower gastrointestinal pain, blood in stool, positive guaiac fecal occult blood test or fecal immunochemical test. - At average risk for developing colorectal cancer, meaning: o Have no personal history of adenomatous polyps, colorectal cancer, inflammatory bowel disease, including Crohn's disease and ulcerative colitis. o Have no family history of colorectal cancer or adenomatous polyps, familial adenomatous polyposis, or hereditary nonpolyposis colorectal cancer.	
COVID-19 vaccine The medical plan covers FDA-authorized COVID-19 vaccines.	**In-network and Out-of-network:** Covered at 100% of the approved amount.
Dental services The medical plan doesn't cover most dental care, dental procedures, or supplies, like cleanings, fillings, tooth extractions, dentures, dental plates or other dental devices. You have coverage for certain dental services that you get when you're in a hospital. You also have coverage for services required for the initial treatment of an injury to the jaws, sound natural teeth, mouth or face.	**In-network and Out-of-network:** Your coinsurance is 10% of the approved amount, after deductible. The deductible and coinsurance apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Dental services, *continued* The injury must have occurred after the effective date of your coverage with your retirement system. Services must be performed by a physician or dentist. The medical plan does not cover injuries resulting from biting or chewing, or preventive or maintenance services.	
Depression screening The plan covers one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and referrals.	**In-network and Out-of-network:** Covered at 100% of the approved amount.
Diabetes Prevention Program The plan covers a once-per-lifetime health behavior change program to help you prevent type 2 diabetes. The program begins with weekly core sessions in a group setting over a six-month period. In these sessions, you'll get: • Training to make realistic, lasting behavior changes around diet and exercise. • Tips on how to get more exercise. • Strategies to control your weight. • A specially trained coach to help keep you motivated. • Support from people with similar goals and challenges. Once you complete the core sessions, you'll get: • Six monthly follow-up sessions to help you maintain healthy habits. • An additional 12 monthly ongoing maintenance sessions if you meet certain weight loss and attendance goals.	**In-network and Out-of-network:** Covered at 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Diabetes Prevention Program, *continued* To be eligible, you must have: • A hemoglobin A1c test result between 5.7% and 6.4%, a fasting plasma glucose of 110-125mg/dL, or a 2-hour plasma glucose of 140-199 mg/dL (oral glucose tolerance test) within 12 months before attending the first core session. • A body mass index (BMI) of 25 or more (BMI of 23 or more if you're Asian). • Never been diagnosed with type 1 or type 2 diabetes, or end-stage renal disease. • Never participated in the Diabetes Prevention Program.	
Diabetes screening The plan covers these screenings if your doctor determines you're at risk for diabetes or diagnosed with prediabetes. You may be eligible for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.	**In-network and Out-of-network:** Covered at 100% of the approved amount.
Diabetes self-management training* The plan covers diabetes outpatient self-management training to teach you to cope with and manage your diabetes. The program may include tips for eating healthy, being active, monitoring blood sugar, taking medication, and reducing risks. You must have diabetes and a written order from your doctor or other qualified healthcare provider.	**In-network and Out-of-network:** Your coinsurance is 10% of the approved amount, after deductible. The deductible and coinsurance apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Diabetes supplies* Includes: • Blood sugar testing monitors (portable blood glucose meters, called glucometers, that monitor blood sugar and continuous glucose monitors). • Blood sugar test strips. • Lancet devices and lancets. • Blood sugar control solutions. • Therapeutic shoes and inserts for the shoes. **Note:** Injectable insulin and needles and syringes for injectable insulin are covered under your prescription drug plan when prescribed by your physician. Continuous glucose monitors must be obtained from a network pharmacy.	**In-network and Out-of-network:** Covered up to 100% of the approved amount, including at network pharmacies.
Diagnostic tests Covered services include, but are not limited to: X-rays, ECG, EKGs, MRAs,* MRIs,* CT scans,* PET scans,* and nuclear medicine.* Radiation (radium and isotope) therapy including technician materials and supplies. Clinical laboratory services including certain blood tests and urinalysis. Pathology services (examination of body tissue). *High-tech radiology services rendered by plan providers require prior authorization. Your plan provider will arrange for this authorization. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	**In-network and Out-of-network:** Clinical lab services are covered up to 100% of the approved amount. For all other services, your coinsurance is 10% of the approved amount, after deductible. The deductible and coinsurance apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Doctor and other healthcare provider services The plan covers medically necessary doctor services and services provided by other healthcare providers, such as physician assistants, nurse practitioners, social workers, physical therapists, and psychologists. Coverage includes, but is not limited to: • Consultation, diagnosis, and treatment by a specialist. • Second surgical opinions, and in some cases third opinions, when performed by a network plan provider.	**In-network and Out-of-network:** Your coinsurance is 10% of the approved amount, after deductible. The deductible and coinsurance apply to the annual out-of-pocket maximum.
Durable medical equipment (DME) and related medical supplies* (For a definition of durable medical equipment, see Chapter 10 of this document as well as Chapter 3, Section 7.) The plan covers medically necessary items that you purchase or rent from an independent medical supplier for use at home. You must have a prescription or a Certificate of Medical Necessity from a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) to obtain durable medical equipment (DME). Covered items include, but are not limited to: • Hospital beds ordered by a provider for use in the home, wheelchairs, walkers, canes, and crutches. • Respiratory equipment such as oxygen concentrators, apnea monitors, nebulizers and CPAP machines. • Home dialysis equipment and supplies. • Medical supplies such as surgical dressings, adult disposable diapers, gradient compression stockings (up to eight per year or four pair), IV infusion pumps, powered mattress systems and speech generating devices.	**In-network:** Your coinsurance is 10% of the approved amount, after deductible. The deductible and coinsurance apply to the annual out-of-pocket maximum. Diabetic testing supplies, diabetic supplies and therapeutic shoes for people with severe diabetic foot disease are covered up to 100% of the approved amount. **Out-of-network:** Your coinsurance is 30% of the approved amount, after deductible. The deductible and coinsurance apply to the annual out-of-pocket maximum. Diabetic testing supplies, diabetic supplies and therapeutic shoes for people with severe diabetic foot disease are covered up to 100% of the approved amount. Continuous glucose monitors must be obtained from a network pharmacy.

Services that are covered for you	What you must pay when you get these services
Durable medical equipment (DME) and related medical supplies,* *continued* • Defibrillator (implantable automatic). Equipment setup and training is covered when medically necessary, such as assistance by an RN or respiratory therapist. People who have diabetes and severe diabetic foot disease have coverage for the furnishing and fitting of either one pair of custom-molded shoes (including inserts provided with such shoes) or one pair of extra-depth shoes each calendar year, prescribed by a podiatrist or other qualified doctor and provided by a podiatrist, orthotist, prosthetist, pedorthist or other qualified individual. The plan covers two additional pairs of inserts each calendar year for custom-molded shoes and three pairs of inserts each calendar year for extra-depth shoes. Note: The plan will cover shoe modifications instead of inserts. If you (or your provider) don't agree with the plan's coverage decision, you (or your provider) may file an appeal. You can also file an appeal about what product or brand is appropriate for your medical condition. (For more information about appeals, see Chapter 7*, What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*.)	
Emergency care The plan covers medical emergency care 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 are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb.	**In-network and Out-of-network:** You pay a $140 copayment for the hospital emergency department visit (waived if admitted within three days). The copay applies to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Emergency care, *continued* The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. You also have coverage for emergency/urgently needed services, worldwide.	
Flu/influenza shots Covered once each flu/influenza season, in the fall or winter.	**In-network and Out-of-network:** Covered at 100% of the approved amount.
Foot exams and treatment (podiatry) The plan covers foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions.	**In-network and Out-of-network:** Your coinsurance is 10% of the approved amount, after deductible. The deductible and coinsurance apply to the annual out-of-pocket maximum.
Glaucoma tests Covered once per year for people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, African Americans aged 50 or older or Hispanic Americans aged 65 or older.	**In-network and Out-of-network:** 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.	**In-network:** Covered at 100% of the approved amount when provided through SilverSneakers. **Out-of-network:** Not covered.

Services that are covered for you	What you must pay when you get these services
Health fitness program, *continued*	
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. • Burnalong® access with a supportive virtual community and thousands of classes for all interests and abilities. • SilverSneakers On-Demand online library with hundreds of workout videos. • SilverSneakers GO mobile app with on-demand videos and live classes. • Online fitness tips and healthy eating information. • Social connections through events such as shared meals, holiday celebrations, and class socials. • GetSetUp virtual enrichment program with classes on topics ranging from healthy eating to aging in place. Fitness services must be provided at SilverSneakers® participating locations. 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. GetSetUp is a third-party provider and is not owned or operated by Tivity Health Inc. ("Tivity") or its affiliates. Users must have internet service to access GetSetUp service. Internet service charges are responsibility of user. Burnalong is a registered trademark of Burnalong Inc. SilverSneakers is a registered trademark of Tivity Health, Inc. © 2024 Tivity Health, Inc. All rights reserved.	

Services that are covered for you	What you must pay when you get these services
Hearing and balance exams The plan covers these exams if your doctor or other qualified healthcare provider orders them to see if you need medical treatment.	**In-network and Out-of-network:** Your coinsurance is 10% of the approved amount, after deductible. The deductible and coinsurance apply to the annual out-of-pocket maximum.
Hearing aids	Refer to the **Routine Hearing Care** section located in Section 2.2 for benefit information.
Hepatitis B vaccine The medical plan covers these shots if you are at medium or high risk for Hepatitis B. Some risk factors include hemophilia, end-stage renal disease, diabetes, if you live with someone who has Hepatitis B, or if you're a medical care worker and have frequent contact with blood or body fluids. Check with your doctor to see if you're at medium or high risk for Hepatitis B.	**In-network and Out-of-network:** Covered at 100% of the approved amount.
Hepatitis B Virus (HBV) infection screening The plan covers HBV infection screenings if you meet one of these conditions: • You're at high risk for HBV infection. • You're pregnant. The plan will only cover HBV infection screenings if they're ordered by a primary care provider. HBV infection screenings are covered: • Annually, only for those with continued high risk who don't get a Hepatitis B vaccination.	**In-network and Out-of-network:** Covered at 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services

Hepatitis B Virus (HBV) infection screening, *continued*
• For pregnant women:
  ○ At the first prenatal visit for each pregnancy.
  ○ At the time of delivery for those with new or continued risk factors.
  ○ At the first prenatal visit for future pregnancies, even if you previously got the Hepatitis B shot or had negative HBV screening results.	

Hepatitis C screenings The plan covers one Hepatitis C screening test if you meet one of these conditions: • You're at high risk because you're currently using illicit injection drugs. • You're at high risk because you have a history of illicit injection drug use. • You had a blood transfusion before 1992. • You were born between 1945-1965. The plan also covers yearly repeat screenings for people at high risk.	**In-network and Out-of-network:** Covered at 100% of the approved amount.
HIV screening The plan covers HIV screenings once every 12 months if you're: • Between ages 15-65. • Younger than 15 and older than 65, and at increased risk. The plan also covers this test up to three times during a pregnancy.	**In-network and Out-of-network:** Covered at 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Home health agency care Medically necessary home healthcare is covered for patients confined to home. Your physician must prescribe the care and prepare a treatment plan. Confined to home means both of the following are true: • You have trouble leaving your home without help (like using a cane, wheelchair, walker, or crutches; special transportation; or help from another person) because of an illness or injury. • Leaving your home isn't recommended because of your condition, and you're normally unable to leave your home because it's a major effort. At each visit, the plan will cover: • Part-time or intermittent skilled nursing care by an employee of the home healthcare agency. • Part-time or intermittent home health aide services. • Nutritional guidance and medical social services. • Medical and surgical supplies such as catheters and colostomy supplies, oxygen, laboratory services, and medications for use at home (refer to the *Durable medical equipment (DME) and related medical supplies* section for information on your costs). • Physical, occupational and speech therapy (may be covered outside the home when equipment cannot be brought into the home). These services are covered only when the services are specific, safe and an effective treatment for your condition.	**In-network and Out-of-network:** Covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Home health agency care, *continued* **Note:** To be covered under the home healthcare benefit, your skilled nursing and home health aide services combined must total fewer than eight hours per day and 35 hours per week.	
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. • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.	**In-network and Out-of-network:** Your coinsurance is 10% of the approved amount, after deductible. The deductible and coinsurance apply to the annual out-of-pocket maximum.
Hospital services* The plan covers 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 are not limited to:	**In-network and Out-of-network:** Clinical lab services are covered up to 100% of the approved amount. For other services, your coinsurance is 10% of the approved amount, after deductible.

