2022

Medicare Plus Blue℠ Group PPO
State Health Plan Medicare Advantage (MA)

January 1 — December 31, 2022

Evidence of Coverage

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

This booklet gives you the details about your Medicare health care from January 1 – December 31, 2022. It explains how to get coverage for the health care services you need. **This is an important legal document. Please keep it in a safe place.**

This plan, Medicare Plus Blue, is administered by Blue Cross Blue Shield of Michigan. (When this *Evidence of Coverage* says "we," "us," or "our," it means Blue Cross Blue Shield of Michigan. When it says "plan" or "our plan," it means Medicare Plus Blue.)

This information is available for free in an alternate format. Please call Customer Service at the phone numbers printed on the back cover of this booklet if you need plan information in another format.

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2023.

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

H9572_SOM22MAEOC_C FVNR 0821
OMB Approval 0938-1051 (Expires: February 29, 2024)

Medicare Advantage Plans

Multi-language Interpreter Services

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-843-4876 (TTY: 711).

Arabic: ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-843-4876 (رقم هاتف الصم والبكم: 711).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-843-4876 (TTY: 711)。

Syriac: ܙܘܗܪܐ: ܐܢ ܐܢܬ ܟܡܡܠܠܬ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܡܫܬܟܚܝܢ ܠܟ ܚܕܡܬܐ ܕܗܝܪܬܐ ܒܠܫܢܐ ܡܓܢܐܝܬ܀ ܩܪܝ ܥܠ ܡܢܝܢܐ: 1-800-843-4876 (TTY: 711)܀

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-843-4876 (TTY: 711).

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-843-4876 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-843-4876 (TTY: 711) 번으로 전화해 주십시오.

Bengali: **মনেরাখবেন**: যদিআপনারভাষাবাংলাহয়, ভাষাসহায়তাপরিষেবা, আপনিবিনামূল্যেপেতেপারেন। কলকরুন1-800-843-4876 (TTY: 711)।

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-843-4876 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-843-4876 (TTY: 711).

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-843-4876 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-843-4876（TTY: 711）まで、お電話にてご連絡ください。

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-843-4876 (телетайп: 711).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-843-4876 (TTY: Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-843-4876 (TTY: 711).

Discrimination is Against the Law

Blue Cross Blue Shield of Michigan and Blue Care Network comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross Blue Shield of Michigan and Blue Care Network:

- Provide free aids and services to people with disabilities 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, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact the Office of Civil Rights Coordinator.

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 with:

Office of Civil Rights Coordinator
600 E. Lafayette Blvd.
MC 1302
Detroit, MI 48226
1-888-605-6461, TTY: 711
Fax: 1-866-559-0578
civilrights@bcbsm.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

2022 Evidence of Coverage

Table of Contents

This list of chapters and page numbers is your starting point. For more help in finding information you need, go to the first page of a chapter. **You will find a detailed list of topics at the beginning of each chapter.**

CHAPTER 1

Getting started as a member

Chapter 1. Getting started as a member

SECTION 1 Introduction

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

You are covered by Medicare, and you have chosen to get your Medicare health care coverage through our plan, Medicare Plus Blue Group PPO. This plan does not administer your Part D prescription drug coverage.

There are different types of Medicare health plans. Medicare Plus Blue Group PPO is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company.

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* booklet about?

This *Evidence of Coverage* booklet explains how to get your Medicare medical care covered through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

The word "coverage" and "covered services" refers to the medical care and services available to you as a member of Medicare Plus Blue Group PPO.

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

If you are confused or concerned or just have a question, please contact our plan's Customer Service (phone numbers are printed on the back cover of this booklet).

Section 1.3 Legal information about the *Evidence of Coverage*

It's part of our contract with you

This *Evidence of Coverage* is part of our contract with you about how Medicare Plus Blue Group PPO covers your care. Other parts of this contract include your enrollment form and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for months in which you are enrolled in Medicare Plus Blue Group PPO between January 1, 2022 and December 31, 2022.

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 Medicare Plus Blue Group PPO after December 31, 2022. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2022.

Medicare must approve the plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve Medicare Plus Blue Group PPO each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue 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 meet the eligibility requirements for the State of Michigan Employees' Retirement System.
    - Please contact the Michigan Office of Retirement Services (ORS) at 1-800-381-5111, Monday through Friday, 8:30 a.m. to 5:00 p.m. Eastern time, for more information.
- You have both Medicare Part A and Medicare Part B (Section 2.2 tells you about Medicare Part A and Medicare Part B)
- -- *and* -- you live in our geographic service area (Section 2.3 below describes our service area)
- -- *and* -- you are a United States citizen or are lawfully present in the United States

Section 2.2 What are Medicare Part A and Medicare Part B?

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services provided by hospitals (for inpatient services, skilled nursing facilities, or home health agencies).
- Medicare Part B is for most other medical services (such as physician's services, home infusion therapy, and other outpatient services) and certain items (such as durable medical equipment (DME) and supplies).

Section 2.3 Here is the plan service area for Medicare Plus Blue Group PPO

Although Medicare is a federal program, Medicare Plus Blue Group PPO is available only to individuals eligible for the State of Michigan Employees' Retirement System sponsored health plan and 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 as the United States and its territories.

If you plan to move out of the service area, please contact ORS. Address and other demographic updates can be provided online at **www.michigan.gov/orsmiaccount**.

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

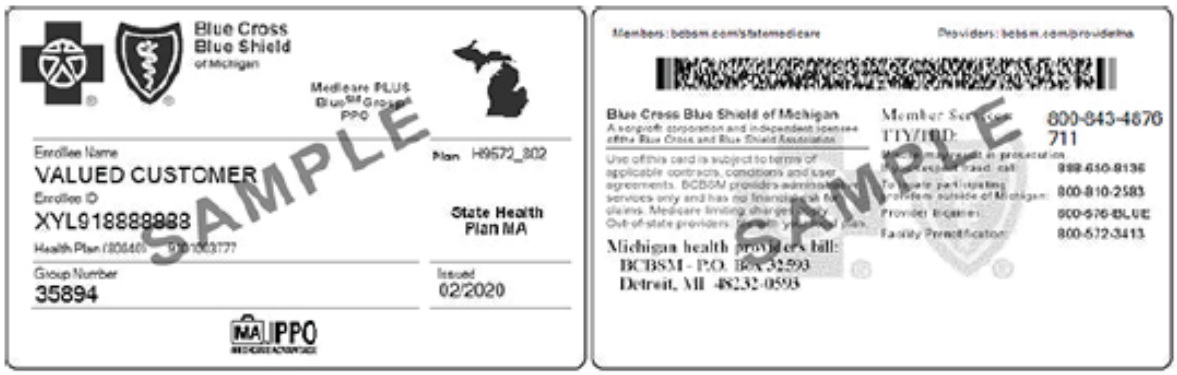
Section 2.4 U.S. Citizen or Lawful Presence

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 Medicare Plus Blue Group PPO if you are not eligible to remain a member on this basis. Medicare Plus Blue Group PPO must disenroll you if you do not meet this requirement.

SECTION 3 What other materials will you get from us?

Section 3.1 Your plan membership card – Use it to get all covered care

While you are a member of our plan, you must use your membership card for our plan whenever you get any services covered by this plan. Your prescription drug card is separate and will need to be provided to obtain prescriptions at in-network pharmacies. You should also show the provider your Medicaid card, if applicable. Here's a sample membership card to show you what yours may look like. Language on the back of your card may vary:



Do NOT use your red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your Medicare Plus Blue Group PPO membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in routine research studies.

Here's why this is so important: If you get covered services using your red, white, and blue Medicare card instead of using your Medicare Plus Blue Group PPO membership card while you are a plan member, you may have to pay the full cost yourself.

If your plan membership card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

Section 3.2 The *Provider Directory*: Your guide to all providers in the plan's network

When you become a new member, we send you either a *Provider Directory* (Michigan) or a *Provider Locator* (outside Michigan). The *Provider Locator* lists our network providers. The *Provider Directory* lists our network providers and durable medical equipment suppliers.

What are "network providers"?

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. We have arranged for these providers and suppliers to deliver covered services to members in our plan. The most recent list of providers is available on our website at **www.bcbsm.com/providersmedicare**.

Why do you need to know which providers are part of our network?

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

Note: If your cost-sharing is the same for services from in-network and out-of-network providers under your group plan, you can use any doctor or hospital that accepts Original Medicare and will accept your Medicare Plus Blue Group PPO card. We encourage you to utilize our network of providers; however, it is not a requirement under your plan.

The *Provider Directory* you receive is based on your address and is not a complete list of network providers. In addition, providers may have multiple locations and not all locations are listed in the *Provider Directory*.

If you don't have your copy of the *Provider Directory* (Michigan) or your *Provider Locator* (outside Michigan), you can request a copy from Customer Service (phone numbers are printed on the back cover of this booklet). You may ask Customer Service for more information about our network providers, including their qualifications. You can use our provider search tool at **www.bcbsm.com/providersmedicare**. Both Customer Service and the website can give you the most up-to-date information about changes in our network providers.

SECTION 4 Your monthly premium for Medicare Plus Blue Group PPO

Section 4.1 Information about your plan premium

As a member of our plan, you may pay a monthly premium. In addition, you must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party). Contact ORS at 1-800-381-5111 if you have questions about your plan premium. 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) if you have questions about your Part A or Part B premium.

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, many members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our plan, you must have both Medicare Part A and Medicare Part B. Some plan members (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A. Most plan members pay a premium for Medicare Part B. **You must continue paying your Medicare premiums to remain a member of the plan.**

Your copy of the *Medicare & You 2022* handbook gives information about these premiums in the section called "2022 Medicare Costs." The booklet explains how the Medicare Part B premium differs for people with different incomes. Everyone with Medicare receives a copy of the *Medicare & You 2022* handbook each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of the *Medicare & You 2022* handbook 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 5 Please keep your plan membership record up to date

Section 5.1 How to help make sure that we have accurate information about you

Your membership record has information from your enrollment form, including your address and telephone number.

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.

You must contact ORS to update the following information:

- Changes to your name, your address, your email address, or your phone number
  - You can go online to **www.michigan.gov/orsmiaccount** or call ORS at 1-800-381-5111
- Corrections to your date of birth or other demographic information
- Enrollment in another group health insurance plan (such as from your employer, your spouse's employer, workers' compensation, or Medicaid) or in another Medicare Advantage plan

Please contact Blue Cross Blue Shield Customer Service about these changes (phone numbers are printed on the back cover of this booklet)**:**

- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If you receive care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
  - This must also be reported to ORS at 1-800-381-5111.
- If you are participating in a clinical research study or receiving hospice care

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.

Read over the information we send you about any other insurance coverage you have

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. (For more information about how our coverage works when you have other insurance, see Section 7 in this chapter.)

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 (phone numbers are printed on the back cover of this booklet).

SECTION 6 We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected

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.

For more information about how we protect your personal health information, please go to Chapter 6, Section 1.3 of this booklet.

SECTION 7 How other insurance works with our plan

Section 7.1 Which plan pays first when you have other insurance?

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.

These rules apply for employer 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 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.

Having other group health coverage may impact your coverage under the Medicare Plus Blue Group PPO plan. If you enroll in another Medicare Advantage plan you will be disenrolled from your Medicare Plus Blue Group PPO plan. You must immediately notify ORS by calling 1-800-381-5111 if you have other group health coverage or enroll in another Medicare Advantage plan to discuss your health coverage options.

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

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

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

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Customer Service (phone numbers are printed on the back cover of this booklet). You may need to give your membership ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

CHAPTER 2

Important phone numbers and resources

Chapter 2. Important phone numbers and resources

SECTION 1 Medicare Plus Blue Group PPO contacts (how to contact us, including how to reach Customer Service at the plan)

How to contact our plan's Customer Service

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

Method	Customer Service – Contact Information
CALL	1-800-843-4876 Calls to this number are free. Available from 8:30 a.m. to 5:00 p.m. Eastern Time, Monday through Friday. Customer Service also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. Available from 8:30 a.m. to 5:00 p.m. Eastern Time, Monday through Friday.
FAX	1-866-624-1090
WRITE	Blue Cross Blue Shield of Michigan Medicare Plus Blue Group PPO Customer Service Inquiry Department – Mail Code X521 600 E. Lafayette Blvd. Detroit, MI 48226-2998
WEBSITE	**www.bcbsm.com/statemedicare**

How to contact us when you are asking for a coverage decision, or making an appeal or complaint 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.

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 asking for coverage decisions, making an appeal or complaint about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

You may call us if you have questions about our coverage decision process, appeals, and complaints.

Method	Coverage Decisions, Appeals, and Complaints about Medical Care – Contact Information
CALL	1-800-843-4876 Calls to this number are free. Available from 8:30 a.m. to 5:00 p.m. Eastern Time, Monday through Friday. Customer Service also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. Available from 8:30 a.m. to 5:00 p.m. Eastern Time, Monday through Friday.
FAX	1-877-348-2251
WRITE	Blue Cross Blue Shield of Michigan Grievances and Appeals Department P.O. Box 2627 Detroit, MI 48231-2627
MEDICARE WEBSITE	You can submit a complaint about Medicare Plus Blue Group PPO directly to Medicare. To submit an online complaint to Medicare, go to **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

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, 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	1-800-843-4876 Available 8:30 a.m. to 5:00 p.m. Eastern Time, Monday through Friday. Calls to this number are free.
TTY	711 Available from 8:30 a.m. to 5:00 p.m. Eastern Time, Monday through Friday. Calls to this number are free.
WRITE	Blue Cross Blue Shield of Michigan Medicare Plus Blue Group PPO Customer Service Inquiry Department – Mail Code X521 600 E. Lafayette Blvd. Detroit, MI 48226-2998
WEBSITE	Medical form available at: **www.bcbsm.com/content/dam/microsites/medicare/documents/medical-claim-form-ppo.pdf**

SECTION 2 Medicare (how to get help and information directly from the Federal Medicare program)

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

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (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.
TTY	1-877-486-2048

Method	Medicare – Contact Information
	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 booklets you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about Medicare Plus Blue Group PPO: • **Tell Medicare about your complaint:** You can submit a complaint about Medicare Plus Blue Group PPO directly to 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, print it out, and send it to 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/Medicaid Assistance Program.

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

Michigan Medicare/Medicaid Assistance Program counselors can help you with your Medicare questions or problems. They 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/Medicaid Assistance Program counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

METHOD TO ACCESS SHIP and OTHER RESOURCES:

- Visit *www.medicare.gov*
- Click on "**Forms, Help, and Resources**" on far right of menu on top
- In the drop down click on "**Phone Numbers & Websites**"
- You now have several options
    - Option #1: You can have a **live chat**
    - Option #2: You can click on any of the "**TOPICS**" in the menu on bottom
    - Option #3: You can select your **STATE** from the dropdown menu and click GO. This will take you to a page with phone numbers and resources specific to your state.

Method	Michigan Medicare/Medicaid Assistance Program – Contact Information
CALL	1-800-803-7174 Available from 8:30 a.m. to 4:45 p.m. Eastern Time, Monday through Friday
TTY	711

Method	Michigan Medicare/Medicaid Assistance Program – Contact Information
WRITE	Michigan Medicare/Medicaid Assistance Program 6105 W. St Joseph Hwy., Suite 204 Lansing, MI 48917-4850
WEBSITE	**www.mmapinc.org**

State Health Insurance Assistance Programs in other states are listed in *Exhibit 1* of the Appendix.

SECTION 4 Quality Improvement Organization
(paid by Medicare to check on the quality of care for people with Medicare)

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 the federal government. This organization is 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 Calls to this number are free. Monday - Friday: 9:00 a.m. to 5:00 p.m. (local time) Saturday - Sunday: 11:00 a.m. to 3:00 p.m. (local time) 24 hour voicemail service is available

TTY	1-888-985-8775 Monday through Friday: 9:00 a.m. to 5:00 p.m. (local time) Saturday and Sunday: 11:00 a.m. to 3:00 p.m. (local time) 24 hour voicemail service is available 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
WEBSITE	**www.livantaqio.com**

Quality Improvement Organizations in other states are listed in *Exhibit 2* of the Appendix.

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 ESRD 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 7:00 a.m. to 7:00 p.m., 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 7:00 a.m. to 7:00 p.m., Monday through Friday.
WEBSITE	**www.ssa.gov**

SECTION 6 Medicaid
(a joint federal and state program that helps with medical costs for some people with limited income and resources)

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.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These “Medicare Savings Programs” help people with limited income and resources save money each year:

- **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 the Michigan Department of Health and Human Services.

Method	Michigan Department of Health and Human Services, Michigan Medicaid – Contact Information
CALL	1-800-642-3195 8:00 a.m. – 7:00 p.m. Eastern time, Monday – Friday Hearing impaired callers may contact the Michigan Relay Center at 711.
WRITE	Michigan Department of Health and Human Services 333 S. Grand Ave P.O. Box 30195 Lansing, MI 48909
WEBSITE	**www.michigan.gov/medicaid**

Medicaid programs in other states are listed in *Exhibit 3* of the Appendix.

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 have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

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.

Method	Railroad Retirement Board – Contact Information
CALL	1-877-772-5772 Calls to this number are free. If you press "0," you may speak with an RRB representative from 9:00 a.m. to 3:00 p.m., Monday through Friday.
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) get benefits from your (or your spouse’s) employer or retiree group as part of this plan, you may call ORS, Monday – Friday, 8:30 a.m. – 5:00 p.m. or Customer Service if you have any questions. You can ask about your (or your spouse’s) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Customer Service are printed on the back cover of this booklet.) 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. If you (or your spouse) are enrolled in other group health insurance from an employer or a retiree group other than the State of Michigan Employees’ Retirement System, you may not be eligible for enrollment in this plan and you must contact ORS at 1-800-381-5111 to discuss your health coverage options.

CHAPTER 3

Using the plan's coverage for your medical services

Chapter 3. Using the plan's coverage for your medical services

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

This chapter explains what you need to know about using the plan to get your medical care coverage. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, 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"?

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

- **"Providers"** are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- **"Network providers"** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We 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, Medicare Plus Blue Group PPO must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

Medicare Plus Blue Group PPO 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 booklet).
- **The care you receive is considered 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.
- **You receive your care from a provider who is eligible to provide services under Original Medicare.** As a member of our plan, you can receive your care from

either a network provider or an out-of-network provider (for more about this, see Section 2 in this chapter).

- The providers in our network are listed in the *Provider Directory* (Michigan) or *Provider Locator* (outside Michigan).
- If you use an out-of-network provider, your share of the costs for your covered services may be higher.
- **Please note:** While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you go to a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

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

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

A specialist is a doctor who provides 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.

It is important to know what Medicare 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 Medicare does not cover the service. Medicare Plus Blue Group PPO members do not need prior authorization to see a specialist. See the Medical Benefits Chart in Chapter 4 for services which may require prior authorization.

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

We may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave 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 make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- 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 an appeal of our decision.
- 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 have questions regarding this process or need to locate a new provider in your area, you may contact Customer Service at the phone number on the back cover of this booklet.

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

As a member of our plan, you can choose to receive care from out-of-network providers. However, please note providers that do not contract with us are under no obligation to treat you, except in emergency situations. Our plan will cover most services from either in-network or out-of-network providers, as long as the services are covered benefits and are medically necessary. However, **if you use an out-of-network provider, your share of the costs for your covered services may be higher.** Here are other important things to know about using out-of-network providers:

- You can get your care from an out-of-network provider; however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you receive care from a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.
- You don't need to get a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers you may want to ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary. (See Chapter 7, Section 4 for information about asking for coverage decisions.) This is important because:
    - Without a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 7 *(What to do if you have a problem or complaint)* to learn how to make an appeal.

- It is best to ask an out-of-network provider to bill the plan first. But, if you have already paid for the covered services, we will reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill that you think we should pay, you can send it to us for payment. See Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services*) for information about what to do if you receive a bill or if you need to ask for reimbursement.
- If you are using an out-of-network provider for emergency care, urgently needed services, or out-of-area dialysis, you may not have to pay a higher cost-sharing amount. See Section 3 for more information about these situations.

SECTION 3 How to get covered 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 loss of life, 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.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your primary care provider.

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the United States, its territories, and worldwide urgently needed services. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Medical Benefits Chart in Chapter 4 of this booklet.

Our plan offers worldwide emergency and urgent coverage. See the Medical Benefits Chart in Chapter 4 for details.

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan. If you get your follow-up care from out-of-network providers, you will pay the higher out-of-network cost-sharing.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If it turns out that it 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, the amount of cost sharing that you pay will depend on whether you get the care from network providers or out-of-network providers. If you get the care from network providers, your share of the costs will usually be lower than if you get the care from out-of-network providers.

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

What are "urgently needed services"?

"Urgently needed services" are non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.

What if you are in the plan's service area when you have an urgent need for care?

In most situations, if you are in the plan's service area and you use an out-of-network provider, you will pay a higher share of the costs for your care. In-network care can be received at urgent care centers, providers' offices or hospitals. For information on accessing in-network urgently needed services, contact Customer Service (phone numbers are printed on the back cover of this booklet). You may also refer to our plan's website at **www.bcbsm.com/statemedicare**.

What if you are <u>outside</u> the plan's service area when you have an urgent need for care?

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 at the lower in-network cost-sharing amount. Our plan covers worldwide emergency and urgent care services outside the United States under the following circumstances:

- **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)

- **Emergency transportation** (transportation needed immediately because a 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: **www.bcbsm.com/statemedicare** for information on how to obtain needed care during a disaster.

