2025

READY TO HELP

BCN Advantage℠ Group HMO-POS

January 1 – December 31, 2025

University of Michigan Evidence of Coverage

Your Medicare health benefits and services and prescription drug coverage as a member of BCN Advantage Group HMO-POS.

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 1-800-658-8878. (TTY users should call 711). Hours are 8 a.m. to 5:30 p.m., Monday through Friday (April 1 through September 30), with weekend hours 8 a.m. to 8 p.m. seven days a week (October 1 through March 31). This call is free.

This plan, BCN Advantage, is offered by Blue Care Network of Michigan. (When this *Evidence of Coverage* says "we," "us," or "our," it means Blue Care Network of Michigan. When it says "plan" or "our plan," it means BCN Advantage.)

This information is available in other formats, including large print, CD and audio. Call customer service if you need plan information in an alternate format.

Benefits, premiums, deductibles, and/or copayments/coinsurance 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.

BCN Advantage [SM] ***HMO-POS***

Medicare and more

Blue Care Network is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

The license permits Blue Care Network to use the Blue Cross and Blue Shield service marks in Michigan. Blue Care Network is not the agent of the Association. Neither the Association nor any other organization using the Blue Cross or Blue Shield brand names acts as a guarantor of Blue Care Network's obligations.

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, call the number on the back of your member ID card. Someone who speaks English 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 de medicamentos. Para hablar con un intérprete, por favor llame al número que figura en el reverso de su tarjeta de identificación de miembro. 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 会员ID卡后的电话号码。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，請致電會員ID卡後的電話號碼。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 ang numero sa likod ng iyong ID kard ng miyembro. 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, appelez le numéro au dos de votre carte d'identité de membre. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi cung cấp dịch vụ thông dịch viên miễn phí để trả lời mọi thắc mắc về chương trình sức khỏe và thuốc điều trị của chúng tôi. Nếu quý vị cần dịch vụ thông dịch viên, vui lòng gọi đến số điện thoại ở mặt sau thẻ ID hội viên của quý vị. Sẽ có nhân viên nói Tiếng Việt có thể hỗ trợ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Um einen Dolmetscherdienst zu erhalten, rufen Sie die Nummer auf der Rückseite Ihres Mitgliedsausweises an. 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 회원 ID 카드 뒷면의 숫자로 전화를 걸어 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 по номеру, указанному на обратной стороне вашей идентификационной карты участника. 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، اتصل بالرقم المكتوب على ظهر بطاقة هوية العضو الخاصة بك. 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, अपने सदस्य आईडी कार्ड के पीछे दिए गए नंबर 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, chiama il numero sul retro della tua carta d'identità. Un nostro incaricato che parla Italiano vi 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, ligue para o número no verso do seu cartão de identificação de membro. 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 ka genyen konsènan plan sante oswa plan medikaman nou an. Pou jwenn yon entèprèt, rele nimero ki nan do kat ID manm ou a. 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,zadzwoń pod numer podany na odwrocie legitymacji członkowskiej. 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ございます。通訳をご用命になるには、会員IDカードの後部に記載されている電話番号にお電話ください。日本語を話す者が対応いたします。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 & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal website at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail, phone, or email at:

U.S. Department of Health & Human Services
200 Independence Ave, SW, Room 509F, HHH Building
Washington, D.C. 20201
Phone: 1-800-368-1019, TDD: 1-800-537-7697
Email: OCRComplaint@hhs.gov

Complaint forms are available on the U.S. Department of Health & Human Services Office for Civil Rights website at http://www.hhs.gov/ocr/office/file/index.html.

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

2025 Evidence of Coverage

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CHAPTER 1:
Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in BCN Advantage, which is a Medicare HMO Point-of-Service Plan

You are covered by Medicare, and you have chosen to get your Medicare health care through our plan, BCN Advantage. We are required to cover all Part A and Part B services. However, cost sharing and provider access in this plan differ from Original Medicare.

BCN Advantage is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) with a Point-of-Service (POS) option approved by Medicare and run by a private company. Point-of-Service means you can use providers outside the plan's network for an additional cost. (See Chapter 3, Section 2.4 for information about using the Point-of-Service option.) BCN Advantage does not include Part D prescription drug coverage.

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: www.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 tells you how to get your medical care. It explains your rights and responsibilities, what is covered, what you pay as a member of the 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 BCN Advantage.

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 our plan's 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 BCN Advantage 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 BCN Advantage between January 1, 2025, and December 31, 2025.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of BCN Advantage after December 31, 2025. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2025.

Medicare (the Centers for Medicare & Medicaid Services) must approve BCN Advantage each year. You can continue each year to get Medicare coverage as a member of our 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 our plan as long as:

- You have both Medicare Part A and Medicare Part B.
- -- *and* -- You live in our geographic service area (Section 2.2 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- -- *and* -- you are a United States citizen or are lawfully present in the United States.

Section 2.2 Here is the plan service area for BCN Advantage

BCN Advantage is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes these counties in Michigan:

Alcona	Ingham	Muskegon
Allegan	Ionia	Newaygo
Alpena	Iosco	Oakland
Antrim	Isabella	Oceana
Arenac	Jackson	Ogemaw
Barry	Kalamazoo	Osceola
Bay	Kalkaska	Oscoda
Benzie	Kent	Otsego
Berrien	Lake	Ottawa
Branch	Lapeer	Presque Isle
Calhoun	Leelanau	Roscommon
Charlevoix	Lenawee	Saginaw
Cheboygan	Livingston	Sanilac
Clare	Luce	Schoolcraft
Clinton	Mackinac	Shiawassee
Crawford	Macomb	St. Clair
Eaton	Manistee	St. Joseph
Emmet	Mason	Tuscola
Genesee	Mecosta	Van Buren

Gladwin	Midland	Washtenaw
Grand Traverse	Missaukee	Wayne
Gratiot	Monroe	Wexford
Hillsdale	Montcalm	
Huron	Montmorency	

If you plan to move out of the service area, you cannot remain a member of this plan. Please contact Customer Service to see if we have a plan in your new area. When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

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.

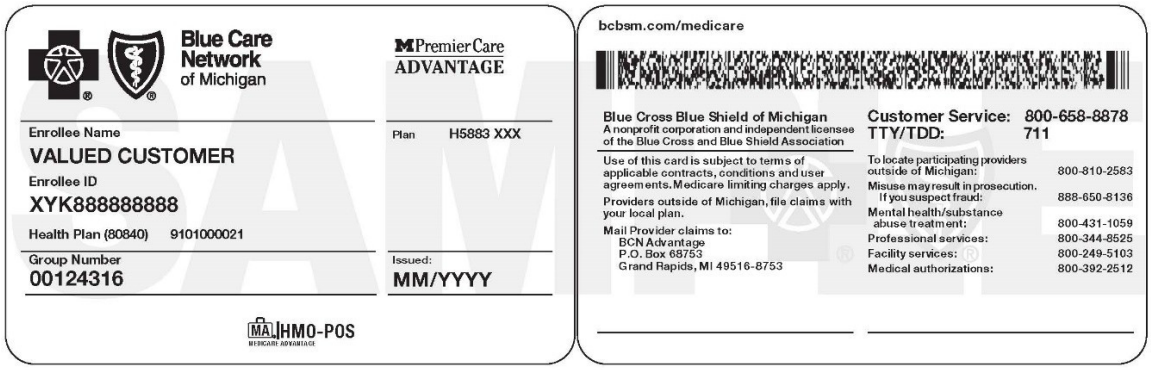
Section 2.3 U.S. Citizen or Lawful Presence

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

SECTION 3 Important membership materials you will receive

Section 3.1 Your plan membership card

While you are a member of our plan, you must use your membership 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 BCN Advantage membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare approved clinical research studies also called clinical trials.

If your plan membership card is damaged, lost, or stolen, call 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 health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full.

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization you will have to pay in full. The only exceptions are emergencies, urgently needed services when the network is not available (that is, in situations when it is unreasonable or not possible to obtain services in-network), out-of-area dialysis services, and cases in which BCN Advantage authorizes use of out-of-network providers.

If you need care when you're traveling outside of Michigan but within the United States and its territories, you can access the Point-of-Service (POS) benefit offered through the nationwide network of Blue Plan Providers via the Blue Cross and Blue Shield Association. BCN Advantage members traveling outside the U.S. and its territories can receive urgent or emergency care through Blue Cross Blue Shield Global Core™. You can access this link: **www.bcbsglobalcore.com** to find doctors and hospitals that participate with Blue Cross. Services, including dialysis services, in U.S. territories are only covered if you go to a Medicare-approved provider. The U.S. includes the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.
The most recent list of providers and suppliers is available on our website at **www.bcbsm.com/providersmedicare**.

If you don't have your copy of the *Provider Directory*, you can request a copy (electronically or in hardcopy form) from Customer Service. Requests for hard copy Provider Directories will be mailed to you within three business days.

SECTION 4 Your monthly costs for BCN Advantage

Your costs may include the following:

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

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums review your copy of *Medicare & You 2025* handbook, the section called 2025 Medicare Costs. If you need a copy, you can download it from the Medicare website (**www.Medicare.gov**). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.1 Plan premium

Your coverage is provided through a contract with the University of Michigan. Please contact the University of Michiganfor information about your plan premium.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

You must continue paying your Medicare premiums to remain a member of the plan. This includes your premium for Part B. It may also include a premium for Part A which affects members who aren't eligible for premium free Part A.

SECTION 5 More information about your monthly premium

Section 5.1 Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year, we will tell you in September and the change will take effect on January 1.

SECTION 6 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 including your primary care provider.

The doctors, hospitals, and other providers in the plan's 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. A network is a group of providers or pharmacies that are under contract or arrangement with our organization to deliver the benefit package approved by CMS.

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation, or Medicaid)
- 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
- 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)

If any of this information changes, please let us know by calling Customer Service.

It is also important to contact 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 7 How other insurance works with our plan

Other insurance

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. This is called **Coordination of Benefits**.

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Customer Service. You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

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

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
    - If you're under 65 and disabled and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
    - If you're over 65 and you or your spouse or domestic partner is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

- No-fault insurance (including automobile insurance)

- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

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

CHAPTER 2:
Important phone numbers and resources

SECTION 1 BCN Advantage HMO contacts (how to contact us, including how to reach Customer Service)

How to contact our plan's Customer

For assistance with claims, billing, or member card questions, please call or write to BCN Advantage Customer Service. We will be happy to help you.

Method	Customer Service – Contact Information
CALL	1-800-658-8878 Calls to this number are free. Hours are 8 a.m. to 5:30 p.m., Monday through Friday (April 1 through September 30), with weekend hours 8 a.m. to 8 p.m. seven days a week (October 1 through March 31). Certain services are available 24/7 through our automated telephone response system. Customer Service also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. 8 a.m. to 8 p.m. Eastern time, Monday through Friday, with weekend hours October 1 through March 31.
FAX	1-866-364-0080
WRITE	**BCN Advantage** PO Box 441936 Mail Code A02B Detroit MI, 48244
WEBSITE	**www.bcbsm.com/medicare**

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	1-800-658-8878 Calls to this number are free. 8 a.m. to 8 p.m. Eastern time, Monday through Friday, with weekend hours October 1 through March 31. Certain services are available 24/7 through our automated telephone response system.
TTY	711 Calls to this number are free. 8 a.m. to 8 p.m. Eastern time, Monday through Friday, with weekend hours October 1 through March 31.

Method	Coverage Decisions and Appeals for Medical Care – Contact Information
FAX	1-866-522-7345
WRITE	**BCN Advantage Care Management Unit** Blue Care Network Utilization Management Mail Code 0520 600 E. Lafayette Blvd. Detroit, MI 48226-2998
WEBSITE	**www.bcbsm.com/complaintsmedicare**

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	1-800-658-8878 Calls to this number are free. 8 a.m. to 8 p.m. Eastern time, Monday through Friday, with weekend hours October 1 through March 31. Certain services are available 24/7 through our automated telephone response system.
TTY	711 Calls to this number are free. 8 a.m. to 8 p.m. Eastern time, Monday through Friday, with weekend hours October 1 through March 31.
FAX	1-866-522-7345
WRITE	**BCN Advantage Appeals & Grievance Unit** BCN Advantage Appeals & Grievance Unit Mail Code A01C Po Box 44200 Detroit, MI 48244-0191
MEDICARE WEBSITE	You can submit a complaint about *BCN Advantage* directly to Medicare. To submit an online complaint to Medicare, go to http://www.medicare.gov/MedicareComplaintForm/home.aspx.