Services that are covered for you	What you must pay when you get these services
Hospital services,* *continued* • Services in an outpatient clinic, such as observation services or outpatient surgery. • Laboratory and diagnostic tests billed by the hospital. • Mental healthcare, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it. • X-rays and other radiology services billed by the hospital. • Medical supplies such as splints and casts. • Certain drugs and biologicals that you can't give yourself. • Blood, including storage and administration. • Substance use disorder services.* **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are 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 are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Medicare Hospital Benefits.* This fact sheet is available on the web 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. You can call these numbers for free, 24 hours a day, 7 days a week.	The deductible and coinsurance apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Hospital services,* *continued* *Outpatient mental health/substance use disorder services rendered by plan providers may require prior authorization. Your plan provider will arrange for this authorization. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	
Kidney disease treatment, services, supplies and education Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease, when referred by their doctor, the plan covers up to six sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible). • Inpatient dialysis treatments (if you are 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.	**In-network and Out-of-network:** Kidney disease education is covered at 100% of the approved amount. Your coinsurance for dialysis is 10% of the approved amount, after deductible. The deductible and coinsurance apply to the annual out-of-pocket maximum. Refer to the *Durable medical equipment (DME) and related medical supplies* section in this Medical Benefits Chart for cost-share information on home dialysis equipment and supplies.

Services that are covered for you	What you must pay when you get these services
Kidney disease treatment, services, supplies and education, *continued* • 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 your medical plan. For information about coverage for medical plan drugs, please go to the section, *Prescription drugs (limited)*.	
Lung cancer screening with low dose computed tomography (LDCT) The plan covers a lung cancer screening with LDCT once every 12 months if you meet all these conditions: • You're 50-77. • You're asymptomatic (don't have signs or symptoms of lung cancer). • You're either a current smoker or have quit smoking within the last 15 years. • You have a tobacco smoking history of at least 20 "pack years" (an average of one pack a day for 20 years). • You get an order from a doctor or other qualified healthcare provider. *For LDCT lung cancer screenings after the initial LDCT screening*: you must receive 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 subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	**In-network and Out-of-network:** Covered at 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Medical nutrition therapy (MNT) The plan covers medical nutrition therapy (MNT) services if you have diabetes or kidney disease, or you've had a kidney transplant in the last 36 months, and your doctor refers you for services. MNT services are furnished only by registered dietitians or nutrition professionals who meet certain requirements.	**In-network and Out-of-network:** Covered at 100% of the approved amount.
Mental healthcare* The plan covers mental healthcare services to help with conditions like depression or anxiety. Coverage includes services generally provided in an outpatient setting (like a doctor's or other healthcare provider's office or hospital outpatient department), including visits with a psychiatrist or other doctor, clinical psychologist, licensed master social worker, licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or clinical nurse specialist. Laboratory tests are also covered. Certain limits and conditions apply. Your coverage includes: • Psychological testing once every 12 months when administered by a fully licensed psychologist employed by or having privileges at the facility. • Counseling for your family members. *Mental healthcare services rendered by plan providers will require prior authorization. Your plan provider will arrange for this authorization. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	**In-network and Out-of-network:** Your coinsurance is 10% of the approved amount, after deductible. The deductible and coinsurance apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, the plan covers intensive counseling to help you lose weight. Up to 22 sessions over a 12-month period are covered. 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 provider to find out more.	**In-network and Out-of-network:** Covered at 100% of the approved amount.
Occupational therapy The plan covers evaluation and treatment to help you perform activities of daily living (like dressing or bathing) to maintain current capabilities or slow decline when your doctor or other healthcare provider certifies you need it.	**In-network and Out-of-network:** Your coinsurance is 10% of the approved amount, after deductible. The deductible and coinsurance apply to the annual out-of-pocket maximum.
Opioid treatment program services The plan covers: • 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 disorder counseling. • Individual and group therapy. • Toxicology testing. • Intake activities. • Periodic assessments.	**In-network and Out-of-network:** Your coinsurance is 10% of the approved amount, after deductible. The deductible and coinsurance apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
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 the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are 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 are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *Medicare Hospital Benefits* This fact sheet is available on the web 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. You can call these numbers for free, 24 hours a day, 7 days a week.	**In-network and Out-of-network:** Your coinsurance is 10% of the approved amount, after deductible. The deductible and coinsurance apply to the annual out-of-pocket maximum.
Partial hospitalization services and intensive outpatient services* Partial hospitalization is a structured program of active psychiatric treatment provided in a hospital outpatient setting or by a community mental health center, that is more intense than the care received in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's	**In-network and Out-of-network:** Your coinsurance is 10% of the approved amount, after deductible. The deductible and coinsurance apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Partial hospitalization services and intensive outpatient services,* *continued* 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 is more intense than the care received 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 rendered by plan providers will require prior authorization. Your plan provider will arrange for this authorization. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	
Physical therapy The plan covers evaluation and treatment for injuries and diseases that change your ability to function, or to maintain current function or slow decline, when your doctor or other healthcare provider certifies your need for it.	**In-network and Out-of-network:** Your coinsurance is 10% of the approved amount, after deductible. The deductible and coinsurance apply to the annual out-of-pocket maximum.
Pneumococcal vaccine The medical plan covers pneumococcal shots to help prevent pneumococcal infections (like certain types of pneumonia). The two shots protect against different strains of the bacteria. The medical plan covers the first shot at any time, and covers a different second shot if it's given one year (or later) after the first shot.	**In-network and Out-of-network:** Covered at 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Pneumococcal vaccine, *continued* Talk with your doctor or other healthcare provider to see if you need one or both pneumococcal shots.	
Prescription drugs (limited)* The medical plan covers a limited number of prescription drugs. Examples of prescription drugs covered under this plan include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services. • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump). • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan. • The Alzheimer's drug, Leqembi®, (generic name lecanemab), which 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. • Clotting factors you give yourself by injection if you have hemophilia. • Injectable osteoporosis drugs if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug.	**In-network and Out-of-network:** Your coinsurance is 10% of the approved amount, after deductible. The deductible and coinsurance apply to the annual out-of-pocket maximum. You will not pay more than $35 for a one month's supply of insulin. Retail and mail-order Part D prescription drugs are not covered by your Medicare Plus Blue Group PPO plan. Certain drugs require prior authorization. Step therapy may be required.

Services that are covered for you	What you must pay when you get these services
Prescription drugs (limited),* *continued* • 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. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does. • 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 End-Stage Renal Disease (ESRD) drugs if the same drug is available in injectable form and the Part B ESRD benefit covers it. • Calcimimetic 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.	

Services that are covered for you	What you must pay when you get these services
Prescription drugs (limited),* *continued* • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa). • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases. • Parenteral and enteral nutrition (intravenous and tube feeding). Self-administered drugs you take on your own that are covered under your prescription drug plan are not covered by this plan. Covered prescription drugs that may be subject to step therapy include: anticancer agents and cancer-supportive therapy agents, anti-gout agents, anti-inflammatory agents, antirheumatic agents, antispasticity agents, bisphosphonates, blood products, gastrointestinal agents, immunosuppressive agents, knee injections, ophthalmic agents and respiratory agents. The following link will take you to a list of drugs that may be subject to step therapy: **https://www.bcbsm.com/amslibs/content/dam/public/consumer/forms-documents/pharmacy/prior-authorization-and-step-therapy-guidelines.pdf** Refer to *Transplants*, in the *Inpatient hospital care* section earlier in this benefits chart for more information on coverage for immunosuppressant drugs.	

Services that are covered for you	What you must pay when you get these services
Prostate cancer screening exams For men aged 50 and older, covered services include the following, once every calendar year: • Digital rectal exam. • Prostate Specific Antigen (PSA) test.	**In-network and Out-of-network:** Covered at 100% of the approved amount.
Prosthetic/orthotic items* The plan covers arm, leg, back, and neck braces; artificial eyes; artificial limbs; some types of breast protheses (after mastectomy); a surgical brassiere after a mastectomy; and prosthetic and/or orthotic devices needed to replace an internal body part or function (including ostomy supplies and parenteral and enteral nutrition therapy) when ordered by a doctor or other healthcare provider. Coverage includes repair and/or replacement of prosthetic and/or orthotic devices. *You must have a prescription or a Certificate of Medical Necessity from your doctor to obtain durable medical equipment (DME) or prosthetic and orthotic (P&O) items and services.	**In-network** Your coinsurance is 10% of the approved amount, after deductible. The deductible and coinsurance apply to the annual out-of-pocket maximum. **Out-of-network** Your coinsurance is 30% of the approved amount, after deductible. The deductible and coinsurance apply to the annual out-of-pocket maximum.
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:** Your coinsurance is 10% of the approved amount, after deductible. The deductible and coinsurance apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Sexually transmitted infections (STIs) screening and counseling The plan covers 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. The plan covers these tests once every 12 months or at certain times during pregnancy. The plan also covers up to two individual 20- to 30-minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. The plan will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	**In-network and Out-of-network:** Covered at 100% of the approved amount.
Speech-language pathology services The plan covers evaluation and treatment to regain and strengthen speech and language skills, including cognitive and swallowing skills, or to maintain current function or slow decline, when your doctor or other healthcare provider certifies you need it.	**In-network and Out-of-network:** Your coinsurance is 10% of the approved amount, after deductible. The deductible and coinsurance apply to the annual out-of-pocket maximum.
Substance use disorder services* Outpatient substance use disorder services include counseling, medical testing, and diagnostic evaluation in a hospital or outpatient substance use disorder treatment facility.	**In-network and Out-of-network:** Your coinsurance is 10% of the approved amount, after deductible. The deductible and coinsurance apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Substance use disorder services,* *continued* Coverage is available for treatment services that are provided in the outpatient department of a hospital to patients who, for example, have been discharged from an inpatient stay for the treatment of drug substance use disorder or who require treatment but do not require the availability and intensity of 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. Coverage includes: • Services of professional and trained staff, and services necessary for your care and treatment, including diagnostic tests. • Individual and group therapy or counseling. • Psychological testing once every 12 months. • Counseling for your family members. *Outpatient mental/substance use disorder services rendered by plan providers may require prior authorization. Your plan provider will arrange for this authorization. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and an order for SET from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.	**In-network and Out-of-network:** Your coinsurance is 10% of the approved amount, after deductible. The deductible and coinsurance apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Supervised Exercise Therapy (SET), *continued* The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication. • Be conducted in a hospital outpatient setting or a physician's office. • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD. • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques. SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a healthcare provider.	
Surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers* Surgical procedures are covered when required for the diagnosis and treatment of a disease or injury and performed in an approved location, such as a hospital, physician's office or ambulatory surgical center. Services received in an ambulatory surgical center generally include elective surgery that does not require the use of hospital facilities and support systems but is not routinely performed in an office setting. **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order	**In-network and Out-of-network:** Your coinsurance is 10% of the approved amount, after deductible. The deductible and coinsurance apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers,* *continued* to admit you as an inpatient to the hospital, you are 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.	
Tobacco-use cessation counseling The plan covers up to eight face-to-face visits in a 12-month period.	**In-network and Out-of-network:** Covered at 100% of the approved amount.
Urgently needed services The plan covers urgently needed care to treat a sudden illness or injury that isn't a medical emergency. You also have coverage for urgently needed services, worldwide.	**In-network and Out-of-network:** You pay a $65 copay. The copay applies to the annual out-of-pocket maximum.
Virtual care Virtual care visits, sometimes called telehealth, give you the opportunity to meet with a healthcare provider through electronic forms of communication. This allows you to meet with a healthcare provider for minor illnesses or conditions that require medical attention when it is not possible for you to meet with your doctor in the office. Certain telehealth services, including primary care provider services and individual sessions for mental health specialty services, are covered. You have the option of getting these services either through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, then you must use a provider who offers the service by telehealth.	**In-network and Out-of-network:** Your coinsurance is 10% of the approved amount, after deductible. The deductible and coinsurance apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Virtual care, *continued* You can access online medical and behavioral health services anywhere in the U.S. You may choose to have an online visit with your own provider, if your provider offers this service. Or you can visit **bcbsm.com/virtualcare.** 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.	
Vision care services The medical plan covers exams to diagnose and treat medical conditions of the eye in case of disease or injury. The medical plan covers one pair of eyeglasses with standard frames (or one set of contact lenses) after cataract surgery that implants an intraocular lens. Routine eye exams and glasses are not covered by this medical plan.	**In-network and Out-of-network:** Your coinsurance is 10% of the approved amount, after deductible. The deductible and coinsurance apply to the annual out-of-pocket maximum.
Welcome to Medicare preventive visit The plan covers a one-time Welcome to Medicare preventive visit, which includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. The plan covers a one-time screening EKG/ECG if referred by your doctor or other healthcare provider as part of your one-time Welcome to Medicare preventive visit.	**In-network and Out-of-network:** Covered at 100% of the approved amount within the first 12 months after you have your Medicare Part B coverage. For EKG/ECG screening, your coinsurance is 10% of the approved amount, after deductible. You may also be charged cost sharing if a service performed (e.g., diagnostic test) is outside the scope of the Welcome to Medicare preventive visit. The deductible and coinsurance apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Welcome to Medicare preventive visit, *continued* **Important:** You must have the physical exam within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your Welcome to Medicare preventive visit.	**Note:** If you are treated or monitored for an existing medical condition during a visit when you receive preventive services, your 10% coinsurance and deductible will apply to the care received for the existing medical condition.