Generally, 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 covered 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 share 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

Medicare Plus Blue Group PPO covers all medical services that are medically necessary. These services are listed in the plan's Medical Benefits Chart (this chart is in Chapter 4 of this booklet), and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services, or plan rules were not followed.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. You also have the right to ask for this in writing. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Customer Service to get more information (phone numbers are printed on the back cover of this booklet).

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. Once your benefit limitation has been reached, these additional services will not be applied toward your out-of-pocket maximum. You can call Customer Service when you want to know how much of your benefit limit you have already used.

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. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. 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*.

Once Medicare approves the study, 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. 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 a Medicare-approved clinical research study, you do *not* need 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.

Although you do not need to get our plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study.**

If you plan on participating in a clinical research study, contact Customer Service (phone numbers are printed on the back cover of this booklet) to let them know that you will be

participating in a clinical trial and to find out more specific details about what your plan will pay.

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

Once you join a Medicare-approved clinical research study, you are covered for 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

Original Medicare pays most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost for these services, our plan will also pay for part of the costs. We will pay the difference between the cost sharing in Original Medicare and your 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.

> *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 we would pay another $10. This means that you would pay $10, which is the same amount you would pay under our plan's benefits.

In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the study and how much you owe. Please see Chapter 5 for more information about submitting requests for payment.

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 and services the study gives you or any participant for free.
- 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.

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/Pubs/pdf/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 covered 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. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

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

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 Will you own the durable medical equipment after making a certain number of payments under 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 Medicare Plus Blue Group PPO, however, you usually will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan. Under certain limited circumstances we will transfer ownership of the DME item to you. Call Customer Service (phone numbers are printed on the back cover of this booklet) to find out about the requirements you must meet and documentation you need to provide. In most circumstances, even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan, you will not acquire ownership no matter how many copayments you make for the item while a member of our plan.

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. Payments you made while in our plan do not count toward these 13 consecutive payments.

If you made fewer than 13 payments for the DME item under Original Medicare *before* you joined our plan, your previous payments also do not count toward the 13 consecutive payments. You will have to make 13 new consecutive payments after you return to Original Medicare in order to own the item. There are no exceptions to this case when you return to Original Medicare.

SECTION 8 Rules for Oxygen Equipment, Supplies, and Maintenance

Section 8.1 What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage, then for as long as you are enrolled, Medicare Plus Blue Group PPO will cover:

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

If you leave Medicare Plus Blue Group PPO or no longer medically require oxygen equipment, then the oxygen equipment must be returned to the owner.

Section 8.2 What is your cost sharing? Will it change after 36 months?

Your cost sharing for Medicare oxygen equipment is covered up to 100% of the approved amount.

Your cost sharing will not change after being enrolled for 36 months in Medicare Plus Blue Group PPO.

If prior to enrolling in Medicare Plus Blue Group PPO you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in Medicare Plus Blue Group PPO is covered up to 100% of the approved amount.

Section 8.3 What happens if you leave your plan and return to Original Medicare?

If you return to Original Medicare, then you start a new 36-month cycle which renews every five years. For example, if you had paid rentals for oxygen equipment for 36 months prior to joining Medicare Plus Blue Group PPO, join Medicare Plus Blue Group PPO for 12 months, and then return to Original Medicare, you will pay full cost sharing for oxygen equipment coverage.

Similarly, if you made payments for 36 months while enrolled in Medicare Plus Blue Group PPO and then return to Original Medicare, you will pay full cost sharing for oxygen equipment coverage.

CHAPTER 4

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

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 focuses on your covered services and what you pay for your medical benefits. It includes a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of Medicare Plus Blue Group PPO. Later in this chapter, you can find information about medical services that are not covered.

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

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

- The **"deductible"** (if applicable) is the amount you must pay for medical services before our plan begins to pay its share.
- A **"copayment"** is the 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 the percentage you pay of the total cost of certain medical services after your annual deductible has been met. (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. If you think that you are being asked to pay improperly, contact Customer Service.

Section 1.2 What is your plan deductible?

Your deductible is $400. This is the amount you have to pay out-of-pocket before we will pay our share for your covered medical services. Until you have paid the deductible amount, you must pay the full cost for most of your covered services. (The deductible does not apply to the services listed below.) Once you have paid your deductible, we will begin to pay our share of the costs for covered medical services and you will pay your share (your copayment or coinsurance amount) for the rest of the calendar year or until your out-of-pocket maximum has been met, whichever comes first.

The deductible does not apply to some services, including certain in-network preventive services. This means that we will pay our share of the costs for these services even if you haven't paid your deductible yet. The deductible does not apply to the following services:

- There is no in- or out-of-network deductible for: Emergency Services, all Medicare zero-cost preventive services, or Urgent Care.

- For all Medicare Plus Blue (PPO) plans, the deductible does not apply to those services not covered by Original Medicare.

Section 1.3 What is the most you will pay for Medicare Part A and Part B covered medical services?

The State of Michigan Employees' Retirement System has a limit to how much you have to pay out-of-pocket each year for certain Medicare Part A and Part B covered medical services. After this level is reached, you will have 100% coverage for these services and will not have to pay any out-of-pocket costs for these services for the remainder of the year. You will continue to pay your premium as required by the retirement system. See your Medical Benefits Chart in this chapter for information on annual out-of-pocket maximum amounts that apply to your plan.

Section 1.4 Our plan does not allow providers to "balance bill" you

As a member of Medicare Plus Blue Group PPO, an important protection for you is that after you meet any applicable deductibles, you only have to pay your cost-sharing amount when you get services covered by our plan. 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.

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. You will generally have higher copays when you obtain care from out-of-network providers.

- If your cost sharing is a coinsurance (a percentage of the total charges), then you never pay more than that 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.

    - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.

- If you believe a provider has “balance billed” you, call Customer Service (phone numbers are printed on the back cover of this booklet).

SECTION 2 Use the Medical Benefits Chart to find out what is covered for you 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 Medicare Plus Blue Group PPO covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, and equipment) 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.
- Some of the services listed in the Medical Benefits Chart are covered as in-network services only if your doctor or other network provider gets approval in advance (sometimes called “prior authorization”) from Medicare Plus Blue Group PPO.
    - Covered services that need approval in advance to be covered as in-network services are marked by an asterisk in the Medical Benefits Chart.
    - You never need approval in advance for out-of-network services from out-of-network providers.
    - While you don’t need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.

Other important things to know about our coverage:

- For benefits where your cost sharing is a coinsurance percentage, the amount you pay depends on what type of provider you receive the services from:
    - 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.
- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2022* 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.
- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2022, either Medicare or our plan will cover those services.

In-network and Out-of-network providers: The following types of providers may administer services under the State Health Plan MA PPO:

- In-network providers who participate in the Blue Cross Medicare Advantage PPO network
- Out-of-network providers who participate with Original Medicare and agree to submit their claim to Blue Cross for the Medicare reimbursement
- Out-of-network providers that will not accept either your Medicare Advantage card or Original Medicare are only allowed to administer Emergency Services.

Annual out-of-pocket amounts that apply to your plan

Deductible: $400 per member, $800 per family

Cost share: After you have met your deductible, you are responsible for the coinsurance, a percentage of the Blue Cross allowed amount. Coinsurance is not the same as your deductible, but your Medicare Advantage plan pays the Medicare coinsurance for services covered under the State Health Plan MA PPO.

Out-of-pocket maximum: $2,000 per member, $4,000 per family. The out-of-pocket maximum is the dollar amount you pay in deductible, copay, and coinsurance during the calendar year. Once you satisfy your out-of-pocket maximum, the State Health Plan MA PPO will cover 100% of the allowed amount for covered services, including coinsurances for behavioral health and substance use disorder and prescription drug copays under the State Prescription Drug plan.

Certain coinsurance, deductible, and other charges cannot be used to meet your out-of-pocket maximum. These coinsurance, deductible, and other charges are:

- Charges for noncovered services
- Charges in excess of our approved amount
- Deductibles or copayments required under other Blue Cross coverage

All Part A and Part B deductibles and cost-share amounts apply to the annual out-of-pocket maximum (OOPM).

Benefit provisions, including copays, deductibles and coinsurance may change based on new and/or changed regulatory guidance issued by the Centers for Medicare and Medicaid. Limitations and restrictions may apply. Please contact your health plan administrator for further information regarding your benefits.

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

Medical Benefits Chart

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 is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered 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, etc. disease); • 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 improving or 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.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Acupuncture for chronic low back pain (continued) 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: • 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 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 • Non-emergency transportation by ambulance* is appropriate if it is 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 • Covers transport of a hospice patient to their home before enrolling in a Medicare-certified hospice program.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Ambulance services* (continued) **Note:** Please see the Exclusions Chart in Chapter 4, Section 3.1 of this booklet. *In-network non-emergency services may require prior authorization; your plan provider will arrange for this authorization, if needed.	
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **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, copayment, or deductible for the annual wellness visit. However, you will be assessed a coinsurance, copayment or deductible if a covered service (e.g., diagnostic test) is outside of 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 have a medical condition or further testing is required, the procedure and/or the subsequent testing is considered diagnostic and your contractual cost sharing for Medicare-covered services will apply.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram, including 3-D mammograms, every 12 months for women age 40 and older	There is no coinsurance, copayment, or deductible for covered screening mammograms. If you have a medical condition, a follow-up (second) mammogram and/or biopsy on a separate day from the screening, the procedure is considered diagnostic and your

Services that are covered for you	What you must pay when you get these services
Breast cancer screening (mammograms) (continued) • Clinical breast exams once every 24 months See Chapter 10 (*Definition of important words*) in the *Evidence of Coverage* for a definition of a mammogram screening.	contractual cost sharing for Medicare-covered services will 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.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the cardiovascular disease risk reduction preventive benefit.
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, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 12 months	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.

Services that are covered for you	What you must pay when you get these services
Cervical and vaginal cancer screening (continued) • 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	

Chiropractic services
Covered services include:
• Manual manipulation of the spine to correct subluxation
• Office visits
• Evaluation and management services
  ○ For new patients, one visit covered every 3 years
  ○ For established patients, one visit covered every year
Your plan includes additional chiropractic services. See **Additional Benefits** for a description and cost sharing.
	In-network and Out-of-network providers who accept the Medicare Advantage card:
	You pay a $20 copayment. Not subject to the deductible. These services apply to the annual out-of-pocket maximum.

Colorectal cancer screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months One of the following every 12 months: • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. If you have a medical condition, such as gastrointestinal symptoms, or further testing is required, the procedure and/or subsequent testing is considered diagnostic and your contractual cost sharing for Medicare-covered surgical services will apply. When a physician performs a screening colonoscopy and nothing is found, the deductible and procedure copay are waived; however, an office visit copay may apply if additional conditions are discussed at the visit.

Services that are covered for you	What you must pay when you get these services
Colorectal cancer screening (continued) For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy Outpatient surgery coinsurance apply to diagnostic colonoscopies (a colonoscopy performed to diagnose a medical problem), which are not considered colorectal cancer screenings. If a physician performs a screening colonoscopy and a polyp or abnormality is found, the procedure is now considered a diagnostic procedure per Medicare guidelines. See Chapter 10 (*Definition of important words)* for a definition of a colonoscopy screening.	
Complete blood count screening Covered once per calendar year	There is no coinsurance, copayment, or deductible for a complete blood count screening.
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental X-rays) are not covered by Original Medicare. We cover *Medicare-covered* dental services *only*. 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. Medicare Plus Blue Group PPO 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.

Services that are covered for you	What you must pay when you get these services
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.
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. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.
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	**In-network and Out-of-network providers who accept the Medicare Advantage card:** Services are covered up to 100% of the approved amount for diabetic services, diabetic shoes and inserts, and supplies. For diabetes self-management training, you pay 2% of the approved amount, after deductible. These services apply to the annual out-of-pocket maximum. If you receive other services during the visit, your copay or coinsurance may apply.

Services that are covered for you	What you must pay when you get these services
Diabetes self-management training, diabetic services and supplies* (continued) • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions. **Note:** For all people who have diabetes and use insulin, covered services include: approved therapeutic continuous glucose monitors and supply allowance for the therapeutic continuous glucose monitor as covered by Original Medicare. *Diabetic services and supplies may require prior authorization; your plan provider will arrange for this authorization, if needed.	
Durable medical equipment (DME) and related supplies* (For a definition of “durable medical equipment,” see Chapter 10 of this booklet.) 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/providersmedicare**.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** Services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Durable medical equipment (DME) and related supplies* (continued) **Note:** You must have a prescription or a Certificate of Medical Necessity from your doctor to obtain Durable Medical Equipment (DME) or Prosthetic and Orthotic (P&O) items and services. *Durable medical equipment and related supplies may require prior authorization; your plan provider will arrange for this authorization, if needed.	
EKG and ECG diagnostic testing Covered once per calendar year.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.
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, 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. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** For emergency room care, you pay a $50 copayment (waived if admitted within three days). Not subject to the deductible. These services apply to the annual out-of-pocket maximum. Emergency room physician services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Emergency care (continued) **Worldwide Coverage** Medicare Plus Blue Group PPO includes coverage of emergent or urgently needed medical items and services furnished outside of the United States and its territories. *Outside the U.S.* You may be responsible for the difference between the approved amount and the provider's charge.	

Health and wellness education programs
Supplemental programs designed to enrich the health and lifestyles of members.
The plan covers the following supplemental education and wellness programs:
• Telemonitoring Services
  ○ Members who are diagnosed with heart failure, COPD or diabetes may be targeted for the remote monitoring intervention.
  ○ Members in the program will be sent a symptom appropriate monitor and provided with the support needed to operate it.
• Tobacco Cessation Coaching: A 12-week telephone-based program administered by WebMD® Health Services that provides counseling and support for members suffering from all forms of tobacco addiction and empowers them to successfully quit using tobacco products. Program includes intervention via telephone-based coaching provided by specially trained health coaches. There is not a limit to the number of calls the member can make within the 12-week program.
	There is no coinsurance, copayment, or deductible for health and wellness education programs.

Services that are covered for you	What you must pay when you get these services
Health and wellness education programs (continued) • Tivity Health™ SilverSneakers® fitness program (see Additional Benefits).	
Hearing services Medicare-covered hearing services include diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment. These are covered when furnished by a physician, audiologist, or other qualified provider. Diagnostic hearing and balance exam – 1 per year Your plan includes both the routine hearing exam and hearing aids benefits. See **Additional Benefits** for a description and cost sharing.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay a $20 copayment. Not subject to the deductible. These services apply to your annual out-of-pocket maximum.
Hepatitis C screening For people who are at high risk for Hepatitis C infection, including persons with a current or 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, copayment, or deductible for beneficiaries eligible for Medicare-covered preventive Hepatitis C screening.
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	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.

Services that are covered for you	What you must pay when you get these services
HIV screening (continued) For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	
Home health agency care (non-DME)* 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) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies *Home health agency care services may require prior authorization; your plan provider will arrange for this authorization, if needed.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** Services are covered up to 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 (DME) and related supplies.** Please Note: Custodial care is not the same as home health agency care. For more information, see Custodial Care in the Exclusions List in Chapter 4, Section 3.1 of this document.
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).	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 10% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Home infusion therapy (continued) 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 Your plan includes additional home infusion therapy services. See **Additional Benefits** for a description and cost sharing.	
Hospice care You may receive care from any Medicare-certified hospice program. 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. 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 enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Medicare Plus Blue Group PPO. You may be asked to provide your Original Medicare beneficiary identifier number off your red, white, and blue Medicare card.

Services that are covered for you	What you must pay when you get these services
Hospice care (continued) For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. 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 covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network: • If you obtain the covered services from a network provider, 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 plan cost sharing for out-of-network services For services that are covered by Medicare Plus Blue Group PPO but are not covered by Medicare A or B: Medicare Plus Blue Group PPO 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 the services.	

Services that are covered for you	What you must pay when you get these services
Immunizations Dosage and frequency for immunizations follows Centers for Disease Control and Prevention guidelines. • Flu shots, each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • Immunizations • Meningococcal shots • Pneumococcal shots • Shingles vaccine ○ **Note:** The shingles vaccine is covered with no restrictions when provided by a licensed physician under Part B. • Yellow fever vaccine • COVID-19 vaccine • Other vaccines if you are at risk and they meet the Medicare Part B coverage rules	There is no coinsurance, copayment, or deductible for immunizations.
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	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum. You have an unlimited number of medically necessary inpatient hospital days. Medicare-approved clinical lab services and preventive services are covered at 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Inpatient hospital care* (continued) • Costs of special care units (such as intensive care or coronary care units) • 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 • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. • Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Medicare Plus Blue Group PPO provides transplant services at a location outside the pattern of care for transplants in your community, and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. Coverage is up to $10,000; travel and lodging is covered for only one year after the initial transplant (includes up to five additional days prior to the initial transplant).	

Services that are covered for you	What you must pay when you get these services
Inpatient hospital care* (continued) Outside of the service area is defined as 100 miles or more, one-way to the facility, from your home address. • Blood – including storage and administration. Coverage of whole blood and packed red cells begins 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 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 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 **www.medicare.gov/Pubs/pdf/11435-Are-You-an-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. Your plan includes additional travel and lodging coverage. See **Additional Benefits** for a description and cost sharing.	
Inpatient mental health care* Covered services include mental health care services that require a hospital stay.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** Services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Inpatient mental health care* (continued) *Inpatient mental health/behavioral health services may require prior authorization; your plan provider will arrange for this authorization, if needed.	You have an unlimited number of medically necessary inpatient hospital days.
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 orthotic devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses; and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition. • Physical therapy*, speech therapy*, and occupational therapy*	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum. Medicare-approved clinical lab services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay (continued) *Physical, speech, and occupational therapy services may require prior authorization; your plan provider will arrange for this authorization, if needed.	
Inpatient substance use disorder care* Covered services include substance use disorder care services that require a hospital stay. *Inpatient substance use disorder services may require prior authorization; your plan provider will arrange for this authorization, if needed.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** Services are covered up to 100% of the approved amount. You have an unlimited number of medically necessary inpatient hospital days.
Lead screening Covered once per calendar year.	There is no coinsurance, copayment or deductible for lead screenings.
Lipid disorders screening Covered once per calendar year.	There is no coinsurance, copayment or deductible for lipid disorders screenings.
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, copayment, or deductible for beneficiaries eligible for Medicare-covered medical nutrition therapy services.

Services that are covered for you	What you must pay when you get these services
Medicare Diabetes Prevention Program (MDPP) 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.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
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 • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the same time of the organ transplant • 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 • Antigens (allergy injections) • Certain oral anti-cancer drugs and anti-nausea drugs	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum. Services are covered up to 100% of the approved amount for drugs used in covered durable medical equipment, certain oral anti-cancer and anti-nausea drugs, and certain immunosuppressive drugs following a Medicare-covered transplant.

Services that are covered for you	What you must pay when you get these services
Medicare Part B prescription drugs* (continued) • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • We also cover some vaccines under our Part B prescription drug benefit. • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Covered Part B drugs that may be subject to step therapy include: o Anti-cancer agents and cancer-supportive therapy agents o Anti-gout agents o Anti-inflammatory agents o Antirheumatic agents o Antispasticity agents o Bisphosphonates o Blood products o Gastrointestinal agents o Immunosuppressive agents o Knee injections o Ophthalmic agents o Respiratory agents The following link will take you to a list of Part B drugs that may be subject to Step Therapy: **www.bcbsm.com/content/dam/public/Providers/Documents/ma-ppo-bcna-medical-drugs-prior-authorization.pdf**	

Services that are covered for you	What you must pay when you get these services
Medicare Part B prescription drugs* (continued) *Medicare Part B drugs may require prior authorization; your plan provider will arrange for this authorization, if needed.	
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling up to 22 sessions over a 12-month period 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.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
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	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 2% of the approved amount. Not subject to the deductible. These services apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these 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 and all other components of blood are covered beginning with the first pint used. • Other outpatient diagnostic tests including sleep studies • High-tech radiology services (e.g., CT scans, echocardiography, MRAs, MRIs, PET scans, or nuclear medicine) rendered by plan providers require prior authorization. **Note:** For Medicare-covered diagnostic radiological services and Medicare-covered X-ray services performed in an outpatient setting, refer to Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers. *Outpatient diagnostic tests and therapeutic services may require prior authorization; your plan provider will arrange for this authorization, if needed.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.
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.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** Services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Outpatient hospital observation (continued) For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at **www.medicare.gov/Pubs/pdf/11435-Are-You-an-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 • X-rays and other radiology services billed by the hospital	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum. For emergency room care, you pay a $50 copayment (waived if admitted within three days). Not subject to the deductible. These services apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Outpatient hospital services* (continued) • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you 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 **www.medicare.gov/Pubs/pdf/11435-Are-You-an-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. You may receive other services while in observation or an outpatient hospital facility. The cost for those services can be found in this Medical Benefits Chart. *Outpatient hospital services may require prior authorization; your plan provider will arrange for this authorization, if needed.	Emergency room physician services are covered up to 100% of the approved amount. For rural health clinic and Federally Qualified Health Clinic, you pay a $20 copayment. Not subject to the deductible. These services apply to the annual out-of-pocket maximum. Outpatient clinics owned and operated by hospitals (known as hospital-based practices) may cost you more.
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, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 2% of the approved amount. Not subject to the deductible. These services apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Outpatient mental health care* (continued) *Outpatient mental/behavioral health services may require prior authorization; your plan provider will arrange for this authorization, if needed.	
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 Comprehensive Outpatient Rehabilitation Facilities (CORFs). *Outpatient rehabilitation services may require prior authorization; your plan provider will arrange for this authorization, if needed.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.
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 mental/substance use disorder services may require prior authorization; your plan provider will arrange for this authorization, if needed.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 2% of the approved amount. Not subject to the deductible. These services apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Outpatient surgery*, including services provided at a hospital outpatient facilities and ambulatory surgical centers Outpatient clinics owned and operated by hospitals (known as hospital-based practices) may cost you more. **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. Even if you stay in the hospital overnight, you might still be considered an "outpatient." *Outpatient surgery services, including services provided at hospital outpatient facilities and ambulatory surgical centers, may require prior authorization; your plan provider will arrange for this authorization, if needed.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.
Partial hospitalization 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 or therapist's office and is an alternative to inpatient hospitalization. *Partial hospitalization services may require prior authorization; your plan provider will arrange for this authorization, if needed.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** Services are covered up to 100% of the approved amount.