Where to send a request asking us to pay for our 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 provider bill, see Chapter 5 (*Asking us to pay our 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	1-800-658-8878 Calls to this number are free. 8 a.m. to 8 p.m. Eastern time, Monday through Friday, with weekend hours October 1 through March 31.
TTY	711 Calls to this number are free. 8 a.m. to 8 p.m. Eastern time, Monday through Friday, with weekend hours October 1 through March 31.
WRITE	**BCN Advantage** Blue Care Network P.O. Box 68753 Grand Rapids, MI 49516-8753
WEBSITE	**https://www.bcbsm.com/content/dam/microsites/medicare/documents/bcna-member-claim-reimbursement-form.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 (sometimes called 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.

Method	Medicare – Contact Information
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	**www.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.
WEBSITE (CONTINUED)	You can also use the website to tell Medicare about any complaints you have about BCN Advantage: • **Tell Medicare about your complaint:** You can submit a complaint about BCN Advantage directly to Medicare. To submit a complaint to Medicare, go to **www.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 TO ACCESS SHIP and OTHER RESOURCES:

- Visit https://www.shiphelp.org (Click on 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.

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

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 health care 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 our plan. 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 health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

Method	Livanta (Michigan's Quality Improvement Organization) – Contact Information
CALL	1-888-524-9900 Monday-Friday: 9 a.m. to 5 p.m. (local time) Saturday-Sunday: 11 a.m. to 3 p.m. (local time)
TTY	711 Monday-Friday: 9 a.m. to 5 p.m. (local time) Saturday-Sunday: 11 a.m. to 3 p.m. (local time) This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Livanta LLC BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701-1105
WEBSITE	**www.livantaqio.com**

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 to let them know.

Method	Social Security– Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.

Method	Social Security– Contact Information
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 8:00 am to 7:00 pm, Monday through Friday.
WEBSITE	www.ssa.gov

SECTION 6 Medicaid

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. 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 deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).).
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).
- **Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact Michigan Department of Community Health Medical Services Administration.

Method	Michigan Department of Community Health Medical Services Administration – Contact Information
CALL	1-800-642-3195 8 a.m. to 5 p.m., Eastern time, Monday - Friday
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Michigan Department of Health and Human Services 333 S. Grand Ave P.O. Box 30195 Lansing, MI 48909
WEBSITE	**www.michigan.gov/mdhhs**

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 3:00 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 Do you have group insurance or other health insurance from an employer?

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner's) employer or retiree group as part of this plan, you may call the University of Michigan benefits administrator or Customer Service if you have any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Customer Service are printed on the back cover of this document.) You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

CHAPTER 3:
Using the plan for your medical services

SECTION 1 Things to know about getting your medical care as a member of our 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, Part B prescription drugs, and other medical care that are covered by the plan.

For the details on what medical care is covered by our 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 health care professionals licensed by the state to provide medical services and care. The term providers also include hospitals and other health care facilities.
- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- **Covered services** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4.

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

As a Medicare health plan, BCN Advantage must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

BCN Advantage will generally cover your medical care as long as:

- **The care you receive is included in the plan's 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 drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
    - In most situations, your network primary care provider must give you approval in advance before you can use other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies.

This is called giving you a referral. For more information about this, see Section 2.3 of this chapter.

- Referrals from your PCP are not required for emergency care or urgently needed services. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 of this chapter).

- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. This means that you will have to pay the provider in full for the services furnished. *Here are four exceptions:*
  - The plan covers emergency or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
  - If you need medical care that Medicare requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost sharing you normally pay in-network. Authorization should be obtained from the plan prior to seeking care. In this situation, you will pay the same as you would pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
  - The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay the plan for dialysis can never exceed the cost sharing in Original Medicare. If you are outside the plan's service area and obtain the dialysis from a provider that is outside the plan's network, your cost sharing cannot exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from a provider outside the plan's network the cost sharing for the dialysis may be higher.
  - If you need care when you're traveling outside of Michigan but within the United States and its territories, you can access the Point-of-Service (POS) benefit offered through the nationwide network of Blue Plan Providers via the Blue Cross and Blue Shield Association. BCN Advantage members traveling outside the U.S. and its territories can receive urgent or emergency care through Blue Cross Blue Shield Global 11.5. You may visit: **http://www.bcbsglobalcore.com** to find doctors and hospitals that participate with Blue Cross.

SECTION 2 Use providers in the plan's network to get your medical care

Section 2.1 You must choose a Primary Care Provider (PCP) to provide and oversee your medical care

What is a PCP and what does the PCP do for you?

Your primary care provider is your partner in health, providing or coordinating your care, and helping you navigate the sometimes-complex health care needs. When you become a member of **BCN Advantage**, you must choose a plan provider to be your PCP.

What types of providers may act as a PCP?

Our PCPs are MDs (medical doctors) or DOs (osteopathic doctors) who specialize in one of the following areas:

- **Family and general practice** - Family practice and general practice physicians treat patients of all ages, from newborns to adults. They commonly provide obstetrical and gynecological care as well. These physicians have a broad range of medical knowledge and have completed training in pediatrics, surgery, internal medicine and geriatrics.

- **Internal medicine** - Internists are trained to identify and treat all aspects of adolescent, adult and geriatric medical conditions. Most of our network internists generally treat patients age 18 and older.

- **Pediatrics** - Pediatricians specialize in the treatment of patients age 21 or younger.

- **Internal medicine/pediatrics** - Physicians in this category are trained as both internists and pediatricians. They treat children and adults.

- **Preventive medicine** - Preventive medicine physicians promote health and well-being for patients of all ages. If you have a qualifying condition such as End-Stage Renal Disease, you may choose a nephrologist to act as your primary care provider.

The role of a PCP

The PCP you choose will help you receive the right care at the right time and the right place. Your PCP will also coordinate the rest of the covered services you get as a member of **BCN Advantage.**

What services does the PCP furnish and how do you get care from your PCP?

You will usually see your PCP first for most of your routine health care needs. Your PCP will provide most of your care and will help arrange or coordinate the rest of the covered services you get as a plan member.

This includes:

- X-rays
- Laboratory tests
- Therapies
- Care from doctors who are specialists
- Hospital admissions
- Follow-up care

What is the role of the PCP in coordinating covered services?
Your PCP coordinates the covered services you get as a member of BCN Advantage. Coordinating your services includes working with, consulting with, or directing you to other plan providers about your health status and specific health care needs as well as providing referrals and arranging for prior authorizations as needed. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office. Chapter 6 tells you how we will protect the privacy of your medical records and personal health information.

What is the role of the PCP in obtaining prior authorization?
If you need certain types of covered services or supplies, your PCP will direct and arrange for prior authorization (prior approval) from BCN Advantage.

How do you choose your PCP?
We offer several resources to help you locate a primary care provider.

Your quickest and most up-to-date option is to log in to the secure member website and choose a PCP at **http://www.bcbsm.com/medicare.**

Our printed *BCN Advantage Provider Directory* lists physicians and health care facilities in your BCN Advantage plan's network service area. The *Provider Directory* you receive will be customized to your geographic area provided by Customer Service upon request. If you need a copy of the *Provider Directory*, call Customer Service at 1-800-658-8878, 8 a.m. to 8 p.m. Eastern time, Monday through Friday, with weekend hours October 1 through March 31. TTY users should call 711. You can order a *Provider Directory*, 24/7 through our automated telephone response system or at our website at **www.bcbsm.com/providersmedicare**.

Or write to us at the following address:
BCN Advantage
PO Box 441936
Mail Code A02B
Detroit MI, 48244

Before selecting a PCP, verify if he or she is accepting new patients. If there is a particular BCN Advantage specialist or hospital you want to use, check first to make sure your PCP uses that hospital. As a reminder, when selecting a PCP, you must receive all medical care, including your PCP, and specialty or hospital care, from your specific plan network.

Call Customer Service for additional information about physicians, such as where a physician attended medical school or completed his or her residency, or to change PCPs. If you have selected a new PCP whom you've never seen before, you should schedule an appointment for a physical exam and establish a health care relationship as soon as possible.

When selecting a PCP, keep in mind that provider offices, health centers or hospital-based outpatient clinics owned and operated by hospitals (also known as hospital-based practices) may cost you more. These hospital-based outpatient facilities conveniently offer a variety of providers and services integrated within one complex. According to Medicare billing rules, when you see a physician in a private office setting, all services and expenses are bundled in a single charge. When you see a physician in a hospital-based practice, physician and hospital charges are billed separately, because from a Medicare perspective, you are being treated within the hospital system rather than a physician's office. This hospital-based usage fee can result in higher out-of-pocket costs for you. Even medical centers and provider offices located a fairly long distance from the main hospital campus can be considered part of the hospital. To find out if your providers are part of a hospital-based practice, ask your providers. ***For more information, see "Outpatient hospital services" in Chapter 4: Section 2 Medical Benefits chart and "Hospital-based practice" in Chapter 10, Definitions of important words.***

Once you've found your PCP, tell us of your selection. There are several ways you can select or change doctors.

- Complete and return a Physician Selection form.
- Call Customer Service at 1-800-658-8878. Hours are 8 a.m. to 5:30 p.m., Eastern Standard Time, Monday through Friday (April 1 through September 30), with weekend hours 8 a.m. to 8 p.m. seven days a week (October 1 through March 31).
- Visit **www.bcbsm.com/medicare** , select *Login*. Once you've logged in, select *View or Change Your PCP* to make changes.

Changing your PCP
You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP who is part of our BCN Advantage network. We'll notify you if your PCP leaves our network. Customer Service can assist you in finding and selecting another provider.

To change your PCP, you can log in to the secure member website and select your PCP at **www.bcbsm.com/medicare** or call Customer Service. When you call, be sure to tell Customer Service if you are seeing specialists or getting other covered services that needed your PCP's approval (such as home health services and durable medical equipment). Customer Service will help make sure that you can continue with the specialty care and other services you have been getting when you change your PCP. They will also check to be sure the PCP you want to switch to is accepting new patients. Customer Service will change your membership record to show the name of your new PCP and tell you when the change to your new PCP will take effect.

Section 2.2 What kinds of medical care can you get without a referral from your PCP?

You can get the services listed below without getting approval in advance from your PCP:

- Routine women's health care, which includes breast exams, screening mammograms (X-rays of the breast), Pap tests, and pelvic exams.
- Flu shots (or vaccines), COVID-19 vaccinations, Hepatitis B vaccinations, and pneumonia vaccinations.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed plan-covered services, which are services requiring immediate medical attention that are not emergencies, provided you are temporarily outside the service area of the plan, or it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. 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.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. If possible, please call Customer Service before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away.
- Bone density studies for routine women's health care as long as you get them from a network provider.
- Routine pediatric care as long as you get them from a network provider.

Section 2.3 How to get care from specialists and other network providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. 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.

What is the role of the PCP in coordinating care with specialists and other providers?
Your PCP is the best resource for coordinating your care, especially if you need to see another in-network specialist or another provider.

What is the role of the PCP in referring members to specialists and other providers?
Your PCP is the best resource for coordinating your care and can help you find an in-network specialist. However, referrals or prior authorizations are not required for certain in-network services. It is recommended that all your care is coordinated through your PCP.

Some in-network specialists may still need to confirm with your PCP that you need specialty care.

For what services will your PCP need to get prior authorization?

Prior authorization is an approval in advance to get services. In an HMO, some in-network services are covered only if your doctor or other network provider gets prior authorization from our plan. See Chapter 4, Section 2.1 for information about services that require prior authorization. Covered services that need prior authorization are noted in italics in the Chapter 4 benefits chart. It is important to know what our plan will or will not cover. Be sure to ask your provider if a service is covered. Providers should let you know when something is not covered. Providers should give you a written notice or tell you verbally when our plan does not cover the service.

What if a specialist or another network provider leaves our plan?

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

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will notify you that your provider is leaving our plan 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 care.
- 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 continues.
- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- We will arrange for any medically necessary covered benefit outside of our provider network, but at in-network cost sharing, when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. *Prior authorization may be required.*
- If you find out your doctor or specialist is leaving your plan, 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 2.4 How to get care from out-of-network providers

Services we always cover without an authorization are medical emergencies and urgently needed services. If providers of specialized services are not available in network, you can request authorization of out-of-network care. Members can request approval in advance (authorization) for out-of-network services by calling Customer Service (using the phone number on the back of your ID card.)

If you need medical care when you're **inside the group service area but seeking services from an out-of-network provider**, your coverage is limited unless BCN Advantage has approved the out-of-network services in advance.

If you need medical care when you're **outside of BCN Advantage's contracted network of physicians in the service area and inside Michigan**, your coverage is limited to medical emergencies, urgently needed services and renal dialysis, unless BCN Advantage has approved the out-of-network services in advance.

