2021

Medicare Advantage Group Administrative Manual

A step-by-step guide to administering your group health plan

Blue Cross Blue Shield of Michigan

Medicare Plus Blue® Group PPO
Prescription Blue® Group PDP

Blue Care Network of Michigan

BCN Advantage℠ HMO-POS

Contents

Shared Contents

Medicare Plus Blue® Group PPO | Prescription Blue® Group PDP

BCN Advantage℠ HMO-POS

Introduction to the Medicare Advantage Group Administrative Manual

The Medicare Advantage group administrative manual covers the processes and procedures for both the Blue Cross Blue Shield Michigan (BCBSM) and Blue Care Network (BCN) Medicare Advantage plans.

Color-coding along the outside edge of the pages differentiates the Shared Content (information that applies to both BCBSM & BCNA groups) and the content specifically for BCBSM or BCNA groups.

		
Shared Content: Information that applies to both BCBSM and BCNA products	BCBSM Medicare Plus Blue Group PPO & PDP	BCN Advantage (BCNA) HMO & HMO-POS

New in the 2021 Manual

In the 2021 manual we've added even more information to help you as you work with your retirees. Here is an overview of the updates.

Updates:

In the Shared Content section:

- Overviews of the *Group Secured Services portal* and the *Agent Secured Services portal* have been added to the *Shared Content* section
- The Opt-in Enrollment timeline has been added to the *Shared Content* section and updated to include BCNA dates (it was formerly in the BCBSM Appendix)
- The Coordination of Benefits Overview content has been added to the *Shared Content* section (formerly in the BCBSM Appendix)
- The Programs and Services to Help Manage Member Care section has been moved to the *Shared Content* section (this content was formerly Section 6 for BCBSM and BCNA) – these programs are available to both BCBSM and BCNA Medicare Advantage Members
- Expanded information about properly staging members in eMVP for Online Enrollment has been added to the *Shared Content* section

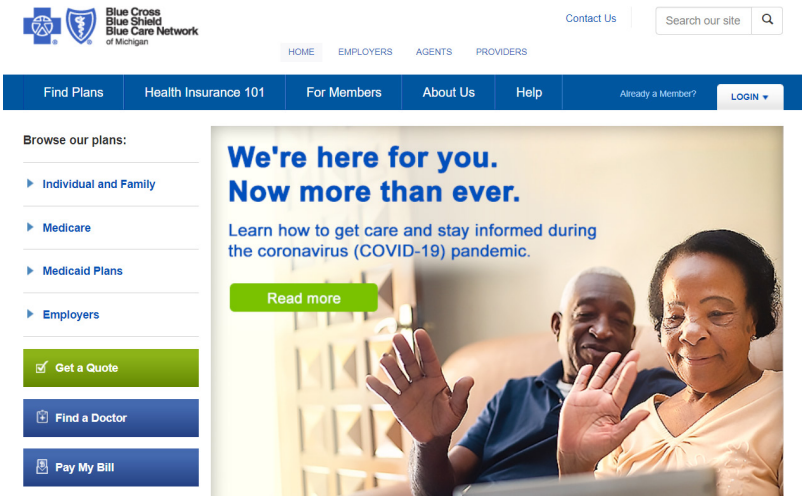
Other updates:

- Step-by-step instructions for staging members in eMVP has been added to *BCBSM Appendix*
- Information about Electronic ACH Billing added for BCBSM and BCNA added to the *Billing Sections* and the *BCBSM and BCNA Appendices*
- Employer, Agent and Group Administrator Resources, as well as Member Resources charts have been added to *BCNA Appendix*
- Documents in appendices updated to current (2021) versions, when applicable

Agent Secured Services portal

The Agent Secured Services portal is an agent administrator's hub for all things Blue Cross. In it you will find materials to help you support your Medicare Advantage group(s). In this portal you will find forms, tutorials and sales and marketing materials.

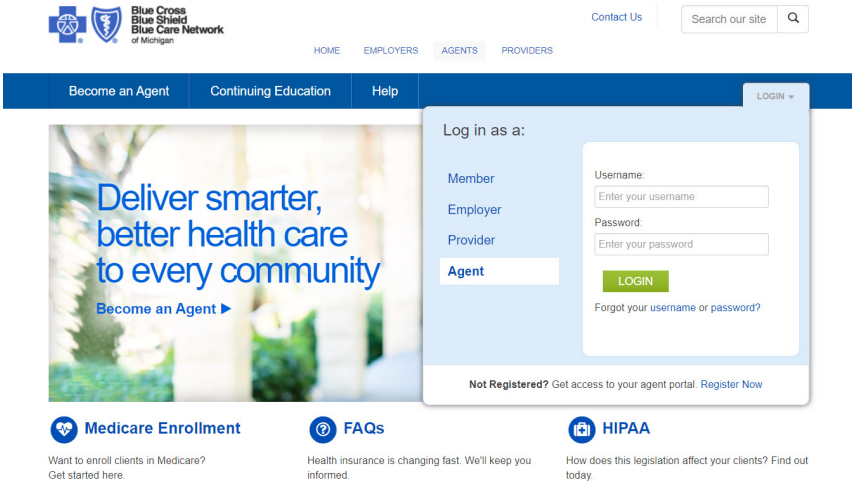
To access the Agent Secured Services portal visit bcbsm.com. You will see tabs at the top of the page. Clicking Agent will provide information and updates, but to dig deeper and access the portal you will need to log in using the Login tab on the right side of the page.



Once the tab has expanded, navigate to *Agent* and then log in with your Blue Cross credentials.

If you've forgotten your credentials use the *Forgot your username or password?* prompt below the login boxes.

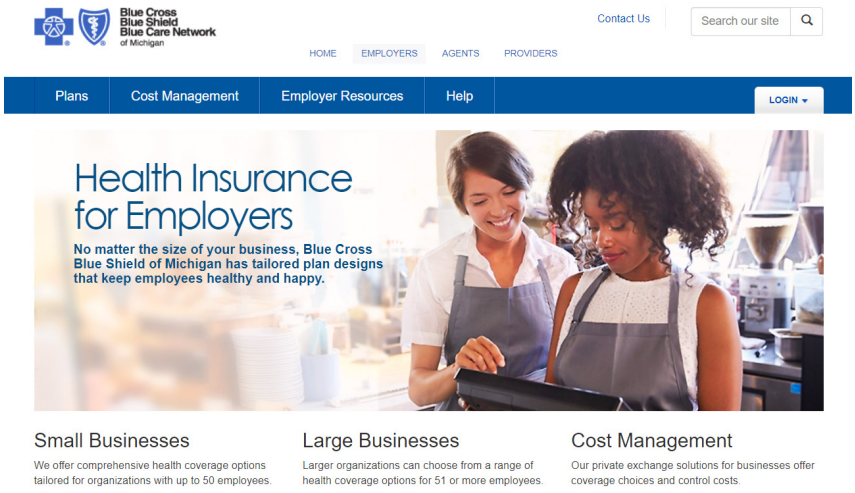
If you don't have credentials scroll down to *Not Registered?* and click *Register Now* to request access to the Agent Secured Services portal.



Group Secured Services portal

The Group Secured Services portal is a group administrator's hub for all things Blue Cross. In it you will find materials to help you support your Medicare Advantage group. In this portal you will find forms, tutorials and other informational materials.

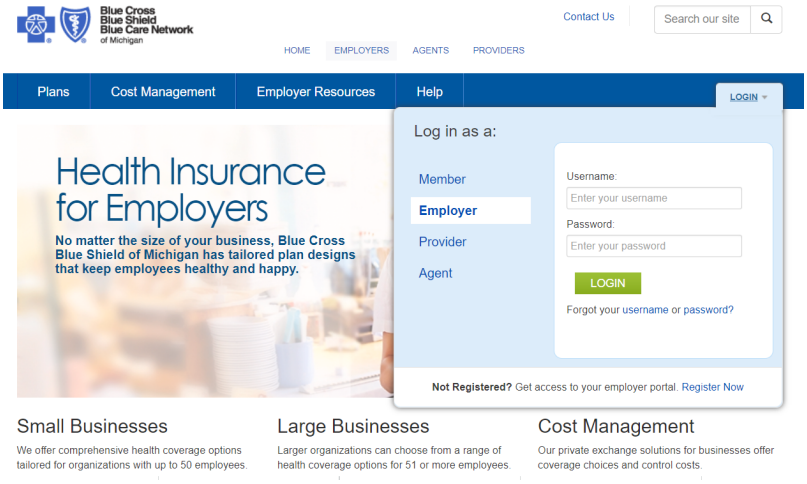
To access the Group Secured Services portal visit bcbsm.com. You will see tabs at the top of the page. Clicking Employer will provide information and updates, but to dig deeper and access the portal you will need to log in using the Login tab on the right side of the page.



Once the tab has expanded, navigate to *Employer* and then log in with your Blue Cross credentials.

If you've forgotten your credentials use the *Forgot your username or password?* prompt below the login boxes.

If you don't have credentials scroll down to *Not Registered?* and click *Register Now* to request access to the Group Secured Services portal.



Member Rights & Responsibilities

Member rights

BCBSM and BCNA believe that members are an essential part of the health care team and should therefore have responsibility for their own health benefits.

All members have the right to:

- Be treated with dignity, respect and fairness
- The privacy of their medical records and personal health information
- See network providers and get covered services within a reasonable period of time
- Know their treatment options and participate in decisions about their health care
- Receive a detailed explanation from BCBSM or BCNA if a provider denies care that they believe they are entitled to receive or should continue to receive
- Refuse treatment
- Use advance directives (such as a living will or a durable power of attorney for health care).
- Get information about our plan
- Get information about our network providers
- Get information about their Medicare Part C medical care or services and costs
- Make complaints

Member responsibilities

All members are responsible for:

- Advising BCBSM or BCNA if they have additional health insurance
- Familiarizing themselves with their coverage and the rules they must follow to get care as a member
- Using all their insurance coverage. If they have other health insurance coverage in addition to our plan, it's important that they use it in combination with their Blue Cross Medicare Advantage plan coverage
- Notifying providers when seeking care (unless it is an emergency) that they're enrolled in Blue Cross Medicare Advantage plans and presenting their Blue Cross Medicare Advantage plans ID card to the provider
- Giving their doctors and other providers the information they need to care for them and follow the treatment plans and instructions agreed upon
- Behaving in a manner that supports the care given to other patients and helps the smooth running of their doctors' offices, hospitals and other facilities
- Paying their co-payment for covered services
- Notifying Medicare, BCBSM or BCNA if they move

CMS Oversight

Like all Medicare Advantage plans, Blue Cross Medicare Advantage plans must comply with the rules established by the Centers for Medicare & Medicaid Services. CMS audits Blue Cross Medicare Advantage plans periodically to ensure compliance.

CMS Five-Star Quality Rating System

The Centers for Medicare & Medicaid Services also assesses the quality of Blue Cross Medicare Advantage plans as part of its national Five-Star Quality Rating System. The star rating system uses measures that are widely recognized within the health care industry as providing an objective method for evaluating health plan quality and performance and member outcomes.

CMS uses information from many different sources to compile its overall star ratings for Blue Cross Medicare Advantage plans. Some of these sources include member surveys administered by Medicare-approved vendors, information from doctors, information we report to CMS and results from Medicare's regular monitoring activities. CMS compiles its overall score for quality of services based on the following:

- How Blue Cross helps members stay healthy through preventive screenings, tests and vaccines and how often our members receive preventive services to help them stay healthy
- How Blue Cross helps members manage chronic conditions
- Member satisfaction with Blue Cross
- How often members filed a complaint against Blue Cross
- How well Blue Cross handle calls from members

Because we offer prescription drug coverage, CMS also evaluates our drug plan for its quality of service, including:

- Customer service
- Member complaints and Medicare audit findings
- Member experience with drug plan
- Drug pricing and patient safety

In 2021 (this is the star rating for the 2020 measurement year, published in October 2020, and called the 2021 Star Rating by CMS), BCBSM earned 3.5 stars out of 5 stars for overall quality and performance. BCNA earned 4 stars out of 5 stars for overall quality and performance.

Complying with CMS guidelines for distributing member materials

CMS guidelines are very strict when it comes to Medicare related marketing materials developed for distribution to beneficiaries. All Medicare-related marketing materials developed for distribution to beneficiaries must comply with CMS guidelines. These include letters, fliers, brochures and postcards. To take the worry out of CMS compliance, Blue Cross we have approved member material for your use. Blue Cross Medicare Advantage groups will keep a copy of the communication on file for 10 years. Groups that don't file copies of documents with Blue Cross Medicare Advantage Group will be responsible for record retention.

BCBSM is committed to member satisfaction and must ensure that the process for members that become eligible to elect Medicare Advantage is handled by the employer group (or its Third Party Administrator on its behalf) consistent with the guidance issued by the Centers for Medicare and Medicaid Services (CMS). It is your responsibility to follow applicable guidance and established BCBSM and BCNA processes to ensure that your Medicare-eligible retirees receive a pre-enrollment kit before he/she can enroll in a Blue Cross Medicare Advantage employer group plan. Your enrollment process for members that become eligible for Medicare Advantage must follow the member enrollment method established for your initial Medicare Advantage Group set-up or as may be later altered by agreement between you and BCBSM or BCNA.

Medicare Overview

Medicare Advantage overview

Medicare is a federally funded, national program that pays for medical care coverage for the following:

- People age 65 and older
- Certain individuals younger than 65 with a qualifying disability
- People with End-Stage Renal Disease

Individuals qualify for full Medicare benefits at age 65 or older if:

- They are a U.S. citizen or a permanent legal resident who have lived in the United States for at least five years; and
- They or their spouse has worked long enough to be eligible for Social Security or railroad retirement benefits — usually having earned 40 credits from about 10 years of work — even if they are not yet receiving these benefits; or
- They or their spouse is a government employee or retiree who have not paid into Social Security but have paid Medicare payroll taxes while working.

Individuals qualify for full Medicare benefits under age 65 if:

- They have been entitled to Social Security disability benefits for at least 24 months (which need not be consecutive); or
- They receive a disability pension from the Railroad Retirement Board and meet certain conditions; or
- They have Lou Gehrig's disease (amyotrophic lateral sclerosis), which qualifies you immediately; or
- They have permanent kidney failure requiring regular dialysis or a kidney transplant — and they or their spouse has paid Social Security taxes for a certain length of time, depending on their age.

Medicare Advantage plans must include the benefits of Original Medicare, and may offer additional value. It's important to make sure Medicare beneficiaries understand that Blue Cross Medicare Advantage group members receive all entitlements and privileges of Original Medicare through their Medicare Advantage plan. When they join a Medicare Advantage plan, they are assigning the administration of their Medicare benefit to a private insurer. Beneficiaries must continue to pay their Medicare Part B premium to receive Medicare benefits.

As an employer offering a Medicare Advantage group plan, retirees can select different types of coverage. A Medicare Advantage plan that does not include Part D Prescription drug coverage is known as a Medicare Advantage (MA) plan. Medicare Advantage plans that combine Medical and Part D prescription drug coverage are known as MA-PD plans.

Part D prescription plan and creditable coverage

Medicare Part D is prescription drug coverage which can be offered as a stand alone, combined with a commercial medical plan or included in the Medicare Advantage plan. Medicare prescription drug coverage is available through private insurance companies either as a stand alone plan, or, in conjunction with a medical plan (MA).

For those enrolled in a MA-PD, there is no need for the beneficiary to enroll in a stand-alone PDP plan. Beneficiaries who have another source of creditable drug coverage – for example, though a spouse that offers a commercial drug plan – may stay in that plan and choose not to enroll in a Medicare Part D plan.

Notice of creditable coverage and late-enrollment penalty

If you provide other prescription drug coverage for retired employees aside from Part D, you must disclose whether this coverage is creditable to CMS.

You must also disclose whether the coverage you provide is creditable to all Medicare-eligible individuals. This ensures that your employees don't have to pay a late-enrollment penalty should a beneficiary decide to enroll in a Part D plan at a later time. CMS assesses a fine if your employee didn't have creditable prescription drug coverage for at least 63 continuous days after the end of the Part D initial enrollment period. The letter does not exempt a beneficiary from a late enrollment penalty if the coverage from the company is not creditable. A Medicare Part D plan notifies an enrollee in writing if the plan determines the enrollee has had a continuous period of 63 days or more without creditable prescription drug coverage at any time following his or her initial enrollment period for the Medicare prescription drug benefit.

NOTE: The member has the right to ask CMS to review the late enrollment penalty.

Eligibility for Medicare Advantage plans

To be eligible for a Medicare Advantage plan, such as BCBSM or BCN Medicare Advantage plan, a retiree must:

- Reside in the U.S.
- Be enrolled in Medicare Part A and Part B
- Meet the qualifications of the sponsoring employer or union group
- Have a valid MBI number on file with the group
- To be eligible to elect an MA plan, an individual must be entitled to Medicare Part A and/or enrolled in Part B, as of the effective date of the MA or MA-PD plan
- To be eligible for Part D and to enroll in a PDP, an individual must be entitled to Medicare Part A or enrolled in Part B as of the effective date of coverage under the PDP Medicare Advantage Plans (Part C)

CMS mandates that Medicare beneficiaries can be enrolled in no more than one Medicare Advantage plan or Part D prescription drug plan at a time.

- Members may not be enrolled in a group Medicare Advantage plan that has prescription drug coverage (MA-PD) and in a individual Medicare Part D plan at the same time.
- Members can not enroll in a Medigap plan when they are enrolled in a Medicare Advantage plan.

NOTE: PO Box Addresses can be used as a mailing address, but the member must have a permanent mailing address in the U.S. to be enrolled in a Medicare Advantage plan.

NOTE: Communications materials for Medicare Advantage members must always be in 12-point Times New Roman type or an equivalent.

Your Medicare Advantage Representative can educate your employees about Medicare Advantage plans as well as coordinate enrollment efforts and can also coordinate the submission of marketing materials to CMS.

For Blue Cross Medicare Advantage plan information
please contact the Sales Department

1-888-563-3307
During regular business hours

Online Enrollment Platform

In 2019, Blue Cross introduced an Online Enrollment Platform to enhance the Medicare Advantage enrollment process for retirees with plans offered by employer groups. The convenient new online and phone enrollment method was made available for all new group implementation, as well as for existing groups using the opt-in enrollment method.

The Online Enrollment Platform makes enrollment easer for retirees and provides on-demand access to benefit information, membership, enrollment, and changes to Group Administrators. Existing PPO and HMO groups that utilize an 834 file for enrollment were not transitioned to the Online Enrollment Platform

The platform enables Group Administrators to:

- View membership and track enrollment/changes
- View documents available to members (Benefits-at-a-Glance documents, Multi-Language, Non-Discrimination, Stars Info, etc.)
- View Retiree dashboard containing retiree status, effective date, and plan selection.
- Enjoy reduced inquires as a result of dedicated online chat and Enrollment Support Call Center
- Access standard reports

The platform enables Retirees to:

- Compare plans and enroll leveraging all types of technology, including telephone, online and mobile capabilities
- Update their demographic information
- View documents related to plans (Benefits-at-a-Glance documents, Multi-Language, Non-Discrimination, & Stars Info, etc.)
- Get support using dedicated online chat and Enrollment Support Call Center
- Get help with enrollment using Enrollment Support Call Center
- Request paper pre-enrollment kit using Enrollment Support Call Center

Initial Enrollment Process

Opt-out and Opt-in for Medicare Advantage Groups

There are two enrollment methods available to groups: opt-out and opt-in. These enrollment options are designed to provide a smooth transition into Medicare Advantage.