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

Physician/Practitioner services, including doctor's office visits
Covered services include:
• Medically-necessary medical care or surgery services furnished in a physician's office, patient's home for evaluation and management, certified ambulatory surgical center, hospital outpatient department, or any other location
• Consultation, diagnosis, and treatment by a specialist
• Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment
• Certain telehealth services, including those for primary care physician 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
  ○ You can use Blue Cross Online visits to access telehealth services. Visit **www.bcbsmonlinevisits.com** for more information.
• 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.
	In-network and Out-of-network providers who accept the Medicare Advantage card:
	For medically necessary medical care or surgical services, you pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.
	For medical office visits, furnished in a physician's office or hospital outpatient department, you pay a $20 copayment. Not subject to the deductible. These services apply to the annual out-of-pocket maximum.
	For medical office visits furnished in a patient's home or any other location, you pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.
	For office visits for mental health or substance use disorder services, you pay 2% of the approved amount. Not subject to the deductible. These services apply to the annual out-of-pocket maximum.
	An annual physical exam is covered up to 100% of the approved amount.
	For diagnostic hearing and balance exams performed by your primary care provider or specialist, you pay a $20 copayment. Not subject to the deductible. These services apply to the annual out-of-pocket maximum.
	If a biopsy or removal of a lesion or growth is performed during an office visit, these procedures are considered diagnostic and you will be responsible for the Medicare-covered surgical

Services that are covered for you	What you must pay when you get these services
Physician/Practitioner services, including doctor's office visits (continued) • 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. • 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 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 • Consultation your doctor has with other physicians via telephone, internet, or electronic health record **if** you are an established patient • Second opinion by another network provider prior to surgery	service cost share in addition to your office visit copayment. **Telehealth services offered using your provider's online tool:** For mental health and substance use disorder services, you pay 2% of the approved amount. Not subject to the deductible. These services apply to the annual out-of-pocket maximum. For other services, you pay a $20 copayment. Not subject to the deductible. These services apply to the annual out-of-pocket maximum. **Telehealth services offered using the Blue Cross online tool powered by American Well®:** For mental health and substance use disorder services, you pay a $10 copayment or 10% of the approved amount, whichever is less. Not subject to the deductible. These services apply to the annual out-of-pocket maximum. For other services, you pay a $10 copayment. Not subject to the deductible. These services apply to the annual out-of-pocket maximum. See **Telehealth (Online Visits)** for details.

Services that are covered for you	What you must pay when you get these services
Physician/Practitioner services, including doctor's office visits (continued) • 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) • One routine physical exam per year • Total body skin examination performed by a trained health care professional, usually a dermatologist, to search for any unusual or suspicious lesions or conditions on the skin's surface, including hands and arms, legs and feet, torso, scalp, inside of the mouth and external genital area. Covered once in a lifetime **Note:** Provider offices or outpatient clinics owned and operated by hospitals (known as hospital-based practices) may cost you more.	
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 • One routine foot exam every six months for diabetes-related nerve damage and certain other conditions **Note:** For services other than specialist office visits, refer to the following sections of this benefit chart for member cost sharing: • Physician/Practitioner services, including doctor's office visits	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum. Toenail clipping is an Outpatient Surgical service. You pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum. For more information, see **Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers**.

Services that are covered for you	What you must pay when you get these services
Podiatry services* (continued) • Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers • Outpatient diagnostic tests and therapeutic services and supplies *Podiatry services may require prior authorization; your plan provider will arrange for this authorization, if needed.	
Prostate cancer screening exams For men age 50 and older, covered services include the following – once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for an annual PSA test or a digital rectal exam.
Prosthetic 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 protheses (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. Your plan offers additional coverage for orthopedic shoes and orthotic inserts beyond diabetic foot disease, based on medical necessity. A medical diagnosis is required to obtain the shoes and/or inserts.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** Services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Prosthetic devices and related supplies* (continued) • Orthopedic shoes – covered one per year or two (individual) shoes per year • Shoe inserts – covered either two inserts every 3 years or two inserts every year, depending on type of insert **Note:** You must have a prescription or a Certificate of Medical Necessity from your doctor to obtain Prosthetic and Orthotic (P&O) items and services. *Prosthetic devices and related supplies may require prior authorization; your plan provider will arrange for this authorization, if needed.	
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.
Screening and counseling to reduce alcohol misuse We cover one 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 four 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.

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 enrollees are:** people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 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. *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 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.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.

Services that are covered for you	What you must pay when you get these services
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs (continued) We also cover up to two individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. 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.	
Services to treat kidney disease* Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • 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)	**In-network and Out-of-network who accept the Medicare Advantage card:** For dialysis services, you pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum. Kidney disease education services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Services to treat kidney disease* (continued) 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.** *Dialysis services may require prior authorization; your plan provider will arrange for this authorization, if needed.	
Skilled nursing facility (SNF) care* (For a definition of "skilled nursing care," see Chapter 10 of this booklet. Skilled nursing facilities are sometimes called "SNFs.") No prior hospital stay is required. 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 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	**In-network and Out-of-network providers who accept the Medicare Advantage card:** **For days 1-20:** Services are covered up to 100% of the approved amount. **For days 21-120:** You pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum. Plan covers up to 120 days for each confinement period.

Services that are covered for you	What you must pay when you get these services
Skilled nursing facility (SNF) care* (continued) • 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 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 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 two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four 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 as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.

Services that are covered for you	What you must pay when you get these services
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) (continued) Tobacco Cessation Coaching: A 12-week telephone-based program administered by WebMD® Health Services that provides counseling and support for members suffering from all forms of tobacco addiction and empowers them to successfully quit using tobacco products. Program includes intervention via telephone-based coaching provided by specially trained health coaches. There is not a limit to the number of calls the member can make within the 12-week program.	
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Supervised Exercise Therapy (SET) (continued) • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	
Telehealth (Online Visits) Remote access technologies give you the opportunity to meet with a health care provider through electronic forms of communication (such as online). This does not replace an in-person visit but allows you to meet with a health care provider when it is not possible for you to meet with your doctor in the office. To access a participating provider, log on at **www.bcbsmonlinevisits.com** • Certain telehealth services including diagnosis and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare. • Telehealth services for monthly ESRD-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 for diagnosis, evaluation or treatment of symptoms of an acute stroke.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** For mental health and substance use disorder services, you pay a $10 copayment or 10% of the approved amount, whichever is less. Not subject to the deductible. These services apply to the annual out-of-pocket maximum. For other services, you pay a $10 copayment. Not subject to the deductible. These services apply to the annual out-of-pocket maximum.
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay a $20 copayment. Not subject to the deductible. These

Services that are covered for you	What you must pay when you get these services
Urgently needed services (continued) Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Cost sharing for necessary urgently needed services furnished out-of-network is the same for such services furnished in-network. **Worldwide Coverage** Medicare Plus Blue Group PPO includes coverage of emergent or urgently needed medical items and services furnished outside of the United States and its territories. *Outside the U.S.:* You may be responsible for the difference between the approved amount and the provider's charge.	services apply to the annual out-of-pocket maximum.
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of disease 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 who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African Americans who are age 50 and older, and Hispanic Americans who are 65 or older. • For people with diabetes, screening for diabetic retinopathy is covered once per year.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** For diagnosis and treatment of conditions of the eye, you pay a $20 copayment. Not subject to the deductible. These services apply to the annual out-of-pocket maximum. Routine eye exams and eyeglasses are not covered by this plan. For corrective eyeglasses or contacts following cataract surgery, you pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Vision care (continued) • One pair of eyeglasses or contact lenses after cataract surgery that includes insertion of an intraocular lens (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.)	
"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, copayment, or deductible for the "Welcome to Medicare" preventive visit. However, you will be assessed a coinsurance, copayment or deductible if a covered service (e.g., diagnostic test) is outside of the scope of the "Welcome to Medicare" preventive visit.
Additional Benefits	
Acupuncture Includes up to 20 visits in a calendar year when performed or supervised and billed by a licensed physician Covers treatment of the following conditions only: • Sciatica • Neuritis • Postherpetic neuralgia • Tic douloureux • Chronic headaches such as migraines • Osteoarthritis	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 20% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Acupuncture (continued) • Rheumatoid arthritis • Myofascial complaints such as neck and lower back pain	
Adult briefs and incontinence liners We cover adult diapers and incontinence liners to provide effective bladder control protection. • There's a maximum count of 200 per month for adult diapers and briefs • There's no monthly maximum count for incontinence liners	**In-network and Out-of-network providers who accept the Medicare Advantage card:** Services are covered up to 100% of the approved amount.

Annual physical and gynecological 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 physician or other 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 intervention.
  ○ Administration or ordering of immunizations, lab tests or diagnostic procedures.
One routine gynecological exam
For all women, including those at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age. Pap and pelvic exams are covered once every 12 months.
	In-network and Out-of-network providers who accept the Medicare Advantage card:
	Services are covered up to 100% of the approved amount.
	However, you will be assessed a coinsurance, copayment or deductible if a covered service (e.g. a diagnostic test) is outside of 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 cost share in addition to your office visit copayment.

Services that are covered for you	What you must pay when you get these services
Behavioral health substance abuse – intensive outpatient programs* Intensive outpatient programs are a step-down level of care for individuals who have completed detox and residential treatment, so they can continue to receive the support of treatment programming without the need for 24-hour supervision. Covered services include: • Intensive outpatient psychiatric services • Intensive outpatient chemical dependency services *Behavioral health substance abuse – intensive outpatient programs may require prior authorization; your plan provider will arrange for this authorization, if needed. If treatment or service is denied, you will receive a written explanation of the reason, your right to appeal the denial, and the appeal process. You will not be held responsible for the charge if the denial is due to a lack of prior authorization.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** Services are covered up to 100% of the approved amount.
Chiropractic services • Spine X-rays, chiropractic radiology and chiropractic physical therapy services • Physical therapy massage: Limits and restrictions apply. Services must be performed by a licensed provider.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** For spine X-rays, chiropractic radiology and chiropractic physical therapy services, you pay 10% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum. For physical therapy massage, you pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Determination of refractive state Determination of refractive state is necessary for obtaining glasses and is covered under these circumstances: • A provider must identify your refractive state to determine an injury, illness or disease • An ophthalmologist or an optometrist must determine the refractive state for corrective lenses • Your refractive state is determined as part of a surgical procedure	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 10% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.
Gradient compression stockings and sleeves* We cover gradient compression stockings that squeeze the leg to reduce and prevent swelling as well as improve blood flow. We cover gradient compression sleeves that apply pressure to the arm, hand, or torso to keep lymph moving in the right direction. There's a maximum of: • 4 pairs of stockings OR 8 individual stockings per 12-month period • 2 compression sleeves per 12-month period *Gradient compression stockings and sleeves may require prior authorization; your plan provider will arrange for this authorization, if needed.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** Services are covered up to 100% of the approved amount.
Hearing aids 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 physician, audiologist, or other qualified provider.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** Standard (analog or basic) hearing aids are covered up to $2,600 every 36 months.

Services that are covered for you	What you must pay when you get these services
Hearing aids (continued) 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 You are responsible for the difference between the plan's benefit and the cost of the hearing aid(s). Excludes additional hearing aid batteries, repairs, adjustments, or reconfigurations.	
Hearing services Tests for hearing services when furnished by a physician, audiologist or other qualified provider: • An audiometric exam to measure hearing ability • An annual evaluation and conformity test	**In-network and Out-of-network providers who accept the Medicare Advantage card:** Services are covered up to 100% of the approved amount.
Home infusion therapy Home infusion therapy is the continuous, slow administration of a controlled drug, nutrient, antibiotic or other fluid into a vein or other tissue on a daily, weekly or monthly basis, depending on the condition being treated and type of therapy. Coverage for additional home infusion therapy service components are provided based on the member's condition. The additional Medicare Plus Blue home infusion therapy benefit provides coverage for the in-home administration of infusion therapy services when the Original Medicare coverage criteria are not met. Coverage is available when the infusion therapy is:	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 10% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.

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

Home infusion therapy (continued)
• Prescribed by a physician to:
  ○ Manage a chronic condition
  ○ Treat a condition that requires acute care if it can be managed safely at home
• Certified by the physician as medically necessary for the treatment of the condition
• Appropriate for use in the patient's home
• Medical IV therapy, injectable therapy or total parenteral nutrition therapy
• Chelation therapy, performed in the patient's home or a nursing home
Components of care available regardless of whether the patient is confined to the home:
• Nursing visits
• Durable medical equipment, medical supplies and solutions
• Catheter care
• Injectable therapy
• Drugs	

Hospice respite care – cost share for respite and drugs Drugs and biologicals • You are liable for a coinsurance payment for each palliative drug and biological prescription furnished by the hospice while you are not an inpatient.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** Services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Hospice respite care – cost share for respite and drugs (continued) • The amount of coinsurance for each prescription approximates five (5) percent of the cost of the drug or biological to the hospice determined in accordance with the drug copayment schedule established by the hospice, except that the amount of coinsurance for each prescription may not exceed $5.00. Respite care • Your coinsurance for each respite care day is equal to five (5) percent of the payment made by CMS for a respite care day. • The amount your coinsurance liability for respite care during a hospice coinsurance period may not exceed the inpatient hospital deductible applicable for the year in which the hospice coinsurance period began.	
Human organ transplants You have additional coverage for certain human organ transplants not covered by Original Medicare. These transplant procedures are included: • Skin	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 10% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.
Human organ transplants • Cornea • Kidney	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 2% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.

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

Human organ transplants – additional coverage
You have additional coverage for certain human organ transplants not covered by Original Medicare. These transplant procedures are included:
• Bone marrow and hematopoietic stem cell transplants when required for the following conditions:
  ○ Allogenic (from a donor) transplants for:
  ▪ Osteoporosis
  ▪ 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
  ▪ Ewing's sarcoma
  ▪ Medulloblastoma
  ▪ Wilms' tumor
  ▪ Primary amyloidosis
  ▪ Rhabdomyosarcoma
  ○ 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.
	In-network and Out-of-network providers who accept the Medicare Advantage card:
	Services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Human organ transplants – additional coverage (continued) 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.	
Non-medically necessary sterilization Sterilization is defined as the process of rendering barren. This is accomplished by surgical removal of testes or ovaries or inactivation by irradiation or by tying off or removing a portion of reproductive ducts (ductus deferens or uterine tubes)	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 10% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.
Private duty nursing We provide nursing to individuals who need skilled care and require individualized continuous 24-hour nursing care that's more intense than what is available under other benefits when ordered by a physician (M.D. or D.O.) who is involved with your ongoing care. • At least two trained caregivers (a family member, a friend, etc.) must be trained and competent to give care when the nurse is not in attendance. • The family or caregivers must provide at least 8 hours of skilled care/day. • Generally, more than 16 hours per day of Private Duty Nursing will not be approved. • However, up to 16 hours per day may be approved for up to 30 days while you are being transitioned from an inpatient setting to home.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 20% of the approved amount, after you meet your annual deductible. These services apply to the annual out-of-pocket maximum.

Services that are covered for you	What you must pay when you get these services
Private duty nursing (continued) Private duty nursing does not cover services provided by, or within the scope or practice of, medical assistants, nurse's aides, home health aides, or other non-nurse level caregivers. This benefit is not intended to supplement the care-giving responsibility of the family, guardian or other responsible parties.	
Self-administered drugs Self-administered drugs are medications that are usually self-administered by the patient, such as pills or those used for self-injection. These drugs are covered only when obtained in inpatient, outpatient and skilled nursing facility settings.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 10% of the approved amount, after you meet your annual deductible.
Temporomandibular joint dysfunction treatment services The following services are covered to treat temporomandibular joint dysfunction (TMJ): • Surgery directly related to the temporomandibular joint (jaw joint) and related anesthesia services • Arthrocentesis performed for the treatment of temporomandibular joint (jaw joint) dysfunction • Diagnostic X-rays (including MRIs) • Trigger point injections • Physical therapy (See Physical therapy services) • Reversible appliance therapy (mandibular orthotic repositioning device, such as a bite splint)	**In-network and Out-of-network providers who accept the Medicare Advantage card:** You pay 10% of the approved amount, after you meet your annual deductible.

Services that are covered for you	What you must pay when you get these services
Tivity Health™ 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: • At participating locations nationwide, you can take classes plus use exercise equipment and other amenities • SilverSneakers FLEX® gives you options to get active outside of traditional gyms (like recreation centers, malls, and parks) • SilverSneakers LIVE™ classes and workshops taught by instructors trained in senior fitness • 200+ workout videos in the SilverSneakers On-DemandTM online library • SilverSneakers GO™ mobile app with digital workout programs • Thousands of locations • Online fitness and nutrition tips • Social connections through events such as shared meals, holiday celebrations, and class socials Go to www.silversneakers.com to learn more or call 1-866-584-7352, 8:00 a.m. to 8:00 p.m. Eastern time, Monday through Friday. TTY users call 711.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** Services are covered at 100%. 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, 8:00 a.m. to 8:00 p.m. Eastern time, Monday through Friday. TTY users call 711.
Travel and lodging for covered transplants • The benefit period begins five days prior to the initial transplant and extends through the patient's transplant episode of care.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** Services are covered up to 100% of the approved amount.

Services that are covered for you	What you must pay when you get these services
Travel and lodging for covered transplants (continued) The transplant surgery must be performed at a Medicare-approved transplant facility. • 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. The maximum amount payable for travel and lodging services related to the initial solid organ transplant is $10,000.	
Weight loss For services to be covered, you must be at least fifty percent over your ideal weight* with a diagnosis of obesity or must be at least twenty five percent over your ideal body weight with a diagnosis of one of the following: • Diabetes • Fasting hyperglycemia • Cardiac insufficiency • Angina pectoris • History of myocardial infarction • Congestive heart failure • Respiratory disease • Chronic obstructive pulmonary disease with decreased P02 tension • Pickwickian syndrome • Documented hypertension Endogenous Obesity Secondary to: • Hypothyroidism • Cushing's disease (adrenal hyperfunction)	**In-network and Out-of-network providers who accept the Medicare Advantage card:** Covered services will be reimbursed up to 100% until the $300 lifetime allowance is met.

Services that are covered for you	What you must pay when you get these services
Weight loss (continued) • Hypothalamic dysfunction due to tumors or trauma • Testicular or ovarian dysfunction due to decreased testosterone level, polycystic ovaries, Polycythemia, renal insufficiency * % over ideal weight is calculated using established Weight Charts. Services rendered by one of the following clinics or centers** are payable if medical criteria are met and the services are referred or prescribed by a physician: • Diet Center • Diet Weight Loss • Family Medical Weight Loss Center • Formu-3 • Jenny Craig • Medical Weight Loss Clinic • Michigan Doctors Diet Control • Nutri-System • Optitrim • Physicians Weight Loss Center • Quick Weight Loss Center • Tops • Weight Watchers ** This list is not all inclusive Approved services that are applied to the $300 lifetime maximum include office visits, nutritional supplements, rice supplements, special diet supplements, vitamins, B-12 injections, HCG, vitamin injections, weight reduction program, and whole-body calorimeter. Office visits and lab tests are also paid under the basic health plan.	

Services that are covered for you	What you must pay when you get these services
Wigs, wig stand, 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 Additional replacements for children due to growth are not limited to the lifetime maximum.	**In-network and Out-of-network providers who accept the Medicare Advantage card:** Services are covered up to 100% of the approved amount until the $300 lifetime limit is met.

Section 2.2 Medicare Plus Blue Group PPO covers services nationwide

This plan's service area includes the entire United States and its territories. You have coverage for health care services regardless of the provider's network affiliation. This plan also covers emergency and urgent care services worldwide (see Chapter 3, Section 3 in the *Evidence of Coverage*).

Note: You are responsible for your deductible and/or copayment, if applicable.

SECTION 3 What services are not covered by the plan?

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

This section tells you what services are "excluded" and therefore are not covered by this plan. If a service is "excluded," it means that this plan doesn't cover the service.

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. We won't cover the excluded medical services listed in the chart below except under the specific conditions listed. The only exception: we will pay if a service in the chart below is found 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 booklet.)

All exclusions or limitations on services are described in the Medical Benefits Chart or in the chart 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.