Worldwide Medical Care

Foreign Travel

Your covered hospital and medical benefits and cost share is the same when you travel to a foreign country as if the services were rendered in the U.S. For covered services performed abroad, your plan will pay the approved amount at the rate of exchange in effect on the date of service. You are responsible for costs that exceed the Medicare Plus Blue Group PPO approved amount plus your coinsurance, copay and deductible. For non-emergency inpatient medical care outside of the U.S., call the BlueCross BlueShield Global Core Service Center at 1-800-810-2583.

Section 2.2 Routine hearing care benefit details

Your routine hearing care benefits are exclusively available through a national network of TruHearing™ providers. Routine hearing exams and hearing aids are only covered when you call TruHearing at 1-855-205-6305, 8 a.m. to 8 p.m. (TTY 711) and follow the directions you are given. (Non-routine hearing and balance exams are covered under your medical plan; for more information, see **Hearing and balance exams** earlier in this chapter.)

Your routine hearing care benefits are not subject to the annual deductible and include the following services:

- **Audiometric examination** – Measures hearing ability, including test for air and bone conduction, speech reception, and speech discrimination.
- **Hearing aid evaluation test** – Determines what type of hearing aid should be prescribed to compensate for loss of hearing.
- **Hearing aid** – TruHearing Advanced or TruHearing Premium monaural (one ear) and binaural (involving both ears) in various fits, styles and colors are covered under your health benefits. Other hearing aids are not covered. When you use TruHearing providers you have:
  - One year of follow-up visits.
  - 60-day trial period.
  - Three-year full manufacturer warranty on all devices.
  - 80 batteries per non-rechargeable hearing aid.

What you pay	
TruHearing Provider	**Non-TruHearing Provider**
• $45 copay for routine hearing exam. • $499 copay per TruHearing Advanced hearing aid. • $799 copay per TruHearing Premium hearing aid.	• You pay all costs.

Frequency Limitation

- Routine hearing exams are covered once every 36 months.
- Up to two TruHearing Advanced or TruHearing Premium hearing aids are covered every 36 months.
- **Note:** Binaural hearing aids, or two hearing aids to correct hearing loss in both ears, are covered only when they are purchased on the same date. Two hearing aids provided to you on different dates are not considered binaural hearing aids and only one will be paid during a 36-month period.

Payment Provisions

- Hearing services must be received from a TruHearing provider to be covered.
- Copays for routine hearing exams and hearing aids are **not** counted toward your deductible and are not included in the annual out-of-pocket maximum.

Using Your Hearing Care Benefits

Call TruHearing at 1-855-205-6305, 8 a.m. to 8 p.m. (TTY 711) to schedule an appointment.

TruHearing will:

- Verify benefit eligibility and answer your questions.
- Schedule your appointment with a local provider.
- Send you an appointment reminder.
- Follow up after your hearing exam to ensure satisfaction.

Routine Hearing Care Appeals, and Complaints - What to do if you have a problem or concern

You should contact TruHearing at 1-855-205-6305, 8 a.m. to 8 p.m. (TTY 711) with questions about your hearing care benefits, including your eligibility for the benefits or the

amount you pay for your hearing care benefits. You should contact TruHearing in any of the following situations:

- If you are unsure about whether a particular service or item is covered.
- You have a complaint about a TruHearing provider, including a complaint about the quality of your care.

All questions about the hearing care benefits should be directed to TruHearing.

SECTION 3 What services are not covered by the plan?

Section 3.1 Services we do *not* cover (exclusions)

This section tells you what services are *excluded* and therefore are not covered by this plan.

The chart below lists services and items that either are not covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you receive the excluded services at an emergency facility, the excluded services are still not covered, and the plan will not pay for them. The only exception is if a service is appealed and decided to be a medical service that should have been paid for or covered because of your specific situation. For information about appealing a decision we have made to not cover a medical service, go to Chapter 7, Section 5.3 in this document.

Services not covered	Not covered under any condition	Covered only under specific conditions
Acupuncture		Covered for people with chronic low back pain under certain circumstances.
Cosmetic surgery or procedures		• Covered in cases of an accidental injury or for improvement of the functioning of a malformed body part. • Covered for all stages of reconstruction of a breast after a mastectomy, as well as for the unaffected breast

Services not covered	Not covered under any condition	Covered only under specific conditions
		to produce a symmetrical appearance.
Custodial care Custodial care is personal care that does not 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**	
Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, anti-aging and mental performance)		Covered only when medically necessary.
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. (See 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**	

Services not covered	Not covered under any condition	Covered only under specific conditions
Home-delivered meals	**Not covered under any condition**	
Homemaker services and basic household assistance including light housekeeping or light meal preparation	**Not covered under any condition**	
Immunizations needed for travel	**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.
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 duty nursing	**Not covered under any condition**	
Private room in a hospital		Covered only when medically necessary.
Reversal of sterilization procedures and contraceptive supplies **Note:** Check with your prescription drug plan about coverage for oral contraceptives.	**Not covered under any condition**	

Services not covered	Not covered under any condition	Covered only under specific conditions
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**	
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, vision therapy, and other low vision aids		Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery.
Routine foot care		Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes).
Routine hearing care: • Hearing aids other than TruHearing Advanced and TruHearing Premium hearing aids. • Ear molds. • Hearing aid accessories. • Provider visits for hearing aid adjustments after the first year (additional visits may cost up to $65). • Extra batteries beyond the first 80 provided per aid (additional batteries may be purchased from TruHearing on a discounted basis). • Charges associated with loss and damage warranty claims (may cost up to $250 per hearing aid for	**Not covered under any condition**	

Services not covered	Not covered under any condition	Covered only under specific conditions
manufacturer and provider programming fees). • Hearing care program services and supplies provided by a provider not associated with TruHearing. • Costs associated with excluded items. • Charges associated with seeing a provider outside of the TruHearing network.		
Routine hearing exams and hearing aids		Only covered when you call **TruHearing** at 1-855-205-6305, 8 a.m. to 8 p.m., Monday through Friday, and follow the instructions you are given.
Services considered not reasonable and necessary, according to Original Medicare standards unless these services are listed by this plan as covered services	**Not covered under any condition**	
Services provided to veterans in Veterans Affairs (VA) hospitals		When emergency services are received at a VA hospital and the VA cost sharing is more than the cost sharing under this plan, we will reimburse veterans for the difference. Members are still responsible for the plan's cost-sharing amounts.
Shingles shot	**Not covered under any condition**	

Services not covered	Not covered under any condition	Covered only under specific conditions
Note: The shingles shot isn't covered by the medical plan. Check with your prescription drug plan about coverage for the shingles shot.		
Travel expenses		Covered only for certain organ transplants. (See the Medical Benefits Chart, earlier in this chapter, for more information on travel expenses for organ transplants.)

CHAPTER 5

Asking us to pay the plan's share of a bill you have received for covered medical services

SECTION 1 Situations in which you should ask us to pay the plan's share of the cost of your covered services

Sometimes when you get medical care, you may need to pay the full cost up front. Other times, you may find that you have paid more than you expected under the plan's coverage rules or you may receive a bill from a provider. In these cases, you can ask us to pay you back (paying you back is often called *reimbursing* you). It is your right to be paid back whenever you've paid more than your share of the cost for medical services that are covered by this plan. There may be deadlines that you must meet to get paid back. Please see 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 have received or possibly for more than your share of the cost as discussed in this document. First, try to resolve the bill with the provider. If that does not work, send the bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly. If we decide not to pay it, we will 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.

Routine hearing exams and hearing aids are not covered unless you call TruHearing at 1-855-205-6305, 8 a.m. to 8 p.m. Monday through Friday (TTY 711) and follow the instructions you are given. You have no benefits if you see a non-TruHearing provider.

Here are examples of situations in which you may need to ask us to pay you back or to pay a bill you have received:

1. When you've received medical care from a provider who is not in our network

When you receive care from a provider who is not part of our network, you are 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 us for the plan's share of the cost.

- Emergency providers are legally required to provide emergency care. You are 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 receive the care, ask us to pay you back for the plan's share of the cost. Send us the bill, along with documentation of any payments you have made.
- You may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
    - If the provider is owed anything, we will pay the provider directly.

- If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for the plan's share of the cost.

- **Please note:** 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 cannot pay a provider who is not eligible to participate in Medicare. If the provider is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive.

2. When a network provider sends you a bill you think you should not pay

Network providers should always bill us 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 do not 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 what the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.
- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. If you are retroactively enrolled in this plan

Sometimes a person's enrollment in the 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 this plan and you paid out of pocket for any of your covered services after your enrollment date, you can ask us to pay you back for the plan's share of the costs. You will need to submit paperwork such as receipts and bills for us to handle the reimbursement.

All the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 of this document has information about how to make an appeal.

SECTION 2 How to ask us to pay you back or to pay a bill you have received

Section 2.1 How and where to send us your request for payment

Send us your request for payment, along with 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 received the service or item.

To make sure you are 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 will help us process the information faster.
- Either download a copy of the form from our website at **www.bcbsm.com/medicare/help/forms-documents/claims.html** or call Blue Cross Customer Service and ask for the form.

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

Medicare Plus Blue Group PPO Part C Claims Department
Blue Cross Blue Shield of Michigan
Imaging and Support Services
P.O. Box 32593
Detroit, MI 48232-0593

SECTION 3 We will consider your request for payment and say yes or no

Section 3.1 We check to see if the services are covered and how to proceed

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the medical care is covered, and you followed all the rules, we will pay the plan's share of the cost. If you have already paid for the service, we will mail your reimbursement of the plan's share of the cost to you. If you have not paid for the service yet, we will mail the payment directly to the provider.
- If we decide that the medical care is *not* covered, or you did *not* follow all the rules, we will not pay for the medical care you received. We will send you a letter explaining

the reasons why we are not sending the payment and your right to appeal that decision.

Section 3.2 If we tell you that we will not pay for all or part of the medical care, you can make an appeal

If you think we have made a mistake in turning down your request for payment or the amount we are paying, you can make an appeal. If you make an appeal, it means you are 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 of this document.

CHAPTER 6
Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities as a member of the plan

Section 1.1 We must provide information in a way that works for you and is consistent with your cultural sensitivities (in languages other than English, in audio CD, in large print, or other alternate formats)

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 a plan may meet these accessibility requirements include, but are not limited to: provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

We have free interpreter services available to answer questions from non-English speaking members. We can also give you information in audio CD, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Blue Cross Customer Service.

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 healthcare services.

If you have any trouble getting information from us in a format that is accessible and appropriate for you, please call to file a grievance with Blue Cross Customer Service (phone numbers are printed on the back cover of this booklet). You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights by calling 1-800-368-1019 or TTY 1-800-537-7697.

Section 1.2 We must ensure that you get timely access to your covered services

You have the right to choose a provider for your care.