Opt-out enrollment method

The Opt-Out enrollment method means that all members identified by the group will have the option to enroll into a qualified plan unless they choose not to participate by completing an Opt-Out form.

NOTE: Most new groups that use the opt-In enrollment method for initial set-up. Most existing opt-out groups will be converted to opt-In enrollment as they're transitioned to the Online Enrollment Platform.

The Medicare-eligible member has up to 90 days prior to their Medicare enrollment effective date to provide the group plan administrator with their information.

This information includes:

- Medicare Beneficiary Identifier
- Part A effective date*
- Part B effective date*

*Part A and Part B effective dates are not a requirement for the enrollment application.

In 2019, Blue Cross launched an Online Enrollment Platform to make Medicare Advantage enrollment easier for members and to provide greater visibility and into member enrollment and on-demand reporting to Group Administrators. The system services group enrollments, manages member status changes, and fields general inquiries. To access the portal visit: www.bcbsmgroupmedicareplan.com.

MOS (MetaVance)

The electronic Membership Viewing and Processing (eMVP) system is a web-based tool that makes it easy for Group Administrators, Managing Agents, and Agents to administer plans by providing access to membership and benefit information. The administrative user can inquire about Group/Division information, add or modify contract/member information, and request ID cards.

Examples of contract level transactions that can be performed within the system are modification of Employment Status and transfer of a contract from one division to another. Examples of member level transactions that can be performed within the system are enrollment of a dependent, modification of an address and update of selected Benefit Package ID.

Important Note: This MOS eMVP process does not apply to groups with only Medicare Advantage coverage. For existing BCBSM groups on MOS, the completed membership file is submitted via census spreadsheet or the AGR Mass Update Request Template (see Appendix, Automated Group Reporting (AGR) Mass Update Request Template). The initial membership file should also contain two months of members who will be aging into the plan.

For instructions on updating member records in eMVP, go to: https://pubpruat.bcbsm.com/content/public/en/employers/resources/manage-employee-records-online.html or contact eMVP support at 1-866-676-4858.

NASCO

Important Note: For existing Blue Cross Medicare Advantage groups or new-to-Blue groups on NASCO, the completed membership file is submitted via census spreadsheet or the AGR 834 template to be used for pre-enrollment mailings. The initial membership file should also contain two months of members who will be aging into the plan. For instructions on updating member records in eMVP, go to: https://pubpruat.bcbsm.com/content/public/en/employers/resources/manage-employee-records-online.html or contact eMVP support at 1-866-676-4858.

Opt-out enrollment process from the member perspective

The Medicare Advantage member enrollment process requires approximately 55 days of lead-time to meet CMS compliance guidelines. All Medicare members will get their own unique Blue Cross Medicare Advantage contract number. All Medicare Advantage members are enrolled as individual contracts; there are no two-person or family Medicare Advantage contracts. As part of the enrollment process, Blue Cross mails Medicare Advantage-eligible members a pre-enrollment kit in accordance with CMS regulations.

The pre-enrollment kit includes:

- A cover letter explaining the enrollment process
- Benefits-at-a-Glance
- CMS Star rating flier
- Anti-discrimination flier required by CMS
- An enrollment opt-out form

Medicare-eligible retirees and eligible dependents who want to continue their group coverage and enroll in a Blue Cross Medicare Advantage plan will be automatically enrolled by their effective date.

NOTE: Should a member decide to cancel after the opt-out period or after submitting a paper application, but prior to the Medicare Advantage effective date, BCBSM or BCNA will work with CMS to cancel the coverage as if it were never effective.

- When the member confirms his or her desire to opt-out of Blue Cross Medicare Advantage coverage, they will not be enrolled in the plan.
- Should a retiree of a group using the opt-out enrollment method decide not to enroll in Blue Cross Medicare Advantage coverage, they must return the opt-out form by the date specified in the pre-enrollment cover letter.
- If the member indicates the opt-out form was sent in error, we will process their enrollment to the plan.
- When benefits include Part D, BCBSM or BCNA will send members a Part D Coordination of Benefits letter. This letter will request confirmation of any prescription drug coverage that a member has in addition to the Blue Cross Medicare Advantage Part D coverage.

Opt-in enrollment method

The opt-In enrollment method means that all members identified by the group will be offered the Blue Cross Medicare Advantage plan and/or PDP plan.

Members can enroll by submitting a paper enrollment application to BCBSM or BCNA or by using the Online Enrollment Platform. For online enrollment, group plan administrators must first properly stage members in eMVP to trigger letters inviting members to use the Blue Cross Online Enrollment Platform to enroll in a plan.

Retiree responsibilities:

The Medicare-eligible member notifies the group administrator of their Medicare information 90 days prior to their Medicare enrollment effective date. This information includes:

- Medicare Beneficiary Identifier
- Part A effective date*
- Part B effective date*

*Part A and Part B effective dates are not required on the enrollment application but are necessary to complete enrollment.

Blue Cross mails all eligible retirees the Online Enrollment Letter*
OR
CMS required enrollment kit, which includes:

- A cover letter explaining the enrollment process
- Benefits-at-a-Glance
- CMS Star Rating flier
- Anti-discrimination flier required by CMS
- An enrollment opt-in application

*Members enrolling online can access all CMS required documents in the Online Enrollment Platform

Group Plan Administrator responsibilities:

CMS requires proof of the eligible retiree, at least 21 days prior to their effective date, in order to receive pre-enrollment materials. If an enrollment record is not created in your group's retiree section, eligible dependents for group enrollment in Medicare Advantage may be declined or delayed.

For paper enrollment

1. The group plan administrator provides a complete membership file (census file) of Medicare-eligible members 60 days prior to their effective date to Blue Cross. Members who enroll in Medicare Plus Blue Group PPO Medicare Advantage plan must return their application to their group plan administrator by the required return date.
2. The group plan administrator confirms the member has a Blue Cross retiree enrollment record in their retiree group. If the member is not enrolled in the Blue Cross retiree group, the group must add them.
3. The retiree's commercial enrollment record must be established with the correct benefit codes to reflect enrollment in Medicare Plus Blue Group. Incorrect enrollment records will cause member claims to pay incorrectly. (Visit MOS or NASCO websites).
4. If an enrollment record is not created in your group's retiree section (i.e. MOS Division or NASCO section), eligible dependents for group enrollment in Medicare Advantage may be declined or delayed.
5. The group plan administrator will email or fax the completed and signed enrollment application.

For online enrollment

Prior to using the Online Enrollment Platform to enroll a member, the Group Plan Administrator must first properly stage all members in eMVP. There are four steps in the staging process that must be completed in to properly stage a member in eMVP:

1. First the group plan administrator must update employment status to retiree if the employment status of the membership record does not currently reflect 'Retiree,' this change will need to be made before any of the subsequent steps.
2. If the contract does not currently reside in a Medicare Advantage pull division, the group plan administrator will have to transfer the member to one.
3. The group plan must ensure that the membership record reflects a Member Type of 'Medicare' and a Comp/Medicare Benefit Package ID (BPID) is selected.
4. Finally, the group plan administrator must ensure that the membership record reflects Medicare A&B—Primary coverage.

Successful staging of a member will trigger the mailing of a letter inviting the member to use the Online Enrollment Platform to enroll in a Medicare Advantage plan. Please visit the Agent Secured Services portal or the Group Secured Services portal or step-by-step instructions and a video tutorial on staging members. Members who enroll in Medicare Plus Blue Group PPO Medicare Advantage plan must enroll online by the required enrollment date.

Send BCBSM member enrollment form to:	Send BCN member enrollment form to:
Blue Cross Blue Shield of Michigan Medicare Plus Blue Group P O Box 44256 Detroit, MI 48244-0256 Fax: 1-866-533-5810 E-mail: fbgrpenrollmentesc@bcbsm.com	BCN Advantage HMO Mail Code H300 P.O. Box 5013 Southfield, MI 48086-9719
Enroll using the Online Enrollment Platform	
www.bcbsmgroupmedicareplan.com	
Telephone enrollment available using the Enrollment Support Call Center	
1-800-284-6994	

If BCBSM or BCNA do not receive the application prior to the member's Medicare enrollment and effective date, the member will be enrolled in Blue Cross Medicare Advantage plan on the first of the month following receipt of the member application. The group should adjust its member's non-Medicare enrollment record according to their eligibility rules.

Blue Cross responsibilities

1. When enrollment in Blue Cross Medicare Advantage plan is confirmed with CMS, BCBSM or BCNA will send the member a welcome packet and member ID card. Members will use their Blue Cross Medicare Advantage plan ID card and keep their Original Medicare card in a safe place.
2. When benefits include Part D as part of the enrollment process, BCBSM or BCNA will send members a Part D Coordination of Benefits letter. This letter will request confirmation of any prescription drug coverage that a member has in addition to the Medicare Plus Blue Part D plan.
3. The member should return the Coordination of Benefits (COB) letter if the information letter on the form is incorrect and add information if the member is enrollment in other plans.

Opt-in Enrollment Timeline		
Initial enrollment (Dates are approximate)		
Responsible party	**Enrollment activity**	**Deadline**
Group administrator (aka – Employer, Union, TPA)	Provide Group Coverage and Enrollment Agreement Package confirming plan options, rates and effective dates to Blue Cross	BCBSM: 90 days prior to effective date BCNA: 45 days prior to effective date
Group administrator	• Identify retirees eligible to enroll in BCN Advantage HMO-POS and Medicare Plus Blue Group PPO. Update key Medicare information in eMVP or NASCO for all members as needed • Add member enrollment record to retiree division (eMVP) with correct benefit codes when the enrollment form is sent to the group.	BCBSM: 60 days prior to member's effective date BCNA: 45 days prior to effective date
Blue Cross	Send online enrollment letter OR pre-enrollment kit to member	BCBSM: 90-55 days prior to member Medicare Plus Blue Group PPO effective date BCNA: 45 days prior to effective date
Member	**Enroll using the Online Enrollment Platform or telephonic enrollment OR Elect enrollment and return completed enrollment form to group or mail directly to Blue Cross. Medicare Beneficiary Identifier and signature are required to process enrollment**	**BCBSM: 45-0 days prior to effective date BCNA: 40-0 days prior to effective date**
Group administrator	• Add member enrollment record to Blue Cross retiree section with correct benefit codes • Send enrollment form to BCBSM or BCNA secured email or mailing address	BCBSM: 30 days prior to effective date BCNA: 30 days prior to effective date
Blue Cross	• Submit enrollment to CMS and process enrollment link to group retiree section • Mail ID card to member • Mail welcome kit to member	BCBSM: 30-0 days prior to effective date BCNA: 30-0 days prior to effective date
Member	**Enrolled in Blue Cross Medicare Advantage plan**	**On effective date (All effective dates are the first of the month.)**

Incomplete or Member Enrollment Information

Note: If a Medicare Beneficiary Identifier submitted for a Medicare-eligible member is identified as invalid, we will attempt to notify the member (not the group) by phone and if that is unsuccessful a letter will be mailed by BCBSM or BCNA. The member will be asked to provide a copy of his or her Medicare card to complete enrollment for the initial requested effective date. Incomplete or invalid member information can delay member enrollment effective dates.

Members who do not respond in a timely manner will be dropped from the enrollment process and their group coverage may be terminated according to the group eligibility rules. If those members subsequently respond that they do want to be enrolled in a Blue Cross Medicare Advantage plan, the enrollment request must be resubmitted and coordinated by the group administrator and BCBSM or BCNA. The effective date for these members will be the first of the month following receipt of the request to have them enrolled.

Each retiree and dependent enrolled in a Blue Cross Medicare Advantage plan is placed on a separate contract and assigned a unique ID number. Each member will receive their own ID card with their own ID number. Members should no longer use their ID card from Original Medicare; however, they should retain it and keep it in a safe place.

Once a member is enrolled in Medicare Advantage and appears on the group bill, group administrators will continue to be able to view the MOS Pull membership record through the electronic Membership Collection System (eMVP). However, the group cannot perform membership updates to a plan's enrollment record of a member enrolled in a Medicare Advantage group number. BCBCM or BCNA will coordinate all updates to this record with CMS so our records are in sync with the federal government's records. Once a record has been staged for Medicare Advantage in a commercial pull division (ex. via eMVP), future changes to that record for MA Medical coverage can only be made through MA Customer Service or your Group Service Consultant (the exception being for ancillary benefit coverage).

Resolving enrollment interruptions

Blue Cross will work with the employer group or union to ensure that all eligible members are enrolled in the plan. Some enrollment interruptions require resolution between Blue Cross and the member. Member enrollment can be interrupted if issues with the group or member are not resolved. Blue Cross Medicare Advantage account service team and/or the Medicare Advantage Enrollment Unit will contact the group administrator to coordinate the resolution and ensure enrollment for the member.

The chart on the next page lists the most common interruptions to member enrollment in a Blue Cross Medicare Advantage plan and steps the group should take to resolve them.

Enrollment interruption	Group administrator (aka – Employer, Union, TPA) action
Incorrect or missing member data and request-for-information letters	
During the enrollment process, a member might not be correctly processed for enrollment because of missing or invalid information (e.g. Medicare Beneficiary Identifier). When this issue is discovered, we may send the member a Request-for-Information letter. The Account Service team may request that the group initiate the corrective action when missing information is returned or validated. Untimely receipt of correct and completed information could delay a member's enrollment.	Assist BCBSM or BCNA in gathering the required information. Any lag in this resolution can lead to delays in coverage.
Duplicate coverage	
We may discover a prospective member already has Medicare Advantage coverage through another employer or union group. The Account Service team will contact the group to confirm if BCBSM or BCNA should proceed with enrolling the member.	Assist BCBSM or BCNA in determining which members with other Medicare Advantage coverage should be enrolled in your plan.
Opt-out enrollment set-up	
During their 21-day opt-out window, members may decline Blue Cross Medicare Advantage coverage. BCBSM or BCNAwill stop the enrollment process for members who confirm their desire to opt out. Member enrollment record is not adjusted in the retiree group section when member declines enrollment in Medicare Advantage.	Update the membership data in your retiree group member enrollment record according to group eligibility rules. BCBSM or BCNA will provide a list of members who opt-out of Blue Cross Medicare Advantage coverage to your retiree benefit administrator.
Opt-in enrollment set-up	
Member is not enrolled in Blue Cross Medicare Advantage plan by effective date.	Make sure member enrollment form was returned, enrollment record was created in retiree section and enrollment form was sent to Blue Cross enrollment for processing. If any of the 3 actions were not complete the member's enrollment may be delayed to the first of the month following completion of the enrollment set up.

Enrollment interruption	Group administrator (aka – Employer, Union, TPA) action
CMS terminations	
At any time after a member's data is sent to CMS for enrollment into a Blue Cross Medicare Advantage plan, Blue Cross may receive a termination from CMS for that member. This can result from a member's voluntary request, the member losing Medicare eligibility, the member enrolling in another Medicare Advantage plan, death or a variety of other reasons. These members will be terminated from your Blue Cross Medicare Advantage plan according to the date received from CMS. We will send a disenrollment letter to these members.	N/A
Updates to eligibility roster	
BCBSM or BCNA will provide a monthly bill of all of your members.	Use this bill to reconcile your membership records and answer member questions you may receive.

Invalid enrollment

Certain circumstances can prevent a Medicare-eligible retiree (or his or her dependents) from enrolling in a Medicare Advantage plan:

- The retiree resides outside of the U.S. or U.S. territories.
- The retiree's Medicare Health Insurance Claim Number on record is not valid. The member's Medicare Beneficiary Identifier must match CMS files to initiate enrollment in a Medicare Advantage plan.
- The commercial membership records are not properly updated.
- The member's permanent address is a PO Box.

Retroactive enrollment

Retroactive enrollment of a member is allowed only in limited circumstances as defined by CMS guidelines for Medicare Advantage group activity at www.cms.gov. Contact your Blue Cross Medicare Advantage representative for more information about retroactive enrollments.

Annual Renewal for Medicare Advantage Groups

BCBSM and BCNA conduct annual renewals based on Medicare's benefit year (January 1 - December 31) and in conjunction with CMS benefit changes. We request the following information from your group as part of your regular annual rate renewal process:

- A review of the enrollment participation minimum
- Confirmation of an open enrollment period as defined below with or without member meetings

Required contract documents

Groups are required to review and sign updated contract documents contained in the Group Coverage and Enrollment Agreement package annually.

Open enrollment

During open enrollment for Medicare Advantage plans, retirees may be offered a choice between two or more health plan options. For groups that offer a choice of two plans or more, an open enrollment period is required to allow retirees an opportunity to review plan options. Groups that offer plan choices must use the opt-in enrollment method.

A group has the option of holding a member meeting that describes the group's benefits and any changes for the coming year. If a group only offers Blue Cross Medicare Advantage plans to its retirees, there is no open enrollment period (generally speaking, these are groups who use the opt-out method of enrollment).

CMS requires that all Medicare Advantage members receive an Annual Notice of Change/Evidence of Coverage each year.

For groups that offer retirees a choice during an open enrollment period, the Annual Notice of Change must be in the retirees' homes 15 days before the scheduled open enrollment period. It is very important that the group and BCBSM or BCNA work together to ensure that open enrollment activities are CMS compliant.

Groups with open enrollment also have greater access to CMS enrollment guidelines:

- All eligible Medicare retirees must receive pre-enrollment materials describing plan options during their open enrollment period.
- BCBSM and BCNA have developed a procedure that ensures all eligible members receive a pre-enrollment kit and that the record is maintained for the required CMS time frame of 10 years. We highly recommend you follow the procedure to make sure you have compliant enrollment records. However, a group may opt to distribute the pre-enrollment materials directly to its retirees. If you choose this method, you are responsible for maintaining an auditable record for 10 years. Your records must clearly demonstrate that every eligible member received the appropriate pre-enrollment materials to be compliant with CMS regulations.

Follow CMS guidelines described above. Groups should inform BCBSM or BCNA of the following at least six months prior to their renewal:

- The group will have an open enrollment or member meeting
- Proposed open enrollment date(s)

Retirees should return their application forms to Blue Cross or directly to the group. The group can choose to have their members return open enrollment forms to them or have the members return their enrollment application to Blue Cross at the addresses listed below.