Services not covered	Not covered under any condition	Covered only under specific conditions
Care provided in conjunction with an ambulance call when no transport is provided. Ambulance service is a transport benefit, and it is only payable when you're transported to a hospital. If an ambulance is called and you receive care, but decide	√	

Services not covered	Not covered under any condition	Covered only under specific conditions
not to be transported to a hospital, we do not cover those services (See *Ambulance Services* section of the Medical Benefits Chart in Chapter 4, Section 2.1.)		
Cosmetic surgery or procedures		√ • Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance
Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing 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.	√	

Services not covered	Not covered under any condition	Covered only under specific conditions
Experimental medical and surgical procedures, equipment, and medications Experimental procedures and items are those items and procedures determined by our plan and 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	√	
Full-time nursing care in your home	√	
Home-delivered meals	√	
Homemaker services and basic household assistance including light housekeeping or light meal preparation	√	
Medicare Part B covered prescription drugs beyond 90-day supply limit including early refill requests	√	
Naturopath services (uses natural or alternative treatments)	√	
Non-routine dental care		√

Services not covered	Not covered under any condition	Covered only under specific conditions
		Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	√	
Phase III cardiac rehabilitation programs *For information on other cardiac rehabilitation programs, see Chapter 4, Section 2.1 and Chapter 10, Definition of important words*.	√	
Prescriptions written by prescribers who are subject to the CMS Exclusion List	√	
Private room in a hospital		√ Covered only when medically necessary
Radial keratotomy (RK) and LASIK surgery	√	
Reversal of sterilization procedures, non-prescription contraceptive supplies, including Intrauterine Devices (IUDs), and/or any contraceptive method not payable under your Part D benefit	√	

Services not covered	Not covered under any condition	Covered only under specific conditions
Routine dental care, such as cleanings, fillings or dentures.	√	
Routine eye examinations, eyeglasses, and other low vision aids		√ Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery.
Routine foot care		√ Some limited coverage provided according to Medicare guidelines, e.g., if you have diabetes
Services considered not reasonable and necessary, according to the standards of Original Medicare	√	
Services from providers who appear on the CMS Exclusion List *For more information, see CMS Exclusion List definition in Chapter 10.*	√	

CHAPTER 5

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

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

Section 1.1 If you pay our plan's share of the cost of your covered services, or if you receive a bill, you can ask us for payment

Sometimes when you get medical care, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, 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 also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this 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.

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 medical care from a provider who is not in our plan's network**

   When you received care from a provider who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. (Your share of the cost may be higher for an out-of-network provider than for a network provider.) You should ask the provider to bill the plan for our share of the cost.

   - If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
   - At times 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.
   - **Please note:** While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If the provider is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive.

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

Network providers should always bill 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 services covered by our plan. 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. For more information about "balance billing," go to Chapter 4, Section 1.4.
- 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. (Retroactive 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 for us to handle the reimbursement.

Please call Customer Service for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

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 booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has information about how to make an appeal.

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

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

Send us your request for payment, along with your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

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

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website at **www.bcbsm.com/claimsmedicare** or call Customer Service and ask for the form. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

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

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

You must submit your claim to us within 12 months of the date you received the service, item, or drug.

Contact Customer Service if you have any questions (phone numbers are printed on the back cover of this booklet). If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

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 for getting the care, 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. (Chapter 3 explains the rules you need to follow for getting your medical services covered.)
- 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. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested 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 you don't agree with 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.

For the details on how to make this appeal, go to Chapter 7 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*). The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 7. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read Section 4, you can go to Section 5.5 in Chapter 7 that tells what to do if you want to make an appeal about getting paid back for a medical service.

CHAPTER 6

Your rights and responsibilities

Chapter 6. Your rights and responsibilities

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

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

To get information from us in a way that works for you, please call Customer Service (phone numbers are printed on the back cover of this booklet).

Our plan has people and free interpreter services available to answer questions from disabled and non-English speaking members. We can also give you information in audio CD, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Customer Service (phone numbers are printed on the back cover of this booklet).

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Customer Service (phone numbers are printed on the back cover of this booklet). You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227), or directly with the Office for Civil Rights. Contact information is included in this *Evidence of Coverage* or with this mailing, or you may contact Customer Service for additional information.

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

You have the right to choose a provider in the plan's network. Call Customer Service to learn which doctors are accepting new patients (phone numbers are printed on the back cover of this booklet). You also have the right to go to a women's health specialist (such as a gynecologist) without a referral and still pay the in-network cost-sharing amount.

As a plan member, you have the right to get appointments and covered services from your providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care.

If you think that you are not getting your medical care within a reasonable amount of time, Chapter 7, Section 9 of this booklet tells what you can do. (If we have denied coverage for your medical care and you don't agree with our decision, Chapter 7, Section 4 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.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a “Notice of Privacy Practices,” that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don’t see or change your records.
- In most situations, if we 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 first.* Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - For example, 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.

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 health care provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Customer Service (phone numbers are printed on the back cover of this booklet).

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

NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.

Affiliated entities covered by this notice

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

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

Our commitment regarding your protected health information

We understand the importance of your Protected Health Information (hereafter referred to as “PHI”) and follow strict policies (in accordance with state and federal privacy laws) to keep your PHI private. PHI is information about you, including demographic data, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health, the provision of health care to you or the payment for that care. Our policies cover protection of your PHI whether oral, written or electronic.

In this notice, we explain how we protect the privacy of your PHI, and how we will allow it to be used and given out (“disclosed”). We must follow the privacy practices described in this notice while it is in effect. This notice takes effect September 30, 2016, and will remain in effect until we replace or modify it.

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

material change to our privacy practices, we will provide a revised notice to our subscribers.

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

Our uses and disclosures of protected health information

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

- **To you and your personal representative:** We may disclose your PHI to you or to your personal representative (someone who has the legal right to act for you).

- **For treatment:** We may use and disclose your PHI to health care providers (doctors, dentists, pharmacies, hospitals, and other caregivers) who request it in connection with your treatment. For example, we may disclose your PHI to health care providers in connection with disease and case management programs.

- **For Payment:** We may use and disclose your PHI for our payment-related activities and those of health care providers and other health plans, including:

    - Obtaining premium payments and determining eligibility for benefits
    - Paying claims for health care services that are covered by your health plan
    - Responding to inquiries, appeals, and grievances
    - Coordinating benefits with other insurance you may have

- **For health care operations:** We may use and disclose your PHI for our health care operations, including for example:

    - Conducting quality assessment and improvement activities, including peer review, credentialing of providers and accreditation
    - Performing outcome assessments and health claims analyses
    - Preventing, detecting and investigating fraud and abuse
    - Underwriting, rating and reinsurance activities (although we are prohibited from using or disclosing any genetic information for underwriting purposes)
    - Coordinating case and disease management activities
    - Communicating with you about treatment alternatives or other health-related benefits and services

- Performing business management and other general administrative activities, including systems management and customer service

We may also disclose your PHI to other providers and health plans who have a relationship with you for certain health care operations. For example, we may disclose your PHI for their quality assessment and improvement activities or for health care fraud and abuse detection.

- **To others involved in your care:** We may, under certain circumstances, disclose to a member of your family, a relative, a close friend or any other person you identify, the PHI directly relevant to that person's involvement in your health care or payment for health care. For example, we may discuss a claim decision with you in the presence of a friend or relative, unless you object.

- **When required by law:** We will use and disclose your PHI if we are required to do so by law. For example, we will use and disclose your PHI in responding to court and administrative orders and subpoenas, and to comply with workers' compensation laws. We will disclose your PHI when required by the Secretary of the Department of Health and Human Services and state regulatory authorities.

- **For matters in the public interest:** We may use or disclose your PHI without your written permission for matters in the public interest, including for example:

  - Public health and safety activities, including disease and vital statistic reporting, child abuse reporting, and Food and Drug Administration oversight
  - Reporting adult abuse, neglect or domestic violence
  - Reporting to organ procurement and tissue donation organizations
  - Averting a serious threat to the health or safety of others

- **For research:** We may use and disclose your PHI to perform select research activities, provided that certain established measures to protect your privacy are in place.

- **To communicate with you about health-related products and services:** We may use your PHI to communicate with you about health-related products and services that we provide or are included in your benefits plan. We may use your PHI to communicate with you about treatment alternatives that may be of interest to you.

  These communications may include information about the health care providers in our networks, about replacement of or enhancements to your health plan, and about health-related products or services that are available only to our enrollees and add value to your benefits plan.

- **To our business associates:** From time to time, we engage third parties to provide various services for us. Whenever an arrangement with such a third party involves the

use or disclosure of your PHI, we will have a written contract with that third party designed to protect the privacy of your PHI. For example, we may share your information with business associates who process claims or conduct disease management programs on our behalf.

- **To group health plans and plan sponsors:** We participate in an organized health care arrangement with our underwritten group health plans. These plans, and the employers or other entities that sponsor them, receive PHI from us in the form of enrollment information (although we are prohibited from using or disclosing any genetic information for underwriting purposes). Certain plans and their sponsors may receive additional PHI from 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: 9/30/2020

Section 1.4 We must give you information about the plan, its network of providers, and your covered services

As a member of Medicare Plus Blue Group PPO, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call Customer Service (phone numbers are printed on the back cover of this booklet):

- **Information about our plan**. This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our network providers.**
    - For example, you have the right to get information from us about the qualifications of the providers in our network and how we pay the providers in our network.
    - For a list of the providers in the plan's network, see the *Provider Directory*.
    - For more detailed information about our providers, you can call Customer Service (phone numbers are printed on the back cover of this booklet) or visit our website at **www.bcbsm.com/providersmedicare** and click on the "Find a Doctor" link.
- **Information about your coverage and the rules you must follow when using your coverage.**
    - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
    - If you have questions about the rules or restrictions, please call Customer Service (phone numbers are printed on the back cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
    - If a medical service is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service from an out-of-network provider.
    - If you are not happy or if you disagree with a decision we make about what medical care is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 7 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter

7 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)

- If you want to ask our plan to pay our share of a bill you have received for medical care, see Chapter 5 of this booklet.

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

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

You have the right to get full information from your doctors and other health care providers when you go for medical care. 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.** This means that 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.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 7 of this booklet tells how to ask the plan for a coverage decision.

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. Submit a copy of the completed form to any entity that your selected representative may need to talk to on your behalf, including ORS and Blue Cross.

- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

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

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

- **Get the form.** If you want to have an advance directive, you can get a 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 (phone numbers are printed on the back cover of this booklet) or download them from **www.bcbsm.com/advancedirectivemedicare**.
- **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 as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to 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**.

- If you are admitted to the hospital, they 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 with:

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, 8:00 a.m. to 5:00 p.m. Monday through Friday. TTY users call 711.
Email: BCHS-Compliants@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 5:00 p.m. Monday through Friday. TTY users call 711.
Email: BPL-Complaints@michigan.gov
Fax: 1-517-241-2389 (Attn: Complaint Intake)

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

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

If you have any problems or concerns about your covered services or care, Chapter 7 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints. What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Customer Service (phone numbers are printed on the back cover of this booklet).

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

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

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, 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** (phone numbers are printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, 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 users should call 1-877-486-2048.

Section 1.8 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** (phone numbers are printed on the back cover of this booklet).
- You can **call your State Health Insurance Assistance Program**. For details about this organization and how to contact it, 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/Pubs/pdf/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 users should call 1-877-486-2048.

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

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Service (phone numbers are printed on the back cover of this booklet). We're here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this Evidence of Coverage booklet 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, including what is covered, what is not covered, rules to follow, and what you pay.
- **If you have any other health insurance coverage in addition to this plan, you are required to tell ORS.**
    - Having other group health coverage may impact your coverage under the Medicare Plus Blue Group PPO plan. If you enroll in another Medicare Advantage plan you will be disenrolled from your Medicare Plus Blue Group PPO plan. **You must immediately notify ORS by calling 1-800-381-5111** if you have other group health coverage or enroll in another Medicare Advantage plan to discuss your health coverage options.
- **You must call Customer Service (phone numbers are printed on the back cover of this booklet) if you have claims involving any of the following types of coverage:**
    - No-fault insurance (including automobile insurance)
    - Liability (including automobile insurance)
    - Black lung benefits
    - Workers' Compensation
- **Tell your doctor and other 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 your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. 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. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.

- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - You must pay your plan premiums to continue being a member of our plan.
  - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. Some plan members must pay a premium for Medicare Part A. Most plan members must pay a premium for 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. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your medical services.
    - If you get any medical services that are not covered by our plan or by other insurance you may have, you must pay the full cost.
    - If you disagree with our decision to deny coverage for a service, you can make an appeal. Please see Chapter 7 of this booklet for information about how to make an appeal.
- **Tell ORS if you move.** If you are going to move, contact ORS at 1-800-381-5111 immediately to update your records to ensure you receive all necessary correspondence.
  - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.)
  - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
  - **If you move, it is also important to tell Social Security (or the Railroad Retirement Board).** You can find phone numbers and contact information for these organizations in Chapter 2.
- **Call Customer Service for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.
  - Phone numbers and calling hours for Customer Service are printed on the back cover of this booklet.
  - For more information on how to reach us, including our mailing address, please see Chapter 2.

CHAPTER 7

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

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 types of problems, you need to use the **process for coverage decisions and appeals**.
- For other types of problems, you need to use the **process for making complaints**.

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? That depends on the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

Section 1.2 What about the legal terms?

There are technical 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 keep things simple, this chapter explains the legal rules and procedures using 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 for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and 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 You can get help from government organizations that are not connected with us

Section 2.1 Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

Get help from an independent government organization

We are always available to help you. But in some situations, you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers in Chapter 2, Section 3 of this booklet and in *Exhibit 1* of the Appendix.

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from 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 visit the Medicare website (**www.medicare.gov**).

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

Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

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.

To figure out which part of this chapter will help with your specific problem or concern, **START HERE**

Is your problem or concern about your benefits or coverage?

(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care.)

Yes. My problem is about benefits or coverage.

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

No. My problem is not about benefits or coverage.

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

The process for coverage decisions and appeals deals with problems related to your benefits and coverage for medical services, including problems related to payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. 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 service 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 a service 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 and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

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 following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review, we give you our decision. Under certain circumstances, which we discuss later, you can request an expedited or "fast coverage decision" or fast appeal of a coverage decision. 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.

If we say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an Independent Review Organization that is not connected to us. (In some situations, your case will be automatically sent to the Independent Review Organization for a Level 2 Appeal. In other situations, you will need to ask for a Level 2 Appeal.) 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 4.2 How to get help when you are asking for a coverage decision or making an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Customer Service** (phone numbers are printed on the back cover of this booklet).
- You can **get free help** from your State Health Insurance Assistance Program (see Section 2 of this chapter and the Appendix).
- **Your doctor can make a request for you.** 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. To request any appeal after Level 2, your doctor must be appointed as your representative.
- **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.

- There may be someone who is already legally authorized to act as your representative under State law.
- If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Customer Service (phone numbers are printed on the back cover of this booklet) 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/medicare/help/forms-documents/appointment-representative.html**.) 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.

- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

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

There are three different types of 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 these services only*: 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 (phone numbers are printed on the back cover of this booklet). You can also get help or information from government organizations such as your State Health Insurance Assistance Program (Chapter 2, Section 3, of this booklet has the phone numbers for this program).

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

Have you read Section 4 of this chapter (*A guide to "the basics" of coverage decisions and appeals*)? If not, you may want to read it before you start this section.

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 and services. These benefits are described in Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*. To keep things simple, we generally refer to "medical care coverage" or "medical care" in the rest of this section, instead of repeating "medical care or treatment or services" every time. The term "medical care" includes medical items and services as well as Medicare Part B prescription drugs. 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.
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.
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.
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.
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.

- 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 a separate section of this chapter because special rules apply to these types of care. Here's what to read in those situations:
    - Chapter 7, Section 6: *How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.*
    - Chapter 7, Section 7: *How to ask us to keep covering certain medical services if you think your coverage is ending too soon.* This section is about

three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.

- For *all other* situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.

Which of these situations are you in?

If you are in this situation:	This is what you can do:
To find out whether we will cover the medical care you want.	You can ask us to make a coverage decision for you. Go to the next section of this chapter, **Section 5.2**.
If we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for.	You can make an **appeal**. (This means you are asking us to reconsider.) Skip ahead to **Section 5.3** of this chapter.
If you want to ask us to pay you back for medical care you have already received and paid for.	You can send us the bill. Skip ahead to **Section 5.5** of this chapter.

Section 5.2 Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want)

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**."

<u>Step 1:</u> You ask our plan to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a "fast coverage decision."

How to request coverage for the medical care you want

- 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.
- For the details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision about your medical care.*

Generally, we use the standard deadlines for giving you our decision

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. **A standard coverage decision 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,** for a request **for a medical item or service we can take up to 14 more calendar days** if you ask for more time, or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, 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" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

If your health requires it, ask us to give you a "fast coverage decision"

- **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,** for a request **for a medical item or service we can take up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing. 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" about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.) We will call you as soon as we make the decision.

- **To get a fast coverage decision, you must meet two requirements:**
    - You can get a fast coverage decision *only* if you are asking for coverage for medical care *you have not yet received*. (You cannot ask for a fast coverage decision if your request is about payment for medical care you have 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 decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
    - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
    - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

Step 2: We consider your request for medical care coverage and give you our answer.

Deadlines for a "fast" coverage decision

- Generally, for a fast coverage decision on a request for a medical item or service, we will give you our answer **within 72 hours**. If your request is for a Medicare Part B prescription drug, we will answer **within 24 hours**.
    - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, 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" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
    - If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), or 24 hours if your request is for a

Part B prescription drug, you have the right to appeal. Section 5.3 below tells how to make an appeal.

- **If our answer is no to part or all of what you requested,** we will send you a detailed written explanation as to why we said no.

Deadlines for a "standard" coverage decision

- Generally, for a standard coverage decision on a request for a medical item or service, we will give you our answer **within 14 calendar days of receiving your request.** If your request is for a Medicare Part B prescription drug, we will give you an answer **within 72 hours** of receiving your request.
    - For a request for a medical item or service, we can take up to 14 more calendar days ("an extended time period") under certain circumstances. If we decide to take extra days to make the coverage decision, 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" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
    - If we do not give you our answer within 14 calendar days (or if there is an extended time period, by the end of that period), or 72 hours if your request is for a Part B prescription drug, you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **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.

<u>Step 3:</u> If we say no to your request for coverage for medical care, you decide if you want to make an appeal.

- If we say no, you have the right to ask us to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 5.3 below).

Section 5.3 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)

Legal Terms
An appeal to the plan about a medical care coverage decision is called a plan **"reconsideration."**

Step 1: You contact us and make your appeal. If your health requires a quick response, you must ask for a **"fast appeal."** What to do:

- **To start an appeal, you, your doctor, or your representative, must contact us.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision, or making an appeal or complaint about your medical care.*
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a request.** You may also ask for an appeal by calling us at the phone number shown in Chapter 2, Section 1 (*How to contact us when you are asking for a coverage decision, or making an appeal or complaint about your medical care*).
    - If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. To get the form, call Customer Service (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. It 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/medicare/help/forms-documents/appointment-representative.html**. While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.
- **If you are asking for a fast appeal, make your appeal in writing or call us** at the phone number shown in Chapter 2, Section 1 (*How to contact us when you are asking for a coverage decision, or making an appeal or complaint about your medical care*).
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a 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 for missing the deadline may include if you had 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 and add more information to support your appeal.**
    - You have the right to ask us for a copy of the information regarding your appeal.
    - If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal" (you can make a request by calling us)

Legal Terms
A "fast appeal" is also called an **"expedited reconsideration."**

- 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."
- The requirements and procedures for getting a "fast appeal" are the same as those for getting a "fast coverage decision." To ask for a fast appeal, follow the instructions for asking for a fast coverage decision. (These instructions are given earlier in this section.)
- If your doctor tells us that your health requires a "fast appeal," we will give you a fast appeal.

Step 2: We consider your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if we need it. We may contact you or your doctor to get more information.

Deadlines for a "fast" appeal

- When we are using the fast deadlines, 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 do so.
    - However, if you ask for more time, or if we need to gather 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 decide to take extra days to make the decision, 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 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. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals 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 automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

Deadlines for a "standard" appeal

- If we are using the standard deadlines, we must give you our answer on a request for a medical item or service **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. 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 to gather 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 decide to take extra days to make the decision, 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" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
  - If we do not give you an answer by the applicable deadline above (or by the end of the extended time period if we took extra days on your request for a medical item or service), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals 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 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 answer is no to part or all of what you requested**, we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

Step 3: If our plan says no to part or all of your appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your appeal, **we are required to send your appeal to the "Independent Review Organization."** When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

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

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews our decision for your first appeal. This organization decides whether the decision we made should be changed.

Step 1: The Independent Review Organization reviews your appeal.

Legal Terms
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 that is hired by Medicare**. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- 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

- If you had a fast appeal at Level 1, you will automatically receive a fast appeal at Level 2. 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

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. 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 or within 72 hours from the date we receive the decision from the review organization for expedited requests.
- **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 under dispute within **72 hours** after we receive the decision from the review organization for **standard requests** or within **24 hours** from the date we receive the decision from the review organization for **expedited requests**.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision." It is also called "turning down your appeal.")
- If the Independent Review Organization "upholds the decision" you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final. The written notice you get

from the Independent Review Organization will tell you how to find out the dollar amount to continue the appeals process.

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 your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third 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 tells more about Levels 3, 4, and 5 of the appeals process.