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 that you are not getting your medical care within a reasonable amount of time, Chapter 7, Section 9 of this document 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 provided 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 later in this Section, called a *Notice of Privacy Practices*, that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don’t see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn’t providing your care or paying for your care, *we are required to first get written permission from you or someone you have authorized in writing to make decisions for you.*
- There are certain exceptions that do not require us to first get your written permission. These exceptions are allowed or required by law.
    - We are required to release health information to government agencies that are checking on quality of care.
    - Because you are a member of this plan through Medicare, we are 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 has been shared with others

You have the right to look at your medical records held by the plan, and to get a copy of your records. We are 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 will work with your healthcare 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 are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Blue Cross Customer Service.

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

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Affiliated entities covered by this notice

This notice applies to the privacy practices of the following affiliated covered entities that may share your protected health information as needed for treatment, payment, and health care operations.

- Blue Cross Blue Shield of Michigan
- Blue Care Network of Michigan

Our commitment regarding your protected health information

We understand the importance of your Protected Health Information (hereafter referred to as “PHI”) and follow strict policies (in accordance with state and federal privacy laws) to keep your PHI private. PHI is information about you, including demographic 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.

- **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 Blue Cross 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 www.bcbsm.com.

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

provided to you in written form or, in certain circumstances, electronic form. If you request an alternative format, such as a summary, we may charge a cost-based fee for preparing the summary. If we deny your request for access, we 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 **www.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 **www.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 Reviewed Date: 12/16/2022

Section 1.4 We must give you information about the plan, its 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, please call Blue Cross Customer Service:

- **Information about the plan.** This includes, for example, information about the 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.
    - Routine hearing exams and hearing aids are not covered unless you call TruHearing at 1-855-205-6305, 8 a.m. to 8 p.m. (TTY 711) and follow the instructions you are given. You have no benefits if you see a non-TruHearing provider.
- **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 is not covered, or if your coverage is limited.

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

You have the right to know your treatment options and participate in decisions about your healthcare

You have the right to get full information from your doctors and other healthcare 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 healthcare. 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 the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by your 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. Of course, 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 is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make healthcare decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *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. Submit a copy of the completed form to any entity that your selected representative may need to talk to on your behalf, including ORS and Blue Cross.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called advance directives. There are different types of advance directives and different names for them. Documents called living will and power of attorney for healthcare are examples of advance directives. An advance directive is not technically needed to conduct business with ORS but may provide guidance to your family members about the kind of healthcare you receive at the end of your life.

If you want to use an advance directive to give your instructions, here is what to do:

- **Get the form.** You can get an advance directive form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Blue Cross Customer Service to ask for the forms.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should 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 are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital**.

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

- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint.

In Michigan, visit: michigan.gov/lara and click *I Need to …* then scroll and click *Make a Complaint About a Licensed Professional or Business.*

To file a complaint against a hospital or other healthcare facility contact:
Department of Licensing & Regulatory Affairs
Bureau of Survey and Certification
P.O. Box 30828
Lansing, MI 48909

Call: 1-800-882-6006, 8 a.m. to 5 p.m. Eastern time, Monday through Friday. TTY users call 711.
Fax: 1-517-763-0214
Email: lara-bcs-complaints@michigan.gov

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. Eastern time, Monday through Friday. TTY users call 711.
Fax: 1-517-241-2389 (Attn: Complaint Intake)
Email: BPL-Complaints@michigan.gov

Outside Michigan, contact your state department of health agency or State Health Insurance Assistance Program (SHIP) for assistance. See *Exhibit 1* in the back of this booklet for SHIP listings.

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

If you have any problems, concerns or complaints and need to request 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 are required to treat you fairly**.

Section 1.7 What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, sexual orientation or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697 or call your local Office for Civil Rights.

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you have by calling:

- **Blue Cross Customer Service.**
- **Your State Health Insurance Assistance Program**. For details, go to Chapter 2, Section 3.
- **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY 1-877-486-2048.

Section 1.8 How to get more information about your rights

There are several ways to get more information about your rights:

- **Call Blue Cross Customer Service.**
- **Call your SHIP**. For details, go to Chapter 2, Section 3.
- **Contact Medicare**.
    - You can visit the Medicare website to read *Your Medicare Rights*. (The publication is available at: **medicare.gov/basics/your-medicare-rights**).
    - Or you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY 1-877-486-2048.

SECTION 2 You have some responsibilities as a member of the plan

Things you need to do as a member of the plan are listed below. If you have any questions, please call Blue Cross Customer Service.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* to learn what is covered for you and the rules you need to follow to get your covered services.
    - Chapters 3 and 4 give the details about your medical services.
- **You must call Blue Cross Customer Service (phone numbers are printed on the back cover of this booklet) if you have claims involving any of the following types of coverage:**
    - No-fault insurance (including automobile insurance).
    - Liability (including automobile insurance).
    - Black lung benefits.
    - Workers' compensation.
- **Tell your doctor and other healthcare providers that you are enrolled in this plan.** Show your plan membership ID 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 that you and your doctors agree upon.
    - Make sure your doctors know all the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
    - If you have any questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect all 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 are responsible for these payments:
    - You must pay your plan premiums.
    - You must continue to pay your Medicare Part B premium to remain a member of the plan.
    - For some of your medical services covered by the plan, you must pay your share of the cost when you get the service.

- **Tell ORS if you move.** If you are going to move, contact ORS at 1-800-381-5111 immediately to update your records to ensure you receive all necessary correspondence.
    - **If you move outside our service area, you cannot remain a member of this plan.** (Chapter 1 tells about our service area.)
    - **If you move, it is also important to tell the Social Security Administration** (or the Railroad Retirement Board).

CHAPTER 7

What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

This chapter explains two 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 these 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 guide in Section 3 will help you identify the right process to use and what you should do.

Section 1.2 What about the 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 and can be hard to understand. To make things easier, this chapter:

- Uses simpler words in place of certain legal terms. For example, this chapter generally says, making a complaint rather than filing a grievance, coverage decision rather than organization determination and independent review organization instead of Independent Review Entity.
- It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms. Knowing which terms to use will help you communicate more accurately to get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 Where to get more information and personalized assistance

We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. Therefore, you should always reach out to Blue Cross Customer Service for help. But, in some situations, you may also want help or guidance from someone who is not connected with us. Below are two entities that can help you.

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 are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers in Chapter 2, Section 3 of this booklet. For a list of SHIP organizations outside Michigan, refer to the appendix at the back of this document.

Medicare

You can also contact Medicare to get help. To contact Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can also visit the Medicare website (**medicare.gov**).

SECTION 3 To deal with your problem, which process should you use?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

Is your problem or concern about your benefits or coverage?

This includes problems about whether medical care (medical items, services and/or medical plan prescription drugs) is covered or not, the way it is covered, and problems related to payment for medical services.

Yes.

Go on to the next section of this chapter, **Section 4, A guide to the basics of coverage decisions and appeals.**

No.

Skip ahead to **Section 9** at the end of this chapter: **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 the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals: the big picture

Coverage decisions and appeals deal with problems related to your benefits and coverage for your medical care (medical items, services and/or medical plan prescription drugs), including payment. To keep things simple, we generally refer to medical items, services and medical plan prescription drugs as medical care. You use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions before receiving services

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical care. For example, if your plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either your network doctor can show you received 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 will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover medical care before you receive it, you can ask us to make a coverage decision for you. 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 will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide medical care is not covered or is no longer covered by Medicare 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 a benefit is received, 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. Under certain circumstances, which we

discuss later, you can request 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 were properly following the rules. When we have completed 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 will 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 that is not connected to us.

- You do not need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care and medical plan drugs to Level 2 if we do not fully agree with your Level 1 appeal.
- See Section 5.4 of this chapter for more information about Level 2 appeals.

If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 8 in this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.2 How to get help when you are 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:

- You can **call Blue Cross Customer Service**.
- You can **get free help** from your State Health Insurance Assistance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call Blue Cross Customer Service and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at **cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.**)
    - For medical care or medical plan prescription drugs, your doctor can request 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.** If you want to, 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 Blue Cross Customer Service and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at **cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.**) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
    - While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will 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 may contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.3 Which section of this chapter gives the details for your situation?

There are three different situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 5** of this chapter: Your medical care: How to ask for a coverage decision or make an appeal.
- **Section 6** of this chapter: How to ask us to cover a longer inpatient hospital stay if you think you are being discharged too soon.
- **Section 7** of this chapter: 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 healthcare, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services).

If you're not sure which section you should be using, please call Blue Cross Customer Service. You can also get help or information from government organizations such as your State Health Insurance Assistance Program.

SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal of a coverage decision

Section 5.1 This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for the plan's share of the cost of your care

This section is about your benefits for medical care. These benefits are described in Chapter 4 of this document: *Medical Benefits Chart (what is covered and what you pay*). In some cases, different rules apply to a request for a medical plan prescription drug. In those cases, we will explain how the rules for medical plan prescription drugs are different from the rules for medical items and services.

This section tells what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that this care is covered by this plan. **Ask for a coverage decision. Section 5.2.**
2. We will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by this plan. **Ask for a coverage decision. Section 5.2.**
3. You have received medical care that you believe should be covered by the plan, but we have said we will not pay for this care. **Make an appeal. Section 5.3.**

4. You have received and paid for medical care that you believe should be covered by this plan, and you want to ask us to reimburse you for this care. **Send us the bill. Section 5.5.**
5. You are being told that coverage for certain medical care you have 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 healthcare, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read sections 6 and 7 of this chapter. Special rules apply to these types of care.

Section 5.2 Step-by-step: How to ask for a coverage decision

Legal Terms
When a coverage decision involves your medical care, it is called an organization determination. A fast coverage decision is also 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 14 calendar days or 72 hours for medical plan prescription drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for medical plan prescription drugs. In order to get a fast coverage decision, you must meet two requirements:

- You may *only ask* for coverage for medical care items and/or services, not requests for payment for items and/or services already received.
- 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 function*.
- **If your doctor tells us that your health requires a fast coverage decision, we will 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 will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
    - Explains that we will use the standard deadlines.
    - Explains if your doctor asks for the fast coverage decision, we will 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 requested.

Step 2: Ask our plan to make a standard 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 will give you an answer within 14 calendar days after we receive your request for a medical item or service. If your request is for a **medical plan prescription drug,** we will give you an answer **within 72 hours** after we receive 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 will tell you in writing. We can't take extra time to make a decision if your request is for a medical plan prescription drug.
- If you believe we should *not* take extra days, you can file a fast complaint. We will 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. See Section 9 of this chapter for information on complaints.)

For fast coverage decisions, we use an expedited timeframe.

A fast coverage decision means we will answer within 72 hours if your request is for a medical item or service. If your request is for a medical plan prescription drug, we will 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 will tell you in writing. We can't take extra time to make a decision if your request is for a medical plan prescription drug.
- If you believe we should *not* take extra days, you can file a fast complaint. (See Section 9 of this chapter for information on complaints.) We will call you as soon as we make the decision.
- **If our answer is no to part or all of what you requested**, we will 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 are going on to Level 1 of the appeals process.

Section 5.3 Step-by-step: How to make a Level 1 appeal

Legal Terms
An appeal to the 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 seven calendar days for medical plan prescription drugs. A fast appeal is generally made within 72 hours.

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we will 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 a standard appeal or a fast appeal.

- **If you are asking for a standard appeal, submit your standard appeal in writing.** Chapter 2 has contact information.
- **If you are 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 requesting an appeal.
- **You can ask for a copy of the information regarding your medical coverage decision. You and your doctor may add more information to support your appeal.**

<u>Step 3:</u> 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 will gather more information if needed, possibly contacting you or your doctor.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires.
    - 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 will tell you in writing. We can't take extra time if your request is for a medical plan prescription drug.
    - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will 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 receives your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a medical plan prescription drug you have not yet received, we will give you our answer **within seven calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires.
    - 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 will tell you in writing. We can't take extra time to make a decision if your request is for a medical plan prescription drug.