For example, for a Jan. 1st implementation, the group should provide the enrollment forms to BCBSM no later than Dec. 10th by email, fax or mail:	For example, for a Jan. 1st implementation, the group should provide the enrollment forms to BCN no later than Dec. 10th by email, fax or mail:
Blue Cross Blue Shield of Michigan Medicare Plus Group PPO P O Box 44256 Detroit, MI 48244-0256 Fax: 1-866-533-5810 E-mail: fbgrpenrollmentesc@bcbsm.com	Blue Care Network Membership and Billing – M.C. C300 P.O. Box 5043 Southfield, MI 48086 Fax: 1-877-218-1466

Groups should also inform Blue Cross of the following at least six months prior to their renewal:

- If Blue Cross retiree group's records need to be updated
- Changes to the current enrollment method
- If additional reports of enrollment activity will be required for new and canceled members

Annual communications and enrollment

Whether a group employs an opt-out or an opt-in method of enrollment or conducts an open enrollment as described above, the following CMS member notifications and processes must be completed as part of the annual renewal process. As required by CMS, BCBSM or BCNA must mail the ANOC/EOC packet to all current Blue Cross Medicare Advantage plan members (groups cannot mail out Annual Notice of Change/ Evidence of Coverage (ANOC/EOC) kits).

For groups without an open enrollment period, the ANOC/EOC mailing must be received in the retiree's home 15 days before the renewal effective date of January 1. For groups with an open enrollment, mailings are scheduled so members receive the ANOC/EOC at least 15 days prior to the group's open enrollment start date. The ANOC/EOC packet includes:

- The Annual Notice of Change and the Evidence of Coverage
- Members of groups with Part D prescription drug coverage also receive a formulary (list of covered drugs)
- Eligible members also receive a Low-Income Subsidy (LIS) rider
- Blue Cross will re-enroll members in the Blue Cross Medicare Advantage plan unless we've been notified by the group that a member is not re-enrolling
- When a member lets the group know he or she is not re-enrolling, the group administrator follows standard disenrollment procedures and provides BCBSM or BCNA with the disenrollment form

Coordination of Benefits Overview

Coordinating with non-governmental benefits

BCBSM is required to review a member's non-governmental benefits and coordinate them with his or her Medicare Advantage coverage. In doing so, BCBSM and BCNA must:

- Identify payers that are primary to Medicare
- Identify the amounts payable by those payers
- Coordinate the BCBSM or BCNA benefits of Medicare Advantage enrollees with the benefits of the primary payers

Coordination of Benefits (COB) with Medicare Part D

Part D plans are subject to specific guidelines for COB under the Medicare Modernization Act. The law expanded Medicare Secondary Payer rules for the Part D benefit. Some CMS regulations related to enrollment may impact coordination of benefits.

Coordinating with governmental benefits

Veterans Affairs benefits

When a member has both Medicare Advantage and Department of Veterans Affairs benefits, treatment may be paid for by either program. When seeking health care services, the member must choose which plan will be billed. This choice must be made each time healthcare services are provided. Medicare Advantage will not duplicate coverage for services provided by Veterans Affairs benefits. Likewise, Veterans Affairs will not duplicate coverage or for services provided through Medicare Advantage.

To get services reimbursed under the VA plan, members should seek services from a VA provider or facility or have the VA authorize services by a non-VA provider or facility. If the VA authorizes services in a non-VA hospital, but doesn't pay for all of the services received during the hospital stay, Medicare Advantage may then pay for the services covered by the Medicare Advantage plan.

Example

Bob, a veteran, goes to a non-VA hospital for a service that is authorized by Veterans Affairs. While at the non-VA hospital, Bob receives other services that are not authorized by Veterans Affairs. Veterans Affairs refuses to pay for those services. Some are Medicare Advantage covered services that Medicare Advantage will pay. Bob will then have to pay for services that aren't covered by Medicare Advantage or Veterans Affairs.

Veterans Affairs charges a co-payment to some veterans. The co-payment is the member's share of the cost of their treatment and is based on income. Medicare Advantage may pay all or part of a member's co-payment, if the member is billed for VA-authorized care by a doctor or hospital not affiliated with Veterans Affairs.

VA identification card

Veterans Affairs provides fee-based ID cards to certain veterans. A member will receive a fee-based ID card if one of the following is true:

- The member needs medical services for an extended period
- The member has a disability from military service
- There are no VA hospitals in the member's area

If the member has a VA fee-based ID card, the provider must accept Veterans Affairs payment as payment in full. The doctor may not bill the member or Medicare Advantage for these services. If their doctor does not accept the fee-based ID card, the member is responsible for filing a claim with Veterans Affairs themselves. Veterans Affairs will pay the approved amount to either the member or their doctor.

Coordinating with TRICARE
TRICARE is a health care program for active duty and retired military personnel and their families. TRICARE includes the following:

- TRICARE Prime
- TRICARE Extra
- TRICARE Standard
- TRICARE for Life (includes prescription drug coverage)

TRICARE for Life
TRICARE for Life (TFL) was created to provide expanded medical coverage to Medicare-eligible military services retirees age 65 or older, their eligible family members and survivors and certain former spouses. To get TFL benefits, the member must have Medicare Part A and Part B.

Some individuals are eligible for both Medicare Advantage and TRICARE. They include:

- Dependents of active duty service members who are entitled to Medicare for any reason
- People younger than age 65 entitled to Medicare Part A because of a disability or end stage renal disease (permanent kidney failure) and enrolled in Medicare Part B
- People 65 or older who are entitled to Medicare Part A and enrolled in Medicare Part B

When coordinating payment for services between Medicare Advantage and TRICARE, Medicare Advantage generally pays first for Medicare-covered services. TRICARE will pay the Medicare deductible and coinsurance amounts for any service not covered by Medicare that TRICARE covers. The member will have to pay the costs of services that Medicare or TRICARE doesn't cover.

When members receive services from a military hospital or any other federal provider, will pay the bills. In most cases, Medicare Advantage does not pay for services rendered to members from a federal provider or other federal agencies.

Coordinating with workers' compensation
Workers' compensation is insurance that employers or unions are required to have to cover employees who get sick or injured on the job. Most employees are covered under workers' compensation plans.

Members must tell their employer or union and file a workers' compensation claim for all work-related illnesses or injuries. The member must also call 1-800-633-4227 as soon as they file their workers' compensation claim. Medicare will connect the member to the Medicare Coordination of Benefits contractor. If the member has an attorney working on his or her behalf, the attorney should call the Benefits Coordination & Recovery Center (BCRC) at 1-855-798-2627 (TTY/TDD: 1-855-797-2627).

Workers' compensation pays first on the bills for health care items or services the member receives because of their work-related illness or injury. There can be a delay between the time a bill is filed for the work-related illness or injury and when Michigan's worker's compensation insurance office determines if they should pay the bill. Medicare will not pay for items or services that workers' compensation will pay for within 120 days. If workers' compensation doesn't pay the members bill within 120 days, Medicare may then make a conditional payment.

Conditional payments
A conditional payment is a payment that Medicare Advantage makes for services even though another payer may be responsible. This conditional payment is made so the member won't have to use their own money to pay the bill. The payment is "conditional" because it must be repaid when a workers' compensation case is approved or a settlement is reached.

Note: If Medicare Plus Blue Group PPO makes a conditional payment, and the member later gets a settlement from the workers' compensation agency, Medicare Advantage will recover the conditional payment from the member's settlement, judgment or award. The member is responsible for making sure Medicare Advantage gets repaid for the conditional payment.

If a member has questions on how they can repay Medicare for a workers' compensation settlement, refer them to 1-800-633-4227 to connect them with a coordination of benefits contractor. Attorneys should call the Benefits Coordination & Recovery Center (BCRC) at 1-855-798-2627. A Medicare contractor will be assigned to work on the case and resolve the conditional payment issue.

Coordinating with Federal Black Lung Program

Healthcare for black lung disease is covered under workers' compensation. For all other healthcare services not related to black lung, the member's bills should be sent directly to Medicare Advantage. Medicare Advantage will not pay for doctor or hospital services that are covered under the Federal Black Lung Program.

The member's provider(s) should send all bills for the diagnosis or treatment of black lung to the following address:
U.S. Department of Labor OWCP/DCMWC
P.O. Box 8307
London, KY 40742-8307

Coordinating with Medicaid

Medicaid is a federally funded health insurance program designed for those who cannot afford to pay for medical care. Members must meet certain income, resource, age or disability requirements, as determined by the state in which they reside, to qualify for this program.

In some cases, members qualify for both Medicaid and Medicare. Beneficiaries who receive benefits from both Medicare and Medicaid are considered dual eligible by the federal government. Dual-eligible beneficiaries generally qualify for assistance with payment of their Medicare Part B premium and assistance in paying the cost of a Medicare Advantage Part D plan. Medicare or the Medicare Advantage plan pays first on the bills for healthcare items or services for the member. Any deductibles, copays or coinsurances for medical services should be billed to the member's Medicaid carrier for payment.

Coordination of benefits surveys

Working Aged Survey: CMS no longer requires BCBSM or BCNA to survey its membership via a working aged survey; as of 2007, CMS now receives working aged data through the MMSEA Section 111, Medicare Secondary Payer Mandatory Reporting statute. CMS compiles the data that is provided and provides a Part C COBC file monthly that contains all members who were identified as having other coverage primary to Medicare. BCBSM or BCNA may survey members as part of a coordination of benefits investigation.

Part D notification: At the time of enrollment (after accretion by CMS), BCBSM or BCNA sends members who have other prescription drug coverage on file with CMS' Part D COBC file a COB notification to verify the validity of the coverage. Also, if a member indicates on his or her enrollment application that he or she will have other prescription drug coverage along with their Medicare Advantage coverage, BCBSM or BCNA also send a COB notification to collect the details of the other coverage.

BCBSM or BCNA send members who show other prescription drug coverage on CMS' COBC file an annual COB notification to verify the validity of the coverage.

Coordination of benefits payment determination

If the member...	And the member...	The primary payer is	The secondary payer is
Is age 65 or older and covered by an employer's group health plan or by the group health plan of a working spouse of any age	Is entitled to Medicare Advantage and the employer has 20 or more employees	Group health plan	Medicare Advantage
	Or the employer has less than 20 employees	Medicare Advantage	Group health plan
Is age 65 or older and has an employer group retiree health plan	Is entitled to Medicare Advantage	Medicare Advantage	Retiree coverage
Is disabled and covered by a large employer group health plan or is a covered dependent on a working family member's plan	Is entitled to Medicare Advantage and the employer has 100 or more employees	Group health plan	Medicare Advantage
	Employer has less than 100 employees	Medicare Advantage	Group health plan (if applicable)

If the member...	And the member...	The primary payer is	The secondary payer is
Is a veteran and has Veterans Affairs benefits	Is entitled to Medicare Advantage and Veterans Affairs benefits	Medicare Advantage pays for Medicare- covered services Veterans Affairs pays for VA authorized services	Usually doesn't apply.
		Note: Generally, Medicare Advantage and Veterans Affairs can't pay for the same service.	
Is covered under TRICARE	Is entitled to both Medicare Advantage and TRICARE	Medicare Advantage for Medicare-covered service	TRICARE may pay secondary
		Medicare Advantage for Medicare-covered service	
Has black lung disease and is covered under the Federal Black Lung Program	Is entitled to both Medicare Advantage and Federal Black Lung Program	Federal Black Lung Program for related services	Medica–re Advantage
Is age 65 or older or disabled and covered by Medicare Advantage and COBRA coverage	Entitled to Medicare Advantage	Medicare Advantage for Medicare-covered services	COBRA

Note: BCBSM or BCNA may make conditional payments when the primary payer cannot be determined.

Coordination with commercial drug coverage with Medicare Advantage plan CMS requires BCBSM or BCNA to coordinate care with another carrier that offers the commercial drug coverage. BCBSM or BCNA will provide the group and other carrier with file layouts for the exchange of information.

As a federal contractor and Medicare Advantage plan sponsor, BCBSM or BCNA must meet regulatory requirements related to coordination of benefits. While you should be aware of these guidelines, you are not required to perform the coordination of benefits process. Where appropriate and if the group has coverage with another carrier, BCBSM or BCNA will work with the other carrier to perform the coordination of benefits activities.

Programs and services to help manage member care and well-being

There are a wide variety of programs BCBSM and BCNA offer to help members live healthier, more active lives and manage chronic conditions. These programs are included at no additional cost to the members and can have a positive impact on their health and well-being. Blue Cross will identify members eligible for these programs and mail information to inform and encourage them to participate.

There is a comprehensive list of programs and services available to help manage member care and well-being available to BCBSM and BCNA members viewable by visiting:
https://www.bcbsm.com/index/members/health-wellness.html

Not all programs and services are available with every plan. Please check with your Medicare Advantage Representative to find out which of the programs and services listed here are part of your plan.

A brief overview of the medical management and well-being programs and services available to Medicare Advantage members follows, please be sure your retirees are aware of the programs that may be of use to them.

24-Hour Nurse Line

This 24 hour a day, 7 day a week telephone triage and health information service, provided by our vendor Carenet, supports members in making healthcare decisions for themselves and their family members. Registered Nurses investigate member health concerns, determine the urgency of medical care and determine the timing of required interventions. Members are given clinically relevant patient education and empowered to make appropriate decisions.

This program is available to BCBSM & BCNA members nationwide.

BCBSM Members call: 1-800-775-2583, TTY users call 711
BCNA members call: 1-855-624-5214, TTY users call 711

Advance Care Planning

Blue Cross partnered with Vital Decisions to provide a highly specialized Advance Care Planning solution designed to overcome systemic, analytic and clinical barriers causing disconnect between members' wishes and care received at end of life (EOL). The program identifies members via proprietary predictive models using BCBSM supplied and third-party data and offers

This behaviorally-based program enables engaged members to overcome emotional, physical and social barriers to communicating care preferences at end of life, allowing for engaged members to articulate their care goals, priorities, and preferences and effectively communicate their wishes to family, caregivers and providers. It includes education on end of life decision making, including hospice and palliative care, Advance Directive including Five Wishes and Living Wills, Healthcare Proxy, and Medical Orders for Life Sustaining Treatment.

This program is available to BCBSM & BCNA members in select geographical areas.

Blue Cross® Coordinated Care

An integrated, member-centric care management program with medical, behavioral health, pharmacy and social needs addressed by teams deployed by region/community including:

- A multi-disciplinary team (RN care managers, MSWs, Pharmacists, Dietitians) lead by a nurse who coordinates the support of the new integrated team.
- Holistic member management (medical, behavioral health, social)
- Community-centric teams and services; teams dedicated to regions/communities to gain a better understanding of the geographic area, providers, available resources and gaps in resources. Regional alignment of resources supports enhanced coordination with local providers and community resources to increase ability to address social determinants of health
- Member-centric engagement channels: Text, telephone, in-person. Includes a digital engagement platform (Wellframe) that increase and enhance member touch points

Eligible members include those selected by high dollar claimant review, meaning that members incurring >$150K in a rolling 12-month period are reviewed by an RN for the purpose of ensuring appropriate care and identifying opportunities for intervention.

Blue Cross® Virtual Well-Being

In this program, Blue Cross offers short weekly webinars designed to support members on their well-being journeys. Webinar content includes:

- Trending topics
- Meditation
- Financial well-being
- Health challenges

Members can visit virtual well-being online to learn more: https://www.bcbsm.com/index/members/health-wellness.html

This program is available to BCBSM & BCNA members nationwide.

Blue Cross Medicare Advantage Rewards

Members can earn rewards for healthy actions through Blue Cross Medicare Advantage Rewards.
Healthy actions include:

- Getting an annual physical
- Getting flu shots
- Monitoring your physical health
- Breast cancer screening
- Diabetes eye exam

Find out more: https://www.bcbsm.com/content/microsites/advantage-rewards/
or call 1-866-572-0155 (TTY: 711)

This program is available to BCBSM & BCNA members nationwide.

Collaborative Care

Collaborative Care is a primary care tool to reduce behavioral health and medical services. It enhances care and improves outcomes of member's behavioral health needs. It includes a multidisciplinary team of professionals providing care in a coordinated manner and empowered to work at the top of their professional training.

Diabetes Management Program

Blue Cross has partnered with Livongo to provide members with a Diabetes Management program designed to help them reduce HgbA1c, improve medication adherence and reduce gaps in care. Members receive multi-modal outreach and have access to wireless, mobile and web-based diabetes management systems and technologies. Also available with the program are 24/7 monitoring and support, as well as

clinical coaching for diabetes education and support. Upon enrollment into the program, members receive a Welcome Kit including:

- A Diabetes blood glucose meter (in-Touch Device)
- Lancing device
- Carrying case
- On-demand supplies (trips, lancets, control solution)

This program is available to BCBSM & BCNA members nationwide who meet the criteria:
Diabetes Type 1 or Type 2, AND one or more of the following:

- HbA1c >8, Insulin first fill (one Rx in past 12 months)
- No HbA1c in past 12 months, or non-adherent to diabetes medication

Members can call Livongo Member Support at 1-800-945-4355, TTY users should call 711
Learn more at: join.livongo.com/MEDICAREBLUE

Meals Delivery

Blue Cross partners with vendor Mom's Meals to ensure that members engaged in Blue Cross Coordinated Care who would benefit from the program are be offered fourteen days of meals (28 meals). Meals are tailored to meet member-specific nutritional needs such as low sodium for members with Hypertension and Heart Failure.

This program is available to BCBSM fully-insured/underwritten members and BCNA members nationwide who are discharged from acute medical or surgical stays and post-acute (SNF, Rehab, LTAC, etc.) and are at risk for re-admission.

MyBlue℠ Concierge

Blue Cross Medicare Advantage plan members have access to a concierge program that helps them learn more about their plan's benefits and how to use them. With this program, members have a dedicated concierge who will call to introduce them to your plan and tell them about benefits they might not be aware of, including preventive services available to them at no additional cost and BlueCard® and Silver Sneakers® (if their plans includes these programs).
They'll also help members:

- Schedule doctor appointments
- Connect with a Customer Service agent when they have a coverage or claim issue
- Get in touch with Blue Cross' care management team if they have a chronic condition
- Learn preventive measures they can take to maintain and improve health

This program is available to BCBSM & BCNA members nationwide.

Online Visits

Members may utilize Blue Cross Online Visits for non-urgent medical and behavioral health concerns. To access this benefit, members should visit bcbsmonlinevisits.com. Members are encouraged to share a visit summary with their provider(s). Members may also have an online visit with their own provider, if the provider offers this service.

Palliative Care

Blue Cross partners with vendor Aspire Health to provide members with non-hospice, palliative care that focuses on symptom management, patient-family communication, advanced care planning, medical crisis prevention and urgent response.
Comprehensive, collaborative care is delivered by community-based providers to members with a life expectancy of less than 12 months and consists of medical care provided by a multidisciplinary team that includes: Palliative Care Physician, Social Worker, Patient Care Coordinator, Palliative Care NP, Registered Nurse, and Chaplain.

Palliative Care is available to members residing in select geographical areas with a telehealth Palliative Care program available to some rural regions in Michigan that lack the population density to support home-based services (Northern Michigan, Thumb area and the Upper Peninsula).