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

If you want to ask us for payment for medical care, start by reading Chapter 5 of this booklet: *Asking us to pay our share of a bill you have received for covered medical services*. Chapter 5 describes the situations in which 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 that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 4.1 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see Chapter 4: Medical Benefits Chart *(what is covered and what you pay)*). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: *Using the plan's coverage for your medical services*).

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days after we receive your request. Or, if you haven't paid for the services, we will send the payment directly to the provider. (When we send the payment, it's the same as saying *yes* to your request for a coverage decision.)
- 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 services

and the reasons why in detail. (When we turn down your request for payment, it's the same as saying *no* to your request for a coverage decision.)

What if you ask for payment and we say that we will not pay?

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. Go to this section for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement, 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 yourself, you are not allowed to ask for a fast appeal.)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider 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 the doctor is discharging 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. For more information about our coverage for your hospital care, including any limitations on this coverage, see Chapter 4: Medical Benefits Chart *(what is covered and what you pay)*.

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

- The day you leave the hospital is called your "**discharge date**."
- When your discharge date has been decided, your doctor or the hospital staff will let you know.
- 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. This section tells you how to ask.

Section 6.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

During your covered hospital stay, 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 whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Customer Service (phone numbers are printed on the back cover of this booklet). 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.

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you about your rights as a hospital patient, including:
   - 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, and your right to know who will pay for it.
   - Where to report any concerns you have about quality of your hospital care.
   - Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon.

Legal Terms

The written notice from Medicare tells you how you can **"request an immediate review."** Requesting an immediate review 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. (Section 6.2 below tells you how you can request an immediate review.)

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. (Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.)
   - Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice **does *not* mean** you are agreeing on a discharge date.

3. **Keep your copy** of the notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.

- If you sign the notice more than two days before the day you leave the hospital, 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 (phone numbers are printed on the back cover of this booklet) 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.html**.

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.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it**. If you have questions or need help at any time, please call Customer Service (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

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.

<u>Step 1:</u> Contact the Quality Improvement Organization for your state and ask for a "fast review" of your hospital discharge. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care professionals who are paid by the Federal government. These experts are not part of our plan. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare.

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, Section 4, of this booklet.)

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.** (Your "planned discharge date" is the date that has been set for you to leave the hospital.)
    - If you meet this deadline, you are allowed to stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision on your appeal 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.
- If you miss the deadline for contacting the Quality Improvement Organization and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see Section 6.4.

Ask for a "fast review":

- You must ask the Quality Improvement Organization for a **"fast review"** of your discharge. Asking for a "fast review" means you are asking for the organization to use the "fast" deadlines for an appeal instead of using the standard deadlines.

Legal Terms
A "**fast review**" is also called an "**immediate review**" or an "**expedited review**."

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

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) 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 informed our plan of your appeal, you will also get a written notice that 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.

Legal Terms
This written explanation is called the "**Detailed Notice of Discharge."** You can get a sample of this notice by calling Customer Service (phone numbers are printed on the back cover of this booklet) 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.html**

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* to your appeal, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See the Medical Benefits Chart).

What happens if the answer is no?

- If the review organization says *no* to your appeal, 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 turned down 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

If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a

Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made 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.

Here are the steps for Level 2 of the appeal process:

Step 1: You 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 second review, the Quality Improvement Organization 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 and will not change it.
- 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 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 the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed 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 6.4 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 6.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. ("Quickly" means before you leave the hospital and no later than your planned discharge date, whichever comes first.) If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Legal Terms
A "fast review" (or "fast appeal") is also called an **"expedited appeal."**

Step 1: Contact us and ask for a "fast review."

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision, or making an appeal or complaint about your medical care*.
- **Be sure to ask for a** "**fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the standard deadlines.

Step 2: We do a "fast" review of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say yes to your fast appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered inpatient hospital services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
    - If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

Step 4: If we say *no* to your fast appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the "Independent Review Organization."** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: Level 2 *Alternate* Appeal Process

During the Level 2 Appeal, an **Independent Review Organization** reviews the decision we made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 9 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says *yes* to your appeal,** then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with us that your planned hospital discharge date was medically appropriate.
    - The notice you get from the Independent Review Organization 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 a Level 3 Appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 3: If the Independent Review Organization turns down your appeal, 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 reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- 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 about three services only:* Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

This section is about the following types of care *only*:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a "skilled nursing facility," see Chapter 10, *Definitions of important words*.)
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 10, *Definitions of important words*.)

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 4 of this booklet: Medical Benefits Chart *(what is covered and what you pay)*.

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 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

1. **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, you will receive a notice.
   - The written notice tells you the date when we will stop covering the care for you.
   - The written notice also tells what you can do if you want to ask us to change this decision about when to end your care, and keep covering it for a longer period of time.

Legal Terms
In telling you what you can do, the written notice is telling 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. (Section 7.3 below tells how you can request a fast-track appeal.) The written notice is called the "**Notice of Medicare Non-Coverage."**

2. You will be asked to sign the written notice to show that you received it.

- You or someone who is acting on your behalf will be asked to sign the notice. (Section 4 tells how you can give written permission to someone else to act as your representative.)
- 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 that it's time to stop getting the care.

Section 7.3 Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 9 of this chapter tells you how to file a complaint.)
- **Ask for help if you need it**. If you have questions or need help at any time, please call Customer Service (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter and the Appendix).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.

Step 1: Make your Level 1 Appeal: contact the Quality Improvement Organization for your state and ask for a review. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?

- The written notice you received 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, Section 4, of this booklet and *Exhibit 2* of the Appendix.)

What should you ask for?

- Ask this organization for a "fast-track appeal" (to do an independent review) of whether it is medically appropriate for us to end coverage for your medical services.

Your deadline for contacting this organization.

- 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 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.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) 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 informed us of your appeal, and you will also get a written notice from us that explains in detail our reasons for ending our coverage for your services.

Legal Terms
This notice explanation is called the "**Detailed Explanation of Non-Coverage.**"

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 to your appeal?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see Chapter 4 of this booklet).

What happens if the reviewers say no to your appeal?

- If the reviewers say *no* to your appeal, then **your coverage will end on the date we have told you.** We will stop paying our share of the costs of this care on the date listed on the notice.
- 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.

- This first appeal you make is "Level 1" of the appeals process. 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 another appeal.
- Making another appeal means you are going on to "Level 2" of the appeals process.

Section 7.4 Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made 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.

Here are the steps for Level 2 of the appeal process:

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

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 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 to your appeal?

- **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 we made to your Level 1 Appeal and will not change it.

- 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 reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed 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 7.5 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 7.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

Legal Terms
A "fast review" (or "fast appeal") is also called an **"expedited appeal."**

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

Step 1: Contact us and ask for a "fast review."

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision, or making an appeal or complaint about your medical care.*
- **Be sure to ask for a "fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: We do a "fast" review of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan's coverage for services you were receiving.
- We will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say yes to your fast appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is

medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)

- **If we say no to your fast appeal,** then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get 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, then **you will have to pay the full cost** of this care yourself.

Step 4: If we say *no* to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the "Independent Review Organization."** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: Level 2 *Alternate* Appeal Process

Legal Terms
The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 9 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says *yes* to your appeal,** then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
    - The notice you get from the Independent Review Organization 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 a Level 3 Appeal.

Step 3: If the Independent Review Organization turns down your appeal, you choose 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 reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed 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. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for 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 **A judge (called 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** - We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the service 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 service 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. If the Administrative Law Judge or attorney adjudicator says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your 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** - We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you if the value of the item or medical service meets the required dollar value.
  - If we decide *not* to appeal the decision, we must authorize or provide the service 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 might 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. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

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

- This is the last step of the appeals process.

Section 8.2 Appeals to the Michigan Civil Service Commission

If you have exhausted the internal grievance procedures with Blue Cross, you may request a review of the denial by the Employee Benefit Division of the Michigan Civil Service Commission. The complaint must be received within 28 calendar days after the date that the final internal decision of Blue Cross was issued.

Appeals can be sent by mail or email.

Mail: Civil Service Commission
Employee Benefits Division
P.O. Box 30002
Lansing, MI 48909

Email: MCSC-EBD@michigan.gov

MAKING COMPLAINTS

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

If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

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

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only.* This includes problems related to quality of care,

waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of the kinds of problems listed in the chart on the next two pages, you can "make a complaint."

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	• Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with how our Customer Service has treated you? • 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, pharmacists, 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 room, or in the exam room.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Do you believe we have not given you a notice that we are required to give? • Do you think written information we have given you is hard to understand?

Complaint	Example
Timeliness (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)	The process of asking for a coverage decision and making appeals is explained in sections 4-8 of this chapter. If you are asking for a coverage decision or making an appeal, you use that process, not the complaint process. However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples: • If you have asked us to give you a "fast coverage decision" or a "fast appeal," and we have said we will not, you can make a complaint. • If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint. • When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint. • When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 9.2 The formal name for "making a complaint" is "filing a grievance"

Legal Terms

- What this section calls a **"complaint"** is also called a **"grievance."**
- Another term for **"making a complaint"** is **"filing a grievance."**
- Another way to say "**using the process for complaints"** is "**using the process for filing a 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. Call Customer Service at 1-800-843-4876. TTY users should call 711. Hours of operation are from 8:30 a.m. to 5:00 p.m. Eastern time, Monday through Friday.
- **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.
- **You or someone you name can file the grievance.** You should mail it to:

  Blue Cross Blue Shield of Michigan
  Grievances and Appeals Department
  P.O. Box 2627
  Detroit, MI 48231-2627

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

  We must address your grievance as quickly as your health status requires, but no later than 30 days after the receipt date of the oral or written grievance. **However, we can take up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing. In certain cases, you have the right to ask for a "fast grievance," meaning we will answer your grievance within 24 hours. There are only two reasons under which we will grant a request for a fast grievance. If you have asked Blue Cross Blue Shield of Michigan to give you a "fast decision" about a service you have not yet received and we have refused. If you do not agree with our request for a 14-day extension to respond to your standard grievance, organization determination or pre-service appeal.
- **Whether you call or write, you should contact Customer Service right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **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**.

Legal Terms
What this section calls a **"fast complaint"** is also called an **"expedited grievance."**

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. If your health condition requires us to answer quickly, we will do that.
- **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 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 let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

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

You can make your complaint about the quality of care you received by using the step-by-step process outlined above.

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization**. If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
    - 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.
    - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet and *Exhibit 2* the Appendix. If you make a complaint to this organization, we will work with them to resolve your complaint.

- **Or you can make your complaint to both at the same time**. If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

Section 9.5 You can also tell Medicare about your complaint

You can submit a complaint about Medicare Plus Blue Group PPO directly to Medicare. To submit a complaint to Medicare, go to **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 have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

Section 9.6 Appeals to the Michigan Civil Service Commission

If you have exhausted the internal grievance procedures with Blue Cross, you may request a review of the denial by the Employee Benefit Division of the Michigan Civil Service Commission. The complaint must be received within 28 calendar days after the date that the final internal decision of Blue Cross was issued.

Appeals can be sent by mail or email.

Mail: Civil Service Commission
Employee Benefits Division
P.O. Box 30002
Lansing, MI 48909

Email: MCSC-EBD@michigan.gov

CHAPTER 8

Ending your membership in the plan

Chapter 8. Ending your membership in the plan

SECTION 1 Introduction

Section 1.1 This chapter focuses on ending your membership in our plan

Ending your membership in Medicare Plus Blue Group PPO may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave.
    - You can disenroll from Medicare Plus Blue Group PPO at any time.
    - If you decide you want to disenroll from Medicare Plus Blue Group PPO, contact ORS at 1-800-381-5111, Monday through Friday, 8:30 a.m. to 5:00 p.m., Eastern time.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 4 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care through our plan until your membership ends.

SECTION 2 You can end your membership in our plan

Section 2.1 Usually, you end your membership by enrolling in another plan

You can end your membership in Medicare Plus Blue Group PPO at any time. Please contact ORS at 1-800-381-5111, Monday through Friday, 8:30 a.m. to 5:00 p.m., Eastern time, if you would like to disenroll from our plan. ORS will contact us, and we will take the necessary steps to cancel your membership. ORS can explain your options, implications of leaving this plan, and the correct process to follow to disenroll.

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

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

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

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

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

If you leave Medicare Plus Blue Group PPO, it may take time before your membership ends and your new Medicare coverage goes into effect. During this time, you must continue to get your medical care through our plan.

- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

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

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

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

- If you no longer have Medicare Part A and Part B.
- If you move out of the United States or its territories.
- If you become incarcerated (go to prison).
- If you are not 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 the 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.
- If you do not pay the plan premiums. (Contact ORS at 1-800-381-5111 for details.)
- You no longer meet the State of Michigan Employees' Retirement System's eligibility requirements.

Where can you get more information?

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

Section 4.2 We cannot ask you to leave our plan for any reason related to your health

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

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

Section 4.3 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. You can also look in Chapter 7, Section 9 for information about how to make a complaint.

CHAPTER 9

Legal notices

Chapter 9. Legal notices

SECTION 1 Notice about governing law

Many laws apply to this *Evidence of Coverage* and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in.

SECTION 2 Notice about nondiscrimination

Our plan must obey laws that protect you from discrimination or unfair treatment. **We don't discriminate** based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

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

If you have a disability and need help with access to care, please call us at Customer Service (phone numbers are printed on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Medicare Plus Blue Group PPO, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

SECTION 4 Additional Notice about Subrogation and Third-Party Recovery

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

Once we have made a payment for covered services, we shall have a lien on the proceeds of any judgment, settlement, or other award or recovery you receive (our recovery shall not be limited by the terms and conditions of any such settlement, award, or judgment), including but not limited to the following:

- Any award, settlement, benefits, or other amounts paid under any workers' compensation law or award;
- Any and all payments made directly by or on behalf of a third-party tortfeasor or person, entity, or insurer responsible for indemnifying the third-party tortfeasor;
- Any arbitration awards, payments, settlements, structured settlements, or other benefits or amounts paid under an uninsured or under insured motorist coverage policy; or
- Any other payments designated, earmarked, or otherwise intended to be paid to you as compensation, restitution, or remuneration for your injury, illness, or condition suffered as a result of the negligence or liability of a third party.

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:

- Responding to requests for information about any accidents or injuries;
- Responding to our requests for information and providing any relevant information that we have requested; and
- Participating in all phases of any legal action we commence in order to protect our rights, including, but not limited to, participating in discovery, attending depositions, and appearing and testifying at trial.

In addition, you agree not to do anything to prejudice our rights, including, but not limited to, assigning any rights or causes of action that you may have against any person or entity relating to your injury, illness, or condition without our prior express written consent. Your

failure to cooperate shall be deemed a breach of your obligations, and we may institute a legal action against you to protect our rights.

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

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

SECTION 5 Notice about member liability calculation

When you receive covered health care services outside of our service area from a Medicare Advantage PPO network provider, the cost of the service, on which your member liability (copayment/coinsurance) is based, will be either:

- The Medicare allowable amount for covered services; or
- The amount either we negotiate with the provider or the local Blue Medicare Advantage plan negotiates with its provider on behalf of our members, if applicable. The amount negotiated may be either higher than, lower than, or equal to the Medicare allowable amount.

Non-participating Health Care Providers Outside Our Service Area

When covered health care services are provided outside of our service area by non-participating health care providers, the amount(s) you pay for such services will be based on either the payment arrangements, described above, for Medicare Advantage PPO network providers, Medicare’s limiting charge where applicable or the provider’s billed charge. Payments for out-of-network emergency services will be governed by applicable federal and state law.

CHAPTER 10

Definitions of important words

Chapter 10. Definitions of important words

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Annual Enrollment Period – A set time each fall when 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 prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for a drug, item, or service you think you should be able to receive. Chapter 7 explains appeals, including the process involved in making an appeal.

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

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of Medicare Plus Blue Group PPO, you only have to pay 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 haven't 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. Chapter 2 explains how to contact CMS.

CMS Exclusion 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 as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

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

- **Routine or Screening** colonoscopy 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.

Combined Maximum Out-of-Pocket Amount – This is the most you will pay in a year for all Part A and Part B services from both network (preferred) providers and out-of-network (non-preferred) providers. See Chapter 4, Section 1.3 for information about your combined maximum out-of-pocket amount.

Complaint – The formal name for “making a complaint” is “filing a grievance.” The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times, and the customer service you receive. See also “Grievance” in this list of definitions.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services 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 of a medical service or supply, like a doctor’s visit, hospital outpatient visit, or a prescription. A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor’s visit or prescription.

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 general term we use in this *Evidence of Coverage* to mean all of the health care services and supplies that are covered by our plan.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care is personal care that can be provided by people who don't have professional skills or training, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

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

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

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. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

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, 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.

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

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

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

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

Home Health Aide – A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Home Infusion Therapy – Home infusion therapy is administration of fluid into tissue or a vein done in a home setting. Types of infusion include, but are not limited to: chemotherapy, hydration, pain management, and antibiotic therapy.

Hospice – A member who has six months or less to live has the right to elect hospice. 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. The hospice will provide special treatment for your state.

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

Hospital-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 fairly long distance from the main hospital campus can be considered part of the hospital. When you use these hospital-based services – 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."

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. See Chapter 4, Section 2.1 for information about your in-network maximum out-of-pocket amount.

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. For example, if you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Low Income Subsidy (LIS) – See "Extra Help."

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

Medicaid (or Medical Assistance) – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

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). People with Medicare can get their Medicare health coverage through Original Medicare, a PACE plan, or a Medicare Advantage Plan.

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 HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. 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**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Advantage health plan that is offered in their area.

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

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost 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 Supplemental 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 Provider – "Provider" is the general term we use 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. We call them "**network providers**" when they 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. Our plan pays network providers based on the agreements we have with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as "plan providers."

Observation (or "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 professionals that helps you learn how to perform activities of daily living, such as eating and dressing by yourself.

Organization Determination – The Medicare Advantage plan has made an organization determination when it makes a decision 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 booklet. Chapter 7 explains how to ask us for a coverage decision.

Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare) – Original Medicare is offered by the government, and not a private health plan such as Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the

Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility with which we have not arranged 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 or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

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

Out-of-Pocket Maximum – The maximum amount that you pay out-of-pocket during the calendar year, usually at the time services are received, for covered Part A (Hospital Insurance) and Part B (Medical Insurance) services. Plan premiums and Medicare Part A and Part B premiums do not count toward the out-of-pocket maximum.

PACE plan – A PACE (Program of All-inclusive Care for the Elderly) plan combines medical, social, and long-term care services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high-quality care they need. 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. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

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

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

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

Primary Care Provider – Your primary care provider is the doctor or other provider you see for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care. Primary care providers include: general practitioners, geriatricians, internists, family practice physicians, physician assistants, nurse practitioners, family nurse practitioners, pediatricians and OB/GYN.

Prior Authorization – Approval in advance to get covered services. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other network provider gets “prior authorization” from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. However, you may want to check with the plan before obtaining services from out-of-network providers to confirm that the service is covered and what your cost-sharing responsibility is. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4.

Prosthetics and Orthotics – These are medical devices ordered by your doctor or other health care provider. Covered items include, 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. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

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

Screenings – Preventive tests performed when no specific sign, symptom, or diagnosis is present. Screenings test for disease or disease precursors so that early detection and treatment can be provided for those who test positive for disease. Screenings are covered with no copayment or deductible. However, when a sign or symptom is found during a screening (e.g., a colonoscopy or mammogram) the testing may transition into a diagnostic procedure, in which case the copayment applies, but the deductible is waived per Medicare guidelines.

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. 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 may disenroll you if you permanently move out of 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 skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

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.

Specialist – A specialist is a doctor who provides health care services for a specific disease or part of the body. Examples: Oncologists, cardiologists, orthopedists, etc.

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.