- If you believe we should *not* take extra days, you can file a fast complaint. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
- If we do not give you an answer by the deadline (or by the end of the extended time period), we will 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 requested**, we must authorize or provide the coverage **within 30 calendar days** if your request is for a medical item or service, or **within seven calendar days** if your request is for a medical plan prescription drug.
- **If our plan says no to part or all of your appeal,** we will automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 5.4 Step-by-step: How a Level 2 appeal is done

Legal Term
The formal name for the independent review organization is the Independent Review Entity. It is sometimes called the IRE**.**

The **independent review organization is an independent organization hired by Medicare**. It is not connected with us and is not 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 will 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 will also have a fast appeal at Level 2

- For the *fast appeal,* the review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it receives your appeal.
- However, 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 medical plan prescription drug.

If you had a standard appeal at Level 1, you will also have a standard appeal at Level 2

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

Step 2: The independent review organization gives you its answer.

The independent review organization will tell you its decision in writing and explain the reasons for it.

- **If the 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 receive the decision from the review organization for standard requests. For expedited requests, we have 72 hours from the date we receive the decision from the review organization.
- **If the review organization says yes to part or all of a request for a medical plan prescription drug**, we must authorize or provide the medical plan prescription drug within **72 hours** after we receive the decision from the review organization for **standard requests**. For **expedited requests** we have **24 hours** from the date we receive the decision from the review organization.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called upholding the decision. It is also called turning down your appeal.) In this case, the independent review organization will send you a letter:
    - Explaining its decision.
    - Notifying you of the 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.
    - Telling 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 three additional levels in the appeals process after Level 2 (for a total of five 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 in this chapter explains the Level 3, 4, and 5 appeals processes.

Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?

Chapter 5 describes when you may need to ask for reimbursement or to pay a bill you have received 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 are asking for a coverage decision. To make this coverage decision, we will check to see if the medical care you paid for is a covered service. We will also check to see if you followed all the rules for using your coverage for medical care.

- **If we say yes to your request:** If the medical care is covered and you followed all the rules, we will send you the payment for the cost 30 to 60 calendar days after we receive your request. If you haven't paid for the medical care, we will 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 will not send payment. Instead, we will send you a letter that says we will not pay for the medical care and the reasons why.

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are 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 that we describe in Section 5.3. For appeals concerning reimbursement, please note:

- We must give you our answer within 60 calendar days after we receive your appeal. If you are asking us to pay you back for medical care you have already received and paid for, you are not 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 requested to you or to the provider within 60 calendar days.

SECTION 6 How to ask us to cover a longer inpatient hospital stay if you think you are being discharged too soon

When you are admitted to a hospital, you have the right to get all your covered hospital services that are necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your discharge date.
- When your discharge date is decided, your doctor or the hospital staff will tell you.
- If you think you are 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 will get a written notice from Medicare that tells about your rights

Within two calendar days of being admitted to the hospital, you will 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 do not get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, please call Blue Cross Customer Service or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

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

- You or someone who is acting on your behalf will be asked to sign the notice.
- Signing the notice shows only that you have received the information about your rights. The notice does not give your discharge date. **Signing the notice does *not* mean you are agreeing on a discharge date.**

3. **Keep your copy** of the notice handy so you will have the information about making an appeal (or reporting a concern about quality of care) if you need it.
   - If you sign the notice more than two calendar days before your discharge date, you will get another copy before you are scheduled to be discharged.
   - To look at a copy of this notice in advance, you can call Blue Cross Customer Service or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see the notice online at **cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.**

Section 6.2 Step-by-step: How to make a Level 1 appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, please call Blue Cross Customer Service. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

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 healthcare professionals who are paid by the federal government to check on and help improve the quality of care for people with Medicare. These experts are not 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 received (*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 or Exhibit 1 of the Appendix.

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 may 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 do not meet this deadline, and you decide to stay in the hospital after your planned discharge date, you may have to pay all the costs for hospital care you receive after your planned discharge date.
- Once you request an immediate review of your original hospital discharge date, the Quality Improvement Organization will contact us. By noon of the day after we are contacted, we will 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 is right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the *Detailed Notice of Discharge* by calling Blue Cross Customer Service or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at **cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices**.

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 may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers told us of your appeal, you will 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 is 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 review organization says yes, we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.
- You will 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 review organization says no, they are 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 review organization says no to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive 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 has said no to your appeal, and you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to *Level 2* of the appeals process.

Section 6.3 Step-by-step: 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 their 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 that 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 their decision.

If the review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you have received 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 is medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

If the 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 wish to continue with the review process.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five 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

Section 7.1 This section is only about three services: Home healthcare, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

When you are getting covered **home healthcare 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 is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *we will stop paying our share of the cost for your care.*

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 7.2 We will tell you in advance when your coverage will be ending

Legal Term
Notice of Medicare Non-Coverage. It tells you how you can request a fast-track appeal. Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care.

1. **You receive a notice in writing** at least two calendar days before our plan is going to stop covering your care. The notice tells you:
   - The date when we will stop covering the care for you.
   - How to request a *fast track appeal* to request 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 received it.** Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan's decision to stop covering the care.

Section 7.3 Step-by-step: 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 will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, please call Blue Cross Customer Service. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

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 healthcare 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 are not 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 received (*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 or Exhibit 1 of the Appendix.

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 wish to file an appeal, you still have appeal rights. Contact your Quality Improvement Organization.

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

Legal Term
Detailed Explanation of Non-Coverage is a notice that provides 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 may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers tell us of your appeal, you will 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 their 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 is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say *no*, then **your coverage will end on the date we have told you.**
- If you decide to keep getting the home healthcare, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will 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 7.4 Step-by-step: 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 healthcare, 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 that 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 their decision.

What happens if the review organization says yes?

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the 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 wish to continue with the review process. It will give you the details about how to go on 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 will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five 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 Level 3 and beyond

Section 8.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

This section may be appropriate for you if you have made a Level 1 appeal and a Level 2 appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have 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 cannot appeal any further. The written response you receive to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is 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 is 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 receiving the Administrative Law Judge's or attorney adjudicator's decision.
    - If we decide to appeal the decision, we will 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 this decision that turns down your appeal, the appeals process is over.
    - If you do not 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 will 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 receiving the Council's decision.
    - If we decide to appeal the decision, we will 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 do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal A judge at the **Federal District Court** will review your appeal.

- A judge will review all the information and decide yes or no to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

MAKING COMPLAINTS

SECTION 9 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 9.1 What kinds of problems are handled by the complaint process?

The complaint process is only used for certain types of problems. This includes problems related to quality of care, waiting times, and your customer service experience. 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 have received (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 Blue Cross Customer Service? • Do you feel you are being encouraged to leave the plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors or other health professionals? Or by Blue Cross Customer Service or other staff at the plan? ○ Examples include waiting too long on the phone, in the waiting or exam room.
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?

Complaint	Example
Timeliness (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)	If you already asked us for a coverage decision or made an appeal, and you think that we are not 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 have said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we are not meeting deadlines for covering or reimbursing you for certain medical services 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 also called filing a grievance. • Using the process for complaints is also called using the process for filing a grievance. • A fast complaint is also called an expedited grievance.

Section 9.3 Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling Blue Cross Customer Service is the first step.** If there is anything else you need to do, Customer Service will let you know.
- **If you do not 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 will 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
  Grievances and Appeals Department
  P.O. Box 2627
  Detroit, MI 48231-2627

  You may also fax it to us at 1-877-348-2251.

  We must address your grievance as quickly as your health status requires, but no later than 30 days after the receipt date of the oral or written grievance. **However, we can take up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing. In certain cases, you have the right to ask for a fast grievance, meaning we will answer your grievance within 24 hours. There are only two reasons under which we will grant a request for a fast grievance.

  - If you have asked Blue Cross Blue Shield of Michigan to give you a fast decision about a service you have not yet received and we have refused.

- If you do not agree with our request for a 14-day extension to respond to your standard grievance, organization determination or pre-service appeal.

- 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 will 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 will tell you in writing.
- **If you are making a complaint because we denied your request for a fast coverage decision or a fast appeal, we will automatically give you a fast complaint.** If you have a fast complaint, it means we will give you **an answer within 24 hours.**
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

Section 9.4 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about quality of care, you also have two 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 healthcare experts paid by the federal government to check on and improve the care given to Medicare patients. Chapter 2 and Exhibit 1 of the Appendix have contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time.**

Section 9.5 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/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 8

Ending your membership in the plan

SECTION 1 Introduction to 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 the plan because you have decided that you *want* to leave.
  - You can disenroll from Medicare Plus Blue Group PPO at any time.
  - If you decide you want to disenroll from Medicare Plus Blue Group PPO, contact ORS at 1-800-381-5111, Monday through Friday, 8:30 a.m. to 5 p.m. Eastern time.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 4 tells you about situations when we must end your membership.

If you are leaving the plan, the plan must continue to provide your medical care and you will continue to pay your cost share until your membership ends.

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

Section 2.1 You can end your membership at any time

You can end your membership in Medicare Plus Blue Group PPO at any time. Please contact ORS at 1-800-381-5111, Monday through Friday, 8:30 a.m. to 5 p.m. Eastern time, if you would like to disenroll from this plan. ORS will contact us, and we will take the necessary steps to cancel your membership. ORS can explain your options, implications of leaving this plan, and the correct process to follow to disenroll.

If you are also enrolled in Medicare prescription drug coverage through the retirement system, disenrolling from Medicare Plus Blue Group PPO will disenroll you from your drug plan as well.

If you decide to disenroll from this plan and enroll in an individual Medicare Advantage Plan, or another employer, union or retiree sponsored Medicare Advantage Plan, you should first contact the plan you wish to enroll in to verify your disenrollment from this plan aligns with the time frame for enrolling in the new plan. This will help you avoid a lapse in healthcare coverage.

You may voluntarily cancel your medical plan coverage at any time by going to **michigan.gov/orsmiaccount** or by completing ORS' *Insurance Enrollment/Change Request (R0452C)* form. The cancellation date will be the last day of the month in which the cancellation request is received unless a future date is indicated. If you choose to reenroll after you cancel your coverage, enrollment will begin on the first day of the sixth month after ORS receives your completed application and proofs.

SECTION 3 Until your membership ends, you must keep getting your medical services through this plan

Section 3.1 Until your membership ends, you are still a member of this plan

If you leave Medicare Plus Blue Group PPO, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical items and services through this plan.

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

SECTION 4 Medicare Plus Blue Group PPO must end your membership in the plan in certain situations

Section 4.1 When must we end your membership in the plan?

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

- You no longer have both Medicare Part A and Part B.
- You move out of the U.S. or its territories for more than 12 months.
- You become incarcerated (go to prison).
- You are not a U.S. citizen or lawfully present in the U.S.
- You lie about or withhold information about other insurance you have that provides medical or prescription drug coverage.

- You intentionally gave incorrect information when you enrolled in the plan and that information affects your eligibility for the plan. (We cannot end your coverage for this reason unless we get permission from Medicare first.)

- 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 the plan. (We cannot end your coverage for this reason unless we get permission from Medicare first.)

- You let someone else use your membership ID card to get medical care. (We cannot end your coverage 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.

- You no longer meet the Michigan Public School Employees' Retirement System's eligibility requirements.

Where can you get more information?

For information about disenrolling from this plan, contact ORS. ORS can explain your options, implications of leaving this plan, and the correct process to follow.

Section 4.2 We cannot ask you to leave the plan for any health-related reason

Medicare Plus Blue Group PPO is not allowed to ask you to leave the plan for any health-related reason.

What should you do if this happens?

If you feel that you are being asked to leave the plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week (TTY 1-877-486-2048).

Section 4.3 You have the right to make a complaint if we end your membership in the plan

If we end your membership in the plan, we must tell you our reasons in writing for ending your coverage. 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, or 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 are not included or explained in this document.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, 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 this 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, please 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 **https://www.hhs.gov/ocr/index.**

If you have a disability and need help with access to care, please call us at Customer Service. 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 about Subrogation and Third-Party Recovery

Legal Term
Subrogation is the substitution of one claim for another, especially the transfer of the right to receive payment of a debt to somebody other than the original creditor.

Subrogation

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:

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

Legal Term
Tortfeasor is a person responsible for damages.

Legal Term
Indemnifying means providing someone with insurance protection against injury or loss.

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.

Legal Term
Liability insurance claims consider who is legally responsible for causing damage or paying.

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:

- Responding to requests for information about any accidents or injuries;
- Responding to our requests for information and providing any relevant information that we have requested; and
- 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 any and all benefit payments we make to you or on your behalf that are the responsibility of any person, organization, or insurer. Our right of reimbursement is separate and apart from our subrogation right and is limited only by the amount of actual benefits paid under the 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 this 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.