This program is available to BCBSM & BCNA members in select geographical areas.

Remote Monitoring

This program targets high risk members diagnosed with Heart Failure or COPD and comorbidities. Our vendor, AMC Health, uses BCBSM claims data to identify members for targeting. Selected members will have a monitor, placed in their homes that transmits biometric and/or other symptom data daily. When data falls outside of usual parameters AMC Health will follow up with member and/or physician. The goal of the program is to reduce avoidable in-patient and out-patient utilization by improving each member's self-management skills.

This program is available to BCBSM & BCNA members nationwide who meet targeting criteria.

Shared Decision Making

Members have access to Welvie℠, an internet-based surgery decision-support program that helps them explore treatment options. Welvie℠ provides guidance from diagnosis to recovery using a six-step interactive web-based curriculum that covers all preference-sensitive surgeries and focuses on health literacy and patient safety. This step-by-step approach helps members understand their options, make their decision and informs them of what to expect along the way. A letter and a flier are sent to each member household (one per household) to encourage them to access the website and register for the program. Targeted mailings are distributed to members with specific claims history or conditions. Blue Cross partners with vendor Welvie℠ to make this program available to members.
This program is available to BCBSM & BCNA members nationwide.
Learn more at: https://welvie.com

SilverSneakers®

If included in your plan, fitness club membership through the SilverSneakers® fitness program is 100% covered. There are +17,000 participating U.S. locations and online support to help members lose weight and reduce stress.
With SilverSneakers® members get:

- Access to more than 17,000 fitness centers
- Specialized classes designed to meet member needs
- Live and on-demand online classes, online tools, and basic fitness equipment to use at home
- Health and well-being educational classes
- Group activities and classes offered outside the gym

Learn more at https://www.SilverSneakers.com

SilverSneakers® Tuition Rewards Program

SilverSneakers® members can visit any SilverSneakers® participating locations seven times per month to accumulate Tuition Rewards Points for students that they designate (from birth to the beginning of their junior year of high school). Participating members get 1,000 Tuition Rewards Points when they sign up for the program. Then each month that they visit any participating location seven times, they'll earn 250 points.

Each Tuition Rewards Point equals $1.00 in tuition discounts at more than 400 colleges and universities.
Learn more at https://www.SilverSneakers.TuitionRewards.com

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. This includes up to 36 sessions over a 12-week period are covered if the SET program requirements are met.

SET program guidelines include treatment under the following conditions:

- Sessions last 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication
- Treatment is conducted in a hospital outpatient setting or a physician's office
- Treatment is delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD
- Treatment is 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 if deemed medically necessary by a health care provider.

This program is available to BCBSM & BCNA members nationwide.

Tobacco Cessation Coaching

This is a telephone-based program provided by WebMD, designed to support members in their efforts to stop smoking. The program's goal is to improve the members' quality of life and reduce costs and hospital utilization for conditions associated with tobacco use.

This program is available to BCBSM & BCNA members nationwide.

Transportation

Blue Cross has partnered with Ride Health to provide Non-Emergency Medical Transportation for members engaged in the Blue Cross Coordinate Care management program. The program is available to members identified as lacking access to transportation to post-discharge follow-up medical appointments. Transportation is limited to physician visits, physical therapy appointments, outpatient laboratory services, diagnostic testing and pharmacy. Members are eligible for this service for up to 28 days post-discharge. Services cover Oakland, Wayne, Macomb and Washtenaw counties.

This program is available to BCBSM & BCNA members in select geographical areas.

Medicare Plus Blue® Group PPO
Prescription Blue® Group PDP

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

SECTION 1:
Medicare Plus Blue® Group PPO Overview

Medicare Plus Blue Group PPO overview

Medicare Plus Blue Group PPO offers a range of additional benefits and conveniences beyond Original Medicare, including:

- Preventive coverage
- Care management programs to manage chronic conditions
- Access to member health plan information anywhere and anytime through the Member Portal and mobile app
- National network of participating Blue Cross providers through the country

Medicare Plus Blue Group PPO is available as a medical-only (MA) or a medical plus prescription drug plan (MA-PD). We also offer a standalone PDP-only plan called Prescription Blue Group PDP that can be combined with the MA plan.

With an extensive statewide and national network, Medicare Plus Blue Group PPO allows members to receive services from any doctor, hospital or other health care provider that accepts Medicare and the Medicare Plus Blue Group PPO ID card. It does not require members to select a primary care doctor or other primary health care provider. Please note that members' out-of-pocket expenses are typically lower when health care services are rendered by providers in the Blue Cross network, both in Michigan and nationally. Medicare Plus Blue offers coverage for non-participating providers but at a higher cost-share.

CMS requires that all PPO plan members receive an explanation of their plan rules and benefits. This information is provided in the following materials:

- Pre-enrollment materials for employees considering joining our plan
- Annual Notice of Change (ANOC) kits for renewing members
- Welcome kits for new members

Group Dental and Vision benefits

Groups that offer Medicare Plus Blue Group PPO or Prescription Blue Group PPO can choose to keep their BCBSM dental and/or vision coverage, in addition to their MA or MA-PD or PDP benefit package. The group may choose to include these benefits on their BCBSM MA ID card or in a separate card, depending on member eligibility. Dental and vision programs are not offered by Original Medicare.

Deductibles

CMS requires plans to have a single combined deductible that applies to the in-network and out-of-network services. CMS does allow an out-of-network deductible if there is not an in-network deductible.

Out-of-Pocket Maximum (OOPM)

Medicare Advantage plans are required to have an in-network OOPM and an out-of-network catastrophic OOPM. The in-network OOPM must count towards the catastrophic OOPM. This does not include the Part D prescription drug benefit.

Durable Medical Equipment (DME), Prosthetic & Orthotic Appliances (P&O) services

DME and P&O are subject to the medical/surgical deductible, coinsurance and out-of- pocket maximum.

Medicare Advantage foreign claim process member reimbursement

Services rendered in a foreign land, and services rendered on a cruise ship that require interpretation or currency conversion must be submitted through Blue Cross Blue Shield Global Core (BCBSGC). Invoices and a BCBSGC International Claim Form must be submitted to the BCBSGC Service Center at the address on the claim form. Claim forms may be obtained by contacting customer service at the number on the back of the member's ID card or directly from the Global Core website at https://www.bcbsglobalcore.com.

SECTION 2:
Group Coverage and Enrollment Agreement

The Group Coverage and Enrollment Agreement is the legal contract between Blue Cross Blue Shield of Michigan and your group. It's signed by your group's decision maker and your Medicare Advantage representative or agent-consultant. It defines administrative rules and regulations and the coverage period for the plan and includes additional documents that describe the plan design and administration. It also confirms the monthly premium for the contract year.

Group Coverage and Enrollment Agreement package – everything you need to get started

- Standard Contract Agreement – defines the administrative contractual obligations of each party
- Schedule A – provides/confirms the coverage period and monthly rates for that coverage period
- Schedule B – describes the benefit plan(s) purchased by the group
- Census/enrollment file
- Part D Late Enrollment Penalty (LEP) Attestation – confirms prior drug coverage for groups that are purchasing an MA-PD plan or PDP-only plan and is an appendix to the standard contractual agreement. For information about LEP from CMS, visit: www.cms.gov
- Completed Medicare Advantage Account Benefit Request (MA ABR) form

To guarantee timely enrollment of members, we need a complete and accurate Group Coverage and Enrollment Agreement package and the census file of eligible members 90 days prior to the initial effective date. You'll need to select the method of member enrollment in the initial group set-up. You can choose from the standard automated opt-out method or the member paper application opt-in process.

Important CMS Uupdate

CMS removed Social Security Numbers from Medicare cards in April 2018. CMS is taking these steps to prevent fraud, fight identity theft and protect the private health care and financial information of Medicare beneficiaries. Members began receiving new Medicare cards from CMS that included the new unique Medicare ID number or Medicare Beneficiary Identifier. The Medicare Beneficiary Identifier replaced the HICN and does not rely on the member's social security number.

The BCBSM MA ID card has its own unique de-identified member number that is not impacted by the Medicare Beneficiary Identifier assignment. BCBSM MA ID card has its own unique de-identified member number that is not impacted by the Medicare Beneficiary Identifier assignment.

What you need to know:

- As of January 1, 2020, Medicare Beneficiary Identifiers are required by all impacted systems. The Medicare Beneficiary Identifier is the only identifier that can be used and accepted for enrollment into a Medicare Advantage plan.
- The Medicare Beneficiary Identifier is required to process enrollment, which means if the field is blank, the enrollment will not be processed until the Medicare Beneficiary Identifier is provided to Blue Cross.
- Additional information on the New Medicare Card is available on the CMS website.

The layout of the files have been updated and will only accept the Medicare Beneficiary Identifier (MBI). The process for enrolling a member will remain the same. Please email any questions to your Medicare Advantage representative.

NOTE: Medicare Plus Blue Group PPO coverage may not begin the same month the member is enrolled in Medicare Part A and Medicare Part B if we don't receive complete member information from the employer or union within the required lead time, including the CMS Medicare Beneficiary Identifier.

Ongoing enrollment process for age-ins and Medicare eligible individuals

Your group's ongoing member enrollment process will follow the member enrollment method established for your initial Medicare Plus Blue Group PPO set-up. An age-in member is someone who will be turning 65 within 90 days and is eligible for Medicare. A Medicare eligible member is anyone 65 or under who is disabled.

Ongoing opt-out enrollment method

The group is responsible for creating an accurate enrollment record in the proper retiree group and suffix for members to automatically be enrolled in the Medicare Plus Blue Group PPO plan. As members become eligible for Medicare, or age-in to Medicare, the group must update its membership record to add Medicare information to its member's current group enrollment record. This includes adding the Medicare number and Part A and Part B effective dates to the membership file. This should be done at least 60-90 days prior to the member's anticipated effective date or as soon as the Medicare information is available to the group, whichever is earlier.

Once updates are completed, members are automatically selected for enrollment if the group selected the opt-out enrollment method. Timely enrollment of all retirees cannot be guaranteed if updates are not received according to the guidelines and time lines provided.

Ongoing opt-in enrollment method

The group is responsible for creating an accurate enrollment record in the proper retiree group and suffix for members to automatically be enrolled in the Medicare Plus Blue Group PPO plan. As members become eligible for Medicare, or age-in to Medicare, the group must update its membership record to add Medicare information to its member's current group enrollment record. This includes adding the

Medicare number and Part A and Part B effective dates to the membership file. This should be done at least 60-90 days prior to the member's anticipated effective date or as soon as the Medicare information is available to the group, whichever is earlier. Members whose enrollment records are not properly staged in eMVP will not be able to enroll via the Online Enrollment Platform and may experience delays with their Medicare Advantage enrollments.

Once updates are completed, members are enrolled if they complete online enrollment using the Online Enrollment Platform or complete and return the enrollment application by the last day of the month, prior to the effective date. Timely enrollment of all retirees cannot be guaranteed if applications are not received according to the guidelines and time lines provided.

Groups must to ensure they have the Medicare Beneficiary Identifiers for members aging into Medicare in order to stage the members.

eMVP Processing – active or retiree division:

You must add contract/member - Medicare primary or working age.
For instructions on updating member records in eMVP, go to: https://pubpruat.bcbsm.com/content/public/en/employers/resources/manage-employee-records-online.html or contact eMVP support at 1-866-676-4858.

You can find step-by-step instructions with the Online Enrollment training materials in the Group or Agent Secured Services portals (see Appendices for more information).

Eligible dependents

Groups can extend coverage to their retirees' non-Medicare dependents. If a retiree wants coverage extended to a spouse or dependent who is not Medicare eligible, the group must open an active segment to cover the non-Medicare dependent. The following dependents are eligible for coverage subject to applicable BCBSM dependent eligibility requirements:

Coverage for eligible dependents include:

- Legally married spouse
- Dependent children (this includes disabled children)
- Surviving spouse - only if available under the group's eligibility rules and approved by BCBSM
- Domestic partners are eligible only when the group includes the domestic partner – same and opposite gender rider in their coverage

Ongoing Opt-In Enrollment Process Timeline		
All dates are approximate.		
Responsible party	**Membership Maintenance Activity**	**Deadline**
Group administrators	Add member Medicare information to BCBSM database (i.e., eMVP, 834, etc.).	60 to 90 days prior to effective date
BCBSM	Pull member information from the BCBSM system and identify members that are eligible to age-in to Medicare.	55 days prior to effective date
BCBSM	Mail online enrollment letter OR Pre-enrollment kits to members.	48 days prior to effective date
Members	Enroll online using Online Enrollment Platform OR Elect enrollment and return enrollment form with complete information either to the group or mailed directly to BCBSM. Note: If mailed directly to BCBSM, the enrollment form will be returned to the group, so that the group can move the member into the appropriate MOS division.	30 to 45 days prior to effective date
Group administrators	Add member enrollment record to BCBSM retiree division (eMVP) with correct benefit codes when the enrollment form is sent to the group.	30 to 45 days prior to effective date
Group administrators	Send enrollment application to Medicare Plus Blue Group PPO secured email or mailing addressee.	30 to 45 days prior to effective date
BCBSM	Submit membership files to CMS for enrollment.	22 days prior to effective date
BCBSM	Mail members' new ID cards.	Within 10 days of the confirmation from CMS or the day prior to their enrollment effective date, whichever is greater.
BCBSM	Mail welcome kits to members.	Mailed within 10 days of member confirmation by CMS
Members	Medicare Advantage is effective.	On effective date (All effective dates are on the first of the month.)

Ongoing opt-out enrollment method

The group is responsible to stage the members in the system so that the members are notified that they are eligible to be enrolled in the Medicare Plus Blue Group PPO plan. Afterwards, BCBSM will send the member a pre-enrollment kit. If member elects the Medicare Plus Blue Group PPO plan, the group should update its membership record to add Medicare information to its member's current group enrollment record. This includes adding the Medicare number and Part A and Part B effective dates to the membership file. **This should be done at least 45 days, and no less than 30 days, prior to the member's anticipated effective date or as soon as the Medicare information is available to the group, whichever is earlier.**

Once updates are completed, members are enrolled though the BCBSM OPT-OUT enrollment method. Timely enrollment of all retirees cannot be guaranteed if updates are not received according to the guidelines and time lines provided.

Ongoing Opt-Out Enrollment Process Timeline for Age-Ins		
All dates are approximate.		
Responsible party	**Membership Maintenance Activity**	**Deadline**
Group administrators (aka – Employer, Union, TPA)	Add member Medicare information to: BCBSM database (i.e., eMVP, 834, etc.).	60 to 90 days prior to effective date
BCBSM	Pull member information from the BCBSM system and identify members that are eligible to age-in to Medicare. Extract candidate membership data and initiate enrollment process.	55 days prior to effective date
BCBSM	Mail pre-enrollment kits to members.	48 days prior to effective date
Member	Notify BCBSM of their decision to decline coverage once they receive a pre-enrollment kit. Opt-out period ends.	60 to 90 days prior to effective date.
Member	Opt-out period ends.	22 days prior to effective date
BCBSM	Submit membership files to CMS for enrollment.	22 days prior to effective date
BCBSM	Mail members' new ID cards.	Within 10 days of the confirmation from CMS or the day prior to their enrollment effective date, whichever is greater.
BCBSM	Mail welcome kits to members.	Mailed within 10 days of member confirmation by CMS
Member	Medicare Advantage is effective.	On effective date (All effective dates are on the first of the month.)

SECTION 3:
Disenrollment Guidelines

Member disenrollment

A disenrollment is the termination of a member's Medicare Plus Blue Group PPO coverage following one or more months of active coverage. Disenrollment differs from a member opt-out or cancellation of coverage, which occur before a member is enrolled in the Medicare Plus Blue Group PPO plan. Disenrollments are effective on the first day of the month following the disenrollment request. Disenrollment can be initiated by the member or the employer or union, and can be voluntary or involuntary.

Voluntary member disenrollment

If a member wishes to voluntarily disenroll from Medicare Plus Blue Group PPO, he or she must make a request in writing to the group or to BCBSM. The effective date will be the last day of the month in which BCBSM receives the disenrollment request.

To process a voluntary member disenrollment, the group must receive the signed disenrollment request in the form of a simple letter from the member or a member-completed Medicare Plus Blue Group PPO disenrollment form. A copy of the disenrollment form is provided in the BCBSM appendix.

The group cannot deny processing a member disenrollment request just because it is not received on the disenrollment form. In this circumstance, the group will complete the information for a voluntary disenrollment on the Medicare Plus Blue Group PPO disenrollment form.

The disenrollment request should be attached to the group disenrollment form and forwarded by email, fax or mail to:

Blue Cross Blue Shield of Michigan Medicare Plus Blue Group PPO
P O Box 44256 Detroit, MI 48244-0256
Fax: 1-866-533-5810
E-mail: fbgrpenrollmentesc@bcbsm.com

Group-initiated disenrollment

If the group determines a member does not meet its eligibility criteria, the group can request the member be disenrolled. Common reasons for group-initiated disenrollment include:

- A change in a member's marital status
- Enrollment in another health plan
- Failure of a member to pay their premium

Group-initiated member disenrollment requires that BCBSM, Group/TPA to notify the member 21 days prior to the effective date. Disenrollments are effective after the 21-day notice period required of CMS and on the first day of the month following the date the notice is received by BCBSM.

Disenrollment when a member dies

If the group is notified of a member's death, the group should inform BCBSM. However, federal guidelines do not permit BCBSM to terminate a deceased member's Medicare Plus Blue Group PPO enrollment until we receive the CMS eligibility files, which report the member's date of death. BCBSM will terminate the member's enrollment upon receipt of the CMS file. The effective date of the contract termination for a deceased member is the first day of the month following the date of death. You will see member cancellations on your premium invoice for deceased members if you were not notified by the beneficiaries survivors.

If the group has paid a premium for the deceased member beyond the month of his or her date of death, the group will receive credit for premiums paid for the months subsequent to the member's death. No credit or proration is done for the month of death. The premium credit will be reflected on the monthly invoice following the cancellation process date by BCBSM.

Canceling a disenrollment

To request cancellation of a disenrollment, please contact your Medicare service representative. Requests for cancellation of voluntary member disenrollment must be accompanied by a written request, with signature and date, from the member. Requests for cancellation of disenrollment can only be processed if they are received by BCBSM prior to the effective date of the disenrollment.

Re-enrolling a disenrolled member

If the member has a lapse in coverage, he or she must complete a new enrollment form.

Example

Disenrollment effective date: Oct. 31, 2021
Reinstatement date: Dec. 1, 2021
Must repeat the enrollment process

Discontinuing your group coverage

Each employer or union determines the impact disenrollment has on members during the Medicare Plus Blue Group PPO plan design stage. If member disenrolls from Medicare Advantage plan, they may lose ancillary dental or vision coverage included on their card. During the disenrollment process, we will send retirees a letter confirming their disenrollment and explaining their coverage options.