If you need medical care when you're **outside of Michigan**, our point-of-service benefit (offered through the nationwide network of Blue Plan Providers via the Blue Cross and Blue Shield Association) allows you to receive preauthorized routine and follow-up care as necessary from providers who participate with Blues plans. BCN Advantage members traveling outside the U.S. and its territories can receive urgent or emergency care and emergency transportation through Blue Cross Blue Shield Global Core™. You can go to **http://www.bcbsglobalcore.com** to find doctors and hospitals that participate with Blue Cross. To locate participating providers outside of Michigan, call 1-800-810-2583, 24 hours a day 7 days a week. TTY users call 711. This phone number is on the back of your ID card.

See Chapter 4 for more detailed information about your medical benefits and Chapter 5 for information about payment for services given by out-of-network providers. If you have questions about what medical care is covered when you travel, please call Customer Service.

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 PCP. You do not need to use a network doctor. You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories and worldwide, and from any provider with an appropriate state license even if they are not part of our network.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Please call Customer Service at the number on the back of your ID card.

What is covered if you have a medical emergency?

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

The doctors 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 doctors will continue to treat you until your doctors contact us and make plans for additional care. Your follow-up care will be covered by our plan. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

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.

However, after the doctor has said that it was *not* an emergency, we will cover additional care *only* if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care.

- – *or* – The additional care you get is considered urgently needed services and you follow the rules for getting this urgent care (for more information about this, see Section 3.2 below).

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

What are urgently needed services?

A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flair-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.

Call your PCP's office if your condition requires prompt attention. If your doctor isn't available, you may visit any urgent care center for covered services.

When you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed services that you get from any provider.
Our plan covers worldwide emergency and urgent care services outside the United States under the following circumstances:

- Urgently needed services- services you require to avoid the likely onset of an emergency medical condition.
- Emergency care- treatment needed immediately because any delay would mean risk of permanent damage to your health.

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 United States 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:
https://www.bcbsm.com/important-information/notices-about-plans/medicare/
for information on how to obtain needed care during a disaster.

If you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost sharing.

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

Section 4.1 You can ask us to pay our 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 our 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 our plan, you must pay the full cost

BCN Advantage 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 or services obtained out-of-network and were not authorized, you are responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you have used up your benefit for that type of covered service. Services that you pay for yourself beyond the benefit limit will not count toward your out-of-pocket maximum.

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, and 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 paid more, for example, if you already paid the Original Medicare cost-sharing amount, 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 our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in any Medicare-approved clinical research study, you do *not* need to tell us or to get approval from us. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers. Please note that this does not include benefits for which our plan is responsible that include, as a component, a clinical trial or registry to assess the benefit. These include certain benefits specified under national coverage determinations (NCDs-CED) and investigational device (IDE) studies and may be subject to prior authorization and other plan rules. Although you do not need to get our plan's permission to be in a clinical research study, covered for Medicare Advantage enrollees by Original Medicare, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study*.

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, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our 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 your plan that you received a qualified clinical trial service and submit documentation such as a provider bill to the plan. The plan would then directly pay you $10. Therefore, your net payment is $10, the same amount you would pay under our plan's benefits. Please note that in order to receive payment from your plan, you must submit documentation to your plan such as a provider bill.

When you are part of a clinical research study, **neither Medicare nor our 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 health care. 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: **www.medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf**) You can also call 1-800-MEDICARE (1-800-633-4227), 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 health care institution

Section 6.1 What is a religious non-medical health care institution?

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

Section 6.2 Receiving Care from a Religious Non-Medical Health Care Institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you 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.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in a facility, 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;
  - – *and* – You must get approval in advance from our plan before you are admitted to the facility, or your stay will not be covered.

Medicare Inpatient Hospital coverage limits apply (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 our 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 months. As a member of BCN Advantage Group HMO-POS, however, you will acquire ownership of select DME items after the12-month rental period.

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

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

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare do not count. You will have to make 13 payments to our plan before owning the item.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You were in our plan but did not obtain ownership while in our 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 our plan or to Original Medicare) do not count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage, *BCN Advantage* 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 BCN Advantage or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

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

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

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 BCN Advantage. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services. You can find a list of durable medical equipment coverage limitations, which shows continuous diabetic blood glucose monitors and traditional blood glucose monitors and test strips in Addendum A in the back of this document.

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 or any Riders issued to you, you need to know about the types of out-of-pocket costs you may pay for your covered services:

- **Deductible** is the amount you must pay for medical services before our plan begins to pay its share. **You have no deductible under your BCN Advantage coverage.**
- **Copayment** is a fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- **Coinsurance** is a percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

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 covered medical services?

Because you are enrolled in a Medicare Advantage Plan, there is a limit on the amount you have to pay out-of-pocket each year for in- -network medical services that are covered under Medicare Part A and Part B. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. For calendar year 2025 this amount is $3,000.
The amounts you pay for copayments, and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. If you reach the maximum out-of-pocket amount of $3,000, you will not have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Type of Maximum	In-and out-of-network
Combined in-network and out-of-network deductible	None
Part A and Part B combined in-network and out-of-network benefit out-of-pocket maximum	$3000

Section 1.3 Our plan does not allow providers to balance bill you

As a member of BCN Advantage, an important protection for you is that, you only have to pay your cost-sharing amount when you get services covered by our 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, $15.00), then you pay only that amount for any covered services from a network provider.

- If your cost sharing is a coinsurance (a percentage of the total charges), then you never pay more than percentage. However, your cost depends on which type of provider you see:

    - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).

    - 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. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral or for emergencies or urgently needed services.)

    - 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. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral, or for emergencies or outside the service area for urgently needed services.)

- If you believe a provider has *balance billed* you, call 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 the plan

The Medical Benefits Chart on the following pages lists the services BCN Advantage covers and what you pay out of pocket for each service. **Please remember if your group purchases a Rider that amends your coverage and applies a Copayment, Coinsurance and/or a Deductible to specific services, the Rider takes precedence over the Evidence of Coverage for non-preventive services.** 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 Part B prescription drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan may not require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider

- You have a primary care provider (a PCP) who is providing and overseeing your care.
- Some of the services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval in advance (sometimes called prior authorization) from us. Covered services that need approval in advance are marked in the Medical Benefits Chart with an asterisk.

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay may *more* in our plan than you would in Original Medicare. For others, you may pay *less.* (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 **www.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.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- If Medicare adds coverage for any new services during 2025, either Medicare or our plan will cover those services.

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

Medical Benefits Chart

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There's no coinsurance or copayment for members eligible for this preventive screening. If you receive other services during the visit, out-of-pocket costs may apply.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:	You pay a $10 copay for acupuncture for chronic low back pain services.

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
Acupuncture for chronic low back pain (continued) • a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.	
Ambulance services • Covered ambulance services, whether for an emergency or nonemergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. • If the covered ambulance services are not for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. • We cover ambulance services even if you are not transported to a facility or if you are stabilized at your home or another location. This service is not covered outside of the U.S. or its territories. **Note:** Your plan includes additional ambulance services. See **Enhanced Benefits** for a description and cost sharing.	**In-network and Out-of-network:** Ambulance services are covered at 100% of the approved amount.

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
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 is enhanced so it can occur anytime throughout the calendar year, regardless of the date of the member's previous year's annual wellness visit. **Note**: Your first annual wellness visit can't take place within 12 months of your Welcome to Medicare preventive visit. However, you don't need to have had a Welcome to Medicare visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance or copayment, for the annual wellness visit. Out-of-pocket costs may apply if a covered service (e.g., diagnostic test) is outside the scope of the annual wellness visit.
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement. If you receive other services during the visit, including diagnostic, out-of-pocket costs may apply.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women aged 40 and older • Clinical breast exams once every 24 months • 3D mammograms are covered when medically necessary	There is no coinsurance or copayment for covered screening mammograms. . If you have a medical condition, a follow-up (second) mammogram and/or biopsy on a separate day from the screening, the procedure is considered diagnostic and your contractual cost

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
• Additional breast cancer screening covered based on medical necessity	sharing for Medicare-covered services will apply. If you receive other services during the visit, out-of-pocket costs may apply.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. *Cardiac rehabilitation services may require prior authorization; your plan provider will arrange for this authorization, if needed. Please see the **Exclusions Chart** in Chapter 4, Section 3.1 of your *Evidence of Coverage.*	Cardiac rehabilitation services are covered at 100% of the approved amount.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover 1 visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance or copayment for the intensive behavioral therapy cardiovascular disease preventive benefit. If you receive other services during the visit, out-of-pocket costs may apply.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance or copayment for cardiovascular disease testing that is covered once every five years. If you receive other services during the visit, out-of-pocket costs may apply.

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 12 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months • Additional pap smears and pelvic exams are covered based on medical necessity	There is no coinsurance or copayment for Medicare-covered cervical and vaginal cancer screening. If you receive other services during the visit, out-of-pocket costs may apply.
Chiropractic services Covered services include manual manipulation of the spine to correct subluxation. Your plan includes additional chiropractic services. See **Enhanced Benefits** for a description and cost sharing.	**In-network and Out-of-network:** You pay a $10 copay for chiropractic services.
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.	There is no coinsurance, or copayment, for a Medicare-covered colorectal cancer screening exam If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam which is covered at 100%.

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
• Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patient not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. Colorectal cancer screening tests include a follow-up screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.	If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic procedure. However, you won't be charged additional out-of-pocket costs. If you receive other services during the visit, out-of-pocket costs may apply.
Dental services* In general, preventive dental services (such as cleaning, routine dental exams, and dental X-rays) are not covered by Original Medicare. However, Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. **Dental services may require prior authorization; your plan provider will arrange for this authorization, if needed.* See the **Physician/Practitioner Services, including doctor's office visits benefit** for examples of Medicare-covered dental services.	Original Medicare covers very limited medically necessary dental services. BCN Advantage Group HMO-POS will cover those same medically necessary services. The cost sharing for those services (e.g. surgery, office visits, X-rays) is referenced in other areas of this benefit chart. For more information, contact Customer Service.
Depression screening	There is no coinsurance or copayment for an annual depression screening visit.

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
We cover 1 screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	If you receive other services during the visit, out-of-pocket costs may apply.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. You may be eligible for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test. Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to 2 diabetes screenings every 12 months.	There is no coinsurance or copayment, for the Medicare-covered diabetes screening tests. If you receive other services during the visit, out-of-pocket costs may apply.
Diabetes self-management training, diabetic services and supplies* For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. For people with diabetes who have severe diabetic foot disease: 1 pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts, or 1 pair of depth shoes and 3 pairs of inserts (not including the	Covered at 100% of the approved amount for diabetes self-management training, diabetic services and supplies. When outside of the plan's service area, members must contact Northwood. To use an in-network supplier for continuous glucose monitors you must go to a network pharmacy. If you receive other services during the visit,

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions. Northwood is our preferred network provider. To coordinate your DME or diabetic care, diabetic supplies, diabetic shoes and inserts, excluding continuous glucose monitors, contact them at 1-800-667-8496, 8:30 a.m. to 5 p.m. Monday through Friday. TTY users call 711. To use another supplier not listed, call Customer Service. **Note**: For all people who have diabetes and use insulin, covered services include – approved continuous glucose monitors and supply allowance for the continuous glucose monitoring as covered by Original Medicare. **Continuous glucose monitors must be obtained from a network pharmacy.** To find a network pharmacy, visit our website **www.bcbsm.com/pharmaciesmedicare*).*** At the back of this *Evidence of Coverage* document, we include an addendum which tells you the brands and manufacturers of continuous diabetic blood glucose monitors and traditional blood glucose monitors and test strips that we will cover. * Diabetic services and supplies may require prior authorization; your plan provider will arrange for this authorization, if needed.	out-of-pocket costs may apply.
Durable medical equipment (DME) and related supplies*	DME items required under the preventive benefit provisions of CMS are covered at 100% of

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
(For a definition of durable medical equipment, see Chapter 10 of this document as well as Chapter 3, Section 7.) Covered items include, but are not limited to wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at **www.bcbsm.com/umichmaplans**. *DME coverage is limited to basic equipment. Deluxe or upgraded equipment must be medically necessary and requires prior authorization for coverage. Custom styles, colors and materials are not covered. Limitations: • The equipment must be considered DME by BCN • Advantage and must be appropriate for home use. • The equipment must be obtained from BCN Advantage or a BCN Advantage approved supplier. • The equipment is the property of Blue Care Network or the supplier. When it is no longer medically necessary, the equipment should be returned to the supplier. • Replacement of equipment is covered only when necessary to accommodate body growth, body change or normal wear. Exclusions: • Deluxe equipment (such as motor-driven wheelchairs and beds) unless medically	approved amount with no in- network cost- sharing when rendered by an in-network provider. For a list of preventive DME items that CMS requires to be covered at 100%, call Customer Service. Member must obtain DME from BCN's DME supplier, Northwood at 1-800-667-8496, 8:30 a.m. to 5 p.m. Monday through Friday. TTY users call 711. When outside of the plan's service area, members must contact Northwood. To use another supplier, contact Customer Service. Your cost sharing for Medicare oxygen equipment is covered up to 100% of the approved amount.