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

Urgently Needed Services – Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible

Appendix

Exhibit 1 State Health Insurance Assistance Programs

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

State:	Alaska
Local:	1-800-478-6065
Anchorage:	1-907-269-3680
TTY:	1-800-770-8973
Website:	**dhss.alaska.gov/dsds/pages/medicare/default.aspx**
Address:	Senior and Disability Services Medicare Information Office 550 W. 7th Ave. Suite 1230 Anchorage, AK 99501

State:	Arizona
Local:	1-602-542-4446
Message Service:	1-800-432-4040
Website:	**des.az.gov/services/older-adults/medicare-assistance**
Address:	DES Division of Aging and Adult Services 1789 W. Jefferson Street Site Code 950A Phoenix, AZ 85007

State:	Arkansas
Local:	1-501-371-2782
Toll-free:	1-800-224-6330
Website:	**www.humanservices.arkansas.gov**
Address:	Arkansas Insurance Dept. 1200 West 3rd Street Little Rock, AR 72201

State:	California
Local:	1-916-419-7500
Toll-free:	1-800-434-0222
TTY:	1-800-735-2929
Website:	**www.aging.ca.gov/HICAP/**
Address:	California Department of Aging 1300 National Drive Suite 200 Sacramento, CA 95834

State:	Colorado
Toll-free:	1-888-696-7213
Website:	**www.colorado.gov/dora/division-insurance**
Address:	SHIP, Division of Insurance Colorado Department of Regulatory Agencies 1560 Broadway Suite 850 Denver, CO 80202

State:	Connecticut
Toll-free:	1-800-994-9422
Website:	**www.ct.gov/agingservices**
Address:	State Department on Aging 55 Farmington Avenue 12th Floor Hartford, CT 06105

State:	Delaware
Local:	1-302-674-7364
Toll-free:	1-800-336-9500
Website:	**www.delawareinsurance.gov/DMAB/**
Address:	Insurance Commissioner 1351 West North Street Suite 101 Dover, DE 19904

State:	District of Columbia
Message Service:	1-202-994-6272
TTY:	771
Website:	**dcoa.dc.gov/service/health-insurance-counseling**
Address:	Department of Aging and Community Living 500 K Street, NE Washington, D.C. 20002

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

State:	Georgia
Local:	1-404-657-5258
Toll-free:	1-866-552-4464 (option 4)
TTY:	1-404-657-1929
Website:	**www.mygeorgiacares.org/Medicare/OriginalMedicare(PartA-andB).aspx**
Address:	Georgia Cares Program (SHIP) 2 Peachtree Street, NW 33rd Floor Atlanta, GA 30303

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

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

State:	Idaho
Toll-free:	1-800-247-4422
Website:	**www.doi.idaho.gov/shiba/default.aspx**
Address:	Idaho Dept. of Insurance 700 West State Street 3rd Floor P.O. Box 83720 Boise, ID 83720

State:	Illinois
Toll-free:	1-800-252-8966
TTY:	1-888-206-1327
Website:	**www.illinois.gov/aging/SHIP**
Address:	Senior Health Insurance Program One Natural Resources Way Suite 100 Springfield, IL 62702

State:	Indiana
Toll-free:	1-800-452-4800
TTY:	1-866-846-0139
Website:	**www.medicare.in.gov**
Address:	SHIP 311 W. Washington Street Suite 300 Indianapolis, IN 46204

State:	Iowa
Toll-free:	1-800-351-4664
TTY:	1-800-735-2942
Website:	**shiip.iowa.gov/**
Address:	SHIP 601 Locust Street 4th Floor Des Moines, IA 50309

State:	Kansas
Toll-free:	1-800-860-5260
Website:	**www.kdads.ks.gov/commissions/commission-on-aging/medicare-programs/shick**
Address:	Kansas Dept. for Aging and Disability Services New England Building 503 S. Kansas Ave. Topeka, KS 66603

State:	Kentucky
Local:	1-502-564-6930
Toll-free:	1-877-293-7447 (option 2)
Website:	**chfs.ky.gov/agencies/dail/Pages/ship.aspx**
Address:	Cabinet for Health and Family Services 275 E. Main Street 3E-E Frankfort, KY 40621

State:	Louisiana
Local:	1-225-342-5301
Toll-free:	1-800-259-5300
Website:	**www.ldi.la.gov/SHIIP**
Address:	Louisiana Dept. of Insurance 1702 N. Third Street P.O. Box 94214 Baton Rouge, LA 70802

State:	Maine
Toll-free:	1-800-262-2232
TTY:	711
Website:	**www.maine.gov/dhhs/oads/community-support/ship.html**
Address:	Office of Aging & Disability Services SHS #11 41 Anthony Avenue Augusta, ME 04333

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

State:	Massachusetts
Local:	1-617-727-7750
Toll-free:	1-800-243-4636
TTY:	1-877-610-0241
Website:	**www.mass.gov/health-insurance-counseling**
Address:	Executive Office of Elder Affairs – SHINE 1 Ashburton Place 5th Floor Boston, MA 02108

State:	Michigan
Local:	1-517-886-1242
Toll-free:	1-800-803-7174
Website:	**www.mmapinc.org**
Address:	MMAP, Inc 6105 W. St. Joe Highway Suite 204 Lansing, MI 48917

State:	Minnesota
Toll-free:	1-800-333-2433
TTY:	1-800-627-3529
Website:	**www.mnaging.org/advisor/SLL.htm**
Address:	Minnesota Board on Aging P.O. Box 64976 St. Paul, MN 55164

State:	Mississippi
Toll-free:	1-844-822-4622
Website:	**www.mississippiaccesstocare.org**
Address:	Mississippi Department of Human Services Division of Aging and Adult Services 750 North State Street Jackson, MS 39202

State:	Missouri
Local:	1-573-817-8300 or 1-573-817-8320
Toll-free:	1-800-390-3330
TTY:	1-800-735-2966
Website:	**www.missouriclaim.org**
Address:	Primaris 4215 Philips Farm Road Suite 101-A Columbia, MO 65201

State:	Montana
Local:	1-800-332-2272
Toll-free:	1-800-551-3191
Website:	**dphhs.mt.gov/sltc/aging/SHIP**
Address:	Senior and Long-Term Care Division P.O. Box 4210 Helena, MT 59604

State:	Nebraska
Toll-free:	1-800-234-7119
TTY:	1-800-833-7352
Website:	**www.doi.nebraska.gov/ship**
Address:	Nebraska Department of Insurance 1033 O Street Suite 307 Lincoln, NE 68508

State:	Nevada
Southern Nevada:	1-800-307-4444
Northern Nevada:	1-844-826-2085
Website:	**www.nevadaship.com**
Address:	Nevada Aging and Disability Services Division 3416 Goni Road Suite D-132 Carson City, NV 89706 Access to Healthcare Network 4001 S. Virginia Street. Suite S Reno, NV 89502

State:	New Hampshire
Toll-free:	1-866-634-9412
TTY:	1-800-735-2964
Website:	**www.servicelink.nh.gov**
Address:	New Hampshire Department of Health and Human Services 129 Pleasant Street Concord, NH 03301

State:	New Jersey
Toll-free:	1-800-792-8820
Website:	**www.state.nj.us/humanservices/doas/services/ship/index.html**
Address:	Division of Aging Services New Jersey Department of Human Services P.O. Box 715 Trenton, NJ 08625

State:	New Mexico
Local:	1-505-476-4846
Toll-free:	1-800-432-2080
TTY:	1-505-476-4937
Website:	**www.nmaging.state.nm.us**
Address:	New Mexico Aging and Long-Term Services Department 2550 Cerrillos Road Santa Fe, NM 87505

State:	New York
Toll-free:	1-800-701-0501
Website:	**www.aging.ny.gov/HealthBenefits/Index.cfm**
Address:	New York State Office for the Aging 2 Empire State Plaza Albany, NY 12223

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

State:	North Dakota
Local:	1-701-328-2440
Toll-free:	1-888-575-6611
TTY:	1-800-366-6888
Website:	**www.insurance.nd.gov**
Address:	North Dakota Insurance Department 600 E. Boulevard Ave. Bismarck, ND 58505

State:	Ohio
Toll-free:	1-800-686-1578
Website:	**insurance.ohio.gov/wps/portal/gov/odi**
Address:	Ohio Department of Insurance 50 W. Town Street Third Floor, Suite 300 Columbus, OH 43215

State:	Oklahoma
Local:	1-405-521-6628
Toll-free:	1-800-763-2828
Website:	**www.ok.gov/oid/Consumers/Information_for_Seniors/SHIP.html**
Address:	Oklahoma Insurance Department 400 North East 50th St. Oklahoma City, OK 73105

State:	Oregon
Local:	1-503-947-7979
Toll-free:	1-800-722-4134
TTY:	711
Website:	**healthcare.oregon.gov/shiba/Pages/index.aspx**
Address:	SHIBA P.O. Box 14480 Salem, OR 97309

State:	Pennsylvania
Toll-free:	1-800-783-7067
Website:	**healthcare.oregon.gov/shiba/Pages/index.aspx**
Address:	Pennsylvania Department of Aging 555 Walnut Street 5th Floor Harrisburg, PA 17101

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

State:	Rhode Island
Local:	1-401-462-0510
TTY:	1-401-462-0740
Website:	**oha.ri.gov/**
Address:	Rhode Island Department of Human Resources Division of Elderly Affairs 57 Howard Ave. Louis Pasteur Bldg. 2nd Floor Cranston, RI 02920

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

State:	South Dakota Eastern
Local:	1-605-333-3314
Toll-free:	1-800-536-8197
Website:	**shiine.net/about-med**
Address:	South Dakota Department of Human Services 2500 W. 46th Suite 101 Sioux Falls, SD 57105

State:	South Dakota Central
Local:	1-605-494-0219
Toll-free:	1-877-331-4834
Website:	**shiine.net/about-med**
Address:	South Dakota Department of Human Services 3800 East Hwy. 34 Hillsview Plaza c/o 500 East Capitol Ave. Pierre, SD 57501

State:	South Dakota Western
Local:	1-605-342-8635
Toll-free:	1-877-286-9072
Website:	**shiine.net/about-med**
Address:	South Dakota Department of Human Services 3800 East Hwy. 34 Hillsview Plaza c/o 500 East Capitol Ave. Pierre, SD 57501

State:	Tennessee
For information and assistance:	1-866-836-6678
Toll-free:	1-877-801-0044
TTY:	1-800-848-0298
Website:	**www.tn.gov/aging/resources/medicare-counseling-sites.html**
Address:	Tennessee Commission on Aging and Disability 502 Deaderick Street 9th Floor Nashville, TN 37243

State:	Texas
Toll-free:	1-800-252-9240
TTY:	1-800-735-2989
Website:	**hhs.texas.gov/services/health/medicare**
Address:	Texas Health and Human Services Commission Office of the Ombudsman MC H-700 P.O. Box 13247 Austin, TX 78711

State:	Utah
Local:	1-801-538-3910
Toll-free:	1-877-424-4640
Website:	**www.daas.utah.gov/**
Address:	Aging Services Administration Office 195 North 1950 West Salt Lake City, UT 84116

State:	Vermont
Local:	1-802-241-0294
Website:	**www.asd.vermont.gov/services/ship**
Address:	Adult Services Division Director HC 2 South, 280 State Drive Waterbury, VT 05671

State:	Virgin Islands
St. Thomas:	1-340-714-4354
Website:	**ltg.gov.vi/departments/vi-ship-medicare/#1546003787075-9ef7eafe-e06c**
Address:	V.I. SHIP Office Representative Schneider Regional Medical Center 9048 Sugar Estate First Floor St. Thomas, VI 00802

State:	Virgin Islands
St. Croix:	1-340-772-7368
Website:	**ltg.gov.vi/departments/vi-ship-medicare/**
Address:	V.I. SHIP Office Representative Gov. Juan F. Luis Hospital & Medical Center 4007 Estate Diamond First Floor St. Croix, VI 00820

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

State:	Washington
Toll-free:	1-800-562-6900
TTY:	1-360-586-0241
Website:	**www.insurance.wa.gov/medicare**
Address:	Office of the Insurance Commissioner P.O. Box 40255 Olympia, WA 98504

State:	West Virginia
Local:	1-304-558-3317
Toll-free:	1-877-987-3646
Website:	**www.wvship.org**
Address:	West Virginia SHIP 1900 Kanawha Blvd. East Charleston, WV 25305

State:	Wisconsin
Toll-free:	1-800-242-1060
Website:	**www.dhs.wisconsin.gov/benefit-specialists/ship.htm**
Address:	Board on Aging & Long-Term Care 1402 Pankratz Street Suite 111 Madison, WI 53704

State:	Wyoming
Toll-free:	1-800-856-4398
Website:	**www.wyomingseniors.com/services/wyoming-state-health-insurance-information-program**
Address:	Wyoming Senior Citizens, Inc. P.O. Box BD Riverton, WY 82501

Exhibit 2 Quality Improvement Organizations

State:	Alabama
Organization:	Kepro
Toll-free:	1-888-317-0751
TTY:	1-855-843-4776
Website:	**www.keproqio.com**
Address:	Kepro 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609

State:	Alaska
Organization:	Kepro
Toll-free:	1-888-305-6759
TTY:	1-855-843-4776
Website:	**www.keproqio.com**
Address:	Kepro 5700 Lombardo Center Dr. Suite 100 Seven Hills, OH 44131

State:	Arizona
Organization:	Livanta, LLC
Toll-free:	1-877-588-1123
TTY:	1-855-887-6668
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701

State:	Arkansas
Organization:	Kepro
Toll-free:	1-888-315-0636
TTY:	1-855-843-4776
Website:	**www.keproqio.com**
Address:	Kepro 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609

State:	California
Organization:	Livanta, LLC
Toll-free:	1-877-588-1123
TTY:	1-855-887-6668
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701

State:	Colorado
Organization:	Kepro
Toll-free:	1-888-317-0891
TTY:	1-855-843-4776
Website:	**www.keproqio.com**
Address:	Kepro 5700 Lombardo Center Dr. Suite 100 Seven Hills, OH 44131

State:	Connecticut
Organization:	Kepro
Toll-free:	1-888-319-8452
TTY:	1-855-843-4776
Website:	**www.keproqio.com**
Address:	Kepro 5700 Lombardo Center Dr. Suite 100 Seven Hills, OH 44131

State:	Delaware
Organization:	Livanta, LLC
Toll-free:	1-888-396-4646
TTY:	1-888-985-2660
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701

State:	District of Columbia
Organization:	Livanta, LLC
Toll-free:	1-888-396-4646
TTY:	1-888-985-2660
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701

State:	Florida
Organization:	Kepro
Toll-free:	1-888-317-0751
TTY:	1-855-843-4776
Website:	**www.keproqio.com**
Address:	Kepro 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609

State:	Georgia
Organization:	Kepro
Toll-free:	1-888-317-0751
TTY:	1-855-843-4776
Website:	**www.keproqio.com**
Address:	Kepro 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609

State:	Hawaii
Organization:	Livanta, LLC
Toll-free:	1-877-588-1123
TTY:	1-855-887-6668
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701

State:	Idaho
Organization:	Kepro
Toll-free:	1-888-305-6759
TTY:	1-855-843-4776
Website:	**www.keproqio.com**
Address:	Kepro 5700 Lombardo Center Dr. Suite 100 Seven Hills, OH 44131

State:	Illinois
Organization:	Livanta, LLC
Toll-free:	1-888-524-9900
TTY:	1-888-985-8775
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701

State:	Indiana
Organization:	Livanta, LLC
Toll-free:	1-888-524-9900
TTY:	1-888-985-8775
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701

State:	Iowa
Organization:	Livanta, LLC
Toll-free:	1-888-755-5580
TTY:	1-888-985-9295
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701

State:	Kansas
Organization:	Livanta, LLC
Toll-free:	1-888-755-5580
TTY:	1-888-985-9295
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701

State:	Kentucky
Organization:	Kepro
Toll-free:	1-888-317-0751
TTY:	1-855-843-4776
Website:	**www.keproqio.com**
Address:	Kepro 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609

State:	Louisiana
Organization:	Kepro
Toll-free:	1-888-315-0636
TTY:	1-855-843-4776
Website:	**www.keproqio.com**
Address:	Kepro 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609

State:	Maine
Organization:	Kepro
Toll-free:	1-888-319-8452
TTY:	1-855-843-4776
Website:	**www.keproqio.com**
Address:	Kepro 5700 Lombardo Center Dr. Suite 100 Seven Hills, OH 44131

State:	Maryland
Organization:	Livanta, LLC
Toll-free:	1-888-396-4646
TTY:	1-888-985-2660
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701

State:	Massachusetts
Organization:	Kepro
Toll-free:	1-888-319-8452
TTY:	1-855-843-4776
Website:	**www.keproqio.com**
Address:	Kepro 5700 Lombardo Center Dr. Suite 100 Seven Hills, OH 44131

State:	Michigan
Organization:	Livanta, LLC
Toll-free:	1-888-524-9900
TTY:	1-888-985-8775
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701

State:	Minnesota
Organization:	Livanta, LLC
Toll-free:	1-888-524-9900
TTY:	1-888-985-8775
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701

State:	Mississippi
Organization:	Kepro
Toll-free:	1-888-317-0751
TTY:	1-855-843-4776
Website:	**www.keproqio.com**
Address:	Kepro 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609

State:	Missouri
Organization:	Livanta, LLC
Toll-free:	1-888-755-5580
TTY:	1-888-985-9295
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701

State:	Montana
Organization:	Kepro
Toll-free:	1-888-317-0891
TTY:	1-855-843-4776
Website:	**www.keproqio.com**
Address:	Kepro 5700 Lombardo Center Dr. Suite 100 Seven Hills, OH 44131

State:	New Hampshire
Organization:	Kepro
Toll-free:	1-888-319-8452
TTY:	1-855-843-4776
Website:	**www.keproqio.com**
Address:	Kepro 5700 Lombardo Center Dr. Suite 100 Seven Hills, OH 44131

State:	Nebraska
Organization:	Livanta, LLC
Toll-free:	1-888-755-5580
TTY:	1-888-985-9295
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701

State:	New Jersey
Organization:	Livanta, LLC
Toll-free:	1-866-815-5440
TTY:	1-866-868-2289
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701

State:	Nevada
Organization:	Livanta, LLC
Toll-free:	1-877-588-1123
TTY:	1-855-887-6668
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701

State:	New Mexico
Organization:	Kepro
Toll-free:	1-888-315-0636
TTY:	1-855-843-4776
Website:	**www.keproqio.com**
Address:	Kepro 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609

State:	New York
Organization:	Livanta, LLC
Toll-free:	1-866-815-5440
TTY:	1-866-868-2289
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701

State:	Ohio
Organization:	Livanta, LLC
Toll-free:	1-888-524-9900
TTY:	1-888-985-8775
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701

State:	North Carolina
Organization:	Kepro
Toll-free:	1-888-317-0751
TTY:	1-855-843-4776
Website:	**www.keproqio.com**
Address:	Kepro 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609

State:	Oklahoma
Organization:	Kepro
Toll-free:	1-888-315-0636
TTY:	1-855-843-4776
Website:	**www.keproqio.com**
Address:	Kepro 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609

State:	North Dakota
Organization:	Kepro
Toll-free:	1-888-317-0891
TTY:	1-855-843-4776
Website:	**www.keproqio.com**
Address:	Kepro 5700 Lombardo Center Dr. Suite 100 Seven Hills, OH 44131

State:	Oregon
Organization:	Kepro
Toll-free:	1-888-305-6759
TTY:	1-855-843-4776
Website:	**www.keproqio.com**
Address:	Kepro 5700 Lombardo Center Dr. Suite 100 Seven Hills, OH 44131

State:	Pennsylvania
Organization:	Livanta, LLC
Toll-free:	1-888-396-4646
TTY:	1-888-985-2660
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701

State:	Puerto Rico
Organization:	Livanta, LLC
Toll-free:	1-866-815-5440
TTY:	1-866-868-2289
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701

State:	Rhode Island
Organization:	Kepro
Toll-free:	1-888-319-8452
TTY:	1-855-843-4776
Website:	**www.keproqio.com**
Address:	Kepro 5700 Lombardo Center Dr. Suite 100 Seven Hills, OH 44131

State:	South Carolina
Organization:	Kepro
Toll-free:	1-888-317-0751
TTY:	1-855-843-4776
Website:	**www.keproqio.com**
Address:	Kepro 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609

State:	South Dakota
Organization:	Kepro
Toll-free:	1-888-317-0891
TTY:	1-855-843-4776
Website:	**www.keproqio.com**
Address:	Kepro 5700 Lombardo Center Dr. Suite 100 Seven Hills, OH 44131

State:	Tennessee
Organization:	Kepro
Toll-free:	1-888-317-0751
TTY:	1-855-843-4776
Website:	**www.keproqio.com**
Address:	Kepro 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609

State:	Texas
Organization:	Kepro
Toll-free:	1-888-315-0636
TTY:	1-855-843-4776
Website:	**www.keproqio.com**
Address:	Kepro 5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609

State:	Utah
Organization:	Kepro
Toll-free:	1-888-317-0891
TTY:	1-855-843-4776
Website:	**www.keproqio.com**
Address:	Kepro 5700 Lombardo Center Dr. Suite 100 Seven Hills, OH 44131

State:	Vermont
Organization:	Kepro
Toll-free:	1-888-319-8452
TTY:	1-855-843-4776
Website:	**www.keproqio.com**
Address:	Kepro 5700 Lombardo Center Dr. Suite 100 Seven Hills, OH 44131

State:	Virgin Islands
Organization:	Livanta, LLC
Toll-free:	1-866-815-5440
TTY:	1-866-868-2289
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701

State:	Virginia
Organization:	Livanta, LLC
Toll-free:	1-888-396-4646
TTY:	1-888-985-2660
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701

State:	Washington
Organization:	Kepro
Toll-free:	1-888-305-6759
TTY:	1-855-843-4776
Website:	**www.keproqio.com**
Address:	Kepro 5700 Lombardo Center Dr. Suite 100 Seven Hills, OH 44131

State:	West Virginia
Organization:	Livanta, LLC
Toll-free:	1-888-396-4646
TTY:	1-888-985-2660
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701

State:	Wisconsin
Organization:	Livanta, LLC
Toll-free:	1-888-524-9900
TTY:	1-888-985-8775
Website:	**www.livantaqio.com**
Address:	Livanta LLC BFCC-QIO Program 10820 Guilford Road Suite 202 Annapolis Junction, MD 20701

State:	Wyoming
Organization:	Kepro
Toll-free:	1-888-317-0891
TTY:	1-855-843-4776
Website:	**www.keproqio.com**
Address:	Kepro 5700 Lombardo Center Dr. Suite 100 Seven Hills, OH 44131

Exhibit 3 State Medicaid Agencies

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

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

State:	Alaska
Agency:	Alaska Medicaid Program
Local:	1-907-352-4150
Toll-free:	1-888-352-4150
Website:	**dhss.alaska.gov/dhcs/Pages/medicaid_medicare/default.aspx**
Address:	Division of Public Assistance Senior Benefits 855 W. Commercial Drive Wasilla, AK 99654