BCBSM requires advanced written notice to cancel group MA coverage as set forth in the Group Enrollment & Coverage Agreement. Please consult your Medicare Advantage representative for additional information. If your group wishes to cancel one or more of its Medicare Plus Blue Group PPO plans, contact your Medicare Advantage representative. If a group discontinues group MA benefits, CMS requires members are notified of its decision to discontinue group MA coverage at least 21 days before the end of coverage. Per CMS rules, members must be given prospective notice that such an event is occurring and be provided with options for obtaining ongoing coverage. Your Medicare Advantage representative can assist you in planning a transition of group coverage that minimizes disruption to your members.

SECTION 4:
Member Enrollment Materials

We send prospective members an online enrollment letter or a pre-enrollment kit, and new members receive a welcome kit. These materials explain how their Medicare Advantage coverage works and provide information about plan benefits and tools to manage their plan. We recommend you inform members of their enrollment in Medicare Plus Blue Group PPO so they'll be prepared when they receive this information.

Online enrollment letter

Prospective members from group onboarded to the Online Enrollment Platform will receive a letter inviting them to enroll using the platform in lieu of the pre-enrollment kit (which can be found when members login to the Online Enrollment Platform). Should the retiree prefer to have the pre-enrollment kit mailed to them, they can call the Online Enrollment Support Call Center at 1-800-284-6994 and request that one be sent.

Pre-enrollment kit

In circumstances when prospective members are not utilizing the Online Enrollment Platform, we send a pre-enrollment kit.

The kit contains:

- Cover letter
- Benefits at a Glance
- CMS Star rating flier for plan
- Anti-Discrimination Notification
- Enrollment or opt-out forms
- Postage-paid return envelope

Please see the BCBSM Appendix for samples of online enrollment letter and pre-enrollment kit materials.

EXCEPTION: For groups that want to perform the open enrollment mailing of pre-enrollment materials to their own retirees, the following steps and information must be documented as evidence that CMS guidelines were met and mailed to:

Blue Cross Blue Shield of Michigan
ATTN: FB Program Oversight & Communication
600 E. Lafayette Blvd, MC 1600
Detroit, MI 48226-2998

Pre-enrollment materials must be in retirees' hands 15 days before the start of the open enrollment period. Anything less is non-compliant per CMS time lines. When a group chooses to send pre-enrollment kits directly to their retirees for opt-in enrollment, they must make a formal request to BCBSM, be approved, and then follow a prescribed procedure, known as the group enrollment attestation process. See the Group Attestation Agreement in the BCBSM Appendix. (Pre-enrollment kits for opt-out must be coordinated by BCBSM. There are no exceptions.)

The group needs to provide BCBSM with a copy of the mail receipt, including but not limited to:

- Date and time the material was mailed
- Number of packages mailed
- Copy of a pre-enrollment kit packet provided to its membership
- Signed attestation letter with attached mailing list of membership

The attestation letter should include language/information like: "On (month, day, year), (number of pre-enrollment kits) were delivered by the group to (post office, UPS, other location) for delivery via (overnight, first class). The enclosed receipt is provided for verification. We (group name) attest that the enclosed pre-enrollment kit was mailed to each person on the attached mail file. The attestation letter must be signed by the group administrator maker

Welcome kit

Within 10 days of CMS confirming enrollment into the plan, we send newly enrolling members a welcome kit with detailed information about Medicare Plus Blue Group PPO coverage. Renewing members receive an Annual Notice of Change mailing, which highlights any benefit changes for the coming plan year.

Enrollment acknowledgment letters

If CMS accepts a member's enrollment, BCBSM sends the member a letter acknowledging the confirmation of his or her enrollment. There may also be circumstances when we send letters to select members requesting information needed to process their enrollment, such as proof of Medicare Part A and Part B coverage.

RFI (Request for Information)

If an RFI is sent, it is important that members respond. If they do not respond with the missing or incorrect information, they may not be enrolled into the Medicare Advantage plan. Some of the most common reasons an RFI letters will be sent are to members, include:

- Full name does not match exactly what is on the CMS file
- Mailing address does not match exactly what is on the CMS file
- Address is a PO Box not a physical address
- Medicare Beneficiary Identifier does not match what is on the CMS file

Annual Notice of Change

The Annual Notice of Change (ANOC) is a document that CMS requires us to send to provide members with advance notice of changes to their Medicare Plus Blue Group PPO plan for the coming plan year. It outlines changes in Original Medicare and Medicare Plus Blue Group PPO plan benefits, premiums and rules. We mail the ANOC to members in November or December of each year. Members will begin to receive their ANOC starting in November and no later than 15 days prior to the start of the new plan year.

The ANOC packet includes:

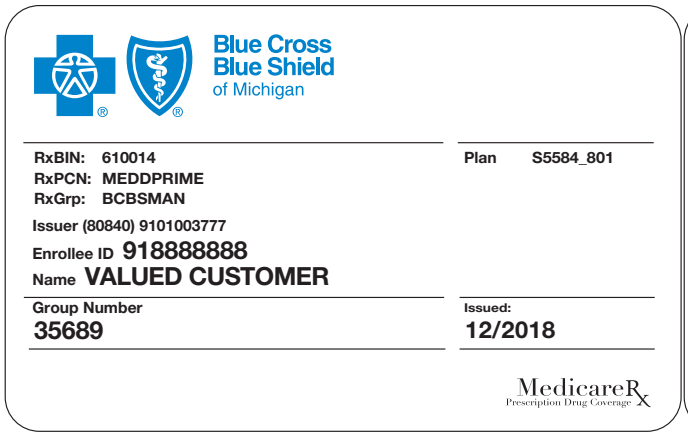
- ANOC document
- Evidence of Coverage
- Members of groups with Part D prescription drug coverage also receive a formulary (list of covered drugs) or information about how to access the formulary online
- Eligible members receive a Low-Income Subsidy (LIS) rider

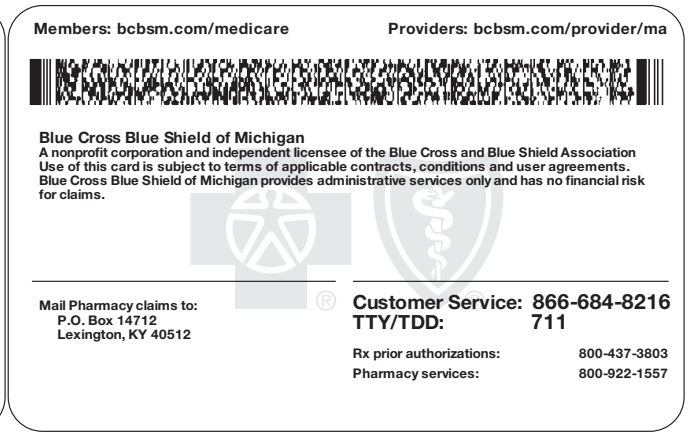
CMS notifies BCBSM regarding which members qualify for LIS, and what LIS levels they qualify for (25%, 50%, 75% or 100%). Refer to section 5 for further details on LIS.

Note: CMS requires that BCBSM send the Annual Notice of Change (ANOC) to all Medicare Plus Blue Group PPO members, whether or not the member has a change in their benefits. When appropriate, the notice will acknowledge that there are no changes for the coming plan year.

Member ID card

Members will receive the card prior to their effective date, except in cases where additional information to enroll the member delays enrollment or the enrollment request is received no later than ten (10) calendar days from receipt of CMS confirmation of enrollment or by the last day of the month prior to the effective date, whichever is later. Members must show this ID card, rather than their Original Medicare card, when receiving health care services. Each member will receive his or her own ID card.





Coordination of Benefits Survey

This assessment to members in January and participation is voluntary, free and confidential. The survey measures general health indicators and helps us determine how to best help your members and:

- Coordinate access to the appropriate services
- Understand members' medical conditions and help them stay as healthy and active as possible
- Better manage their health

SECTION 5:
Billing and Low-Income Subsidy Guidelines

BCBSM bills group premium one month in advance. Invoices are mailed on or before the 15th of the month prior to coverage period. Invoices can be paid by check or electronic (ACH) payment, if enrolled.

Note: Employees are invoiced for initial coverage period based on when eligibility is active and invoice cycle.

Example: Invoices created for July coverage on June 6th. Employee(s) not yet eligible in system at time of invoice run. No current coverage period premiums will be invoiced Invoices created for August coverage on July 6th. Employee(s) eligible for effective date July 1st. Group will be invoiced for current period August premiums, as well as for prior coverage period premiums for July coverage.

Note: The Payment Coupon accompanying the invoice has a unique PO Box Number for Medicare Advantage and differs from the commercial active bill membership. If a group remits more than one payment to BCBSM, the group should pay each invoice (Medicare Advantage and/or Commercial) by a separate check and mail it with a copy of the payment coupon to the PO Box on the Payment Coupon.

Payment due dates

Medicare Plus Blue Group PPO health coverage is only offered on a prepaid basis. All premiums must be paid in full on the first of the month, the first day of the coverage period.

If a group opts for ACH deductions, the withdrawals will be taken the 5th of the month (the fifth day of the coverage period). Exceptions for weekends and holidays –in which case the deduction will be made the next business day after a weekend or holiday.

Setting up ACH deductions

To set up ACH deductions, a group will need to fill out an ACH form (see BCBSM Appendix).
The form can be obtained by emailing: MAEmployerGroupBill@BCBSM.com.

Once completed, the form can be faxed to:	The completed form can also be mailed to:
1-866-533-5810	Blue Cross Blue Shield Michigan PO Box 44256 Detroit, MI 48244-0256

Once the form has been submitted, it can take up to two billing cycles (60 days) for deductions to begin. Employer group bank accounts with fraud protection at receiving bank may need to verify that bank account permits debit transactions. Account must be enabled for ACH transactions – you will need BCBSM's ACH Debit ID code. The code can be obtained using the billing inquires email address below.

Note: If payment checks are issued directly from your bank, please make sure that you update the remittance address online so checks are routed correctly.

Where to pay:

The remittance address for premium payments is:
Blue Cross Blue Shield of Michigan
PO BOX 553912
Detroit, MI 48255-3912

Non-payment of premiums

A group is considered delinquent when we have not received the required payment by the invoice due date.

Returned checks (non-sufficient funds)

If a premium payment check is returned from the bank for any reason, the group will be contacted by their account representative in order to replace the check as soon as possible.

Billing inquiries

Group billing inquiries can be emailed to: MAEmployerGroupBill@BCBSM.com.

Low-income subsidy (LIS)

Under Medicare Part D, beneficiaries with limited income and resources may qualify for financial assistance to pay for prescription drugs costs. Those who are eligible for this Low-Income Subsidy (LIS) will get help paying their monthly premium, yearly deductible and prescription coinsurance and co-payments — with no gap in coverage. Several levels of LIS are available based on the member's income (25%, 50%, 75% or 100% subsidy). Eligibility is determined by CMS, not BCBSM. CMS will notify BCBSM of those members who are entitled to the LIS.

People who are automatically eligible for the LIS include:

- Individuals who are dual-eligible for Medicare's full benefits
- Supplemental Security Income recipients with Medicare
- Participants in the Medicare Savings Program

CMS provides an employer or union group the following options for members who receive the Low-Income Subsidy (LIS):

- If the member is charged a premium by the group for healthcare coverage and the amount of the premium is greater than the LIS, the group must reduce the member's premium by the amount of the subsidy. If the member is charged a premium by the group for healthcare coverage and the amount of the premium is less than the LIS, the group may keep the LIS.
- If the total monthly combined premiums between the member and union group plan sponsor are less than the monthly low-income premium subsidy amount, any portion of the low- income subsidy premium amount above the total monthly premium must be returned to CMS.

CMS notifies BCBSM of those members entitled to the LIS. The group is billed a reduced amount for these members based on the amount of the member's LIS.

Late enrollment penalty (LEP) for Part D prescription drug coverage

Medicare beneficiaries who don't join a Medicare drug plan when they are first eligible for Medicare Part A or Part B, and who go without creditable prescription drug coverage for 63 days or more, may have to pay a late enrollment penalty assessed by CMS when they join a plan at a later date. Creditable prescription drug coverage means coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. The penalty amount changes every year. The beneficiary will have to pay the penalty each month as long as they have Medicare prescription drug coverage.

The late enrollment penalty is calculated when a member first joins a Medicare drug plan. The current late enrollment penalty amount is one percent of the national base beneficiary premium (the national average premium) for each full uncovered month the person was eligible to join a Medicare drug plan and did not. The monthly penalty is rounded to the nearest dime. BCBSM is notified by CMS of those members who have been assessed a late enrollment penalty. CMS allows an employer or union group, at its discretion, to pass on the additional cost of the late enrollment penalty to the member if the member is charged a premium for health care coverage. This additional cost is shown as a member-level charge in addition to the premium.

If your group has been supplying retiree prescription drug coverage under a creditable commercial prescription drug plan, this member late enrollment penalty will not be incurred. In the event your retirees are transferring from a creditable plan to a Part D plan, be sure to notify your Medicare sales account representative.

Members who pay extra Part D amount due to income

Most people pay a standard monthly Part D premium. However, some people pay an extra amount because of their yearly income. If a member's income is $88,000 or above for an individual (or married individuals filing separately) or $176,000 or above for married couples, the member must pay an extra amount directly to the federal government for their Medicare Part D coverage. This is a CMS requirement, not a Blue Cross requirement. This changes annually, please visit CMS website for most up-to-date amounts.

If a member must pay an extra amount, Social Security Administration will send the member a letter notifying them of what the extra amount will be and how to pay it. The extra money will be withdrawn from the member's Social Security, Railroad Retirement Board or Officer of Personal Management benefit check. The extra amount must be paid separately and cannot be paid with the member's monthly plan premium.

If the member disagrees about paying an extra amount based on his or her income, he or she can contact the Social Security Administration at 1-800-772-1213 (TTY 1-800-325-0778), and ask for a review of the decision.

If members refuse to pay the extra amount, paid directly to the federal government, they will be disenrolled from the plan and lose prescription drug coverage.

How much does Part D cost?

Part D premium varies based on the modified adjusted gross income (MAGI) as reported on the member's IRS tax return.

Part D co-payment recovery

CMS requires that BCBSM bill members who were undercharged for prescription drugs. Occasionally, BCBSM's records may not reflect claims activity. This may happen when there's:

- A discrepancy in the member's enrollment information that had to be reconciled with CMS records
- A change from one drug plan to another, requiring a transfer of member information
- A retroactive change to the member's group coverage out of pocket costs

Part D records are reviewed annually.

Creditable coverage prescription drug coverage

Under commercial coverage, the plan sponsor must notify their retiree in writing as to the creditableness of their prescription drug plan. This letter may be used by the retiree to avoid the late penalty in the event the creditable commercial plan is dropped or is otherwise no longer creditable. BCBSM supplies testing results of our core product line, but notification to the retirees is the responsibility of the plan sponsor Click here for more detailed information on the Creditable coverage.

SECTION 6:
Member Guidelines and Updates

Address changes

Members who have a change in their permanent residential address should immediately notify:

- The Centers for Medicare & Medicaid Services (CMS)
- Their local Social Security Administration office
- Their group administrator
- Medicare Plus Blue Group PPO Member Services

Please advise members to contact CMS and their local Social Security Administration office to report a permanent residential address change. The address in the CMS file must be updated prior to contacting Medicare Plus Blue Group PPO Member Services. The group should then notify their Support service representative of the address change for their Medicare Plus Blue Group PPO member(s). Once the Medicare sales account representative receives the address change, they will submit the change to the BCBSM service consultants. The BCBSM service consultants will verify that the CMS file has been updated before changing the permanent address on the Medicare Advantage file.

A mailing or alternate address can be updated without requesting a change through CMS. The group may update the member's retiree enrollment file in the alternate enrollment record.

It's important to confirm with your member what type of address change they are requesting. A permanent residential address change may impact their eligibility to remain enrolled in a Medicare Advantage plan. If a member moves away from the plan's service area, it may make them ineligible to remain in the plan.

The Medicare Advantage Service Center can be reached at 1-866-684-8216 from 8 a.m. to 8 p.m., Monday through Friday, with weekend hours October 1 through February 14. TTY users should call 711. Certain services are available 24/7 through our automated telephone response system.

The member may also need to log into the Online Enrollment Platform at:
www.bcbsmgroupmedicareplan.com to update their address.

BCBSM Appendix

The Appendix includes additional resources, instructions, and examples of standard letters and forms.

Employer, Agent and Group Administrator Resources

Your Medicare Advantage representative and group service representative are your primary contacts for Medicare Advantage inquiries. They serve as your liaison to our internal operations departments and will respond to your inquiries. Below are types of inquiries and who you should contact to initiate a response to your call.

Inquiry type	Contact
General Inquiries: • Claims • Enrollment and pre-enrollment • Group benefits • ID cards • Membership eligibility • Pharmacy (MA-PD only) **Escalations:** • Membership eligibility • Enrollment inquiries	Medicare Advantage representative or Blue Cross contracted agent
Group specific: • Benefit changes • Coordinating or conducting open enrollment meetings and mailings • Pre-enrollment and other group-specific materials • Rates and rate renewals	Medicare Advantage representative or Blue Cross contracted agent
Online Enrollment Support	**Enrollment Support Call Center** 1-800-284-6994 8:00 a.m. to 5:00 p.m. Eastern (Monday-Friday) **Online Enrollment Platform (24/7)** www.bcbsmgroupmedicareplan.com Online chat assistance available 8:00 a.m. to 5:00 p.m. Eastern (Monday-Friday)
Programs or services offered through Blue Cross Health & Well-being	**Blue Cross Engagement Center** 1-800-775-2583 8:00 a.m. to 6:00 p.m. Eastern TTY users call 1-800-240-3050 8 a.m. to 8 p.m. Eastern time (Monday-Friday)
Report fraud	**Medicare Anti-Fraud hotline** 1-888-650-8136 TTY users call 711 8:30 a.m. to 4:30 p.m. Eastern (Monday-Friday)
Membership and Billing Inquiries	**Membership and Billing Customer Service** MAEmployerGroupBill@BCBSM.com **eMVP Processing Assistance** 1-866-676-4858

Member Resources

Provider directories

Members should always verify the providers they select participate in the Medicare Plus Blue Group PPO network. Hard-copy directories for Michigan-based providers are available to members; however, the most up-to-date provider listings by visiting the website at:
https://www.bcbsm.com/medicare/find-a-doctor.html or use the Blue Cross Mobile app.