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
necessary for the member and required so the member can operate the equipment themselves. • Items that are not considered medical items • Duplicate equipment **Durable medical equipment (DME) and related supplies (continued)** • Physician's equipment (such as blood pressure monitors and stethoscopes) • Disposable supplies (such as sheets, bags, elastic) • Exercise and hygienic equipment (such as exercycles, bidet toilet seats, bathtub seats, treadmills) • Self-help devices that are not primarily medical items (such as sauna baths, elevators and ramps, special telephone or communication devices) • Equipment that is experimental or for research • Repair or replacement due to loss or damage • Assistive technology and adaptive equipment such as communication boards and computers, supine boards, prone standers and gait trainers and such equipment not intended for use in the home. *Durable medical equipment and related supplies may require prior authorization. Your plan provider will arrange for this authorization, if needed. See **Addendum A** of this *Evidence of Coverage* document **for a list of *DME coverage limitations*.** The list tells you the **brands and manufacturers of certain types of DME that we will cover**.	

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, 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. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.	You pay a $65 copay for Medicare-covered emergency room visits, (waived if admitted within 3 days). **Outside the U.S.** You may be responsible for the difference between the approved amount and the provider's charge. You have BCBS Global Core Coverage (foreign travel) for worldwide emergency and urgent care.

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
Your plan includes the BCBS Global Core Coverage (foreign travel) health care benefit. See **Enhanced Benefits** for a description and cost sharing.	Out-of-pocket costs are the same for necessary emergency services received in- or out-of-network.
Glaucoma screening Glaucoma screening once per year for people who fall into at least one of the following high-risk categories: • People with a family history of glaucoma • People with diabetes • African Americans who are age 50 and older • Hispanic Americans who are age 65 and older	There is no coinsurance or copayment for glaucoma screening. If you receive other services during the visit, out-of-pocket costs may apply.
Health and wellness education programs BCN Advantage offers health education programs that include: **Tobacco cessation coaching:** Our Tobacco Cessation Coaching program is a yearly program offered as a self-guided experience with 24/7 access via web or mobile, or live coaching with enrollment online or over phone and available via telephonic or platform chat. Members should call 1-833-380-8436. TTY users should call 711. Member services support is available Monday through Friday, 8 a.m. to 9 p.m., Eastern Time. Health coaches are available: Monday through Thursday, 8 a.m. to 11 p.m.; Friday, 8 a.m. to 7 p.m. and Saturday, 9 a.m. to 3 p.m.; all Eastern Time. Other programs designed to enrich the health and lifestyles of members such as Blue Cross Virtual Well-Being, are available on our website at **www.bcbsm.com/medicare**.	There is no coinsurance or copayment for health and wellness education programs. If you receive other services during the visit, out-of-pocket costs may apply.

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist or other qualified provider. Diagnostic hearing exam – 1 per year. Diagnostic testing covered once every 36 months. **Note:** Your plan includes additional hearing and hearing aid services. See **Enhanced Benefits** for a description and cost sharing.	For diagnostic hearing office visits, you pay a $10 copay with a primary care provider or a specialist.
Hepatitis C screening For people who are at high risk for Hepatitis C infection, including persons with a current or past history of illicit injection drug use; and persons who have a history of receiving a blood transfusion prior to 1992, we cover: • One screening exam • Additional screenings every 12 months for persons who have continued illicit injection drug use since the prior negative screening test. For all others born between 1945 and 1965, we cover one screening exam.	There is no coinsurance or copayment for members eligible for Medicare-covered preventive Hepatitis C screening. If you receive other services during the visit, out-of-pocket costs may apply.
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to 3 screening exams during a pregnancy	There is no coinsurance or copayment for members eligible for Medicare-covered preventive HIV screening. If you receive other services during the visit, out-of-pocket costs may apply.

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
Home health agency care* Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) **Home health agency care (continued)** • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies *Home health agency care services may require prior authorization. Your plan provider will arrange for this authorization, if needed.	Home health agency care is covered at 100% of the approved amount. Medical supplies ordered by physicians, such as durable medical equipment are not covered under home health agency care. See Durable Medical Equipment for more information. **Note:** Custodial care is not the same as home health agency care. For information, see Custodial Care in the exclusion list in Chapter 4, Section 3.1 of your *Evidence of Coverage*.
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	Home infusion therapy is covered at 100% of the approved amount.

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
furnished by a qualified home infusion therapy supplier Home infusion therapy: • Must be medically necessary • Must be given by a participating Home Infusion Therapy (HIT) provider or in a participating freestanding Ambulatory Infusion Center (AIC) • May use drugs that require prior authorization, consult with your provider *Home infusion therapy services may require prior authorization. Your plan provider will arrange for this authorization, if needed. **Note:** Your plan includes additional HIT benefits. See **Enhanced Benefits** for a description and cost sharing.	
Hospice care You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organizations owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you are admitted to a hospice you have the right to remain in your plan you must continue to pay plan premiums. <u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis:</u> Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal	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 BCN Advantage.

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost sharing. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization). • If you obtain the covered services from a network provider and follow plan rules for obtaining service, you only pay the plan cost-sharing amount for in-network services. • If you obtain the covered services from an out-of-network provider, you pay the cost sharing under Fee-for-Service Medicare (Original Medicare). For service that are covered by BCN Advantage but are not covered by Medicare Part A or B: BCN Advantage will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange for these services. Your plan includes additional Hospice 5th level coverage. See **Enhanced Benefits** for a description and out-of-pocket costs. You may be asked to provide your Original Medicare beneficiary identifier number off your red, white, and blue Medicare card.	
Immunizations Covered Medicare Part B services include: • Pneumonia vaccines	There is no coinsurance or copayment for the pneumonia, flu/influenza,

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
• Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you are at risk and they meet Medicare Part B coverage rules	Hepatitis B and COVID-19 vaccines . Flu, pneumonia, COVID-19 and other vaccines are also available at retail network pharmacies. If you receive other services during the visit, out-of-pocket costs may apply.
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you 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 but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance use disorder services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a	Inpatient hospital care is covered at 100% of the approved amount. You have an unlimited number of medically necessary inpatient hospital days. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital, if applicable.

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If *BCN Advantage* provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at a distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. Coverage is up to $10,000. Travel and lodging is covered for only one year after the initial transplant (includes up to five additional days prior to the initial transplant). Outside of the service area is defined as 100 miles or more, one-way to the facility, from your home address.	
Inpatient hospital care (continued) Limitations apply. Call BCN Advantage Customer Service for details. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used • Physician services *Inpatient hospital care services rendered by plan providers may require prior authorization; your plan provider will arrange for this authorization, if needed.* **Note**: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an *outpatient*. If you are not sure if you are an inpatient or an outpatient, you should	

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
ask the hospital staff. You can also find more information in a Medicare fact sheet called *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available at https://es.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.	
Inpatient services in a psychiatric hospital Covered services include mental health care services that require a hospital stay. You have unlimited days of inpatient services in a psychiatric hospital. Inpatient services in a psychiatric hospital may require prior authorization; your plan provider will arrange for this authorization, if needed.	Inpatient services in a psychiatric hospital are covered at 100% of the approved amount.
***Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay** If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services 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 (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part	Covered services received in a hospital or SNF during a non-covered stay are covered at 100% of the approved amount. Additional out-of-pocket costs may apply for professional services. We will cover medical services; however, we do not cover SNF facility charges unless there is an approved authorization on file.

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy **Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay (continued)** *Physical therapy, speech therapy, and occupational therapy services may require prior authorization; your plan provider will arrange for this authorization, if needed.	
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	There is no coinsurance or copayment for members eligible for Medicare-covered medical nutrition therapy services. If you receive other services during the visit, out-of-pocket costs may apply.
Medicare Diabetes Prevention Program (MDPP)	There is no coinsurance or copayment for the MDPP services. If you receive

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	other services during the visit, out-of-pocket costs may apply.
Medicare Part B prescription drugs* These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you 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 • 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	Covered at 100% for approved Medicare Part B drugs. Including those used in, certain oral anti-cancer and anti-nausea drugs, and certain immunosuppressive drugs following a Medicare-covered transplant. This plan only covers Medicare Part B prescription drugs. Medicare Part B drugs may be subject to step therapy. You will pay no more than $35 for a one-month's supply of insulin.

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
• 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 • 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 oral 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 • 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 [plans may delete any of the following drugs that are not covered under the plan] (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa Mircera®, or Methoxy polyethylene glycol-epoetin beta) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases	

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
• Parenteral and enteral nutrition (intravenous and tube feeding) The following link will take you to a list of Part B Drugs that may be subject to step therapy: **http://www.bcbsm.com/amslibs/content/dam/public/providers/documents/ma-ppo-bcna-medical-drugs-prior-authorization.pdf** We also cover some vaccines under our Part B prescription drug benefit. *Medicare Part B drugs may require prior authorization; your plan provider will arrange for this authorization, if needed.	
Mobile Crisis and Crisis Stabilization for Behavioral Health Mobile Mental Health Crisis Solutions will improve care for people that are in crisis, ideally to prevent higher levels of care. Services include onsite services, mobile crisis intervention by telehealth or face to face, along with crisis stabilization. Services also include crisis stabilization centers, where clinicians provide assessment, diagnosis, treatment planning, initiation of treatment, lab exams and other interventions similar to medical/surgical observation services. Mobile intervention is provided by a crisis intervention team led by social workers who can obtain consultations from, psychologists, or consulting psychiatrists. Mobile crisis services onsite in the field can include assessment, diagnosis, short term crisis psychotherapy intervention either face to face or via telehealth, medication consultation, and triage to the appropriate level of care. For more information or to find a provider near you, visit **www.bcbsm.com/mentalhealth** or contact your Medicare Advantage plan's customer service.	Services are covered at 100% of the approved amount for mobile crisis and crisis stabilization for behavioral health.
🍎 **Obesity screening and therapy to promote sustained weight loss**	There is no coinsurance, copayment, or deductible for

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	preventive obesity screening and therapy. If you receive other services during the visit, out-of-pocket costs may apply.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications. • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities Periodic assessments	$0 copay for opioid treatment program services.
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the first pint of blood that you	$0 copay for outpatient diagnostic tests and therapeutic services and supplies.

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
need. All other components of blood are covered beginning with the first pint used. • Other outpatient diagnostic tests • High-tech radiology services (e.g., CT scans, echocardiography, MRAs, MRIs, PET scans, or nuclear medicine) rendered by plan providers require prior authorization *Outpatient diagnostic tests and therapeutic services and supplies may require prior authorization; your plan provider will arrange for this authorization, if needed.*	
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. **Outpatient hospital observation (continued)** **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital *and BCN Advantage authorizes the admission*, 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 *"Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!"* This fact sheet is available on the Web at **https://www.medicare.gov/sites/default/files/2021-**	Outpatient hospital observation is covered at 100% of the approved amount.

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
10/11435-Inpatient-or-Outpatient.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.	
Outpatient hospital services We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself	Outpatient hospital services are covered at 100% of the approved amount. Emergency room physician services are covered at 100% of the approved amount.
Outpatient hospital services (continued) **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital *and BCN Advantage authorizes the admission*, 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 *Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!* This fact sheet is available on the Web at	

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.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. *Outpatient hospital services may require prior authorization; your plan provider will arrange for this authorization, if needed.*	
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.	You pay a $10 copay for an outpatient mental health office visit with your primary care provider. You pay a $10 copay for an outpatient mental health care office visit with a specialist. Outpatient mental health services rendered at a mental health facility are covered at 100% of the approved amount. You pay a $10 copay for a telehealth mental health visit with your primary care provider. You pay a $10 copay for a telehealth mental health visit with a specialist.
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and	You pay a $10 copay for physical therapy, speech therapy and occupational therapy visits.

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
Comprehensive Outpatient Rehabilitation Facilities (CORFs). *Outpatient rehab services may require prior authorization; your plan provider will arrange for this authorization, if needed.*	
Outpatient substance use disorder services Coverage under Medicare Part B is available for treatment services provided in the outpatient department of a hospital. A coverage example is a patient who has been discharged from an inpatient stay for the treatment of substance use disorder or who requires additional treatment but does not require services found only in the inpatient hospital setting. The coverage available for these services is subject to the same rules generally applicable to the coverage of outpatient hospital services. Outpatient substance use disorder visits include counseling, detoxification, medical testing and diagnostic evaluation.	Outpatient substance use disorder treatment services at approved facilities are covered at 100% of the approved amount.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you 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 to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for	Outpatient surgery is covered at 100% of the approved amount, including services provided at hospital outpatient facilities and ambulatory surgical centers.