State:	Arizona
Agency:	Arizona Health Care Cost Containment System (AHCCCS)
Local:	1-855-432-7587
TTY:	1-800-367-8939
Website:	**www.azahcccs.gov**
Address:	Arizona Health Care Cost Containment System (AHCCCS) 801 East Jefferson St., Phoenix, AZ 85034

State:	Arkansas
Agency:	Arkansas Medicaid Program
Local:	1-800-482-5431
Local and Out-of-State:	1-501-682-8233
Toll-free:	1-800-482-8988
Website:	**medicaid.mmis.arkansas.gov**
Address:	Arkansas Division of Medical Services Department of Human Services Donaghey Plaza South P.O. Box 1437, Slot S401 Little Rock, AR 72203-1437

State:	California
Agency:	Medi-Cal
Out-of-State:	1-916-636-1980
Toll-free:	1-800-541-5555
Website:	**www.dhcs.ca.gov/services/medi-cal/Pages/default.aspx**
Address:	Medi-Cal Eligibility Division P.O. Box 997417, MS 4607 Sacramento, CA 95899-7417

State:	Colorado
Agency:	Health First Colorado
Toll-free:	1-800-221-3943
TTY:	711
Website:	**www.healthfirstcolorado.com**
Address:	Colorado Department of Health Care Policy & Financing 1570 Grant Street Denver, CO 80203-1818

State:	Connecticut
Agency:	Husky Health Connecticut
Local:	1-877-284-8759
TTY:	1-866-492-5276
Website:	**ct.gov/hh/site/default.asp**
Address:	Connecticut Department of Social Services HUSKY Health Program c/o Department of Social Services 55 Farmington Avenue Hartford, CT 06105-3730

State:	Delaware
Agency:	Delaware Medicaid Program
Local:	1-302-571-4900
Toll-free:	1-866-843-7212
Website:	**dhss.delaware.gov/dmma**
Address:	Delaware Health and Social Services 1901 N. DuPont Highway New Castle, DE 19720

State:	District of Columbia
Agency:	DC Medicaid Program
Local:	1-202-727-5355
TTY:	711
Website:	**www.dc-medicaid.com/dcwebportal/home**
Address:	Department of Human Services 64 New York Avenue, NE, 6th Floor Washington, DC 20002

State:	Florida
Agency:	Florida Medicaid Program
Local:	1-850-300-4323
Toll-free:	1-866-762-2237
TTY:	711/800-955-8771
Website:	**www.myflorida.com/accessflorida/**
Address:	ACCESS Central Mail Center P.O. Box 1770 Ocala, FL 34478-1770

State:	Georgia
Agency:	Georgia Department of Community Health Georgia Medicaid Program
Toll-free:	1-866-211-0950
Website:	**medicaid.georgia.gov/**
Address:	Georgia Department of Community Health 2 Peachtree Street, NW Atlanta, GA 30303

State:	Guam
Agency:	Medicaid Assistance Program
Local:	1-671-735-7356/7168
TTY:	1-671-735-7302
Website:	**dphss.guam.gov/division-of-public-welfare/**
Address:	Department of Public Health and Social Services 123 Chalan Kareta Mangilao, GU 96913-6304

State:	Hawaii
Agency:	Hawaii Department of Human Services Med-QUEST
Oahu Local:	1-808-524-3370
TTY:	1-808-692-7182
Neighbor Islands:	1-800-316-8005
TTY:	1-800-603-1201
Website:	**medquest.hawaii.gov/**
Address:	Department of Human Services Director's Office P.O. Box 3490 Honolulu, HI 96811

State:	Hawaii
Agency:	Med-QUEST
Oahu Section:	1-808-587-3540
Website:	**medquest.hawaii.gov/**
Address:	Med-QUEST Oahu Section P.O. Box 3490 Honolulu, HI 96811-3490

State:	Hawaii
Agency:	Med-QUEST
Kapolei Unit:	1-808-692-7364
Website:	**medquest.hawaii.gov/**
Address:	Med-QUEST Kapolei Unit P.O. Box 29920 Honolulu, HI 96820-2320

State:	Hawaii
Agency:	Med-QUEST
Local:	Med-QUEST
East Hawaii Section:	1-808-933-0339
Website:	**medquest.hawaii.gov/**
Address:	East Hawaii Section 1404 Kilauea Ave. Hilo, HI 96720-4670

State:	Hawaii
Agency:	Med-QUEST
West Hawaii Section:	1-808-327-4970
Website:	**medquest.hawaii.gov/**
Address:	Med-QUEST West Hawaii Section Lanihau Professional Center 75-5591 Palani Road Suite 3004 Kailua-Kona, HI 96740-3633

State:	Hawaii
Agency:	Med-QUEST
Lanai Unit:	1-808-553-1758
Website:	**medquest.hawaii.gov/**
Address:	Med-QUEST Lanai Unit P.O. Box 631374 Lanai City, HI 96763

State:	Hawaii
Agency:	Med-QUEST
Maui Section:	1-808-243-5780
Website:	**medquest.hawaii.gov/**
Address:	Med-QUEST Maui Section Millyard Plaza 210 Imi Kala Street Suite 110 Wailuku, HI 96793-1274

State:	Hawaii
Agency:	Med-QUEST
Molokai Unit:	1-808-553-1758
Website:	**medquest.hawaii.gov/**
Address:	Med-QUEST Molokai Unit P.O. Box 1619 Kaunakakai, HI 96748-1619

State:	Hawaii
Agency:	Med-QUEST
Kauai Unit:	1-808-241-3575
Website:	**medquest.hawaii.gov/**
Address:	Med-QUEST Kauai Unit Dynasty Court 4473 Pahee Street Suite A Lihue, HI 96766-2037

State:	Idaho
Agency:	Idaho Medicaid Program
Local:	1-877-456-1233
Website:	**healthandwelfare.idaho.gov/Medical/Medicaid/tabid/123/Default.aspx**
Address:	Self Reliance Programs P.O. Box 83720 Boise, ID 83720-0026

State:	Illinois – Chicago Office
Agency:	Illinois Medicaid Program
Local:	1-800-843-6154
TTY:	1-866-324-5553
Website:	**www.illinois.gov/hfs/Pages/default.aspx**
Address:	Department of Human Services – Chicago Office 401 South Clinton Street Chicago, IL 60607

State:	Illinois – Springfield Office
Agency:	Illinois Medicaid Program
Local:	1-800-843-6154
TTY:	1-866-324-5553
Website:	**www.illinois.gov/hfs/Pages/default.aspx**
Address:	Department of Human Services – Springfield Office 100 S. Grand Avenue East Springfield, IL 62704

State:	Indiana
Agency:	Indiana Medicaid Program
Local:	1-800-403-0864
Website:	**www.in.gov/medicaid/**
Address:	Family & Social Services Administration (FSSA) Document Center P.O. Box 1810 Marion, IN 46952

State:	Iowa
Agency:	Iowa Medicaid Program IA Health Link
Local:	1-800-338-8366
Des Moines area:	515-256-4606
TTY:	1-800-735-2942
Website:	**dhs.iowa.gov/**
Address:	Iowa Department of Human Services Member Services P.O. Box 36510 Des Moines, Iowa 50315

State:	Kansas
Agency:	KanCare Medicaid for Kansas
Local:	1-800-792-4884
Website:	**www.kancare.ks.gov**
Address:	KanCare Clearinghouse P.O. Box 3599 Topeka, KS 66601-9738

State:	Kentucky
Agency:	Kentucky Medicaid Program
Local:	1-502-564-4321
Toll-free:	1-855-306-8959
TTY:	1-800-627-4702
Website:	**chfs.ky.gov/agencies/dms/Pages/default.aspx**
Address:	Department for Medicaid Services 275 E. Main St. 3W-A Frankfort, KY 40621

State:	Louisiana
Agency:	Louisiana Medicaid Program
Local:	1-888-342-6207
Website:	**ldh.la.gov/index.cfm/subhome/1**
Address:	Louisiana Department of Health P. O. Box 629 Baton Rouge, LA 70821-0629

State:	Maine
Agency:	MaineCare
Local:	1-800-977-6740
TTY:	711
Website:	**www.maine.gov/dhhs/oms**
Address:	Office of MaineCare Services 11 State House Station Augusta, ME 04333-0011

State:	Maryland
Agency:	Maryland Medical Assistance Program
Local:	1-410-767-6500
Assistance Program:	1-877-463-3464
Website:	**mmcp.health.maryland.gov/Pages/home.aspx**
Address:	Maryland Department of Health 201 West Preston St. Baltimore, MD 21201-2399

State:	Massachusetts
Agency:	MassHealth
Local:	1-800-841-2900
TTY:	1-800-497-4648
Website:	**www.mass.gov/topics/masshealth**
Address:	Health Insurance Processing Center P.O. Box 4405 Taunton, MA 02780

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

State:	Minnesota
Agency:	Minnesota Medicaid Program 1-651-431-2670
Local:	1- 800-657-3739
Website:	**mn.gov/dhs/**
Address:	Minnesota Health Care Programs Member and Provider Services P.O. Box 64993 St. Paul, MN 55164-0993

State:	Mississippi
Agency:	Mississippi Medicaid Program 1-601-359-6050
Local:	1-800-421-2408
TDD:	1-228-206-6062
Website:	**www.medicaid.ms.gov**
Address:	Mississippi Division of Medicaid 550 High Street Suite 1000 Jackson, MS 39201

State:	Missouri
Agency:	MO HealthNet Division
Local:	1-573-751-3425
TTY:	1-800-735-2966
Website:	**mydss.mo.gov/msmed**
Address:	The State of Missouri MO HealthNet Division 615 Howerton Court P.O. Box 6500 Jefferson City, MO 65102-6500

State:	Montana
Agency:	Montana Medicaid Program
Montana Public Assistance Helpline:	1-888-706-1535
TTY:	Relay: Dial 711 then 1-888-706-1535
Website:	**dphhs.mt.gov/MontanaHealthcarePrograms/MemberServices**
Address:	Human and Community Services P.O. Box 202925 Helena, MT 59620

State:	Nebraska
Agency:	Nebraska Medicaid Program
Local:	1-855-632-7633
Lincoln:	1-402-473-7000
Omaha:	1-402-595-1178
TTY:	1-402-471-7256
Website:	**dhhs.ne.gov/Pages/Medicaid-Clients.aspx**
Address:	Department of Health & Human Services P.O. Box 95026 Lincoln, NE 68509-5026

State:	Nevada
Agency:	Nevada Medicaid Program
Local:	1-877-638-3472
TTY:	711
Website:	**dwss.nv.gov**
Address:	Nevada Medicaid Customer Service P.O. Box 30042 Reno, NV 89520-3042

State:	New Hampshire
Agency:	New Hampshire Medicaid Program
Local:	1-603-271-4344
Local Toll Free:	1-800-852-3345 ext. 4344
TDD:	1-800-735-2964
Toll-free:	1-844-275-3447
Website:	**www.dhhs.nh.gov/ombp/medicaid**
Address:	Office of Medicaid Business & Policy NH Department of Health & Human Services 129 Pleasant Street Concord, NH 03301

State:	New Jersey
Agency:	New Jersey Medicaid Program NJ FamilyCare
Local:	1-800-356-1561
TTY:	711
Website:	**www.njfamilycare.org**
Address:	NJ Department of Human Services Division of Medical Assistance & Health Services P.O. Box 712 Trenton, NJ 08625-0712

State:	New Mexico
Agency:	New Mexico Medicaid Program Centennial Care
Local:	1-888-997-2583
Toll-free:	1-855-227-5485
Website:	**www.hsd.state.nm.us**
Address:	NM Human Services Department P.O. Box 2348 Santa Fe, NM 87504-2348

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

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

State:	North Dakota
Agency:	North Dakota Medicaid Program
Local:	1-701-328-7068
Toll-free:	1-800-755-2604
TTY:	1-800-366-6888 or 711
Website:	**www.nd.gov/dhs/services/medicalserv/medicaid**
Address:	Medical Services Division North Dakota Department of Human Services 600 E. Boulevard Ave., Dept. 325 Bismarck, ND 58505-0250

State:	Ohio
Agency:	Ohio Department of Medicaid
Local:	1-800-324-8680
TTY:	1-800-750-0750
Website:	**www.ohiomh.com**
Address:	Ohio Department of Medicaid 505 South High Street Columbus, OH 43215

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

State:	Oregon
Agency:	Oregon Health Plan
Local:	1-800-273-0557
TTY:	711
Website:	**www.oregon.gov/oha/hsd/ohp/pages/index.aspx**
Address:	Oregon Health Authority Director's Office 500 Summer Street NE, E-20 Salem, OR 97301-1097

State:	Pennsylvania
Agency:	Pennsylvania Medical Assistance Program
Local:	1-877-395-8930
TTY:	1-800-451-5886
Website:	**www.dhs.pa.gov**
Address:	Department of Human Services P.O. Box 2675 Harrisburg, PA 17105-2675

State:	Puerto Rico
Agency:	Puerto Rico Department of Health Medicaid Program
Local:	1-787-641-4224
TTY:	711
Website:	**www.medicaid.pr.gov/**
Address:	Medicaid Program Department of Health P.O. Box 70184 San Juan, PR 00936-8184

State:	Rhode Island
Agency:	HealthSourceRI
Local:	1-855-840-4774
TTY:	1-888-657-3173
Website:	**www.healthsourceri.com/medicaid**
Address:	HealthSourceRI P.O. Box 8709 Cranston, RI 02920

State:	South Carolina
Agency:	South Carolina Medicaid Program
Local:	1-888-549-0820
TTY:	1-888-842-3620
Website:	**www.scdhhs.gov**
Address:	SCDHHS P.O. Box 100101 Columbia, SC 29202

State:	South Dakota
Agency:	Healthy Connections
Local:	1-800-597-1603
TTY:	711
Website:	**dss.sd.gov/medicaid**
Address:	South Dakota Department of Social Services 700 Governors Drive Pierre, SD 57501

State:	Tennessee
Agency:	TennCare
Local:	1-855-259-0701
TTY:	1-800-848-0298
Website:	**www.tn.gov/tenncare.html**
Address:	TennCare P.O. Box 305240 Nashville, TN 37230-5240

State:	Texas
Agency:	Texas Medicaid Program
Local:	1-800-252-8263
TTY:	711
Website:	**www.https://hhs.texas.gov/services/health/medicaid-chip**
Address:	Texas Health and Human Services P. O. Box 149024 Austin, TX 78714-9024

State:	Utah
Agency:	Utah Medicaid Program
Local:	1-801-538-6155
Toll-free:	UT, ID, WY, CO, NM, AZ, and NV 1-800-662-9651
TTY:	711
Website:	**medicaid.utah.gov/**
Address:	Utah Department of Health Division of Medicaid and Health Financing P.O. Box 143106 Salt Lake City, UT 84114-3106

State:	Vermont
Agency:	Green Mountain Care
Local:	1-800-250-8427
TTY:	711
Website:	**www.greenmountaincare.org**
Address:	Green Mountain Care Health Access Member Services Department of Vermont Health Access 280 State Dr. Waterbury, VT 05671-1010

State:	Virgin Islands - St. Thomas
Agency:	Medical Assistance Program
St. Thomas:	1-340-774-0930
Website:	**www.dhs.gov.vi/financial_programs/medical_assistance.html**
Address:	Department of Human Services – St. Thomas 1303 Hospital Ground Knud Hansen Complex Building A St. Thomas, VI 00802

State:	Virgin Islands - St. Croix
Agency:	Medical Assistance Program
St. Croix:	1-340-773-2323
Website:	**www.dhs.gov.vi/financial_programs/medical_assistance.html**
Address:	Department of Human Services – St. Croix 3011 Golden Rock Christiansted St. Croix, VI 00820

State:	Virginia
Agency:	Department of Medical Assistance Services (DMAS)
Local:	1-804-786-6145
Toll-free:	1-855-242-8282
TDD:	1-888-221-1590
Website:	**www.coverva.org**
Address:	Cover Virginia P.O. Box 1820 Richmond, VA 23218-1820

State:	Washington
Agency:	Apple Health
Local:	1-877-501-2233
TRS:	711
Website:	**www.washingtonconnection.org**
Address:	Washington State Health Care Authority P.O. Box 45531 Olympia, WA 98504

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

State:	Wisconsin
Agency:	Wisconsin Medicaid Program
Local:	1-800-362-3002 or 1-608-266-1865
TTY:	711 or 1-800-947-3529
Website:	**www.dhs.wisconsin.gov/medicaid/index.htm**
Address:	Department of Health Services 1 West Wilson Street Madison, WI 53703

State:	Wyoming
Agency:	EqualityCare
Local:	1-855-294-2127 or 1-307-777-7531
TTY:	711
Website:	**www.health.wyo.gov/healthcarefin/medicaid**
Address:	Wyoming Department of Health – Customer Service Center 2232 Dell Range Boulevard Suite 300 Cheyenne, WY 82009

Exhibit 4 State Pharmaceutical Assistance Programs

Additional information about State Pharmaceutical Assistance Programs can be found at these websites:
www.medicare.gov/pharmaceutical-assistance-program/state-programs.aspx
www.needymeds.org/state_programs.taf

State:	Alabama
Program Name:	AIDS Drug Assistance Program (ADAP)
Toll-free:	1-866-574-9964
TTY:	711
Website:	**www.alabamapublichealth.gov/hiv/adap.html**
Address:	Alabama AIDS Drug Assistance Program HIV/AIDS Division Alabama Department of Public Health The RSA Tower 201 Monroe Street Suite 1400 Montgomery, AL 36104

State:	Alabama
Program Name:	SenioRx/Wellness
Toll-free:	1-800-243-5463
Website:	**www.eastalabamaaging.org/senior-rx/**
Address:	Alabama Department of Senior Services 201 Monroe Street Suite 350 Montgomery, AL 36104

State:	Alaska - Anchorage
Program Name:	AIDS Drug Assistance Program (ADAP)
Local:	1-907-263-2050
General:	1-907-276-4880
Helpline:	1-800-478-AIDS (2437)
Website:	**www.dhss.alaska.gov/dph/epi/hivstd/pages/hiv.aspx**
Address:	Alaskan AIDS Assistance Association – Anchorage 1057 W. Fireweed Lane Suite 102 Anchorage, AK 99503

State:	Alaska - Juneau
Program Name:	AIDS Drug Assistance Program (ADAP)
Juneau:	1-907-586-6089
Toll-free:	1-888-660-2437
Website:	**www.dhss.alaska.gov/dph/epi/hivstd/pages/hiv.aspx**
Address:	Southeast Office of Alaskan AIDS Assistance Association P.O. Box 21481 Juneau, AK 99802

State:	Arizona
Program Name:	AIDS Drug Assistance Program (ADAP)
Local:	1-602-364-3610
Toll-free:	1-800-334-1540
Website:	**www.azdhs.gov/phs/hiv/adap**
Address:	Arizona Department of Health Services Office of Disease Integration and Services 150 N. 18th Avenue Suite 110 Phoenix, AZ 85007

State:	Arkansas
Program Name:	AIDS Drug Assistance Program (ADAP)
Local:	1-501-661-2408
Toll-free:	1-888-499-6544
Website:	**www.healthy.arkansas.gov/programs-services/topics/infectious-disease**
Address:	Arkansas Department of Health HIV/STD/Hepatitis C Section 4815 West Markham St. Slot 33 Little Rock, AR 72205

State:	California
Program Name:	Prescription Drug Discount Program
Local:	1-800-541-5555 or (916) 636-1980
Website:	**www.dhcs.ca.gov/provgovpart/pharmacy/Documents/SB393Inst.pdf**
Address:	California Department of Health Care Services Pharmacy Benefits Division MS 4604 P.O. Box 997413 Sacramento, CA 95899

State:	California
Program Name:	AIDS Drug Assistance Program (ADAP)
Local:	1-844-421-7050
Website:	**www.cdph.ca.gov/Programs/CID/DOA/Pages/OAmain.aspx**
Address:	Office of AIDS – California Dept. of Public Health MS 7700 P.O. Box 997426 Sacramento, CA 95899

State:	Colorado
Program Name:	AIDS Drug Assistance Program (ADAP)
Local:	1-303-692-2716
Website:	**www.colorado.gov/pacific/cdphe/state-drug-assistance-program**
Address:	Colorado Department of Public Health and Environment -DCEED--STI/HIV-A3 4300 Cherry Creek Drive South Denver, CO 80246

State:	Connecticut
Program Name:	CT Aids Drug Assistance Program (CADAP)
Local:	1-800-424-3310
Website:	**portal.ct.gov/dss/Health-And-Home-Care/CADAP/Connecticut-AIDS-Drug-Assistance-Program-CADAP**
Address:	State of CT Department of Public Health c/o Magellan Rx Management P.O. Box 13001 Albany NY 12212-3001

State:	District of Columbia
Program Name:	DC AIDS Drug Assistance Program (DC ADAP)
Local:	1-202-671-4815
Website:	**dchealth.dc.gov/node/137072**
Address:	Administration for HIV/AIDS DC Department of Health 899 North Capitol St. NE Washington, D.C. 20002

State:	Delaware
Program Name:	Delaware Prescription Assistance Program
Local:	1-800-996-9969 (option 2)
Website:	**dhss.delaware.gov/dhss/dmma/dpap.html**
Address:	EDS DPAP Division of Medicaid & Medical Assistance 1901 N. DuPont Hwy -Lewis Bldg P.O. Box 950 New Castle, DE 19720