Pharmacy directory

Visit the Group Pharmacy Directory link at: http://www.bcbsm.com/pharmaciesmedicare
Medicare Plus Blue Group PPO comprehensive formulary (list of covered prescription drugs) To access the Group Comprehensive Formularies as well as changes to the formularies,
visit: https://www.bcbsm.com/medicare/help/forms-documents/drug-lists.html

Online enrollment contacts

Retirees using the Online Enrollment Platform should contact the Enrollment Support Call Center to resolve issues concerning:

- Basic enrollment and pre-enrollment
- Benefits
- Claims status and information
- Address or other demographic info changes

Member service contacts

Retirees not using the Online Enrollment Platform should contact Medicare Plus Blue Group PPO Member Services to resolve issues concerning:

- Basic enrollment and pre-enrollment
- Benefits
- Claims status and information
- Grievances and appeals
- ID cards
- Address changes

If the member is not satisfied with the response from Medicare Plus Blue Group PPO Member Services, he or she has the right to escalate his or her concern within BCBSM. Per CMS guidelines, members also have the right to file a grievance or appeal with Medicare. The Evidence of Coverage (EOC) provided to all members enrolled in an MA plan provides detailed step-by-step guidelines on how to submit an appeal.

Inquiry type	Contact
• Claims • Enrollment and pre-enrollment • Group benefits • ID cards • Membership eligibility • Grievances or appeals • Pharmacy (if the plan includes Part D prescription drugs) • Durable medical equipment • Prosthetic and orthotic devices	**Medicare Plus Blue Group PPO Member Services** 1-866-684-8216 TTY users call 711 8:30 a.m. to 5:00 p.m. Eastern (Monday-Friday) **MPSERS Service Center** 1-800-422-9146 TTY users call 711 8:30 a.m. to 5:00 p.m. Eastern (Monday-Friday) **URMBT Medicare Advantage Service Center** 1-888-322-5616 TTY users call 711 8:30 a.m. to 5:00 p.m. Eastern (Monday-Friday)
Online Enrollment Support	**Enrollment Support Call Center** 1-800-284-6994 8:00 a.m. to 5:00 p.m. Eastern (Monday-Friday) **Online Enrollment Platform (24/7)** www.bcbsmgroupmedicareplan.com Online chat assistance available 8:00 a.m. to 5:00 p.m. Eastern (Monday-Friday)
• Benefit changes • Premium rates • Premium rate renewals	**Group administrator**
Programs or services offered through Blue Cross Health & Well-being	**Blue Cross Engagement Center** 1-800-775-2583 8:00 a.m. to 6:00 p.m. Eastern TTY users call 1-800-240-3050 8 a.m. to 8 p.m. Eastern time (Monday-Friday)
Report fraud	**Medicare Anti-Fraud hotline** 1-888-650-8136 TTY users call 711 8:30 a.m. to 4:30 p.m. Eastern (Monday-Friday)
Lab services	**Quest Diagnostics** www.questdiagnostics.com **Joint Venture Hospital Laboratories (JVHL)** www.jvhl.org
Exclusive discounts and Programs for members	https://www.blue365deals.com/ and https://www.bcbsm.com/index/members/discounts.html

Members Outside of Michigan

Verifying eligibility and coverage for out-of-area members

Providers may determine eligibility and cost-sharing amounts for out-of-area members (members who reside outside the state of Michigan) by calling 1-800-676-2583 and providing the member's three-digit alpha prefix ID card. Electronic eligibility requests for our Medicare Advantage PPO members may also be submitted.

Home vs. host: How out-of-state claims are processed

The Medicare Advantage PPO network sharing arrangement through the Blue Cross and Blue Shield Association makes all Blue Medicare Advantage PPO provider networks available to other Plans' members while they are traveling. As a result, members have access to other Blues provider networks outside their Blue Plan's licensed area.

The Blue Cross home plan controls all aspects of benefit plan delivery and coordinates with the member and the account.

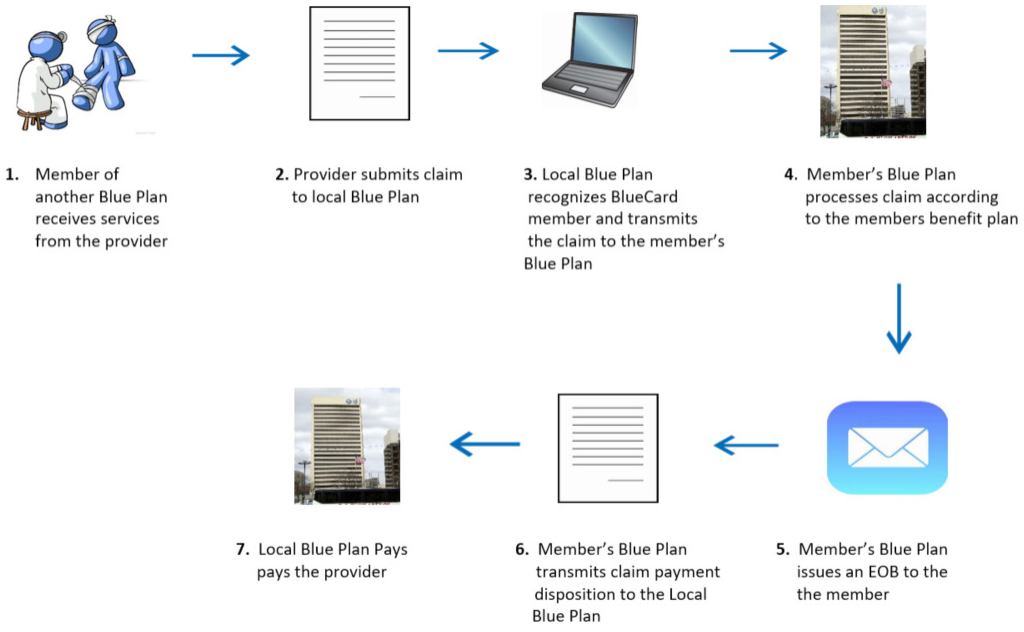
BCBSM responsibilities include:

- ID cards
- Customer or member service
- Membership and eligibility
- Claims adjudication
- Account interactions
- Reporting

The Blue Cross Host Plan manages the relationship with providers in its service area.

Host responsibilities include:

- Provider contracting and education
- Receipt and pricing of claims
- Routing claims and pricing data to the home plan
- Reimbursing providers
- Servicing provider claims inquiries



Inter–plan Medicare Advantage process flow

Preferred Provider Organization network sharing

Licensees with Medicare Advantage PPO provider networks give all Blue MA PPO members access to their locally contracted providers by including them as covered in provider contracts.

The PPO locally contracted providers receive their contracted MA PPO rates. All MA PPO individual and group products must allow members to receive in- network benefits when receiving services from out-of-area Blue contracted Medicare Advantage PPO providers. Contracted providers submit claims for out-of-area members to the local plan. The host plan prices the claim according to the provider's contracted rate.

Non-network sharing

All Blue plans are considered Host Plans for the Inter-Plan Program (IPP) MA Program and, therefore, any Blue MA member may request services from any Medicare eligible provider out of their Control/Home Plans' service area. Plans not participating in network sharing should still perform provider and customer service education activities related to MA PPO network sharing. Providers are educated on network sharing and that they may provide services to out-of-area Blue MA PPO members and be reimbursed at the Medicare allowed amount for approved services. Providers are also educated on verification of member eligibility and benefits, claims submissions, and appeals. Non-network sharing Plans will price claims at charges. Medicare eligible providers are reimbursed at the Medicare allowed amount.

Member in-network cost sharing

Member in-network cost sharing is applied to all out-of-state service. Although BCBSM refers our members to MA PPO network providers, we will not penalize the member for receiving services from an out-of-network provider.

Member out-of-network cost sharing

Only applies to services rendered in Michigan from a non-contracted provider.

Medicare Advantage Group Staging Job Aid

The purpose of this section is to provide important information related to the staging of the enrollment process via the electronic Membership Viewing and Processing (eMVP System). Members should be staged 60-90 days before the requested effective date. However, members cannot be staged more than 90 days before the requested effective date. It is critical that the members are enrolled on time and in the correct Medicare Advantage product. The Medicare Advantage Enrollment Unit (MAEU) creates and sends a pre-enrollment kit to members who are about to enroll in the group's Medicare Advantage plan.

Staging members in eMVP

Users can login to the Agent or Group Secured Services portals from the BCBSM.com homepage. Once logged in, users can select eMVP to access it. In order to properly stage a member, the four actions below must be completed. Please note that not all of these steps are required for every single record, depending on existing setup, see **Member staging scenarios** chart below for examples of scenarios with a different process. Also note that some transactions can be performed simultaneously (ex. modifying Member Type & adding Medicare Data).

- Update Employment Status to Retiree
- Transfer to Medicare Advantage Pull Division
- Update BPID to Comp/Medicare and Member Type to Medicare
- Update Medicare to Part A&B and set as Primary

The steps in each action are detailed below. For a more in-depth tutorial, a PDF with screenshots and an instructional video are available in the Agent and Group Secured Services portals.

Update Employment Status to Retiree

If the Employment Status of the membership record does not currently reflect 'Retiree,' this step will need to be completed before any of the subsequent steps in this document.

1. Navigate to **Contract** then select **Modify Contract.**
2. Enter search criteria and click **Continue**.
3. Click on the result in blue under **Contract Number**.
4. To change the active employment status end date, enter an **End Date** one (1) day prior to the desired date of change in **Employment Status** and then click **Submit**.
5. The **Medicare Advantage Effective Date** will update to one (1) day after the **End Date** entered in the previous step.
6. Update the **Employment Status** dropdown to **Retiree** and then click **Submit**.

A confirmation will show that the status change has been successful.

Transfer to Medicare Advantage Pull Division

If the contract does not currently reside in a Medicare Advantage Pull Division, please follow these steps to complete the transfer.

1. Navigate to **Contract** then select **Transfer Contract.**
2. Enter search criteria and click **Continue**.
3. Select the result in blue under **Contract Number**.
4. Enter the **Division ID** that you are transferring to (MA Pull Division).
5. Enter the **Effective Date** of the transfer to the new division and then click **Submit**.
6. Select new **Benefit Package ID (BPID)** from the dropdown and then click **Submit**.

A confirmation will show that the change has been successful.

Update BPID to Comp/Medicare and Member Type to Medicare

The following steps ensure that the membership record reflects a Member Type of 'Medicare' and a Comp/Medicare Benefit Package ID (BPID) is selected.

1. Navigate to **Member** then select **Modify Member**.
2. Enter search criteria and click **Continue**.
3. Select the result in blue under **Contract Number**.
4. Click on the desired member in blue under **Name**.
5. Access the **Eligibility** tab.
6. Change the **End Date** to one (1) day prior to the date of the desired **BPID/Member Type** change (or the same day as the current effective date, if voiding and replacing the existing coverage span).
7. Use the **Change Reason** dropdown to select an appropriate entry and then click **Submit**.
8. Use the **Member Type** dropdown to select **Medicare**.
9. Select new **Benefit Package ID (BPID)** from the dropdown (Medicare/Comp BPID) and then click **Submit**.

A confirmation will show that the change has been successful

Update Medicare to Part A&B and set as Primary

The following steps ensure that the membership record reflects Medicare A&B—Primary coverage.

1. Navigate to **Member** then select **Modify Member.**
2. Enter search criteria and click **Continue**.
3. Click on the result in blue under **Contract Number**.
4. Click on the desired member in blue under **Name**.
5. Access the **Medicare** tab.
6. Use the **Medicare Indicator** dropdown to select **Both Part A and Part B (or Part A, B & D)**
7. Use the **Status Indicator** dropdown to select **Primary**.
8. Enter the **Medicare ID**.
9. Enter the **Effective Date** of **Medicare Primary coverage**.
10. Use the **Eligibility Reason** dropdown to select the appropriate rationale and then click **Submit**.

A confirmation will show that the change has been successful

Member staging scenarios

The following charts detail various scenarios for staging Medicare Advantage members when an active member becomes a retiree. Next to the scenarios are the eMVP steps required for each.

Scenario	Steps
Member is Aged over 65	• Transfer contract to a "pull" division (45 days before MA effective date) • Member Type= Medicare Primary • BPID = Comp • Medicare Beneficiary ID # • Med A/B dates • Medicare Status Indicator= Primary • Eligibility Reason= Age
Member is Aged under 65 Disabled	• Transfer contract to a "pull" division (45 days prior to effective date for MA) • Member Type = Medicare Primary • BPID = Comp • Medicare Beneficiary ID # • Med A/B dates • Medicare Status Indicator = Primary • Eligibility Reason = Disability
Member is Aged Under 65	• Transfer contract to a "pull" division • Member Type = Regular • BPID = Regular
Member does not qualify for Medicare Advantage	• Transfer contract to a "safe" division • Type = Regular • BPID – Regular • If a member has only one-part Medicare • Medicare Beneficiary ID # • Med A or B date • Medicare Status Indicator = Secondary • Eligibility Reason = Age or Disability
Member is aged 64 and 8 months	• Update membership (45 days prior to effective date for MA) • Member Type = Medicare Primary • BPID = Comp • Medicare Beneficiary ID # • Med A/B dates • Medicare Status Indicator = Primary • Eligibility Reason = Age

Key time frames for a member to enroll in Medicare Advantage

- 60-90 days prior to the member becoming eligible a listing of members will be generated to mail
- opt-out kits
- 60 days prior to eligibility the Medicare Part A and Part B effective dates must be provided
- 30 days prior to eligibility and the commercial group/division must have a future end date with the XL BPID for the MA member
- If the member does not return the opt-out form, the member will be enrolled 21 days later
- Upon verification by CMS the member will be added to the MA group/division (MA Premium Bill)

The Account Service Representatives (ASR) supporting the commercial group/division, receives weekly membership reports and works with the group to monitor the status of age-in members. This is extremely important to ensuring the contracts migrate correctly and on time.

Medicare Advantage group/division numbers

A group's Medicare Advantage (MA) division number on our MOS system is used for MA membership billing functions for groups:

1. Staging of records for enrollment into Medicare Advantage coverage
2. Indicates the final enrollment location for an MA enrollee
3. Generates the bill for a group's MA membership premium
4. May house/bill ancillary benefit enrollment and Medical benefits for non-MA eligible members

All groups have a group/suffix for MA while the Commercial has either a NASCO Shell or MOS Shadow group/ suffix which is used to pull enrollment to the MA group suffix.

Commercial Safe Group/Division Number

The safe group/division number is the group's active or retiree group/division number established on the BCBSM MOS or NASCO system. The group may have retirees who cannot enroll in Medicare Advantage (The retiree may not pay for or qualify for Medicare Part B).

When this occurs, your Medicare Advantage representative will discuss the availability of a safe division with the group for the retirees who do not qualify for Medicare Advantage. If the group agrees to pay and maintain a supplemental coverage for those group members, a safe division number is established.

Commercial Group/Division Numbers – existing MOS groups

A commercial division number is considered a pull division. This is a number assigned in the MOS system for all group membership. A division is a number assigned to an existing retiree of the commercial group. The pull division number can be used by the group (or group delegate) to make changes to membership on eMVP.

The commercial or pull group/division number is used for several things including the following:

- The enrollment division/segment for MA members with ancillary coverage (dental/vision/ commercial prescription drugs)
- Benefit Package IDs (BPID) are used to pay MA ancillary and split contract claims. Note that these are identifiable by inclusion of the MOS816 Rider
- Generate bills for group
- Premiums for those under age 65
- It does NOT bill the premium for their MA (Medicare) coverage when properly set up with the XLBC, XLBS riders
- MA members should not be terminated from the commercial pull division/segment when they are enrolled in MA
- Used for a group's retirees who are under 65. Groups used an existing retiree commercial division on MOS with their retirees who are under 65 as their pull division
- Ninety days prior to the member's Medicare Advantage plan effective date, the group should update the membership file with Employment Status of Retiree, Medicare Benefit Package ID, Medicare Type Code to Medicare, Medicare Part A/B effective dates and Primacy, correct Medicare Beneficiary Identifier

For additional instructions (and training videos) for eMVP, visit: https://pubpruat.bcbsm.com/content/public/en/employers/resources/manage-employee-records-online.html
You can also contact eMVP support at 1-866- 676-4858

	Medicare Advantage	Commercial Retiree Group/Division*	Commercial Safe Group/Division
Identifies active MA enrollees	☑		
Indicates the final enrollment location for an MA enrollee	☑		
Identifies age-in members		☑	
Stages opt-in age-in members in eMVP to enable enrollment through Online Enrollment Platform		☑	
Initiates the mailing of pre-enrollment opt-out kits for existing group		☑	
MA member identified with member type of Medicare 3x or 5x	☑	☑	☑

* For NASCO groups this will be the shell group/division. For MOS groups this will be the shadow group/division.

Commercial XL Riders

Commercial XL riders include the following:

- XLBC65 EX CROSS MEDADV
- XLBS65 EX SHIELD MEDADV
- XLPD65 EX PD MED ADV
- XLMM65

When one of these riders is loaded to the member's Commercial record the following message will appear on the membership files:

The Medicare Supplemental Member(s) on this contract are no longer receiving medical or pharmacy benefits under this contract number.

The member may be receiving these benefits under a new contract number. Please obtain the new ID card and contract number from the member.

NOTE:
Non-Medicare Supplemental member(s) continue to have benefits under this contract number.

Automated Group Reporting (AGR) Mass Update Request Template – Manual Entry

The complete Automated Group Reporting (AGR) Mass Update Request Template will be provided by your Medicare Advantage representative.

	BCBSM MembersEdge Automated Membership Template v2.4						
1	Provided by Automated Group Reporting						
2	Subscriber (Y/N) (Require	ME Group Number (Require	ME Division Number (Require	Subscriber SSN (Required	Member Last Name (Required)	Member First Name (Required)	M

Anti-Discrimination Statement

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

Discrimination is Against the Law

Blue Cross Blue Shield of Michigan and Blue Care Network comply with applicable Federal civil rights laws and does 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.

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Listing of Multi-Language Interpreter Services

Blue Cross Blue Shield Blue Care Network of Michigan

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

Multi-language Interpreter Services

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-684-8216 (TTY: 711).

Arabic: ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-684-8216 (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 1-866-684-8216 (TTY: 711)。

Syriac: ܙܘܗܪܐ: ܐܢ ܐܢܬ ܡܡܠܠܬ ܣܘܪܝܝܐ، ܬܫܡܫܬܐ ܕܥܘܕܪܢܐ ܒܠܫܢܐ ܕܝܠܘܟ ܐܝܬ ܠܘܟ ܡܓܢܐܝܬ܀ ܩܪܝ ܠܡܢܝܢܐ: 1-866-684-8216 (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 1-866-684-8216 (TTY: 711).

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-866-684-8216 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-684-8216 (TTY: 711) 번으로 전화해 주십시오.

Bengali: **মনে রাখবেন**: যদি আপনার ভাষা বাংলা হয়, ভাষা সহায়তা পরিষেবা আপনি বিনামূল্যে পেতে পারেন। কল করুন 1-866-684-8216 (TTY: 711)।

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-684-8216 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-684-8216 (TTY: 711).

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-684-8216 (TTY: 711).

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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。
1-866-684-8216（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 1-866-684-8216 (телетайп: 711).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-866-684-8216 (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 1-866-684-8216 (TTY: 711).

Process for Groups with 834

When the Group/TPA receives the opt-out they are supposed to submit the members on the file as a cancellation to ensure we remove the enrollment.