CHAPTER 10

Definitions of important words

Chapter 10. Definitions of important words

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 does not exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of healthcare services or payment for services you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving.

Approved Amount (or Allowed Amount) – The dollar amount Blue Cross Blue Shield of Michigan has agreed to pay for healthcare services covered by your plan. It may be more or less than the actual amount a doctor or supplier charges. Any required coinsurance, copayments and deductibles are subtracted from this amount before payment is made.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of Medicare Plus Blue Group PPO, you only have to pay the plan's cost-sharing amounts when you get services covered by this plan. We do not allow providers to *balance bill* or otherwise charge you more than the amount of cost-sharing your plan says you must pay.

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

Coinsurance – A percentage you pay for most covered medical services (for example, 10%) after you have met your deductible.

Colonoscopy – An examination of the colon by way of a scope inserted into the rectum. Members are advised to have a *routine* or *screening* colonoscopy.

- **Routine or screening colonoscopy** is an examination of a healthy colon when there is no sign, symptom or disease present.
- **Diagnostic colonoscopy** is performed to diagnose and, consequently, establish treatment if the colon is unhealthy (there is a sign, symptom or disease present). Diagnostic colonoscopies are often prescribed when there are colon health concerns such as certain symptoms or medical history.

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 related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not 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, speech-language pathology services and home environment evaluation services.

Copayment (or copay) – A flat dollar amount you pay for specific services.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services are received. This is in addition to the plan's monthly premium. Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose on covered services before the plan begins to pay; (2) any coinsurance amount, a percentage of the approved amount for a service that the plan requires when a specific service is received; or (3) any flat dollar copayment amount that the plan requires when a specific service is received.

Coverage Decisions – A decision by your medical plan about whether a service is a benefit.

Covered Services – The term we use in this EOC to mean all the healthcare services and supplies that are covered by this plan.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care, provided by people who do not 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. The plan doesn't pay for custodial care.

Customer Service – A department within Blue Cross responsible for answering your questions about your membership, benefits, grievances, and appeals.

Deductible – The amount you must pay for covered services before the retirement system begins to pay.

Diagnostic Procedure – Testing to rule out or to confirm a suspected diagnosis because there is a sign or symptom of disease. When a screening procedure uncovers a symptom of disease, such as a polyp found during a colonoscopy, it is considered a diagnostic procedure. (See Screenings.)

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

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

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are 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 the plan.

Grievance – A type of complaint you make about the plan or providers including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Home Health Aide – A person who provides services that do not 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 six months or less. We must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you are still a member of this plan. You can still obtain all medically necessary services as well as the supplemental benefits your plan offers.

Hospice Care – A special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients in the last months of life by giving comfort and relief from pain. The focus is on care, not cure.

Hospital Stay (Inpatient) – A hospital stay when you have 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*.

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 sign or symptom of breast cancer has been found.

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 healthcare costs are covered if you qualify for both Medicare and Medicaid.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be: 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 Plan can also be a Special Needs Plan (SNP). Medicare Plus Blue Group PPO is a Medicare Advantage Plan administered by Blue Cross Blue Shield of Michigan.

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 Part B. The term Medicare-covered services does not include the extra benefits, such as 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 the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans and Demonstration/Pilot Programs.

Member (Plan Member) – A person with Medicare who is eligible to get covered services, who has enrolled in this plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network Provider – Provider is the general term for doctors, other healthcare professionals, hospitals, and other healthcare facilities that are licensed or certified by Medicare and by the state to provide healthcare services. Network providers have an agreement with us to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of the plan. Network providers are also called plan providers.

Organization Determination – A decision the 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 – Original Medicare is offered by the government, and not a private health plan such as Medicare Advantage Plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other healthcare providers payment amounts established by Congress. You can see any doctor, hospital, or other healthcare provider that accepts Medicare. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance) and is available everywhere in the U.S.

Out-of-Network Provider – A provider or facility that does not have a contract with us to coordinate or provide covered services to members of this plan. Out-of-network providers are providers that are not employed, owned, or operated by the plan.

Out-of-Pocket Costs – See the definition for cost sharing above. A member's cost-sharing requirement to pay for a portion of services received is also referred to as the member's out-of-pocket cost requirement.

Out-of-Pocket Maximum – This is the most you will pay in a calendar year for all services, excluding routine hearing care, from both network providers and out-of-network providers. See Chapter 4, Section 1.2 for information about your maximum out-of-pocket amount.

Part C – See Medicare Advantage (MA) Plan.

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 are received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are received from out-of-network providers.

Premium – The periodic payments you make to Medicare and your retirement system for health coverage.

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 us. In a PPO, you do not need prior authorization to obtain out-of-network services. However, you may want to check with us before obtaining services from out-of-network providers to confirm that the service is covered 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 healthcare experts paid by the federal government to check and improve the care given to Medicare patients.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Screenings – Preventive tests performed when no specific sign, symptom, or diagnosis is present. Screenings test for disease or disease precursors so that early detection and treatment can be provided for those who test positive for disease. Covered screenings have no coinsurance, copayment or deductible. However, when a sign or symptom is discovered during a screening, the testing may transition into a diagnostic procedure. (See Diagnostic procedure.)

Service Area – The geographic area in which you must reside to be eligible for coverage in this plan. Our service area is the U.S. and its territories.

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.

Urgently Needed Services – Urgently needed services are covered services that require immediate medical attention but are not considered emergencies. These services are covered by your plan even when you are temporarily outside the service area of the plan, or even if you are inside the service area of the plan and unable to obtain the service from network providers due to time, location or circumstances. 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, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable.

Virtual Care – Meeting with a healthcare provider through electronic forms of communication.

Appendix

Table of Contents

Exhibit 1 State Health Insurance Assistance Programs

Exhibit 1 State Health Insurance Assistance Programs

State:	Alabama	**State:**	Arkansas
Local:	1-334-242-5743	**Local:**	1-501-371-2782
Toll-free:	1-877-425-2243	**Toll-free:**	1-800-224-6330
Website:	**www.alabamaageline.gov**	**Website:**	**www.shiipar.com**
Address:	RSA Tower 201 Monroe Street Suite 350 Montgomery, AL 36104	**Address:**	1 Commerce Way Little Rock, AR 72202
State:	Alaska	**State:**	California
Local:	1-907-269-3666	**Local:**	1-916-419-7500
Toll-free:	1-800-478-9996	**Toll-free:**	1-800-510-2020
Website:	**dhss.alaska.gov/dsds/pages/medicare/default.aspx**	**TTY:**	1-800-735-2929
Address:	Senior and Disability Services 1835 Bragaw Street Suite 350 Anchorage, AK 99508	**Website:**	**www.aging.ca.gov/HICAP/**
		Address:	California Department of Aging 2880 Gateway Oaks Drive Suite 200 Sacramento, CA 95833
State:	Arizona	**State:**	Colorado
Local:	1-602-542-4446	**Local:**	1-303-894-7499
Toll-free:	1-800-432-4040	**Toll-free:**	1-800-930-3745
Website:	**des.az.gov/medicare-assistance**	**Website:**	**doi.colorado.gov**
Address:	DES Division of Aging and Adult Services 1789 W. Jefferson Street Suite Code 950A Phoenix, AZ 85007	**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:	1-860-247-0775
TTY:	
Website:	**portal.ct.gov/aginganddisability**
Address:	Department of Aging and Disability Services 55 Farmington Avenue, 12th floor Hartford, CT 06105

State:	Florida
Local:	1-800-963-5337
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:	1-302-674-7364
TTY:	1-800-336-9500
Website:	**https://insurance.delaware.gov/divisions/dmab/**
Address:	Insurance Commissioner 1351 West North Street Suite 101 Dover, DW 19904

State:	Georgia
Local:	1-404-657-5258
Toll-free:	1-866-552-4464
TTY:	1-404-657-1929
Website:	**aging.georgia.gov/georgia-ship**
Address:	Georgia SHIP 47 Trinity Ave. SW 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 500 K Street, NE Washington DC 20002

State:	Guam
Local:	1-671-735-7421
TTY:	1-671-735-7416
Website:	**http://dphss.guam.gov/division-of-senior-citizens-2/**
Address:	Division of Senior Citizens University Castle Mall 130 University Drive Suite 8 Mangilao, GU 96913

Exhibit 1 State Health Insurance Assistance Programs

State:	Hawaii
Toll-free:	1-888-875-9229
Oahu:	1-808-586-7299
TTY:	1-866-810-4379
Website:	**www.hawaiiship.org**
Address:	Executive Office on Aging No. 1 Capital District 250 South Hotel Street Suite 406 Honolulu, HI 96813

State:	Indiana
Local:	1-800-452-4800
TTY:	1-866-846-0139
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 West 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:	SHIIP- SMP 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://kdads.ks.gov/kdads-commissions/aging-and-disability-resource-centers**
Address:	Kansas Department for Aging and Disability Services New England Building 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 40621

State:	Maryland
Local:	1-410-767-1100
Toll-free:	1-800-243-3425
TTY:	711
Website:	**aging.maryland.gov/Pages/state-health-insurance-programs.aspx**
Address:	Maryland Department of Aging 301 W. Preston Street Suite 1007 Baltimore, MD 21201

State:	Louisiana
Local:	1-225-342-5301
Toll-free:	1-800-259-5300
Website:	**www.ldi.la.gov/consumers/senior-health-shiip**
Address:	Louisiana Dept. of Insurance P.O. Box 94214 Baton Rouge, LA 70802

State:	Massachusetts
Local:	1-617-727-7750
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, 3rd floor Boston MA 02108

State:	Maine
Local	1-207-287-9200
Toll-free:	1-800-262-2232
TTY:	711
Website:	**https://www.maine.gov/dhhs/oads**
Address:	Office of Aging & Disability Services 11 State House Station 41 Anthony Avenue Augusta, ME 04333

State:	Michigan
Toll-free:	1-800-803-7174
TTY:	711
Website:	**www.mmapinc.org**
Address:	Michigan Medicare / Medicaid Assistance Program 6015 W. St. Joesph Hwy Suite 103 Lansing, MI 48917

Exhibit 1 State Health Insurance Assistance Programs

State:	Minnesota	**State:**	Montana
Local:	1-651-431-2500	**Local:**	1-406-444-4077
TTY:	1-800-627-3529	**Toll-free:**	1-800-551-3191
Website:	**https://mn.gov/board-on-aging/connect-to-services/healthy-aging/**	**Website:**	**dphhs.mt.gov/sltc/aging/SHIP**
Address:	Minnesota Board on Aging P.O. Box 64976 St. Paul, MN 55164	**Address:**	Senior and Long-Term Care Division 1100 N. Last Chance Gulch 4th Floor Helena, MT 59601
State:	Mississippi	**State:**	Nebraska
Toll-free:	1-844-822-4622	**Toll-free:**	1-800-234-7119
Website:	**www.mississippiaccesstocare.org**	**Local:**	1-402- 471-2841
		TTY:	711
		Website:	**https://doi.nebraska.gov/ship-smp**
Address:	Mississippi Dept. of Human Services Division of Aging and Adult Services 1170 Lakeland Dr. Jackson MS 39216	**Address:**	SHIP 2717 S. 8th Street Suite 4 Lincoln, NE 68508
State:	Missouri	**State:**	Nevada
Toll-free:	1-800-390-3330	**Local:**	1-775-687-4210
TTY:	711	**Website:**	**https://adsd.nv.gov/**
Website:	**www.missouriship.org**	**Address:**	Nevada Aging and Disability Services Division 3308 Goni Rd., Building I Suite 181 Carson City, NV 89706
Address:	MO SHIP 601 N Nifong Blvd Suite 3A Columbia, MO 65203		