State:	Delaware
Program Name:	Delaware Chronic Renal Disease Program
Local:	1-800-372-2022 or 1-302-424-7180
Website:	**dhss.delaware.gov/dhss/dmma/crdprog.html**
Address:	DHSS - Division of Social Services – CRDP Lewis Bldg, Herman Holloway Sr. Campus 1901 N. DuPont Highway New Castle, DE 19720

State:	Florida
Program Name:	AIDS Drug Assistance Program (ADAP)
Local:	1-800-352-2437
Website:	**www.floridahealth.gov/diseases-and-conditions/aids/adap**
Address:	Florida Department of Health HIV/AIDS Section 4052 Bald Cypress Way Tallahassee, FL 32399

State:	Florida
Program Name:	Florida Discount Drug Card Program
Local:	1-866-341-8894
TTY:	711
Website:	**www.floridadiscountdrugcard.com/index.aspx**
Address:	No Address

State:	Georgia
Program Name:	HIV Care (Ryan White Part B) Program
Local:	1-404-656-9805
Website:	**dph.georgia.gov/hiv-care**
Address:	Georgia Department of Public Health Health Protection Office of HIV/AIDS 2 Peachtree St. NW Atlanta, GA 30303

State:	Guam
Program Name:	AIDS Drug Assistance Program (ADAP)
Local:	1-671-735-3603
Website:	**targethiv.org/library/topics/part-b-aids-drug-assistance-program-adap**
Address:	Department of Public Health & Social Services Bureau Communicable Disease - Ryan White 123 Charlan Kareta Room 156 Mangilao, GU 96913

State:	Hawaii
Program Name:	HIV Drug Assistance Program (HDAP)
Local:	1-808-733-9360
Website:	**health.hawaii.gov/harmreduction/about-us/hiv-programs/hiv-medical-management-services/**
Address:	Dept. of Health - STD/AIDS Prevention Branch 3627 Kilauea Avenue Suite 306 Honolulu, HI 96816

State:	Idaho
Program Name:	Idaho Prescription Drug Assistance
Local:	211 or 1-800-926-2588
TTY:	711
Website:	**211idaho.communityos.org/zf/taxonomy/detail/id/936707**
Address:	Department of Health and Welfare 211 Idaho CareLine P. O. Box 83720 Boise, ID 83720

State:	Idaho
Program Name:	Ryan White Part B AIDS Drug Assistance Program (ADAP)
Local:	1-208-334-5612
Website:	**healthandwelfare.idaho.gov/health-wellness/diseases-conditions/hiv**
Address:	Idaho Department of Health & Welfare HIV Care and Treatment - Ryan White Program 450 West State Street P.O. Box 83720 Boise, ID 83720

State:	Illinois
Program Name:	AIDS Drug Assistance Program (ADAP)
Local:	1-800-825-3518
Website:	**www.dph.illinois.gov/topics-services/diseases-and-conditions/hiv-aids/ryan-white-care-and-hopwa-services**
Address:	Illinois Department of Public Health Office of Health Protection - HIV/AIDS 525 West Jefferson Street First Floor Springfield, IL 62761

State:	Indiana
Program Name:	HIV Medical Services Program
Local:	1-866-588-4948
Website:	**www.in.gov/fssa/ompp/**
Address:	Indiana State Department of Health HIV/STD Division - HIV Medical Services 2 North Meridian Street Indianapolis, IN 46204

State:	Indiana
Program Name:	HoosierRx
Local:	1-866-267-4679
Website:	**www.in.gov/fssa/ompp/2669.htm**
Address:	HoosierRx 402 W. Washington St., Room W374, MS07 Indianapolis, IN 46204

State:	Iowa
Program Name:	AIDS Drug Assistance Program (ADAP)
Local:	1-515-725-2011
Website:	**idph.iowa.gov/hivstdhep/hiv/support**
Address:	Iowa Department of Public Health Division of Acute Disease Prevention - HIV/AIDS 321 E. 12th St. Lucas State Office Bldg. Des Moines, IA 50319

State:	Kansas
Program Name:	AIDS Drug Assistance Program (ADAP)
Local:	1-785-296-6174
Website:	**www.kdheks.gov/sti_hiv/ryan_white_care.htm**
Address:	HIV/AIDS - Ryan White Program – ADAP Kansas Dept of Health & Environment - BDCP 1000 SW Jackson Suite 210 Topeka, KS 66612

State:	Kentucky
Program Name:	KY AIDS Drug Assistance Program (KADAP)
Local:	1-866-510-0005
Website:	**chfs.ky.gov/agencies/dph/dehp/hab/Pages/services.aspx**
Address:	HIV-AIDS Main Branch 275 E. Main St. HS2E-C Frankfort, KY 40621

State:	Louisiana
Program Name:	Louisiana Health Access Program (ADAP)
Local:	1-504-568-7474
Website:	**dhh.louisiana.gov/index.cfm/page/1118**
Address:	Louisiana Health Access Program (LA HAP) Louisiana Department of Health & Hospitals 628 North Fourth Street Baton Rouge, LA 70802

State:	Maine
Program Name:	Maine AIDS Drug Assistance Program (ADAP)
Local:	1-207-287-3747
Website:	**adap.directory/maine**
Address:	Maine Ryan White Program 40 State House Station Augusta, ME 04330

State:	Maryland
Program Name:	Maryland AIDS Drug Assistance Program
Local:	1-410-767-6535
Toll-free:	1-800-205-6308
Website:	**phpa.health.maryland.gov/oidpcs/CHCS/Pages/madap.aspx**
Address:	Maryland Department of Health 201 W Preston St. Baltimore, MD 21201

State:	Massachusetts
Program Name:	Massachusetts HIV Drug Assistance Program (HDAP)
Local:	1-800-228-2714
Website:	**crine.org/hdap**
Address:	Community Research Initiative 529 Main Street, Suite 330 Boston, MA 02129

State:	Massachusetts
Program Name:	Massachusetts Prescription Advantage
Local:	1-800-243-4636 (Option 2)
TTY:	1-877-610-0241
Website:	**www.mass.gov/prescription-drug-assistance**
Address:	Prescription Advantage Exec. Office of Elder Affairs One Ashburton Place Fifth Floor Boston, MA 02108

State:	Michigan
Program Name:	Michigan Drug Assistance Program (MIDAP)
Local:	1-888-826-6565
Website:	**www.michigan.gov/mdhhs/0,5885,7-339-71550_2955_2982_70541_70542_77771---,00.html**
Address:	Michigan Drug Assistance Program HIV Care Section Division of Health, Wellness and Disease Control Michigan Department of Health and Human Services 109 Michigan Avenue 9th Floor Lansing, MI 48913

State:	Minnesota
Program Name:	AIDS Drug Assistance Program (ADAP)
Local:	1-800-657-3761 or 1-651-431-2414
Website:	**mn.gov/dhs/people-we-serve/children-and-families/health-care/hiv-aids/programs-services/**
Address:	Minnesota Department of Human Services HIV/AIDS Programs - ADAP P.O. Box 64972 St. Paul, MN 55164

State:	Mississippi
Program Name:	AIDS Drug Assistance Program (ADAP)
Local:	1-601-362-4879
Toll-free:	1-888-343-7373
Website:	**msdh.ms.gov/msdhsite/_static/14,0,150.html**
Address:	Care & Services Division-Office of STD/HIV Department of Health - ADAP P.O. Box 1700 Jackson, MS 39215

State:	Missouri
Program Name:	AIDS Drug Assistance Program (ADAP)
Local:	1-573-751-6439
Website:	**www.health.mo.gov/living/healthcondiseases/communicable/hivaids/casemgmt.php**
Address:	Bureau of HIV, STD, and Hepatitis Missouri Department of Health and Senior Services 912 Wildwood P.O. Box 570 Jefferson City, MO 65102

State:	Missouri
Program Name:	Missouri Rx Plan
Local:	1-800-392-2161
Website:	**morx.mo.gov/**
Address:	Missouri RX Plan MO HealthNet Division (MHD) 615 Howerton Court P.O. Box 6500 Jefferson City, MO 65102

State:	Montana
Program Name:	AIDS Drug Assistance Program (ADAP)
Local:	1-406-444-3565
Website:	**dphhs.mt.gov/publichealth/hivstd/treatment**
Address:	Public Health/Human Services - HIV/STD Cogswell Building Room C-211 1400 Broadway P.O. Box 202951 Helena, MT 59620

State:	Montana
Program Name:	Montana Big Sky Rx Program
Local:	1-866-369-1233
Website:	**dphhs.mt.gov/MontanaHealthcarePrograms/BigSky**
Address:	Big Sky Rx Program P.O. Box 202915 Helena, MT 59620-2915

State:	Nebraska
Program Name:	Ryan White AIDS/HIV Program
Local:	1-402-471-2101
Website:	**dhhs.ne.gov/Pages/Ryan-White.aspx**
Address:	Nebraska Dept. of Health & Human Services P.O. Box 95026 Lincoln, NE 68509

State:	Nevada
Program Name:	Nevada Senior Rx
Local:	1-702-486-4307
Toll-free:	1-866-303-6323
Website:	**adsd.nv.gov/Programs/Seniors/SeniorRx/SrRxProg/**
Address:	Aging & Disability Services Division - Senior Rx Dept. Health & Human Svcs. 3416 Goni Road Suite D-132 Carson City, NV 89706

State:	Nevada
Program Name:	Ryan White HIV/AIDS Part B Program (RWPB)
Local:	1-775-684-2219
Website:	**dpbh.nv.gov/Programs/HIV-OPHIE/HIV/AIDS_Surveillance_Program_(HIV-OPHIE)_-Home/**
Address:	Dept. Health & Human Services - HIV/AIDS Surveillance Program (HIV-OPHIE) 4126 Technology Way Suite 200 Carson City, NV 89706

State:	New Hampshire
Program Name:	Ryan White CARE Program
Local:	1-800-852-3345 ext. 4502
Toll-free:	1-603-271-4502
Website:	**www.dhhs.nh.gov/dphs/bchs/std/care.htm**
Address:	DHHS - NH CARE Program 29 Hazen Drive Concord, NH 03301

State:	New Jersey
Program Name:	AIDS Drug Distribution Program (ADDP)
Local:	1-877-613-4533
Website:	**www.nj.gov/health/hivstdtb/hiv-aids/medications.shtml**
Address:	New Jersey Dept. of Health AIDS Drug Distribution Program (ADDP)/Health Insurance Continuation Program (HICP) P.O. Box 722 Trenton, NJ 08625

State:	New Jersey
Program Name:	New Jersey Pharmaceutical Assistance to the Aged and Disabled Program (PAAD)
Local:	1-800-792-9745
Website:	**www.state.nj.us/humanservices/doas/services/paad/index.html**
Address:	NJ Department of Human Services Division of Aging Services 12B Quakerbridge Plaza P.O. Box 715 Mercerville, NJ 08625

State:	New Mexico
Program Name:	HIV/AIDS Treatment and Services
Local:	1-505-476-3628
Website:	**nmhealth.org/about/phd/idb/hats/**
Address:	New Mexico AIDS Services - Dept Health 1190 St. Francis Drive Suite 1200 Santa Fe, NM 87502

State:	New York
Program Name:	AIDS Drug Assistance Program (ADAP)
Local:	1-800-542-2437 or 1-844-682-4058
Out of State:	1-518-459-1641
TDD:	1-518-459-0121
TTY:	1-800-332-3742
Website:	**www.health.ny.gov/diseases/aids/general/resources/adap/index.htm**
Address:	HIV Uninsured Care Programs Department of Health Empire Station P.O. Box 2052 Albany, NY 12220

State:	New York
Program Name:	Elderly Pharmaceutical Insurance Coverage (EPIC)
Local:	1-800-332-3742
TTY:	1-800-290-9138
Website:	**www.health.ny.gov/health_care/epic/index.htm**
Address:	EPIC P.O. Box 15018 Albany, NY 12212-5018

State:	North Carolina
Program Name:	HIV Medication Assistance Program (HMAP)
In NC Only:	1-877-466-2232 or 1-919-733-9161
Website:	**epi.dph.ncdhhs.gov/cd/hiv/hmap.html**
Address:	Division of Public Health - Epidemiology North Carolina HIV/STD Prevention/Care Branch 1902 Mail Service Center Raleigh, NC 27699-1902

State:	North Dakota
Program Name:	AIDS Drug Assistance Program (ADAP)
Local:	1-800-472-2180
Website:	**www.ndhealth.gov/hiv/Resources/**
Address:	HIV/Ryan White - HIV Care – ADAP Dept. of Health - HIV/AIDS Program 2635 East Main Ave Bismarck, ND 58506

State:	Ohio
Program Name:	Ohio HIV Drug Assistance Program (OHDAP)
Local:	1-800-777-4775
Website:	**odh.ohio.gov/wps/portal/gov/odh/know-our-programs/ryan-white-part-b/welcome-to**
Address:	Ohio AIDS Drug Assistance Program (ADAP) HIV Client Services – Ohio Dept. of Health 246 N. High Street Columbus, OH 43215

State:	Ohio
Program Name:	Ohio's Best Rx Program
Local:	1-866-923-7879
TTY:	711
Website:	**www.ohiobestrx.org/en/index.aspx**
Address:	Ohio's Best Rx 2181 East Aurora Road, Suite 201 Twinsburg, OH 44087

State:	Oklahoma
Program Name:	HIV Drug Assistance Program (HDAP)
Local:	1-918-599-4678
Website:	**www.ok.gov/health/Prevention_and_Preparedness/HIV_STD_Service/Ryan_White_Programs/index.html**
Address:	HIV/STD Service - Ryan White Program Oklahoma State Dept. of Health 744 W. Ninth St. Tulsa OK 74127

State:	Oregon
Program Name:	CAREAssist – AIDS Medical Care and Drug Assistance Program
Local:	1-800-777-2437
Website:	**www.oregon.gov/oha/PH/DISEASESCONDITIONS/HIVSTDVIRALHEPATITIS/HIVCARETREATMENT/CAREASSIST/Pages/Clients.aspx**
Address:	CAREAssist Program 800 NE Oregon Suite 1105 Portland, OR 97232

State:	Pennsylvania
Program Name:	PACE, PACENET, PACE plus Medicare (Pharmaceutical Assistance Contract for the Elderly)
Local:	1-800-225-7223
Website:	**www.aging.pa.gov/prescriptions**
Address:	Pennsylvania Department of Aging Bureau of Pharmaceutical Assistance P.O. Box 8806 Harrisburg, PA 17105-8806

State:	Pennsylvania
Program Name:	Special Pharmaceutical Benefits Program – HIV/AIDS Drug Assistance
Local:	1-800-922-9384
Website:	**www.health.pa.gov/topics/programs/HIV/Pages/Special-Pharmaceutical-Benefits.aspx**
Address:	SPBP - HIV/AIDS Pennsylvania Dept. of Health and Mental Health P.O. Box 8808 Harrisburg, PA 17105

State:	Puerto Rico
Program Name:	Ryan White Part B HIV/AIDS Program
Local:	1-787-765-2929
Website:	**www.salud.gov.pr/Dept-de-Salud/Pages/Unidades-Operacionales/Secretaria-Auxiliar-de-Salud-Familiar-y-Servicios-Integrados/Division%20Central%20de%20Asuntos%20de%20SIDA%20y%20Enfermedades%20Transmisibles/Programa-Ryan-White.aspx**
Address:	Departmento de Salud OSCASET Program Ryan White Parte B/ADAP P.O. Box 70184 San Juan, PR 00936-8184

State:	Rhode Island
Program Name:	Rhode Island Prescription Assistance for the Elderly (RIPAE)
Local:	1-401-462-3000
TTY:	1-401-462-0740
Website:	**oha.ri.gov/what-we-do/access/health-insurance-coaching/ripae/**
Address:	Office of Health Aging 25 Howard Ave, Louis Pasteur Bldg. #57 Cranston, RI 02920

State:	South Carolina
Program Name:	AIDS Drug Assistance Program (ADAP)
Local:	1-800-856-9954
Website:	**www.scdhec.gov/infectious-diseases/hiv-std-viral-hepatitis/aids-drug-assistance-program**
Address:	SC ADAP Department of Health & Environmental Control 2600 Bull Street Columbia, SC 29201

State:	South Dakota
Program Name:	Ryan White Part B CARE Program
Local:	1-800-592-1861 or 1-605-773-3737
Website:	**doh.sd.gov/diseases/infectious/ryanwhite/**
Address:	Ryan White Title II CARE Program South Dakota Department of Health 615 East 4th Street Pierre, SD 57501

State:	Tennessee
Program Name:	Ryan White HIV Drug Assistance Program (HDAP)
Local:	1-800-525-2437 or 1-615-741-1000
Website:	**www.tn.gov/health/health-program-areas/std/std/ryanwhite.html**
Address:	HIV/STD Program Ryan White Part B Services Andrew Johnson Tower, 4TH Floor 710 James Robertson Parkway Nashville, Tennessee 37243

State:	Texas
Program Name:	Texas HIV Medication Program
Local:	1-800-255-1090 or 1-737-255-4300
Website:	**www.dshs.state.tx.us/hivstd/meds/default.shtm**
Address:	Texas HIV Medication Program ATTN: MSJA, MC 1873 P.O. Box 149347 Austin, TX 78714

State:	Utah
Program Name:	HIV/AIDS – ADAP AIDS DrugAssistance Program
Local:	1-801-538-6197
Website:	**health.utah.gov/epi/treatment/index.html**
Address:	Utah Department of Health Bureau of Epidemiology 288 North 1460 West Box 142104 Salt Lake City, UT 84114

State:	Vermont
Program Name:	Vermont Medication Assistance Program (VMAP)
Local:	1-802-863-7245
Website:	**healthvermont.gov/prevent/aids/aids_index.aspx#forms**
Address:	Health Surveillance Division P.O. Box 70 Burlington, VT 05402

State:	Virgin Islands
Program Name:	U.S. Virgin Islands Department of Human Services Senior Citizens Affairs Pharmaceutical Assistance to the Aged
Local:	St. Thomas: 1-340-774-0930 St. Croix: 1-340-718-2980 St. John: 1-340-776-6334
Website:	**www.dhs.gov.vi/seniors/pharmaceutical.html**
Address:	Department of Human Services – St. Thomas 1303 Hospital Ground Knud Hansen Complex, Building A St. Thomas, VI 00802 Department of Human Services – St. Croix 3011 Golden Rock Christiansted St. Croix, VI 00820

State:	Virginia
Program Name:	AIDS Drug Assistance Program (ADAP)
Local:	1-855-362-0658
Website:	**www.vdh.virginia.gov/epidemiology/DiseasePrevention/Programs/ADAP/eligibility.htm**
Address:	Virginia Department of Health 109 Governor Street 1st Floor Richmond, VA 23219

State:	Washington
Program Name:	Washington State Health Care Authority Washington Prescription Drug Program (WPSDP)
Local:	1-800-913-4311
Website:	**www.rx.wa.gov/discountcard.html**
Address:	Washington State Health Care Authority 626 8th Ave. SE Olympia, WA 98501

State:	West Virginia
Program Name:	West Virginia Rx
Local:	1-877-388-9879
Website:	**www.wvrx.org/**
Address:	WVRx Patient Eligibility 1520 Washington Street East Charleston, WV 25311

State:	West Virginia
Program Name:	Ryan White Part B Program
Local:	1-800-642-8244 or 1-304-558-2195
Website:	**oeps.wv.gov/rwp/pages/default.aspx**
Address:	West Virginia Bureau for Public Health HIV/AIDS & STD Program 350 Capitol St., Room 125 Charleston, WV 25301

State:	Wisconsin
Program Name:	Wisconsin SeniorCare
Local:	1-800-657-2038
TTY:	711
Website:	**www.dhs.wisconsin.gov/seniorcare/index**
Address:	SeniorCare P.O. Box 6710 Madison, WI 53716

State:	Wisconsin
Program Name:	AIDS/HIV Drug Assistance Program (ADAP)
Local:	1-800-991-5532
Website:	**www.dhs.wisconsin.gov/hiv/index.htm**
Address:	Department of Health Services (DHS) Wisconsin ADAP 1 West Wilson Street Room 434 P.O. Box 2659 Madison, WI 53707

State:	Wyoming
Program Name:	HIV Services Program
Local:	1-307-777-5856
Website:	**health.wyo.gov/publichealth/communicable-disease-unit/**
Address:	The Wyoming Department of Health Communicable Disease Unit -HIV/AIDS 6101 Yellowstone Rd. Suite 510 Cheyenne, WY 82002

Medicare Plus Blue Group PPO Customer Service

Call	**1-800-843-4876** Calls to this number are free. Available from 8:30 a.m. to 5:00 p.m. Eastern time Monday through Friday. Customer Service also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. Available from 8:30 a.m. to 5:00 p.m. Eastern time Monday through Friday.
Fax	**1-866-624-1090**
Write	**Blue Cross Blue Shield of Michigan** Medicare Plus Blue Group PPO Customer Service Inquiry Department – Mail Code X521 600 E. Lafayette Blvd. Detroit, MI 48226-2998
Website	**www.bcbsm.com/statemedicare**

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 9:00 a.m. to 4:30 p.m. Eastern time Monday through Friday.
TTY	**711**
Write	**Michigan Medicare and Medicaid Assistance Program** 6105 West St. Joseph Hwy. Suite 204 Lansing, MI 48917-4850
Website	**www.mmapinc.org**

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