834 Process

The 834 file is used to submit terminations, cancellations, make updates and enroll new members, in the MA Plan. When the 834 enrollment file is used to enroll members, MA eligible members complete an opt-out form to decline enrollment in the plan.

The MA eligible only need to respond if they want to opt out of the plan. They are instructed to send their opt-out enrollment forms directly to their group or TPA address. Group or TPA will:

- Receive opt-out enrollment forms
- Contact member to confirm opt-out choice

Group or TPA: Manage Membership

Add age-ins to Mail File 60-90 days prior to member effective date.

Add drop-ins to Mail File:

- Send Mail File to the Medicare Service Consultant and copy Medicare Representative
- If there are no members aging-in to Group or TPA, send an email to Medicare Service Consultant and copy the Medicare Representative at least 60 days in advance
- Fill in Mail File columns (Group, First Name, Last Name, Address, City, State, Zip, and Zip4)

NOTE: New members must first have been placed on Mail File before appearing on the 834 production file

Mail File to BCBSM based on Member effective date

Group administrators should send BCBSM the file containing the members that need pre-enrollment kits at least 60-90 days prior to the effective date. The 834 file should be submitted 30 days prior to the members' effective date.

Manage Membership

Full file of Medicare eligible members that indicates the actions to be taken based on the status of the members: Adds, Changes, Audit (No Changes), and Terminations.

PPO Opt-In Cover Letter

Medicare PLUS Blue℠ Group PPO

Blue Cross Blue Shield of Michigan

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

<Date>

Dear <Group Name>Retiree:

<Group Name> offers a Medicare Advantage plan for its Medicare-eligible members. The plan is called **Medicare Plus Blue Group PPO** and is administered by Blue Cross Blue Shield of Michigan. Blue Cross has a network of more than 52,000 doctors and specialists and 128 hospitals, making it easy for you to find doctors and network hospitals near you. If you travel, we offer out-of-state and worldwide urgent and emergency care services through our BlueCard® program wherever you go, you can go confidently!

You will have three options to visit your primary care physician (PCP) for preventive services covered at 100%. Your PCP can help you determine if a Welcome to Medicare, Annual Wellness Visit, or Routine Annual Physical is right for you. Plus, you have access to the same preventive services offered by Original Medicare at no additional cost to you. By choosing Blue Cross, you are making the best choice in a health plan that can support your individual health care needs. Blue Cross has the experience and the knowledge to help you reach and maintain your healthcare goals.

What is a Medicare Advantage Plan?
Medicare Advantage plans are health plans that are approved by Medicare and administered by private insurance companies. Medicare Advantage plans provide all of your Original Medicare Part A (hospital) and Part B (medical) benefits, as well as offer supplemental benefits not offered under Original Medicare.
The Medicare Plus Blue Group PPO combines Medicare Part A and Part B benefits with coverage by <Group Name>.

If you or your Medicare-eligible spouse or dependent wish to enroll in this Medicare Plus Blue Group PPO plan, please complete the enclosed enrollment request form and return in the enclosed return envelope by <Date + 25>. Please use one form per person enrolling in the Medicare Plus Blue Group PPO plan. Each individual enrolling in the plan must sign his or her own form.

NOTE: Please keep in mind that an individual can only be enrolled in one Medicare Advantage plan at a time. Enrolling in the <Group Name> Medicare Plus Blue Group PPO will automatically disenroll you from any other Medicare Advantage health plan or Individual Part D Medicare Prescription drug plan in which you are enrolled.

Medicare Plus Blue is a PPO plan with a Medicare contract. Enrollment in Medicare Plus Blue depends on contract renewal.

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To enroll in Medicare Plus Blue Group PPO, please complete, sign and return the enrollment request form.

We understand that health care can sometimes be confusing and we're here to help. If you have questions about Medicare Plus Blue Group PPO, please call our Customer Service, toll free, at 1-866-684-8216 (TTY users call 711), 8:30 a.m. to 5 p.m., Eastern time, Monday through Friday (October 1 through March 31, 8 a.m. to 9 p.m., Eastern time, seven days a week). Calls to these numbers are free.

Sincerely,

Susan Schram

Susan Schram
Director, Medicare Employer Group Sales and Development

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

PPO Opt-In Enrollment Form

Enrollment request for <GROUP NAME> <Group Number> <BCBSM ID #>

Medicare PLUS Blue℠ Group PPO

Blue Cross Blue Shield of Michigan

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

Please contact <Medicare Plus Blue Group PPO> if you need information in another language or format.

Please provide the following information. Please print.			
☐ Mr. ☐ Ms. ☐ Mrs.	First name Middle initial Last name		
Birth date (mm/dd/yyyy)	Sex ☐ Male ☐ Female	Phone number	Alternate phone number
Permanent residence street address (*cannot be a post office box*)		City	State
ZIP code	County	Email address (optional)	
Mailing address (*if different from your permanent residence address*)			
Street address	City	State	ZIP code
Optional information			
Emergency contact name			
Relationship to you	Telephone number		

Please provide your Medicare insurance information		
Please take out your red, white and blue Medicare card to complete this section. • Fill out this information as it appears on your Medicare card -OR- • Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.	Name (as it appears on your Medicare card)	
	Medicare Number:	
	Is Entitled To:	Effective Date:
	HOSPITAL (Part A)	
	MEDICAL (Part B)	
	You must have Medicare Part A and Part B to join a Medicare Advantage plan.	

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-NEW. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT
Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See page 4 to send your completed form to the plan.

H9572_Grp21MAEnrllFrm_C FVNR 0920
OMB No. 0938-1378
Expires: 07/31/2023

DF 17441 SEP 20

Please respond to all questions	
1. Are you the retiree? If yes, retirement date (month/day/year): _____ If no, name of retiree: _____	☐ **Yes** ☐ **No**
2. Are you covering a spouse or dependent under this employer or union plan? If yes, name of spouse: _____ Name(s) of dependent(s): _____	☐ **Yes** ☐ **No**
3. Do you work? **Does your spouse work?**	☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No**
4. Do you have other drug coverage, including other private insurance,workers compensation, VA benefits or state pharmaceutical assistance programs? If yes, please provide: Company name: _____ Name of other drug plan: _____ ID # for coverage: _____	☐ **Yes** ☐ **No**
5. Are you a resident of a long-term care facility, such as a nursing home? If yes, please provide: Name of facility: _____ Facility street address: _____ City: _____ State: _____ ZIP code: _____ Phone number: _____	☐ **Yes** ☐ **No**
6. (Optional)**Please enter the name of your primary doctor:** _____	**Primary doctor's telephone:**

This enrollment application is part of your <Medicare Plus Blue Group PPO> enrollment kit. Other important materials you should review before joining this plan are included with this form:

- A cover letter with important deadlines and information (such as the date your enrollment form is due and where to send it)
- A Summary of Benefits booklet
- A Centers for Medicare & Medicaid Services Stars Ratings flier (measures how well Medicare Advantage plans perform in several areas)

Please contact <Medicare Plus Blue Group PPO> Customer Service at <**1-866-684-8216**> (TTY users call **711**) if you need information in an accessible format or language other than what is listed below.

Select one if you want us to send you information in a language other than English.
<☐ Spanish ☐ Other>

Select one if you want us to send you information in an accessible format.
☐ Large print ☐ Audio CD

Customer Service hours are 8:30 a.m. to 5 p.m., Eastern time, Monday through Friday (October 1 through March 31, 8 a.m. to 9 p.m., Eastern time, seven days a week). You can also visit us at **www.bcbsm.com/medicare**.

Important: Please read and sign below.

By completing this enrollment application, I agree to the following:

<Medicare Plus Blue Group PPO> is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can only be in one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I do not have Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future.

Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available, or under certain special circumstances. As a Medicare Advantage PPO member, <Medicare Plus Blue Group PPO> works differently than a Medicare supplemental plan. <Medicare Plus Blue Group PPO> pays instead of Medicare, and I will be responsible for the amounts that <Medicare Plus Blue Group PPO> does not cover, such as copayments or coinsurances. Original Medicare will not pay for my health care while I am enrolled in <Medicare Plus Blue Group PPO>.

Before seeing a provider, I should verify that the provider will accept Medicare. I understand that if my provider does not accept Medicare, I will need to find another provider who will or my out-of-pocket costs may be greater. Out-of-Network/non-contracted providers are under no obligation to treat <Medicare Plus Blue Group PPO> members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

<Medicare Plus Blue Group PPO> serves a specific service area. If I move out of the area that <Medicare Plus Blue Group PPO> serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of <Medicare Plus Blue Group PPO>, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Evidence of Coverage* document from <Medicare Plus Blue Group PPO> when I receive it to know which rules I must follow in order to receive coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with <Medicare Plus Blue Group PPO>, he/she may be paid based on my enrollment in <Medicare Plus Blue Group PPO>.

Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options, medical assistance through the State Medicaid Program and the Medicare Savings Program.

Release of Information: By joining this Medicare health plan, I acknowledge that the <Medicare Plus Blue Group PPO> will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that <Medicare Plus Blue Group PPO> who will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes that follow all applicable federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under state law to complete this enrollment and 2) documentation of this authority is available upon request by <Medicare Plus Blue Group PPO> or by Medicare.

Please sign below. By signing below, you have read the above information and you acknowledge you received a cover letter with this form as well as a Summary of Benefits, Star rating flyer.			
Signature:		Today's date:	
If you are the authorized representative, you must sign above and provide the following information:			
Name			
Address			
City		State	ZIP code
Phone number	Relationship to enrollee		

Please send your completed enrollment application to:

Medicare Plus Blue Group PPO
P.O. Box 44256
Detroit, Michigan 48244-0256

OR

Fax to: 1-866-533-5810

PRIVACY ACT STATEMENT
The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

DF 17441 SEP 20
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PPO Opt-Out Cover Letter

Medicare PLUS Blue℠ Group PPO

Blue Cross Blue Shield of Michigan

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

<MAIL DATE>

Dear <Retiree>:

As a Medicare-eligible group member, the <Group Name> group is offering you a Medicare Advantage plan, called **Medicare Plus Blue Group PPO**, through Blue Cross Blue Shield of Michigan. We know choosing health care coverage is a big decision. We're here to help you. This letter will help you understand some important information about Medicare Plus Blue Group PPO and how enrollment in this plan works.

What is Medicare Advantage?

As you think about your health care choices, you should know that Medicare Advantage plans are health plans that are approved by Medicare and administered by private insurance companies. Medicare Advantage plans provide all of your Original Medicare Part A (hospital) and Part B (medical) benefits, and offer supplemental benefits not covered under Original Medicare.

Medicare Plus Blue Group PPO combines Medicare Part A and Part B benefits with additional coverage offered by the <Group Name> group. This combination counts as one plan.

What does this mean for me?

Because one or more members on your contract recently became eligible for Medicare Plus Blue Group PPO, **we will automatically submit an application for enrollment in Medicare Plus Blue Group PPO for each Medicare eligible member on your contract**. If you receive a request for additional information, please make sure you reply by the date indicated on that request so we can complete your enrollment.

If you or your dependents **do not want the coverage** offered through the <Group Name> group, please make sure you read the enclosed opt-out form and provide all requested information, including your signature. You must mail the opt-out form using the enclosed postage-paid envelope by <mail file create + 25 days>. Again, **only return the opt-out form if you or your Medicare-eligible dependents *do not* want the Medicare Advantage coverage from <Group Name>.**

Medicare Plus Blue is a PPO plan with a Medicare contract. Enrollment in Medicare Plus Blue depends on contract renewal.

H9572_Grp21OptOutCvrMA_M FVNR 0920

Advantages to choosing Medicare Plus Blue

With Medicare Plus Blue Group PPO, you get:

- Freedom to choose any doctor or hospital that accepts Original Medicare, **without a referral**
- Lower out-of-pocket costs when you receive services from a doctor or hospital in our network. Our network includes more than 52,000 doctors and specialists and 128 hospitals
- Access to specialists with no referrals required
- BlueCard® travel benefits that cover you anywhere in the U.S.
- Wherever you go, go confidently; knowing you have coverage worldwide for emergency and urgent care
- One ID card for health coverage
- Three options to visit your primary care physician (PCP) for your free preventive services. Your PCP can help you determine if a Welcome to Medicare, Annual Wellness Visit, or Routine Annual Physical is right for you
- Access to the same preventive services offered by Original Medicare at no additional cost to you

Important information for you to know – keep in mind you can only be enrolled in one Medicare Advantage plan

- If you or another Medicare-eligible member on your contract has other coverage that pays before your <Group Name> coverage and you wish to keep that coverage arrangement, please contact your <Group Name> immediately. Be sure to complete the opt-out form so you are not enrolled in this plan.

- Enrolling in the <Group Name> Medicare Plus Blue Group PPO **will automatically disenroll** you from any other Medicare Advantage health plan in which you are enrolled.

- Please remember that because Medicare has an annual enrollment period for individuals who aren't eligible for a group plan, you may receive several health care options from which to choose. **If you choose to enroll in an individual plan, any coverage you have through your employer group with Blue Cross will be cancelled.** You may not be able to re-enroll in your employer's plan. Please check with your employer for enrollment eligibility.

If you don't want Medicare Advantage coverage

How to opt out of Medicare Plus Blue℠ PPO Group coverage

<GROUP NAME> provides Medicare-eligible members with Medicare Plus Blue Group PPO, a Medicare Advantage plan. You will be automatically enrolled in the Medicare Plus Blue Group PPO plan unless you notify Blue Cross Blue Shield of Michigan that you do not want this coverage.

How to opt out of Medicare Plus Blue Group PPO coverage

If you decide that you **do not** want to retain coverage under the **<GROUP NAME>** health care plan, then complete the form on the back of this page, sign where requested and send it to Blue Cross Blue Shield of Michigan using the enclosed return envelope.

Important:

- Only return this form if you do not want to be covered by the Medicare Advantage plan offered through the **<GROUP NAME>**.
- If you, as the contract holder, decide to opt out of the Medicare Advantage plan, everyone on your health care contract will also be removed. **All members on your contract will no longer have coverage through <GROUP NAME>**.
- Declining Medicare Plus Blue Group PPO coverage may affect other coverage your employer or union group offers, such as prescription drugs, vision or dental coverage. Before submitting this form, contact your employer or union group to find out what will happen to those benefits if you decline Medicare Advantage coverage.

Blue Cross Blue Shield of Michigan may contact you for verification of your coverage selection. Please make sure you provide your current phone number on the form below your signature.

Return the form in the enclosed postage-paid envelope to:

Medicare Plus Blue Group PPO
600 Lafayette East
Detroit, Michigan 48226
Mail Code: 1604

If you want Medicare Plus Blue Group PPO coverage, do not return this form. However, if you receive a letter requesting additional information regarding your enrollment, please respond promptly so that we can complete the enrollment process. Once we receive your information, we will submit your enrollment request to the Centers for Medicare & Medicaid Services (CMS).

For questions about this form or the Medicare Plus Blue Group PPO plan, please call Customer Service, toll free at the telephone number below:

1-866-684-8216
Monday through Friday from 8:30 a.m. to 5 p.m., Eastern time,
(October 1 through March 31, 8 a.m. to 9 p.m., Eastern time,
seven days a week). **TTY users should call 711.**

PPO Opt-Out Form

If you don't want Medicare Advantage coverage
How to opt out of
Medicare Plus Blue℠ PPO Group coverage

<GROUP NAME> provides Medicare-eligible members with Medicare Plus Blue Group PPO, a Medicare Advantage plan. You will be automatically enrolled in the Medicare Plus Blue Group PPO plan unless you notify Blue Cross Blue Shield of Michigan that you do not want this coverage.

How to opt out of Medicare Plus Blue Group PPO coverage
If you decide that you **do not** want to retain coverage under the **<GROUP NAME>** health care plan, then complete the form on the back of this page, sign where requested and send it to Blue Cross Blue Shield of Michigan using the enclosed return envelope.

Important:

- Only return this form if you do not want to be covered by the Medicare Advantage plan offered through the **<GROUP NAME>**.
- When you, as the contract holder, decide to opt out of the Medicare Advantage plan, the dependents on your health care contract will no longer qualify for coverage. You will need to add their names to the form included here to confirm their removal from the Medicare Advantage plan offered through the **<GROUP NAME>**.
- Declining Medicare Plus Blue Group PPO coverage may affect other coverage your employer or union group offers, such as prescription drugs, vision or dental coverage. Before submitting this form, contact your employer or union group to find out what will happen to those benefits if you decline Medicare Advantage coverage.

Blue Cross Blue Shield of Michigan may contact you for verification of your coverage selection. Please make sure you provide your current phone number on the form below your signature.

Return the form in the enclosed postage-paid envelope to:

Medicare Plus Blue Group PPO
600 Lafayette East
Detroit, Michigan 48226
Mail Code: 1604

If you want Medicare Plus Blue Group PPO coverage, do not return this form. However, if you receive a letter requesting additional information regarding your enrollment, please respond promptly so that we can complete the enrollment process. Once we receive your information, we will submit your enrollment request to the Centers for Medicare & Medicaid Services (CMS).

For questions about this form or the Medicare Plus Blue Group PPO plan, please call Customer Service, toll free at the telephone number below:

1-866-684-8216
Monday through Friday from 8:30 a.m. to 5 p.m., Eastern time,
(October 1 through March 31, 8 a.m. to 9 p.m., Eastern time,
seven days a week). **TTY users should call 711.**

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Page 1 of 2

OPT-OUT FORM

<GROUP NAME> Medicare Plus Blue Group PPO

If you wish to decline coverage, complete all sections below and return to Blue Cross. Please print.

Name of contract holder	
BCBSM contract no.	**Medicare ID no.**

Important: *You can only be enrolled in one group sponsored Medicare Advantage plan and one group sponsored prescription drug plan. If you are already enrolled in an individual Medicare Advantage plan and/or individual Medicare prescription drug plan, or if you are covered through your spouse's Medicare Advantage and/or prescription drug plan, you must decide which plans you wish to keep. If you do not use this form to notify us that you are enrolled in other plans, we will enroll you in* **<GROUP NAME>** *Medicare Advantage plan and Medicare will automatically cancel your other Medicare health plan and Medicare prescription drug plan coverage.*

- ❑ **I decline Medicare Advantage coverage for myself (the contract holder) and any eligible dependents listed below. I understand this will result in cancellation of all health benefits currently covered by <GROUP NAME>.**
- ❑ **I want to join <GROUP NAME>'s Medicare Plus Blue Group PPO plan, but wish to remove the following Medicare-eligible dependents from my contract.**

Dependent's last name	Dependent's first name	Date of birth	Dependent's signature
			X
			X
			X
			X

Once you or your representative have checked one box above and provided any requested information, please complete the information below, sign, and date.

X_____ _____

Contract holder's signature **Date**

(___)_____

Daytime phone no.

If you are signing as the contract holder's authorized representative, please complete the section below.

The following is authorized to act on behalf of the individual above under the laws of the State in which the individual resides. If signed by an authorized individual, this signature certifies that: 1) this person is authorized under State law to complete this opt-out form and 2) documentation of this authority is available upon request.