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an *outpatient*. *Outpatient surgery may require prior authorization; your plan provider will arrange for this authorization, if needed.*	Outpatient clinics owned and operated by hospitals (known as hospital-based practices) may cost you more.
Partial hospitalization services and Intensive outpatient services* *Partial hospitalization* is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that 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 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 and Intensive outpatient services may require prior authorization, your plan provider will arrange for this authorization, if needed.*	Partial hospitalization and Intensive outpatient services are covered at 100% of the approved amount.
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location	**Office visits** You pay a $10 copay for an office visit with a primary care provider or with a specialist. **Telehealth (online visit)** You pay a $10 copay for telehealth visit with a

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
• Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP, if your doctor orders it to see if you need medical treatment • Certain telehealth services, including: primary care physician services and individual sessions for mental health specialty services • You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. • As part of your Medicare Advantage plan, we offer safe and secure Virtual Care. Virtual Care gives you urgent care and behavioral health care through your phone, tablet, or computer from anywhere in the United States. Virtual urgent care visits from U.S. board-certified doctors are available 24/7, without an appointment. Virtual behavioral health visits are available by appointment from licensed behavioral health providers such as therapists, counselors, and U.S. board-certified psychiatrists Virtual Care is available through Teladoc Health™, an independent company and our plan-approved vendor. This service is separate from any virtual care your personal doctor might offer. • You can also use Teladoc Health™ to access telehealth services. Visit **www.bcbsm.com/virtualcare** for more information or call 1-800-835-2362, available 24 hours a day, 7 days a week, 365 days a year. TTY users call 1-855-636-1578. • Urgent general medical appointments available 24 hours a day, 7 days a week, 365 days a year (e.g., sore throat, fever, etc.) • Mental health appointment availability is 7 days a week, 7 a.m. to 9 p.m. local time. • Providers will contact members directly. Appointments are not conducted through the 800 number above.	primary care provider or with a specialist. Surgical services performed in an office are covered at 100% of the approved amount. After the first 12 months of Part B coverage, an annual routine physical exam is covered at 100% You pay a $10 copay for physical therapy, speech therapy and occupational therapy visits. If a surgical or diagnostic procedure is performed during an office visit, these procedures are considered diagnostic and you will be responsible for the Medicare-covered surgical service out-of-pocket costs in addition to your office visit copay.

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
• Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: o You have an in-person visit within 6 months prior to your first telehealth visit o You have an in-person visit every 12 months while receiving these telehealth services Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: o You're not a new patient and o The check-in isn't related to an office visit in the past 7 days and o The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours if: o You're not a new patient and o The evaluation isn't related to an office visit in the past 7 days and	

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

Certain services may require a physician's order.	
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 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test • Additional prostate cancer screening covered based on medical necessity	There is no coinsurance or copayment for an annual PSA test or a digital rectal exam. If you receive other services during the visit, out-of-pocket costs may apply.
Prosthetic and orthotic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see **Vision Care** later in this section for more detail. Prosthetics and orthotics coverage is limited to basic equipment. Deluxe or upgraded equipment must be medically necessary and requires prior authorization for coverage. Custom styles, colors and materials are not covered. Member must obtain prosthetics and orthotics from BCN's P&O supplier, Northwood at 1-800-667-8496, 8:30 a.m. to 5 p.m. Monday through Friday. TTY users call 711. When outside of the plan's service area, members must contact Northwood. To use another supplier, contact Customer Service. **Note:** You must have a prescription from your provider to obtain Prosthetic and Orthotic (P&O) items and services.	Medicare-approved prosthetic and related supplies are covered at 100% of the approved amount.

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
Prosthetic devices and related supplies may require prior authorization; your plan provider will arrange for this authorization, if needed.	
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. Pulmonary rehabilitation services may require prior authorization; your plan provider will arrange for this authorization, if needed.	Pulmonary rehabilitation services covered at 100% of the approved amount.
Retail health clinic services We cover visits to **plan-contracted** walk-in health clinics (located in a pharmacy setting) for minor health issues that require attention fast, but are non-emergency conditions such as sore throat, earaches, sunburn, sprains and strains, and suture removal.	$10 copay for retail health clinic services.
Screening and counseling to reduce alcohol misuse We cover 1 alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit. . If you receive other services during the visit, out-of-pocket costs may apply.

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are**: people aged 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner.	There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision-making visit or for the LDCT. If you receive other services during the visit, out-of-pocket costs may apply.
Screening for lung cancer with low dose computed tomography (LDCT) (continued) *For LDCT lung cancer screenings after the initial LDCT screening:* the member must receive a written 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.	
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit. .

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We 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.	If you receive other services during the visit, out-of-pocket costs may apply.
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to 6 sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)	Kidney disease education services are covered at 100% of the approved amount. Dialysis services are covered at 100% of the approved amount. Professional charges are covered at 100% of the approved amount.

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, **Medicare Part B prescription drugs**.	
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, see Chapter 10 of this document. Skilled nursing facilities are sometimes called SNFs.) Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost sharing for a	Skilled nursing facility care is covered at 100% of the approved amount. 120 days are covered per benefit period. No prior hospitalization is required. A benefit period starts the day you are admitted to a hospital or skilled nursing facility as an inpatient and ends after you have not been an inpatient at a hospital or skilled nursing facility for 60 consecutive days. Once the benefit period ends, a new benefit period begins if you are admitted as an inpatient to a hospital or SNF. New benefit periods do not begin due to a change in diagnosis, condition, or calendar year.

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital *Skilled nursing facility care may require prior authorization; your plan provider will arrange for this authorization, if needed.*	
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover 2 counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to 4 face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost sharing. Each counseling attempt includes up to 4 face-to-face visits.	There is no coinsurance or copayment for Medicare-covered smoking and tobacco use cessation preventive benefits. . If you receive other services during the visit, out-of-pocket costs may apply.
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD). Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office	Supervised exercise therapy is covered at 100% of the approved amount

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
• 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 Continued on next page **Supervised Exercise Therapy (SET) (continued)** SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider. Supervised Exercise Therapy (SET) may require prior authorization; your plan provider will arrange for this authorization, if needed.	
Urgently needed services A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or even if you are inside the service area of the plan, it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. Your plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. 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.	For urgent care visits, you pay a $10 copay. **Outside the U.S.** You may be responsible for the difference between the approved amount and the provider's charge. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network.

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
BCN Advantage Group HMO-POS includes coverage of emergent or urgently needed medical items and services furnished outside of the United States and its territories. Your plan includes the BCBS Global Core Coverage (foreign travel) health care benefit. See **Enhanced Benefits** for a description and cost sharing.	
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (If you have 2 separate cataract operations, you cannot reserve the benefit after the first surgery and receive two sets of eyeglasses after the second surgery.) Routine eye exams are covered. See **Enhanced Benefits** for additional information and out-of-pocket costs. **Note:** Medically necessary contacts (not elective contacts) require provider approval and must meet criteria of 'medically necessary'.	There is no coinsurance or copayment for vision care. If you receive other services during the visit, out-of-pocket costs may apply.

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
Welcome to Medicare preventive visit The plan covers the one-time ***Welcome to Medicare*** preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important**: We cover the ***Welcome to Medicare*** preventive visit only 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.	There is no coinsurance or copayment for the ***Welcome to Medicare*** preventive visit . Out-of-pocket costs may apply if a covered service (e.g., diagnostic test) is outside the scope of the Welcome to Medicare preventive visit.
Worldwide emergency coverage If you need care when you're outside of the United States and its territories, you have coverage for emergency services, urgently needed services, and emergency transportation only. In general, health care you get while traveling outside the United States and its territories is limited to: • Urgently needed services (services you require in order to avoid the likely onset of an emergency medical condition) • Emergency care (treatment needed immediately because any delay would mean risk of permanent damage to your health) • You have coverage for worldwide emergency transportation (transportation needed immediately because a delay would mean risk of permanent damage to your health) **Services not covered while traveling outside the United States and its territories** • By federal law, BCN Advantage can't cover prescription drugs you purchase outside the United States and its territories • Maintenance dialysis	There is no coinsurance, copayment, or deductible for worldwide emergency coverage. There is a combined $50,000 lifetime limit that applies to both urgent and emergent medical care and emergency transportation outside of the United States and its territories. BCN Advantage has limited coverage for healthcare services outside the United States and its territories. You may choose to buy a travel insurance policy to get more coverage.

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
Enhanced Benefits	
Adult briefs and incontinence liners We cover adult briefs and incontinence liners to provide effective bladder control protection. **Wipes are not covered.**	Adult briefs and incontinence liners are covered at 100% of the approved amount when deemed medically necessary and ordered through the durable medical equipment (DME) provider. Please refer to the DME and related supplies section.
Annual physical exam Covered services include: • One yearly routine physical exam (an annual preventive medical exam that is more comprehensive than an annual wellness visit) ○ An examination performed by a primary care provider that collects health information. Services include: ○ An age and gender appropriate physical exam, including vital signs and measurements. ○ Guidance, counseling and risk factor reduction interventions. ○ Administration or ordering of immunizations, lab tests or diagnostic procedures. ○ Covered only in the following locations: provider's office, outpatient hospital or a member's home.	Services are covered up to 100% of the approved amount. Out-of-pocket costs may apply if a covered service (e.g., diagnostic test) is outside the scope of the annual physical exam. Note: If a biopsy or removal of a lesion or growth is performed during an office visit, these procedures are considered diagnostic. You will be responsible for the Medicare-covered surgical service out-of-pocket costs in addition to your office visit copayment
Autism Spectrum Disorder Services (No age limit) • Applied behavioral analysis (ABA) treatment - when rendered by an approved board-certified behavioral analyst. Subject to prior authorization. • Outpatient physical therapy, speech therapy, occupational therapy, nutritional counseling for autism spectrum disorder	Applied behavioral analysis treatment is covered at 100% of the approved amount. $10 copay for outpatient physical therapy, speech therapy, occupational therapy, and

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
• Other covered services, including mental health services, for autism spectrum disorder	nutritional counseling visits with a specialist. $10 copay for other covered services including mental health services for autism spectrum disorder.
BCBS Global Core Coverage (foreign travel) Your plan provides coverage outside the United States for medical care that is urgent or an emergency.	Your cost-share amount is the same as if services are rendered in the United States.
Chiropractic services **Covered services include:** • X-rays (one per year) and chiropractic radiology services • Evaluation and management services • Chiropractic physical therapy visits	You pay a $10 copay for chiropractic services.
Contraceptive devices and injections Contraception (i.e., birth control, prevention of pregnancy) is the means by which an individual uses methods that will prevent pregnancy. Methods of contraception include barrier methods, non-hormonal contraception, hormonal contraception, and injections performed by a licensed provider.	Contraceptive devices and injections are covered at 100% of the approved amount.
Determination of Refractive State Eye exam for determination of refractive state is necessary for obtaining glasses and is covered under these circumstances: • A provider must identify your refractive state to determine an injury, illness or disease	Determination of refractive state is covered at 100% of the approved amount.

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
• An ophthalmologist or an optometrist must determine the refractive state for corrective lenses • Your refractive state is determined as part of a surgical procedure.	
Gender reassignment and gender affirming procedures Certain gender affirming services are payable by participating providers for members over the age of 18. Subject to prior authorization.	Gender reassignment and gender affirming procedures are covered at 100% of the approved amount. Must meet approved medical criteria.
Compression wear We cover gradient compression stockings that squeeze the leg to reduce and prevent swelling as well as improve blood flow. Also including mastectomy sleeves, two per 12 months. Gradient compression stockings may require prior authorization; your plan provider will arrange for this authorization, if needed.	Gradient compression stockings are covered at 100% of the approved amount.
Hearing aids and services Hearing aids must be prescribed by a provider, audiologist, or hearing aid dealer based on the most recent audiometric examination and hearing aid evaluation test. • Audiometric exam - one every 36 months • Hearing aid evaluation - one every 36 months **Hearing aids and services (continued)** • Ordering and fitting the hearing aid (monaural or binaural hearing aid) one every 36 months	A $10 specialist office visit copay may apply. **Binaural (both ears)** Covered up to the maximum allowance of $2,707 maximum allowance for both ears, every 36 months, including applicable dispensing fees **Monaural (one ear)** Covered up to the maximum allowance of $1,507 maximum allowance for one ear,

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
• Hearing aid conformity test - one every 36 months Please see associated **Rider** for benefit coverage information.	every 36 months, including applicable dispensing fees **Ordering and fitting the hearing aid** Covered at 100% of allowed amount once every 36 months **Hearing aid conformity test** Covered 100% of the allowed amount once every 36 months
Hearing services- routine exam A medical evaluation to find the cause of the hearing loss and determine if it can be improved with a hearing aid is covered as an office visit when furnished by a provider, audiologist, or other qualified provider. The following tests are covered under the hearing aids benefit: • A hearing aid evaluation test to determine what type of hearing aid should be prescribed • A test to evaluate the performance of a hearing aid (conformity exam) The following test is covered as an office visit under the hearing services benefit when furnished by a physician, audiologist or other qualified provider: • Annual routine exam to measure hearing ability	Hearing services are covered at 100% of the approved amount.
Home infusion therapy* Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals,	**In-network and Out-of-network:** Home infusion therapy is covered at 100% of the approved amount.