Exhibit 1 State Health Insurance Assistance Programs

State:	New Hampshire	**State:**	New York
Local:	1-603-271-9000	**Local:**	1-800-701-0501
Toll-free:	1-800-852-3345	**Toll-free**	1-800-342-9871
TTY:	1-800-735-2964	**Website:**	**https://aging.ny.gov/programs/medicare-and-health-insurance**
Website:	**www.dhhs.nh.gov/programs-services/adult-aging-care/servicelink**	**Address:**	Office for the Aging 2 Empire State Plaza 5th Floor Albany, NY 12223
Address:	New Hampshire Department of Health and Human Services 129 Pleasant Street Concord, NH 03301		
State:	New Jersey	**State:**	North Carolina
Local:	1-800-792-8820	**Local:**	1-855-408-1212
TTY:	711	**Website:**	**www.ncdoi.com/SHIIP**
Website:	**https://www.nj.gov/humanservices/doas/**	**Address:**	NC Department of Insurance 1201 Mail Service Center Raleigh NC 27699-1201
Address:	Division of Aging Services New Jersey Department of Human Services P.O. Box 715 Trenton, NJ 08625		
State:	New Mexico	**State:**	North Dakota
Local	1-505-476-4799	**Local:**	1-701-328-2440
Toll-free:	1-800-432-2080	**Toll-free:**	1-888-575-6611
TTY:	1-505-476-4937	**TTY:**	1-800-366-6888
Website:	**www.nmaging.state.nm.us**	**Website:**	**https://www.insurance.nd.gov/consumers/medicare**
Address:	New Mexico Aging and Long-Term Services Department 2550 Cerrillos Road Santa Fe, NM 87505	**Address:**	North Dakota Insurance Department 600 E. Boulevard Ave Bismack, 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 3rd Floor, Suite 300 Columbus, OH 43215

State:	Pennsylvania
Local:	1-717-783-1550
Toll-free:	1-800-783-7067
TTY:	
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 (San Juan)
Toll-free:	1-888-884-8721
Website:	**agencias.pr.gov/agencias/oppea/educacion/Pages/ship.aspx**
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, E15 Salem OR 97301

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: **Local:** **TTY:** **Website:** **Address:**	South Carolina 1-803-734-9900 1-800-868-9095 **www.aging.sc.gov/Pages/default.aspx** or **getcaresc.com** South Carolina Department on Aging 1301 Gervais Street Suite 350 Columbia, SC 29201
State: **Toll-free:** **Website:** **Address:**	South Dakota Western 1-877-286-9072 **https://dhs.sd.gov/en** South Dakota Department of Human Services 3800 East Highway 34 Hillsview Plaza c/o 500 East Capitol Ave Pierre, SD 57501
State: **Local:** **Toll-free:** **Website:** **Address:**	South Dakota Eastern 1-605-773-5990 1-800-265-9684 **https://dhs.sd.gov/en** South Dakota Department of Human Services 3800 E Highway 34 Hillsview Plaza c/o 500 East Capitol Ave. Pierre, SD 57501
State: **Local:** **Toll-free:** **Website:** **Address:**	Tennessee 1-615-862-8828 1-877-801-0044 **https://www.tn.gov/aging/our-programs/state-health-insurance-assistance-program--ship-.html** Tennessee Commission on Aging And Disability 502 Deadrick Street 9th Floor Nashville, TN 37243
State: **Toll-free:** **Website:** **Address:**	South Dakota Central 1-877-331-4834 **https://dhs.sd.gov/en** South Dakota Department of Human Services 3800 East Highway 34 Hillsview Plaza c/o 500 East Capitol Ave Pierre, SD 57501
State: **Local:** **TTY:** **Website:** **Address:**	Texas 1-512-424-6500 1-512-424-6597 **hhs.texas.gov/services/health/medicare** 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 N. 1460 West Salt Lake City, UT 84116

State:	Virgin Islands
St. Croix:	1-340-773-6449, opt. 9
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:	Vermont
Local:	1-802-241-0294
Toll-free:	1-800-642-5119
Website:	711
Address:	**www.asd.vermont.gov/services/ship** Adult Services Division Director HC2 South 280 State Drive Waterbury, VT 05671

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 Henrico, VA 23229

State:	Virgin Islands
St. Thomas:	1-340-774-2991, opt. 9
Website:	**ltg.gov.vi/department/vi-ship-medicare**
Address:	VI State Health Insurance Program/Medicare 5049 Kongens Gade St. Thomas, VI 00802

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 P.O. Box 40255 Olympia, WA 98504

Exhibit 1 State Health Insurance Assistance Programs

State:	West Virginia
Local:	1-304-558-3317
Toll-free:	1-877-987-3646
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, Street #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

Exhibit 2 Quality Improvement Organizations

Exhibit 2	Quality Improvement Organization

State:	Alabama
Organization:	Acentra Health
Toll-free:	1-888-317-0751
TTY:	1-844-878-7921
Website:	**www.acentraqio.com**
Address:	Acentra Health 5201 W. Kennedy Blvd Suite 900 Tampa, FL 33609

State:	Arkansas
Organization:	Acentra Health
Toll-free:	1-888-315-0636
TTY:	1-844-878-7921
Website:	**www.acentraqio.com**
Address:	Acentra Health 5201 W. Kennedy Blvd Suite 900 Tampa, FL 33609

State:	Alaska
Organization:	Acentra Health
Toll-free:	1-888-305-6759
TTY:	1-844-878-7921
Website:	**www.acentraqio.com**
Address:	Acentra Health 5201 W. Kennedy Blvd Suite 900 Tampa, FL 33609

State:	California
Organization:	Livanta, LLC
Toll-free:	1-877-588-1123
TTY:	711
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guilford Rd Suite 202 Annapolis Junction, MD 20701

State:	Arizona
Organization:	Livanta, LLC
Local:	1-877-588-1123
TTY:	711
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701

State:	Colorado
Organization:	Acentra Health
Toll-free:	1-888-317-0891
TTY:	1-844-878-7921
Website:	**www.acentraqio.com**
Address:	Acentra Health 5201 W. Kennedy Blvd Suite 900 Tampa, FL 33609

Exhibit 2	Quality Improvement Organization

State:	Connecticut
Organization:	Acentra Health
Toll-free:	1-888-319-8452
TTY:	1-844-878-7921
Website:	**www.acentraqio.com**
Address:	Acentra Health 5201 W. Kennedy Blvd Suite 900 Tampa, FL 33609

State:	Florida
Organization:	Acentra Health
Toll-free:	1-888-317-0751
TTY:	1-844-878-7921
Website:	**www.acentraqio.com**
Address:	Acentra Health 5201 W. Kennedy Blvd Suite 900 Tampa, FL 33609

State:	Delaware
Organization:	Livanta, LLC
Toll-free:	1-888-396-4646
TTY:	711
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guildford Rd. Suite 202 Annapolis Junction, MD 20701

State:	Georgia
Organization:	Acentra Health
Toll-free:	1-888-317-0751
TTY:	1-844-878-7921
Website:	**www.acentraqio.com**
Address:	Acentra Health 5201 W. Kennedy Blvd Suite 900 Tampa, FL 33609

State:	District of Columbia
Organization:	Livanta, LLC
Toll-free:	1-888-396-4646
TTY:	711
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guildford Rd. Suite 202 Annapolis Junction, MD 20701

State:	Hawaii
Organization:	Livanta, LLC
Toll-free:	1-877-588-1123
TTY:	711
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guildford Rd. Suite 202 Annapolis Junction, MD 20701

Exhibit 2	Quality Improvement Organization

State:	Idaho
Organization:	Acentra Health
Toll-free:	1-888-305-6759
TTY:	1-844-878-7921
Website:	**www.acentraqio.com**
Address:	Acentra Health 5201 W. Kennedy Blvd Suite 900 Tampa, FL 33609

State:	Iowa
Organization:	Livanta, LLC
Toll-free:	1-888-755-5580
TTY:	711
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guildford Rd. Suite 202 Annapolis Junction, MD 20701

State:	Illinois
Organization:	Livanta, LLC
Toll-free:	1-888-524-9900
TTY:	711
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guildford Rd. Suite 202 Annapolis Junction, MD 20701

State:	Kansas
Organization:	Livanta, LLC
Toll-free:	1-888-755-5580
TTY:	711
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guildford Rd. Suite 202 Annapolis Junction, MD 20701

State:	Indiana
Organization:	Livanta, LLC
Toll-free:	1-888-524-9900
TTY:	711
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guildford Rd. Suite 202 Annapolis Junction, MD 20701

State:	Kentucky
Organization:	Acentra Health
Toll-free:	1-888-317-0751
TTY:	1-844-878-7921
Website:	**www.acentraqio.com**
Address:	Acentra Health 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609

Exhibit 2	Quality Improvement Organization

State:	Louisiana
Organization:	Acentra Health
Toll-free:	1-888-315-0636
TTY:	1-844-878-7921
Website:	**www.acentraqio.com**
Address:	Acentra Health 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609

State:	Massachusetts
Organization:	Acentra Health
Toll-free:	1-888-319-8452
TTY:	1-844-878-7921
Website:	**www.acentraqio.com**
Address:	Acentra Health 5201 W. Kennedy Blvd Suite 900 Tampa, FL 33609

State:	Maine
Organization:	Acentra Health
Toll-free:	1-888-319-8452
TTY:	1-844-878-7921
Website:	**www.acentraqio.com**
Address:	Acentra Health 5201 W. Kennedy Blvd Suite 900 Tampa, FL 33609

State:	Michigan
Organization:	Livanta, LLC
Toll-free:	1-888-524-9900
TTY:	711
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guildford Rd. Suite 202 Annapolis Junction, MD 20701

State:	Maryland
Organization:	Livanta, LLC
Toll-free:	1-888-396-4646
TTY:	711
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guildford Rd. Suite 202 Annapolis Junction, MD 20701

State:	Minnesota
Organization:	Livanta, LLC
Toll-free:	1-888-524-9900
TTY:	711
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guildford Rd. Suite 202 Annapolis Junction, MD 20701

Exhibit 2 Quality Improvement Organization

State:	Mississippi
Organization:	Acentra Health
Toll-free:	1-888-317-0751
TTY:	1-844-878-7921
Website:	**www.acentraqio.com**
Address:	Acentra Health 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609

State:	Nebraska
Organization:	Livanta, LLC
Toll-free:	1-888-755-5580
TTY:	711
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guildford Rd. Suite 202 Annapolis Junction, MD 20701

State:	Missouri
Organization:	Livanta, LLC
Toll-free:	1-888-755-5580
TTY:	711
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guildford Rd. Suite 202 Annapolis Junction, MD 20701

State:	Nevada
Organization:	Livanta, LLC
Toll-free:	1-888-588-1123
TTY:	711
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guildford Rd. Suite 202 Annapolis Junction, MD 20701

State:	Montana
Organization:	Acentra Health
Toll-free:	1-888-317-0891
TTY:	1-844-878-7921
Website:	**www.acentraqio.com**
Address:	Acentra Health 5201 W. Kennedy Blvd Suite 900 Tampa, FL 33609

State:	New Hampshire
Organization:	Acentra Health
Toll-free:	1-888-319-8452
TTY:	1-844-878-7921
Website:	**www.acentraqio.com**
Address:	Acentra Health 5201 W. Kennedy Blvd Suite 900 Tampa, FL 33609

Exhibit 2 Quality Improvement Organization

State:	New Jersey
Organization:	Livanta, LLC
Toll-free:	1-888-815-5440
TTY:	711
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guildford Rd. Suite 202 Annapolis Junction, MD 20701

State:	North Carolina
Organization:	Acentra Health
Toll-free:	1-888-317-0751
TTY:	1-844-878-7921
Website:	**www.acentraqio.com**
Address:	Acentra Health 5201 W. Kennedy Blvd Suite 900 Tampa, FL 33609

State:	New Mexico
Organization:	Acentra Health
Toll-free:	1-888-315-0636
TTY:	1-844-878-7921
Website:	**www.acentraqio.com**
Address:	Acentra Health 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609

State:	North Dakota
Organization:	Acentra Health
Toll-free:	1-888-317-0891
TTY:	1-844-878-7921
Website:	**www.acentraqio.com**
Address:	Acentra Health 5201 W. Kennedy Blvd Suite 900 Tampa, FL 33609

State:	New York
Organization:	Livanta, LLC
Toll-free:	1-866-815-5440
TTY:	711
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guildford Rd. Suite 202 Annapolis Junction, MD 20701

State:	Ohio
Organization:	Livanta, LLC
Toll-free:	1-888-524-9900
TTY:	711
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guildford Rd. Suite 202 Annapolis Junction, MD 20701

Exhibit 2 Quality Improvement Organization

State:	Oklahoma
Organization:	Acentra Health
Toll-free:	1-888-315-0636
TTY:	1-844-878-7921
Website:	**www.acentraqio.com**
Address:	Acentra Health 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609