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
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 Home infusion therapy: • Must be medically necessary • Must be given by a participating Home Infusion Therapy (HIT) provider or in a participating freestanding Ambulatory Infusion Center (AIC) • May use drugs that require prior authorization, consult with your provider • The additional BCN Advantage home infusion therapy benefit provides coverage for the in-home administration of infusion therapy services when the Original Medicare coverage criteria are not met. Coverage is available when the infusion therapy is: • Prescribed by a physician to: • Manage a chronic condition • Treat a condition that requires acute care if it can be managed safely at home • Certified by the physician as medically necessary for the treatment of the condition • Appropriate for use in the patient's home • Medical IV therapy, injectable therapy or total parenteral nutrition therapy • Chelation therapy, performed in the patient's home or a nursing home Components of care available regardless of whether the patient is confined to the home:	Based on your provider's treatments, your home infusion therapy services may be considered as enhanced benefits, which are covered by your plan. Home infusion therapy enhanced benefits are covered at 100% of the approved amount.

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
• Nursing visits • Durable medical equipment, medical supplies and solutions • Catheter care • Injectable therapy • Drugs * Home infusion therapy services may require prior authorization. Your plan provider will arrange for this authorization, if needed.	
Hospice room and board (5th Level) The 5th level hospice care benefit covers inpatient room and board hospice care in a skilled nursing or hospice facility. There is a lifetime maximum of 45 days of coverage for hospice care in the 5th level. This coverage doesn't apply when hospice care is received in the home. Original Medicare covers expenses related to hospice care in the home.	**In-network and Out-of-network:** Hospice Care (5th Level) services are covered at 100% of the approved amount. Limited to 45 days per lifetime.

Human organ transplants*
 	
• Bone marrow and hematopoietic stem cell transplants when required for the following conditions:
• Allogeneic (from a donor) transplants for:
  ○ Osteopetrosis
  ○ Renal cell cancer
  ○ Primary amyloidosis
• Autologous (from the patient) transplants for:
  ○ Renal cell cancer
  ○ Germ cell tumors of ovary, testis, mediastinum, retroperitoneum
  ○ Neuroblastoma (stage III or IV)
  ○ Primitive neuroectodermal tumors
	In-network and Out-of-network:
	Human Organ Transplants are covered up to 100% of the approved amount.
	
	Additional coverage for certain human organ transplants not covered by Original Medicare includes: Bone Marrow, Oncology, Kidney, Cornea and Skin.
	
	Human organ transplant services may require prior

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
○ Ewing's sarcoma ○ Medulloblastoma ○ Wilms' tumor • A second bone marrow transplant for multiple myeloma after a failed first bone marrow transplant. When directly related to a covered transplant, we cover immunosuppressive drugs and other transplant–related prescription drugs, during and after the benefit period. For non–covered transplants, your prescription drug plan is responsible for immunosuppressive drugs and other transplant–related prescription drugs. There is no lifetime maximum for non-Medicare covered organs. *Human organ transplants may require prior authorization.	authorization. Your plan provider will arrange for this authorization, if needed
In Vitro Fertilization (IVF) Eligible conditions for the diagnosis and treatment of infertility are: • Encounter for assisted reproductive fertility procedure cycle and/or encounter for fertility preservation (the retrieval of mature eggs and/or sperm for the creation of embryos that are frozen for future use) • Iatrogenic infertility (impairment of fertility by surgery, radiation, chemotherapy, or medical treatment affecting the ability to produce sperm or eggs) Age restrictions: • IVF is payable for women up to the age of 43 with the following guidelines. • Ages up to and including 35 single embryo transfer only • Ages between 36 and 43 double embryo transfer	In vitro fertilization assessment services are covered at 100% of the approved amount. All other In vitro fertilization services are covered at 20% of the approved amount.

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
• Iatrogenic infertility covered for female members up to age 43 • Members with a genetic condition that will result in early menopause or impaired sperm production in later years are covered up to age 26 Fertility preservation procedures are available for both women and men. Must meet approved guidelines. Covered infertility diagnosis, treatment, assisted reproduction, artificial conception and fertility preservation procedures are payable when rendered only by the UMHS Center for Reproductive Medicine. A lifetime plan maximum of $20,000 applies to covered infertility diagnosis, treatment, assisted reproduction, artificial conception and fertility preservation procedures. In vitro fertilization may require prior authorization; your plan provider will arrange for this authorization, if needed. Subject to medical criteria.	
Nutritional counseling Covered benefit must be related to approved medical conditions such as: • Diabetes • Chronic renal disease • Kidney transplant • Eating disorders Must be medically necessary and meet Medicare-approved criteria.	Nutritional counseling related to approved medical conditions is covered at 100% of the approved amount.
Postnatal care visits (applies to member only) The postnatal period begins after childbirth and is typically considered to end within six weeks. Postnatal care is the care that the mother receives after delivery. It includes counseling and health education on	Postnatal care visits are covered at 100% of the approved amount.

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
recognition of danger signs and appropriate care seeking. Postnatal care can be provided in a health facility or at home, depending on the needs of the mother. **Postnatal care visits (applies to member only) (continued)** Postnatal care is to be provided by your primary care provider, participating OB/GYN, or participating certified nurse midwife.	
Pregnancy Terminations Medically necessary or voluntary. Pregnancy terminations may require prior authorization; your plan provider will arrange for this authorization, if needed.	Pregnancy terminations are covered at 100% of the approved amount.
Routine eye exam Routine eye exams are covered once per calendar year. Glasses, lenses, frames and contacts are not covered.	Routine eye exams are covered at 100% of the approved amount.
SilverSneakers® Members are covered for a fitness benefit through SilverSneakers®. SilverSneakers is a comprehensive program that can improve overall well-being and social connections. Designed for all levels and abilities, SilverSneakers provides convenient access to a nationwide fitness network, a variety of programming options and activities beyond the gym that incorporate physical well-being and social interaction. Benefits include: • Use of exercise equipment, classes, and other amenities at thousands of participating locations	$0 copay for SilverSneakers. Fitness services must be provided at SilverSneakers® participating locations. You can find a location or request information at www.silversneakers.com or 1-866-584-7352, 8 a.m. to 8 p.m. Eastern time, Monday through Friday. TTY users call 711.

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
• 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 • Use of exercise equipment, classes, and other amenities at thousands of participating locations • SilverSneakers LIVE online classes and workshops taught by instructors trained in senior fitness • SilverSneakers On-Demand online library with hundreds of workout videos • SilverSneakers GO mobile app with on-demand videos and live classes • SilverSneakers Community gives you options to get active outside of traditional gyms (like recreation centers, malls, and parks) • Online fitness tips and healthy eating information • Social connections through events such as shared meals, holiday celebrations, and class socials • GetSetUp virtual enrichment program with classes on topics ranging from healthy eating to aging in place Go to **www.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. Please see associated **Rider** for benefit coverage information. Burnalong is a registered trademark of Burnalong, Inc. 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. SilverSneakers is a registered trademark of Tivity Health, Inc. ©2024 Tivity Health, Inc. All rights reserved.	

Certain services may require a physician's order.	
Services that are covered for you	**What you must pay** when you get these services
Other programs designed to enrich the health and lifestyles of members such as Blue Cross Virtual Well-Being, available on our website at **www.bcbsm.com/medicare**	

Temporomandibular joint dysfunction (TMJ) treatment Temporomandibular joint (TMJ) dysfunction may be the result of congenital or developmental anomalies; fractures or dislocations resulting from trauma, internal derangement or ankylosis (stiffening or fixation of a joint); arthritic diseases or neoplastic diseases. Following services are covered to treat TMJ: • Surgery directly related to the temporomandibular joint (jaw joint) and related anesthesia services • Arthrocentesis performed for the treatment of temporomandibular joint (jaw joint) dysfunction) • Diagnostic X-rays (including MRIs) • Trigger point injections • Physical therapy (See physical therapy services) • Reversible appliance therapy (mandibular orthotic repositioning device such as a bite splint)	You pay a $10 copay for temporomandibular joint dysfunction treatment office visit with your primary care provider or specialist. Temporomandibular joint dysfunction (TMJ) treatment is covered at 100% of the approved amount.
Travel and lodging for covered transplants and clinical trials • The benefit period begins five days prior to the initial transplant and extends through the patient's transplant episode of care. The transplant surgery must be performed at a Medicare-approved transplant facility at least 100 miles from home. • Travel and lodging benefits are also payable during covered clinical trials and begin with the first service date of the clinical trials and end 180 days after that date. • Coverage includes expenses for the patient and one other person eligible to accompany the patient and two persons if the patient is a child under age 18 or if the transplant involves a living donor. • Benefits are payable up to a combined maximum of $150 per day for the covered duration.	**In-network and Out-of-network:** Travel and lodging for covered transplants and clinical trials are covered at 100% of the approved amount.

Travel and lodging for covered transplants and clinical trials (continued) The maximum amount payable for travel and lodging services related to the initial solid organ transplant is $10,000. The maximum amount payable for services related to an approved clinical trial or bone marrow transplant is $5,000.	
Voluntary sterilization Sterilization is accomplished by surgical removal of testes or ovaries or inactivation by irradiation or by tying off or removing a portion of reproductive ducts.	Voluntary sterilization is covered at 100% of the approved amount.
Weight reduction/Bariatric surgery We cover weight reduction procedures and surgery when medically necessary based on BCN's medical criteria and established guidelines related to the procedure. Your provider approves the service and must notify BCN prior to the procedure taking place. Must meet approved criteria. Weight reduction/Bariatric procedures and surgery may require prior authorization; your plan provider will arrange for this authorization, if needed.	Weight reduction/bariatric surgery is covered at 100% of the approved amount.
Well woman visit/Gynecological exam • Gynecological exam, one per calendar year • Additional well-woman visits may be allowed based on medical necessity	Well-woman visit/ gynecological exam is covered at 100% of the approved amount, one per member per calendar year.

Wigs (including stands and adhesive) Wigs must be prescribed by a physician and one of the following conditions is required: • Hair loss due to chemotherapy; or • Alopecia or disease that caused hair loss Please see associated **Rider** for benefit coverage information. Wigs may require prior authorization; your plan provider will arrange for this authorization, if needed.	Wigs are covered at 100% of the approved amount.

Point-of-Service Benefit Services that are covered for you	What you must pay when you get these services
Inside the United States, including the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. If you need care when you're outside of Michigan, but inside the United States our point-of-service benefit (offered through the nationwide network of Blue Plan Providers via the Blue Cross and Blue Shield Association) allows you to receive routine and follow-up care as necessary from providers who participate with Blues plans. In most cases, we do not cover durable medical equipment, lab services and specialty drugs provided by out-of-state providers unless the member is traveling outside of Michigan. We do not cover out-of-state non-Medicare-covered transportation services. We do not cover visits to retail health clinics as a point-of-service benefit above	When you use the nationwide network of Blue Plan Providers benefit, your applicable cost sharing will be the same as described in the Medical Benefits Chart above or any riders issued to you. **The specialist copay amount applies to both primary care provider and specialist visits outside of your network service area.** The cost of the service, on which your liability (copayment/coinsurance) is based, is the Medicare allowable amount for covered services. If you know you'll need care when you are traveling, you need to coordinate care with your primary care provider prior to traveling out-of-state. *Authorization rules may apply.* The only services we always cover without an authorization are medical emergencies and urgently needed services. Care received through our point-of-service nationwide network of Blue Plan Providers benefit will not count toward your maximum out-of-pocket amount. **To locate participating doctors, facilities, labs** and **durable medical** same as described in the **equipment providers** outside of Michigan, call 1-800-810-2583, 24 hours a day, 7 days a week. TTY users call 711.

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 from Medicare coverage 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 our plan will not pay for them. The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 7, Section 5.3 in this document.)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Acupuncture		Available for people with chronic low back pain under certain circumstances.
Cardiac rehabilitation, Phase III programs (For information on other cardiac rehabilitation programs, see Chapter 4, Section 2.1, and Chapter 12, Definitions of important words.)	**Not covered under any condition**	
Cosmetic surgery or procedures		• Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
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**	
Dental services, dental prostheses, replacement of teeth, X-rays, oral surgery or anesthesia for dental procedures except those described in the Dental services section of the Medical Benefits Chart in Chapter 4, Section 2.1.	**Not covered under any condition**	
Elective of voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.		When it is considered necessary and covered under Original Medicare.
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.		May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (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**	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Full-time nursing care in your home.	**Not covered under any condition**	
Hearing aids, hearing aid batteries, repairs, adjustments or reconfigurations.		If you are issued a Rider that covers these items.
Home-delivered meals	**Not covered under any condition**	
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.	**Not covered under any condition**	
Intrauterine insemination	**Not covered under any condition**	
Naturopath services (uses natural or alternative treatments).	**Not covered under any condition**	
Non-routine dental care		Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Orthopedic shoes or supportive devices for the feet.		Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease.
Payment is excluded for any item or service to the extent that payment has been made or reasonably can be expected to be made promptly under an automobile or liability insurance policy or plan, self-insured plan, or under no-fault insurance.	**Not covered under any condition**	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Payment is excluded for any item or service to the extent that payment has been made or reasonably can be expected to be made under a workers' compensation law or plan.	**Not covered under any condition**	
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 nurses.	**Not covered under any condition**	
Private room in a hospital.		Covered only when medically necessary.
Reversal of sterilization procedures and/or non-prescription contraceptive supplies.	**Not covered under any condition**	
Routine chiropractic care.		Manual manipulation of the spine to correct a subluxation.
Routine dental care, such as cleanings, fillings or dentures.		If you are issued a Rider that covers these items
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids.		Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery. You may have additional coverage if you are issued a rider that covers these items.
Routine foot care		Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes).
Services considered not reasonable and necessary, according to Original Medicare standards.	**Not covered under any condition**	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services from providers who appear on the CMS Preclusion List. *For more information, see CMS Preclusion List definition in Chapter 10.*	**Not covered under any condition**	
Services you receive from non-network providers that have not been pre-arranged or pre-approved by BCN Advantage		• Care for a medical emergency and urgently needed services worldwide. • Renal (kidney) dialysis services that you get from a Medicare-certified dialysis facility when you are within the United States and its territories and temporarily outside the BCN Advantage service area. • Certain services received when traveling outside of Michigan but within the United States and its territories, when arranged through the nationwide network of Blue Plan Providers.
Services you receive without prior authorization from BCN Advantage, when prior authorization from BCN Advantage is required for that service.	**Not covered under any condition**	

CHAPTER 5:

Asking us to pay our share of a bill you have received for covered medical services

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

Sometimes when you get medical care, you may need to pay the full cost. Other times, you may find that you have paid more than you expected under the coverage rules of the plan or you may receive a bill from a provider. In these cases, you can ask our plan to pay you back (paying you back is often called reimbursing you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services that are covered by our 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 cost sharing as discussed in the 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.

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

1. **When you've received emergency or urgently needed medical care from a provider who is not in our plan's network**

   Outside the service area, you can receive emergency or urgently needed services from any provider, whether or not the provider is a part of our network.

   You are only responsible for paying your share of the cost for emergency or urgently needed services. Emergency providers are legally required to provide emergency care. If you pay the entire amount yourself at the time you receive the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you 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 our share of the cost.

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

   Network providers should always bill the plan directly and ask you only for your share of the cost. But sometimes they make mistakes and ask you to pay more than your share.

   - You only have to pay your cost-sharing amount when you get covered services. We 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 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 our 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 our 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 our share of the costs. You will need to submit paperwork such as receipts and bills for us to handle the reimbursement.

All of 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

You may request us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records. **You must submit your claim to us within one year** 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.
  - The following information is necessary to help us process your claim if you do not use the claim form:
    - Enrollee ID
    - Name of Patient
    - Date(s) of service
    - Who provided the service (doctor or facility name), phone number, Tax ID and National Provider Identifier (or NPI)
    - Amount charged for each service
    - Procedure code (the description of service) AND Diagnosis code (the reason for visit)

  - Proof of payment (i.e. an itemized statement from your provider that shows the amount paid. Cash register receipts and canceled checks are accepted as proof of payment in certain cases. Money orders and personal itemizations are not accepted as proof of payment.)
- Either download a copy of the form from our website (**www.bcbsm.com/medicare**) or call Customer Service and ask for the form.

Mail your request for payment together with any bills or paid receipts to us at this address:
BCN Advantage
Blue Care Network
P.O. Box 68753
Grand Rapids, MI 49516-8753

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

Section 3.1 We check to see whether we should cover the service and how much we owe

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 for our share of the cost. If you have already paid for the service, we will mail your reimbursement of our 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 our share of the cost. We will send you a letter explaining the reasons why we are not sending the payment and your rights 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 the 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 consistent with your cultural sensitivities (in languages other than English, , in large print, or other alternate formats, etc.)

Your 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.

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information, in large print, or other alternate formats at no cost if you need it. We 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 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 health care services.

If providers in the plan's network for a specialty are not available, it is the plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you will only pay in-network cost sharing. If you find yourself in a situation where there are no specialists in the plan's network that cover a service you need, call the plan for information on where to go to obtain this service at in-network cost sharing.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, please call to file a grievance with BCN Advantage at 1-800-658-8878, TTY users call 711. 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 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 primary care provider (PCP) in the plan's network to provide and arrange for your covered services. We do not require you to get referrals to go to network providers.
You have the right to get appointments and covered services from the plan's network of 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 tells what you can do.

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

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

- Your *personal health information* includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a Notice of Privacy Practice, that talks 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 get written permission from you or someone you have given legal power to make decisions for you first.*
- There are certain exceptions that do not require us to get your written permission first. 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 our 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 at 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 Customer Service.

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

NOTICE OF PRIVACY PRACTICES

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

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

Affiliated entities covered by this notice

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

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

Our commitment regarding your protected health information

We understand the importance of your Protected Health Information (hereafter referred to as “PHI”) and follow strict polices (in accordance with state and federal privacy laws) to keep your PHI private. PHI is information about you, including demographic 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 BCBSM and BCN. Whenever we disclose PHI to plans or their sponsors, they must

follow applicable laws governing use and disclosure of your PHI including amending the plan documents for your group health plan to establish the limited uses and disclosures it may make of your PHI.

You may give us written authorization to use your PHI or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Some uses and disclosures of your PHI require a signed authorization:

- **For marketing communications:** Uses and disclosures of your PHI for marketing communications will not be made without a signed authorization except where permitted by law.

- **Sale of PHI:** We will not sell your PHI without a signed authorization except where permitted by law.

- **Psychotherapy notes**: To the extent (if any) that we maintain or receive psychotherapy notes about you, disclosure of these notes will not be made without a signed authorization except where permitted by law.

Any other use or disclosure of your protected health information, except as described in this Notice of Privacy Practices, will not be made without your signed authorization.

Disclosures you may request

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

Individual rights

You have the following rights. To exercise these rights, you must make a written request on our standard forms. To obtain the forms, call the customer service number on the back of your membership ID card or call 1-313-225-9000. These forms are also available online at 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 BCN Advantage, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call Customer Service:

- **Information about our 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.

- **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 restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.

Section 1.6 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 health care

You have the right to get full information from your doctors and other health care providers. Your providers must explain your medical condition and your treatment choices *in a way that you can understand*.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

To know about all of your choices. You have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan.

To know about the risks. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.

The right to say "no." You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. 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 health care 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.

- **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 health care** are examples of advance directives.

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 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 or not 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:
Visit: www.michigan.gov/lara and click on *File a complaint*

To file a complaint against a hospital or other health care facility contact:
Department of Licensing & Regulatory Affairs
Bureau of Community and Health Systems - Health Facility Complaints
P.O. Box 30664
Lansing, MI 48909-8170

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

Fax: 1-517-335-7167

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

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

Call: 1-517-241-0205, 8 a.m. to 5 p.m. Monday through Friday, TTY users call 711.
Fax: 1-517-241-2389 (Attn: Complaint Intake)
E-mail: BPL-Complaints@michigan.gov

Section 1.7 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 1.8 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 are having:

- You can **call Customer Service**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

Section 1.9 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can call Customer Service.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.

- You can contact **Medicare**.
  - You can visit the Medicare website to read or download the publication "Medicare Rights & Protections." (The publication is available at: **www.medicare.gov/publications/11534-medicare-rights-and-protections.pdf**)
  - 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 Customer Service.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this Evidence of Coverage document 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.
- **If you have any other health insurance coverage in addition to our plan, or separate prescription drug coverage, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of 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 continue to pay your premium for your Medicare Part B 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.

- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.

- **If you move *outside* of our plan service area, you cannot remain a member of our plan.**

- If you move, it is also important to tell Social Security (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 of 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 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 assist 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 and website URLs in Chapter 2, Section 3 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 (www.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 Part B prescription drugs) are covered or not, the way they are covered, and problems related to payment for medical care.

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 (services, items, and Part B prescription drugs, including payment). To keep things simple, we generally refer to medical items, services and Medicare Part B 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 prior to receiving benefits
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 that 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 a 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 to Level 2 if we do not fully agree with your Level 1 appeal.
- See **Section 6.4** of this chapter for more information about Level 2 appeals.
- For Part D drug appeals, if we say no to all or part of your appeal, you will need to ask for a Level 2 appeal. Part D appeals are discussed further in Section 7 of this chapter.

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 us at Customer Service**.
- You **can get free help** from your SHIP.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call Customer Service and ask for the Appointment of Representative form. (The form is also available on Medicare's website at **www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf** or on our website at **www.bcbsm.com/appointrep.)**
    - For medical care or Part B 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 Customer Service and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.bcbsm.com/appointrep.) 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 before 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 3 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 the doctor is discharging you 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 to only these services*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which section you should be using, please call Customer Service. You can also get help or information from government organizations such as your SHIP.

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 our 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 Part B prescription drug. In those cases, we will explain how the rules for Part B 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 our plan. **Ask for a coverage decision. Section 5.2.**
2. Our plan 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 the 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 the plan, and you want to ask our plan 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 health care, 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 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 Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B 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 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 **Medicare Part B 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 Medicare Part B 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 Medicare Part B 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 Medicare Part B 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 7 calendar days for Part B 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 an 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 decision.
You and your doctor may add more information to support your appeal.

Step 3: We consider your appeal and we give you our answer.

When our plan is reviewing your appeal, we take a careful look at all of 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 us to.
    - However, if you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service**.** If we take extra days, we will tell you in writing. We can't take extra time if your request is for a Medicare Part B 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 Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.
    - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B 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. (See Section 9 of this chapter for information on complaints.)
    - 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 7 calendar days** if your request is for a Medicare Part B 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.

<u>Step 1:</u> 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 of 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 Medicare Part B 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 Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 appeal **within 7 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 Medicare Part B prescription drug.

Step 2: The independent review organization gives you their 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 Medicare Part B prescription drug**, we must authorize or provide the Part B 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* or *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 decision, we will check to see if the medical care you paid for is covered. 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 our share of the cost typically within 30 calendar days, but no later 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 you too soon

When you are admitted to a hospital, you have the right to get all of 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 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 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 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 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 www.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 Customer Service. Or call your SHIP, 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 health care professionals paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts 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.

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 of the costs* for hospital care you receive after your planned discharge date.

- Once you request an immediate review of your hospital discharge 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 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 www.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 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 of 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. This is called *upholding the decision*.
- 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 health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services**

When you are getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it 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 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 Customer Service. Or call your SHIP, 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 health care experts paid by the Federal government to check on and help 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.

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.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see Section 7.5.

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

Legal Term
Detailed Explanation of Non-Coverage. 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 copayments, if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say *no*, then **your coverage will end on the date we have told you.**
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you 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 health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day when the Quality Improvement Organization said *no* to your Level 1 appeal. You could 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 of 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 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 Taking your appeal to Level 3 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 of 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 the customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you 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 our 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 our 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?
Timeliness (These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals)	If you have asked 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 items or 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 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 wish 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.
- If you do this, it means that we will use our *formal procedure* for answering grievances called *Resolving Concerns: Member Grievance Program*. Here's how it works:

◦ **If you ask for a written response, file a written grievance, or your complaint is related to quality of care, we will respond in writing to you.** Grievances must be filed within 60 calendar days of the condition, situation, event or issue that resulted in the dissatisfaction. The BCN Advantage Grievance and Appeals unit will generally mail written acknowledgment of grievances within 24 hours of receipt.
Grievances related to the following two decisions must be acknowledged within 24 hours of receipt:

- Refusal to grant a request for an expedited organization determination or reconsideration

- An extension, or refusal to grant a member's request for extension, of the time frame to make an organization determination or reconsideration
  - To file a grievance, you or your properly appointed authorized representative must call or provide a signed, written statement of the grievance (letter, fax or BCN Advantage request form) to:

    BCN Advantage Appeals and Grievances Unit
    Mail Code A01C
    Po Box 44200
    Detroit, MI 48244-0191

    Fax: 517-763-0214
    Email: lara-bsc-complaints@michigan.gov
    Mailing:
    P.O. Box 30004
    Lansing, MI 48909

Call 1-800-658-8878, hours are 8 a.m. to 5:30 p.m., Monday through Friday (April 1 through September 30), with weekend hours 8 a.m. to 8 p.m. seven days a week (October 1 through March 31).TTY users call 711

- We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 calendar days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest. If we deny your grievance in whole or in part, our written decision will explain why we denied it, and will tell you about any dispute resolution options you may have.