State:	Puerto Rico
Organization:	Livanta, LLC
Toll-free:	1-866-815-5440
TTY:	711
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701

State:	Oregon
Organization:	Acentra Health
Toll-free:	1-888-305-6759
TTY:	1-844-878-7921
Website:	**www.acentraqio.com**
Address:	Acentra Health 5201 W. Kennedy Blvd Suite 900 Tampa, FL 33609

State:	Rhode Island
Organization:	Acentra Health
Toll-free:	1-888-319-8452
TTY:	1-844-878-7921
Website:	**www.acentraqio.com**
Address:	Acentra Health 5201 W. Kennedy Blvd Suite 900 Tampa, FL 33609

State:	Pennsylvania
Organization:	Livanta, LLC
Toll-free:	1-888-396-4646
TTY:	711
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701

State:	South Carolina
Organization:	Acentra Health
Toll-free:	1-888-317-0751
TTY:	1-844-878-7921
Website:	**www.acentraqio.com**
Address:	Acentra Health 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609

Exhibit 2 Quality Improvement Organization

State:	South Dakota
Organization:	Acentra Health
Toll-free:	1-888-317-0891
TTY:	1-844-878-7921
Website:	**www.acentraqio.com**
Address:	Acentra Health 5201 W. Kennedy Blvd Suite 900 Tampa, FL 33609

State:	Utah
Organization:	Acentra Health
Toll-free:	1-888-317-0891
TTY:	1-844-878-7921
Website:	**www.acentraqio.com**
Address:	Acentra Health 5201 W. Kennedy Blvd Suite 900 Tampa, FL 33609

State:	Tennessee
Organization:	Acentra Health
Toll-free:	1-888-317-0751
TTY:	1-844-878-7921
Website:	**www.acentraqio.com**
Address:	Acentra Health 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609

State:	Vermont
Organization:	Acentra Health
Toll-free:	1-888-319-8452
TTY:	1-844-878-7921
Website:	**www.acentraqio.com**
Address:	Acentra Health 5201 W. Kennedy Blvd Suite 900 Tampa, FL 33609

State:	Texas
Organization:	Acentra Health
Toll-free:	1-888-315-0636
TTY:	1-844-878-7921
Website:	**www.acentraqio.com**
Address:	Acentra Health 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609

State:	Virgin Islands
Organization:	Livanta, LLC
Toll-free:	1-866-815-5440
TTY:	711
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701

Exhibit 2 Quality Improvement Organizations

State:	Virginia
Organization:	Livanta, LLC
Toll-free:	1-888-396-4646
TTY:	711
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701

State:	Wisconsin
Organization:	Livanta, LLC
Toll-free:	1-888-524-9900
TTY:	711
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701

State:	Washington
Organization:	Acentra Health
Toll-free:	1-888-305-6759
TTY:	1-844-878-7921
Website:	**www.acentraqio.com**
Address:	Acentra Health 5201 W. Kennedy Blvd Suite 900 Tampa, FL 33609

State:	Wyoming
Organization:	Acentra Health
Toll-free:	1-888-317-0891
TTY:	1-844-878-7921
Website:	**www.acentraqio.com**
Address:	Acentra Health 5201 W. Kennedy Blvd Suite 900 Tampa, FL 33609

State:	West Virginia
Organization:	Livanta, LLC
Toll-free:	1-888-396-4646
TTY:	711
Website:	**www.livantaqio.com**
Address:	Livanta LLC-BFCC QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701

State:	Wisconsin
Organization:	Livanta, LLC
Toll-free:	1-888-524-9900
TTY:	711
Website:	**www.livantaqio.com**
Address:	Livanta LLC-BFCC QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701

Exhibit 3 - State Medicaid Agencies

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:	**www.medicaid.alabama.go**
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:	Arkansas Division of Medical Services Donaghey Plaza P.O. Box 1437 Little Rock, AR 72203

State:	Alaska
Agency:	Alaska Medicaid Program
Toll-free:	1-800-478-7778
Website:	**health.alaska.gov/dpa/pages/medicaid/default.aspx**
Address:	Division of Public Assistance Senior Benefits 855 W. Commercial Drive Wasilla, AK 99654

State:	California
Agency:	Medi-Cal
Out-of-State:	1-916-636-1980
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 997417, MS 4607 Sacrament, CA 95899

State:	Arizona
Agency:	Arizona Health Care Cost Containment System (AHCCCS)
Local:	1-800-654-8713
TTY:	1-800-842-6520
Website:	**www.azahcccs.gov**
Address:	Arizona Health Care Cost Containment System (AHCCCS) 801 E. Jefferson St Phoenix, AZ 85034

State:	Colorado
Agency:	Health First Colorado
Toll-free:	1-800-221-3943
TTY:	711
Website:	**www.healthfirstcolorado.com**
Address:	Colorado Department of Health Care Policy & Financing 1570 Grant Street Denver, CO 80203

Exhibit 3 State Medicaid Agencies

State:	Connecticut
Agency:	Husky Health Connecticut
Local:	1-855-686-6632
Toll-free:	1-866-492-5276
Website:	**portal.ct.gov/HUSKY/How-to-Contact-Us**
Address:	Husky Health Program c/o Department of Social Services 55 Farmington Avenue Hartford, CT 06105

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:	1-302-255-9500
Toll-free:	1-800-372-2022
Website:	**dhss.delaware.gov/dmma**
Address:	Delaware Health and Social Services 1901 N. Dupont Highway New Castle, DE 19720

State:	Georgia
Agency:	Georgia Department of Community Health Georgia Medicaid Program
Toll-free:	1-404-657-5468
Website:	**medicaid.georgia.gov/**
Address:	Georgia Department of Community Health 2 Martin Luther King Jr. Dr. SE 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 64 New York Avenue, NE 6th Floor Washington, DC 200002

State:	Guam
Agency:	Medicaid Assistance Program
Local:	1-671-735-7356 / 2/5
TTY:	1-671-735-7302
Website:	**dphss.guam.gov/division-of-public-welfare/**
Address:	Department of Public Health and Social Services 123 Chalan Kareta Mangilao, GY 96913

Exhibit 3 State Medicaid Agencies

State:	Hawaii
Agency:	Hawaii Department of Human Services Med-Quest
Oahu Local:	1-808-524-3370
Neighbor Islands:	1-800-316-8005
TTY:	711
Website:	**medquest.hawaii.gov/**
Address:	Department of Human Services Directors Office P.O. Box 3490 Honolulu, HI 96811

State:	Hawaii
Agency:	Med-Quest
East Hawaii Section:	1-808-933-0339
Website:	**medquest.hawaii.gov/**
Address:	East Hawaii Section 88 Kanoelehua Ave Room 107 Hilo, HI 96720

State:	Hawaii
Agency:	Med-Quest
Waipahu Section:	1-808-587-3521
Website:	**medquest.hawaii.gov/**
Address:	Med-Quest Oahu Section P.O. Box 3490 Honolulu HI 86820

State:	Hawaii
Agency:	Med-Quest
West Hawaii Section:	1-808-327-4970
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:	1-808-692-7364
Website:	**medquest.hawaii.gov/**
Address:	Med-Quest Kapolei Unit P.O. Box 29920 Honolulu, HI 96820

State:	Hawaii
Agency:	Med-Quest
Lanai Unit:	1-808-565-7102
Website:	**medquest.hawaii.gov/**
Address:	Med-Quest Lanai Unit P.O. Box 631374 Lanai City, HI 96763

Exhibit 3 State Medicaid Agencies

State: Hawaii **Agency:** Med-Quest **Maui Section:** 1-808-243-5780 **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:** 1-808-553-1758 **Website:** **medquest.hawaii.gov/** **Address:** Med-Quest Molokai Unit P.O. Box 1619 Kaunakakai, HI 96748	**State:** Illinois – Chicago Office **Agency:** Illinois Medicaid Program **Local:** 1-800-843-6154 **TTY:** 1-866-324-5553 **Website:** **www.dhs.state.il.us/page.aspx?item=33698** **Address:** Department of Human Services– Chicago Office 401 South Clinton Street 7th floor Chicago, IL 60607
State: Hawaii **Agency:** Med-Quest **Kauai Unit:** 1-808-241-3575 **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:** 1-866-324-5553 **Website:** **www.illinois.gov/hfs/Pages/default.aspx** **Address:** Department of Human Services – Springfield Office 100 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:	Family & Social Services Administration (FSSA) Document Center P.O. Box 1810 Marion, IN 46952

State:	Kentucky
Agency:	Kentucky Medicaid Program
Local:	1-502-564-5497
Toll-free:	1-800-372-2973
TTY	711
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:	1-800-338-8366
Des Moines area:	1-515-256-4606
TTY:	1-800-735-2942
Website:	**dhs.iowa.gov/**
Address:	Iowa Department of Human Services Member Services P.O. Box 36510 Des Moines, Iowa 50315

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
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:	Office of MaineCare Services 109 Capitol Street Augusta, ME 04333

Exhibit 3 State Medicaid Agencies

State:	Maryland
Agency:	Maryland Medical Assistance Program
Toll-free:	1-410-767-6500
Assistance Program:	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:	1-651-431-2670
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:	1-800-497-4648
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 550 High Street Suite 1000 Jackson, MS 39201

State:	Michigan
Agency:	Michigan Medicaid Program
MI Enrolls:	1-800-975-7630
Beneficiary Helpline:	1-800-642-3195
TTY:	1-800-263-5897
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:	1-573-751-3425
TTY:	711
Website:	**https://mydss.mo.gov/mhd**
Address:	The State of Missouri MO HealthNet Division 615 Howerton Court P.O. Box 6500 Jefferson City, MO 65109

Exhibit 3 State Medicaid Agencies

State:	Montana
Agency:	Montana Medicaid Program
Montana Public Assistance Hotline:	1-888-706-1535
TTY:	Relay: Dial 711 then 1-888-706-7535
Website:	**https://dphhs.mt.gov/MontanaHealthcarePrograms/MemberServices**
Address:	Human and Community Services P.O. Box 202925 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
Lincoln:	1-402-323-3900
Omaha:	1-402-595-1258
TTY:	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
Local:	1-603-271-4451
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:	1-800-356-1561
TTY:	711
Website:	**www.njfamilycare.org**
Address:	NJ Department of HumanServices Division of Medical Assistance & Health Services P.O. Box 712 Trenton, NJ 712

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:	1-701-328-2310
TTY:	711 / 1-800-366-6888
Website:	**https://www.hhs.nd.gov/adults-and-aging**
Address:	Medical Services Division North Dakota Department of Human Services 600 E. Boulevard Ave., Dept. 325 Bismarck, ND 58505-0250

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 Plaza, Corner Tower, State Street Albany, NY 12237

State:	Ohio
Agency:	Ohio Department of Medicaid
Local:	1-800-324-8680
TTY:	1-800-750-0750
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, 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 Sauld 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:	HealthSourceRI
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
TTY:	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 Department of Health Division of Medicaid and Health Financing 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:	**www.greenmountaincare.org**
Address:	Green Mountain Health Care Access Member Services 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:	**www.dhs.gov.vi/index.php/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:	**www.dhs.gov.vi/index.php/office-of-medicaid/**
Address:	Department of Human Services St. Croix 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:	1-833-522-5582
TTY:	1-888-221-1590
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:	1-307-777-7531
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 **1-800-422-9146**
Calls to this number are free. Available from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday. Customer Service also has free language interpreter services availablefor non-English speakers.

TTY **711**
Calls to this number are free. Available from 8:30 a.m. to 5 p.m. Eastern time, Monday through Friday.

Fax **1-866-458-9342**

Write **Blue Cross Blue Shield of Michigan**
MPSERS — Medicare Plus Blue Group PPO
Customer Service Inquiry Department – P.O. Box 441790
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

Website **bcbsm.com/mpsers**

Michigan Medicare Assistance Program

Michigan Medicare Assistance Program 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 9:00 a.m. to 4:30 p.m. Eastern time Monday through Friday.

TTY **711**

Write **Michigan Medicare Assistance Program**
6105 West St. Joseph Hwy. Suite 103
Lansing, MI 48917-4850

Website **www.mmapinc.org**

Medicare PLUS Blue℠ Group PPO

Blue Cross Blue Shield of Michigan

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