- 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 health care experts paid by the Federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

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

Section 9.5 You can also tell Medicare about your complaint

You can submit a complaint about *BCN Advantage* directly to Medicare. To submit a complaint to Medicare, go to www.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 BCN Advantage may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave. Sections 2 and 3 provide information on ending your membership voluntarily.

- There are also limited situations where we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, our 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 our plan?

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

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

The **Annual Enrollment Period** is from **October 21 to November 1.**

Choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:

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

OR

- Original Medicare *without* a separate Medicare prescription drug plan.

Your membership will end in our plan when your new plan's coverage begins on January 1.

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

You have the opportunity to make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period**.
The annual Medicare Advantage Open Enrollment Period is from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in an MA plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.

During the annual Medicare Advantage Open Enrollment Period, you can:

- Switch to another Medicare Advantage Plan with or without prescription drug coverage.

- Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.

Your membership will end on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

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

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

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply to you**.** These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (www.medicare.gov):

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

The enrollment time periods vary depending on your situation.

To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:

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

OR

- Original Medicare *without* a separate Medicare prescription drug plan.

Your membership will usually end on the first day of the month after your request to change your plan is received.

Section 2.4 Where can you get more information about when you can end your membership?

If you have any questions about ending your membership, you can:

- **Call Customer Service**.
- Find the information in the ***Medicare & You 2025*** handbook.

- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

SECTION 3 How do you end your membership in our plan?

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

If you would like to switch from our plan to:	This is what you should do:
• Another Medicare health plan.	• Enroll in the new Medicare health plan. • You will automatically be disenrolled from *BCN Advantage* when your new plan's coverage begins.
• Original Medicare *with* a separate Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan. • You will automatically be disenrolled from *BCN Advantage* when your new plan's coverage begins.
• Original Medicare *without* a separate Medicare prescription drug plan.	• **Send us a written request to disenroll** Contact Customer Service if you need more information on how to do this. • You can also contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from *BCN Advantage* when your coverage in Original Medicare begins.

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

SECTION 4 Until your membership ends, you must keep getting your medical items, and services through our plan

Until your membership ends, and your new Medicare coverage begins, you must continue to get your medical care through our 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 our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 BCN Advantage must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

BCN Advantage must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B
- If you move out of our service area
- If you are away from our service area for more than six months
    - If you move or take a long trip, call Customer Service to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison)
- If you are no longer a United States citizen or lawfully present in the United States
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

Where can you get more information?

If you have questions or would like more information on when we can end your membership call Customer Service.

Section 5.2 We cannot ask you to leave our plan for any health-related reason

BCN Advantage is not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

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

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

CHAPTER 9:
Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, 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 our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, 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.html.

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, BCN Advantage, 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

If we make any payment to you or on your behalf for covered services, we are entitled to be fully subrogated to any and all rights you have against any person, entity, or insurer that may be responsible for payment of medical expenses and/or benefits related to your injury, illness, or condition.

Once we have made a payment for covered services, we shall have a lien on the proceeds of any judgment, settlement, or other award or recovery you receive (our recovery shall not

be limited by the terms and conditions of any such settlement, award, or judgment), including but not limited to the following:

1. Any award, settlement, benefits, or other amounts paid under any workers' compensation law or award;

2. Any award, settlement, benefits, or other amounts paid under any automobile insurance policy law or award, including no-fault;

3. Any and all payments made directly by or on behalf of a third-party tortfeasor or person, entity, or insurer responsible for indemnifying the third-party tortfeasor;

4. Any arbitration awards, payments, settlements, structured settlements, or other benefits or amounts paid under an uninsured or under insured motorist coverage policy; or

5. Any other payments designated, earmarked, or otherwise intended to be paid to you as compensation, restitution, or remuneration for your injury, illness, or condition suffered as a result of the negligence or liability of a third party.

Liability insurance claims are often not settled promptly. We may at our discretion make conditional payments while the liability claim is pending. We may also receive a claim and not know that a liability or other claim is pending. In those situations, our payments are 'conditional.' Conditional payments must be refunded to us upon receipt of the insurance liability payment including medical payments or settlement.

You agree to cooperate with us and any of our agents and/or representatives and to take any and all actions or steps necessary to secure our lien, including but not limited to:

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

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

3. Participating in all phases of any legal action we commence in order to protect our rights, including, but not limited to, participating in discovery, attending depositions, and appearing and testifying at trial.

In addition, you agree not to do anything to prejudice our rights, including, but not limited to, assigning any rights or causes of action that you may have against any person or entity relating to your injury, illness, or condition without our prior express written consent. Your failure to cooperate shall be deemed a breach of your obligations, and we may institute a legal action against you to protect our rights.

We are also entitled to be fully reimbursed for all benefit payments we make to you or on your behalf that are the responsibility of any person, organization, or insurer. Our right of reimbursement is separate and apart from our subrogation right and is limited only by the amount of actual benefits paid under our plan. You must immediately pay to us any amounts you recover by judgment, settlement, award, recovery, or otherwise from any liable third party, his or her insurer, to the extent that we paid out or provided benefits for your injury, illness, or condition during your enrollment in our plan.

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

CHAPTER 10:
Definitions of important words

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

Allowed Amount – The dollar amount Blue Care Network has agreed to pay for health care services covered by your plan. It may be more or less than the actual amount a doctor or supplier charges. Any required copayments are subtracted from this amount before payment is made. Also see Approved Amount.

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.

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

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

Approved Amount – The dollar amount Blue Care Network of Michigan has agreed to pay for health care services covered by your plan. It may be more or less than the actual amount a doctor or supplier charges. Any required copayments are subtracted from this amount before payment is made.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of BCN Advantage, you only have to pay our plan's cost-sharing amounts when you get services covered by our 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.

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

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

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

CMS Preclusion List – A list maintained by CMS of individuals or entities that are currently revoked from the Medicare program, or that have engaged in behavior which CMS determines is detrimental to the best interests of the Medicare program. Medicare Advantage plans are prohibited from paying individuals or entities that appear on this list.

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

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** is an examination of a healthy colon when there is no sign, symptom or disease present. When a routine or screening colonoscopy uncovers a symptom of disease, such as a polyp, it is then considered a diagnostic colonoscopy.

- **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. When a sign or symptom is discovered during a screening colonoscopy, the testing may transition to a diagnostic procedure.

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 and speech-language pathology services, and home environment evaluation services.

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

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services are 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 before services are covered; (2) any fixed *copayment* amount that a plan requires when a specific service is received; or (3) any *coinsurance* amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is received.

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

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

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you 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. Medicare doesn't pay for custodial care.

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

Deductible – The amount you must pay for health care before our plan pays. BCN Advantage does not have a deductible unless a Rider is issued to you to add a deductible.

Diagnostic Procedure – Testing to rule out or to confirm a suspected diagnosis because there is a sign or symptom of disease. A diagnostic procedure is not the same as a screening. If a symptom of disease, such as a polyp or other abnormality, is found during a screening procedure, the procedure is then considered diagnostic.

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

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

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 our plan.

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

Grievance - A type of complaint you make about our plan or providers, including a complaint concerning the quality of your care. This 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 6 months or less. We, your plan, 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 our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer.

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

Hospital-Based Practice – Many provider offices, health centers or hospital-based outpatient clinics owned and operated by hospitals may charge an additional hospital usage fee when you see any provider in the office, health center or clinic. These hospital-based outpatient facilities conveniently offer a variety of providers and services integrated within one complex. From a Medicare perspective, you are being treated within the hospital system rather than a physician’s office and can be subject to a hospital-based usage fee. Even medical centers and provider offices located a long distance from the main hospital campus can be considered part of the hospital. When you use these hospital-based practices – also known as “provider-based” in Medicare terms – they bill a single service in two parts: one bill for the physician’s care and another bill for the hospital/facility fees. This can result in higher out-of-pocket costs for you. To find out if your providers are part of a hospital-based or provider-based practice, ask your provider. For more information, see “Outpatient Hospital Services” in Chapter 4, Section 2 Medical Benefits chart.

Hospital Inpatient Stay – A hospital stay when you 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*.

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

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

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

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

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

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

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

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

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

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an i) HMO, ii) PPO, a iii) Private Fee-for-Service (PFFS) plan, or a iv) Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer

Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, must cover all of the services that are covered by Medicare Part A and B. The term Medicare-Covered Services does not include the extra benefits, such as vision, dental or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

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

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

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

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

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

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

Occupational Therapy – Therapy given by licensed health care professionals that helps you learn how to perform activities of daily living, such as eating and dressing by yourself.

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called *coverage decisions* in this document.

Original Medicare (Traditional Medicare or Fee-for-service Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

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

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

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

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

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

Part C – see **Medicare Advantage (MA) Plan**.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

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

Point of Service (POS) – Point-of-Service means you can use providers outside the plan's network for an additional cost. (Also see Global Core). See Chapter 1, Section 1.1 "You are enrolled in BCN Advantage, which is a Medicare HMO Point-of-Service plan".

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

Prescription Drug Benefit Manager – Also known as Pharmacy Benefit Manager (PBM). Our prescription drug benefit manager is a vendor that BCN Advantage partners with to process and pay prescription drug claims.

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

Prior Authorization – Approval in advance to get services. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4.

Prosthetics and Orthotics – Medical devices including, but are not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

Referral – Approval your primary care physician may give you before you can use other providers in the plan's network. A referral and prior authorization are not the same thing: Only BCN Advantage can issue a prior authorization. Your primary care physician can issue a referral. (Also see Prior Authorization).

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 check for disease or signs of disease so that early detection and treatment can be provided for those who test positive for disease. A screening is not the same as a diagnostic procedure. (Also see Diagnostic Procedure).

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

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

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

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

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

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

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

Urgently Needed Services – A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contract. 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.

Addendum A. Durable medical equipment coverage limitations

For the following types of durable medical equipment, BCN Advantage limits coverage to the following brands or models:

Continuous Airway Pressure (CPAP) Devices:

- ResMed
- Respironics

The above CPAP devices must include, as standard equipment, integrated heat and humidification, and must have a minimum two-year manufacturer warranty.

Oxygen Concentrators:

- Caire
- DeVilbiss
- Drive Medical
- Invacare
- ResMed
- Respironics
- SeQual

The above concentrators must have a built-in continuous flow analyzer feature with automatic sensor alarm, a minimum five-year manufacturer warranty and minimum manufacturer oxygen output concentration level at any flow rate of at least 87 percent.

Diabetic Blood Glucose Monitors and Test Strips:

- FreeStyle Libre
- Dexcom G Series
- Medtronic Guardian
- FreeStyle
- Glucocard
- Contour
- Foracare
- OneTouch
- EasyMax
- Prodigy
- Accu-Chek

Lancets:

- FreeStyle
- Delica (With additional documented medical necessity)
- OneTouch
- Medicore ReadyLance Safety (With additional documented medical necessity)
- Aqualance and Equivalent
- AccuCheck SoftClix (With additional documented medical necessity).
- AccuCheck FastClix (With additional documented medical necessity)

Lancing Device:

- FreeStyle
- OneTouch
- Aqualance and Equivalent
- Accu-Check

Insulin Pumps:

- Medtronic MiniMed
- Tandem t:slim

Insulin Pump Supplies:

- Medtronic MiniMed
- Tandem t:slim

BCN Advantage Customer Service

Call **1-800-658-8878**
Calls to this number are free. Hours are 8 a.m. to 5:30 p.m. Eastern time, Monday through Friday, with weekend hours October 1 through March 31 between 8 a.m. and 8 p.m. seven days a week.

Certain services are available 24/7 through our automated telephone response system.

Customer Service also has free language interpreter services available for non-English speakers.

TTY **711**
Calls to this number are free. Hours are 8 a.m. to 8 p.m. Eastern time, Monday through Friday, with weekend hours October 1 through March 31.

Fax 1-866-364-0080

Write BCN Advantage – Mail Code C225
Blue Care Network
P.O. Box 5043
Southfield, MI 48086-5043

Website **www.bcbsm.com/medicare**

Michigan Medicare and Medicaid Assistance Program

Michigan Medicare and Medicaid 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 8:30 a.m. to 4:45 p.m. Eastern time, Monday through Friday.

TTY **711**

Write Michigan Medicare and Medicaid Assistance Program 6105
West St. Joseph Hwy., Suite 204
Lansing, MI 48917-4850

Website **www.mmapinc.org**

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