Name of representative	**Daytime phone no.**
Address	**Relationship to retiree**

FOR OFFICE USE ONLY					
BCBSM Rec'd date:		Confirm date		BCBSM Rep name	
Please check one	❑ Opt-out confirmed ❑ Opt-out reversed (Member will be enrolled) ❑ Enroll contract holder/remove dependent				
Comments:					

MAPD Opt-In Cover Letter

Medicare PLUS Blue℠ Group PPO

Blue Cross Blue Shield of Michigan

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

<Date>

Dear <Group Name>Retiree:

<Group Name> offers a Medicare Advantage plan for its Medicare-eligible members. The plan is called **Medicare Plus Blue Group PPO** and is administered by Blue Cross Blue Shield of Michigan. Blue Cross has a network of more than 52,000 doctors and specialists and 128 hospitals, making it easy to find doctors and network hospitals near you. If you travel, we offer out-of-state and worldwide urgent and emergency care services through our BlueCard® program. Wherever you go, you can go confidently!

You will have three options to visit your primary care physician (PCP) for preventive services covered at 100%. Your PCP can help you determine if a Welcome to Medicare, Annual Wellness Visit, or Routine Annual Physical is right for you. Plus, you have access to the same preventive services offered by Original Medicare at no additional cost to you. By choosing Blue Cross, you are making the best decision to be with a company that can support your individual health care needs. Blue Cross has the experience and knowledge to help you reach and maintain your healthcare goals.

What is a Medicare Advantage Plan?
Medicare Advantage plans are health plans that are approved by Medicare and administered by private insurance companies. Medicare Advantage plans provide all of your original Medicare Part A (hospital) and Part B (medical) benefits as well as offer supplemental benefits not offered under Original Medicare. This specific Medicare Advantage plan also includes prescription drug coverage under Medicare Part D. The Medicare Plus Blue Group PPO combines Medicare Part A and Part B benefits with coverage by <Group Name>.

If you or your Medicare-eligible spouse or dependent wish to enroll in this Medicare Plus Blue Group PPO plan, please complete the enclosed enrollment request form and return in the enclosed return envelope by <Date + 25>. Please use one form per person enrolling in the Medicare Plus Blue Group PPO plan. Each individual enrolling in the plan must sign his or her own form.

NOTE: Please keep in mind that an individual can only be enrolled in one Medicare Advantage plan at a time. Enrolling in the <Group Name> Medicare Plus Blue Group PPO will automatically disenroll you from any other Medicare Advantage health plan or Individual Part D Medicare Prescription drug plan in which you are enrolled.

Medicare Plus Blue is a PPO plan with a Medicare contract. Enrollment in Medicare Plus Blue depends on contract renewal.

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To enroll in Medicare Plus Blue Group PPO, please complete, sign and return the enrollment request form.

We understand that health care can sometimes be confusing and we're here to help. If you have questions about **Medicare Plus Blue Group PPO,** please call our Customer Service, toll free, at 1-866-684-8216 (TTY users call 711), 8:30 a.m. to 5 p.m., Eastern time, Monday through Friday (October 1 through March 31, 8 a.m. to 9 p.m., Eastern time, seven days a week). Calls to these numbers are free.

Sincerely,

Susan Schram

Susan Schram
Director, Medicare Employer Group Sales and Development

MAPD Opt-In Enrollment Form

Enrollment request for <GROUP NAME> <Group Number> <BCBSM ID #>

Medicare PLUS Blue℠ Group PPO

Blue Cross Blue Shield of Michigan

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Please contact <Medicare Plus Blue Group PPO> if you need information in another language or format.

Please provide the following information. Please print.			
☐ Mr. ☐ Ms. ☐ Mrs.	First name Middle initial Last name		
Birth date (mm/dd/yyyy)	Sex ☐ Male ☐ Female	Phone number	Alternate phone number
Permanent residence street address (*cannot be a post office box*)		City	State
ZIP code	County	Email address (optional)	
Mailing address (*if different from your permanent residence address*)			
Street address	City	State	ZIP code
Optional information			
Emergency contact name			
Relationship to you	Telephone number		

Please provide your Medicare insurance information		
Please take out your red, white and blue Medicare card to complete this section. • Fill out this information as it appears on your Medicare card -OR- • Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.	Name (as it appears on your Medicare card)	
	Medicare Number:	
	Is Entitled To:	Effective Date:
	HOSPITAL (Part A)	
	MEDICAL (Part B)	
	You must have Medicare Part A and Part B to join a Medicare Advantage plan.	

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Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See page 4 to send your completed form to the plan.

H9572_Grp21MAPDEnrllFrm_C FVNR 0920
OMB No. 0938-1378
Expires: 07/31/2023

DN 15179 SEP 20

Please respond to all questions	
1. Are you the retiree? If yes, retirement date (month/day/year): _____ If no, name of retiree: _____	☐ **Yes** ☐ **No**
2. Are you covering a spouse or dependent under this employer or union plan? If yes, name of spouse: _____ Name(s) of dependent(s): _____	☐ **Yes** ☐ **No**
3. Do you work? **Does your spouse work?**	☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No**
4. Do you have other drug coverage, including other private insurance,workers compensation, VA benefits or state pharmaceutical assistance programs? If yes, please provide: Company name: _____ Name of other drug plan: _____ ID # for coverage: _____	☐ **Yes** ☐ **No**
5. Are you a resident of a long-term care facility, such as a nursing home? If yes, please provide: Name of facility: _____ Facility street address: _____ City: _____ State: _____ ZIP code: _____ Phone number: _____	☐ **Yes** ☐ **No**
6. (Optional)**Please enter the name of your primary doctor:** _____	**Primary doctor's telephone:**

This enrollment application is part of your <Medicare Plus Blue Group PPO> enrollment kit. Other important materials you should review before joining this plan are included with this form:

- A cover letter with important deadlines and information (such as the date your enrollment form is due and where to send it)
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Select one if you want us to send you information in a language other than English.
<☐ Spanish ☐ Other>

Select one if you want us to send you information in an accessible format.
☐ Large print ☐ Audio CD

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Counseling services may be available in my state to provide advice concerning Medicare supplement insurance or other Medicare Advantage or Prescription Drug plan options, medical assistance through the State Medicaid Program and the Medicare Savings Program.

Release of Information: By joining this Medicare health plan, I acknowledge that the <Medicare Plus Blue Group PPO> will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that <Medicare Plus Blue Group PPO> who will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes that follow all applicable federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under state law to complete this enrollment and 2) documentation of this authority is available upon request by <Medicare Plus Blue Group PPO> or by Medicare.

Please sign below. By signing below, you have read the above information and you acknowledge you received a cover letter with this form as well as a Summary of Benefits, Star rating flyer.			
Signature:		Today's date:	
If you are the authorized representative, you must sign above and provide the following information:			
Name			
Address			
City		State	ZIP code
Phone number	Relationship to enrollee		

Please send your completed enrollment application to:

Medicare Plus Blue Group PPO
P.O. Box 44256
Detroit, Michigan 48244-0256

OR

Fax to: 1-866-533-5810

PRIVACY ACT STATEMENT
The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

MAPD Opt-Out Cover Letter

Medicare PLUS Blue℠ Group PPO

Blue Cross Blue Shield of Michigan

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

<MAIL DATE>

Dear <Retiree>:

As a Medicare-eligible group member, the <Group Name> group is offering you a Medicare Advantage plan, called **Medicare Plus Blue Group PPO**, through Blue Cross Blue Shield of Michigan. We know choosing health care coverage is a big decision. We're here to help you. This letter will help you understand some important information about Medicare Plus Blue Group PPO and how enrollment in this plan works.

What is Medicare Advantage?

As you think about your health care choices, you should know that Medicare Advantage plans are health plans that are approved by Medicare and administered by private insurance companies. Medicare Advantage plans provide all of your original Medicare Part A (hospital) and Part B (medical) benefits, and offer supplemental benefits not covered under Original Medicare. Your employer selected a Medicare Advantage plan that includes Medicare prescription drug coverage under Part D.

Medicare Plus Blue Group PPO combines Medicare Part A and Part B benefits with additional coverage, and includes Part D offered by the <Group Name> group plan. This combination provides coverages as one full plan.

What does this mean for me?

Because one or more members on your contract recently became eligible for Medicare Plus Blue Group PPO, **we will automatically submit an application for enrollment in Medicare Plus Blue Group PPO for each Medicare eligible member on your contract**. If you receive a request for additional information, please make sure you reply by the date indicated on that request so we can complete your enrollment.

If you or your dependents **do not want the coverage** offered through the <Group Name> group, please make sure you read the enclosed opt-out form and provide all requested information, including your signature. You would then mail the opt-out form using the enclosed postage-paid envelope by <mail file create + 25 days>. Again, **only return the opt-out form if you or your Medicare-eligible dependents *do not* want the Medicare Advantage coverage from <Group Name>.**

Medicare Plus Blue is a PPO plan with a Medicare contract. Enrollment in Medicare Plus Blue depends on contract renewal.

H9572_Grp21MAPDOptOutCvr_M FVNR 1020

Advantages to choosing Medicare Plus Blue Group PPO

With Medicare Plus Blue Group PPO, you get:

- Freedom to choose any doctor or hospital that accepts Original Medicare, **without a referral**
- Lower out-of-pocket costs when you receive services from a doctor or hospital in our network. Our network includes more than 52,000 doctors and specialists and 128 hospitals.
- Access to specialists with no referrals required
- BlueCard® travel benefits that cover you anywhere in the U.S. and its territories
- Wherever you go, go confidently, knowing you have coverage worldwide for emergency and urgent care
- One ID card for health and prescription drug coverage
- Three options to visit your primary care physician (PCP) for your free preventive services. Your PCP can help you determine if a Welcome to Medicare, Annual Wellness Visit, or Routine Annual Physical is right for you.
- Access to the same preventive services offered by Original Medicare at no additional cost to you.

Important information for you to know – keep in mind you can only be enrolled in one Medicare Advantage plan

- If you or another Medicare-eligible member on your contract has other coverage that pays before your <Group Name> coverage and you wish to keep that coverage arrangement, please contact your <Group Name> immediately.
- Enrolling in the <Group Name> Medicare Plus Blue Group PPO **will automatically disenroll** you from any other Medicare Advantage health plan or individual Part D Medicare Prescription drug plan in which you are enrolled.
- Please remember that because Medicare has an annual enrollment period for individuals who aren't eligible for a group plan, you may receive several health care options from which to choose. **If you choose to enroll in an individual Medicare plan, any coverage you have through your employer group with Blue Cross will be cancelled.** You may not be able to re-enroll in your employer's group plan. Please check with your employer for enrollment eligibility.

We're here to help!

If you have questions about Medicare Plus Blue Group PPO, please call us, toll free, at 1-866-684-8216, Monday through Friday from 8:30 a.m. to 5 p.m., Eastern time (October 1 through March 31, 8 a.m. to 9 p.m., Eastern time, seven days a week). TTY users should call 711.

Thank you for considering Medicare Plus Blue Group PPO for your healthcare needs.

Sincerely,

Susan Schram

Susan Schram
Director, Medicare Employer Group Sales and Development

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

MAPD Opt-Out Enrollment Form

If you don't want Medicare Advantage coverage
How to opt out of
Medicare Plus Blue℠ PPO Group coverage

<GROUP NAME> provides Medicare-eligible members with Medicare Plus Blue Group PPO, a Medicare Advantage plan. You will be automatically enrolled in the Medicare Plus Blue Group PPO plan, unless you notify Blue Cross Blue Shield of Michigan that you do not want this coverage.

How to opt out of Medicare Plus Blue Group PPO coverage
If you decide that you **do not** want to retain coverage under the **<GROUP NAME>** health care plan, complete the form on the back of this page, sign where requested and send it to Blue Cross Blue Shield of Michigan using the enclosed return envelope.

Important Information:

- Only return this form if you do not want to be covered by the Medicare Advantage plan offered through the **<GROUP NAME>**.
- When you, as the contract holder, decide to opt out of the Medicare Advantage plan, the dependents on your health care contract will no longer qualify for coverage. You will need to add their names to the form included here to confirm their removal from the Medicare Advantage plan offered through the **<GROUP NAME>**.
- Declining Medicare Plus Blue Group PPO coverage may affect other coverage your employer or union group offers, such as prescription drugs, vision or dental coverage. Before submitting this form, contact your employer or union group to find out what will happen to those benefits if you decline Medicare Advantage coverage.

Blue Cross Blue Shield of Michigan may contact you for verification of your coverage selection. Please make sure you provide your current phone number on the form below your signature.

Return the form in the enclosed postage-paid envelope to:

Medicare Plus Blue Group PPO
600 Lafayette East
Detroit, Michigan 48226
Mail Code: 1604

If you want to enroll in Medicare Plus Blue Group PPO coverage, do not return this form. However, if you receive a letter requesting additional information regarding your enrollment, please respond promptly so that we can complete the enrollment process. Once we receive your information, we will submit your enrollment request to the Centers for Medicare & Medicaid Services (CMS).

For questions about this form or the Medicare Plus Blue Group PPO plan, please call Customer Service, toll free at the telephone number below:

1-866-684-8216
Monday through Friday from 8:30 a.m. to 5 p.m., Eastern time,
(October 1 through March 31, 8 a.m. to 9 p.m., Eastern time,
seven days a week). **TTY users should call 711.**

If you don't want Medicare Advantage coverage

How to opt out of Medicare Plus Blue℠ PPO Group coverage

<GROUP NAME> provides Medicare-eligible members with Medicare Plus Blue Group PPO, a Medicare Advantage plan. You will be automatically enrolled in the Medicare Plus Blue Group PPO plan unless you notify Blue Cross Blue Shield of Michigan that you do not want this coverage.

How to opt out of Medicare Plus Blue Group PPO coverage

If you decide that you **do not** want to retain coverage under the **<GROUP NAME>** health care plan, then complete the form on the back of this page, sign where requested and send it to Blue Cross Blue Shield of Michigan using the enclosed return envelope.

Important:

- Only return this form if you do not want to be covered by the Medicare Advantage plan offered through the **<GROUP NAME>**.
- When you, as the contract holder, decide to opt out of the Medicare Advantage plan, the dependents on your health care contract will no longer qualify for coverage. You will need to add their names to the form included here to confirm their removal from the Medicare Advantage plan offered through the **<GROUP NAME>**.
- Declining Medicare Plus Blue Group PPO coverage may affect other coverage your employer or union group offers, such as prescription drugs, vision or dental coverage. Before submitting this form, contact your employer or union group to find out what will happen to those benefits if you decline Medicare Advantage coverage.

Blue Cross Blue Shield of Michigan may contact you for verification of your coverage selection. Please make sure you provide your current phone number on the form below your signature.

Return the form in the enclosed postage-paid envelope to:

Medicare Plus Blue Group PPO
600 Lafayette East
Detroit, Michigan 48226
Mail Code: 1604

If you want Medicare Plus Blue Group PPO coverage, do not return this form. However, if you receive a letter requesting additional information regarding your enrollment, please respond promptly so that we can complete the enrollment process. Once we receive your information, we will submit your enrollment request to the Centers for Medicare & Medicaid Services (CMS).

For questions about this form or the Medicare Plus Blue Group PPO plan, please call Customer Service, toll free at the telephone number below:

1-866-684-8216
Monday through Friday from 8:30 a.m. to 5 p.m., Eastern time,
(October 1 through March 31, 8 a.m. to 9 p.m., Eastern time,
seven days a week). **TTY users should call 711.**

PDP Opt-In Cover Letter

Prescription Blue℠ Group PDP

Blue Cross Blue Shield of Michigan

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

<Date>

Dear Retiree:

<Group Name> offers a Medicare prescription drug plan for its Medicare-eligible members. The plan is called **Prescription Blue Group PDP** and is administered by Blue Cross Blue Shield of Michigan.

What is a Medicare Prescription Drug Plan?

Medicare Prescription Drug Plans are stand-alone prescription drug plans that are approved by Medicare and administered by private insurance companies. Prescription drug plans provide all of your Original Medicare Part D benefits with additional coverage by <Group Name>.

If you, your Medicare-eligible spouse or dependent wish to enroll in this Prescription Blue Group PDP plan, please complete the enclosed enrollment request form and return in the enclosed return envelope by <Date + 25>. Please use one form per person enrolling in the Prescription Blue Group PDP plan. Each individual enrolling in the plan must sign his or her own form.

NOTE: Please keep in mind that an individual can only be enrolled in one Medicare Prescription Drug Plan at a time. Enrolling in the <Group Name> Prescription Blue Group PDP will automatically disenroll you from any Medicare Prescription Drug Plan in which you are currently enrolled.

If you still wish to enroll in Prescription Blue Group PDP, please complete, sign and return the enrollment request form.

If you have questions about this Medicare Prescription Drug Plan, please call Customer Service at 1-866-684- 8216, (TTY users call 711), 8:30 a.m. to 5 p.m., Eastern time, Monday through Friday (October 1 through March 1,8 a.m. to 9 p.m., Eastern time, seven days a week). TTY users call: 711. Calls to these numbers are free.

Sincerely,

Susan Schram

Susan Schram
Director, Medicare Employer Group Sales and Development

Prescription Blue is a PDP plan with a Medicare contract. Enrollment in Prescription Blue depends on contract renewal.

S5584_L_Grp21OptInCvr FVNR 0920

PDP Opt-In Enrollment Form

Enrollment request for <GROUP NAME> <Group Number> <BCBSM ID #>

Prescription Blue℠ Group PDP

Blue Cross Blue Shield of Michigan

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

Please contact <Prescription Blue Group PDP> if you need information in another language or format.

Please provide the following information. Please print.			
☐ Mr. ☐ Ms. ☐ Mrs.	First name Middle initial Last name		
Birth date (mm/dd/yyyy)	Sex ☐ Male ☐ Female	Phone number	Alternate phone number
Permanent residence street address (*cannot be a post office box*)		City	State
ZIP code	County	Email address (optional)	
Mailing address (*if different from your permanent residence address*)			
Street address	City	State	ZIP code
Optional information			
Emergency contact name			
Relationship to you	Telephone number		

Please provide your Medicare insurance information		
Please take out your red, white and blue Medicare card to complete this section. • Fill out this information as it appears on your Medicare card -OR- • Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.	Name (as it appears on your Medicare card)	
	Medicare Number:	
	Is Entitled To:	Effective Date:
	HOSPITAL (Part A)	
	MEDICAL (Part B)	
	You must have Medicare Part A or Part B, or both to join a Medicare Advantage plan.	

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-NEW. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT

Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See page 4 to send your completed form to the plan.

S5584_Grp21PDPEnrollFrm_C FVNR 0920
OMB No. 0938-1378
Expires: 07/31/2023

DN 15180 SEP 20

Please respond to all questions	
1. Are you the retiree? If yes, retirement date (month/day/year): _____ If no, name of retiree: _____	☐ **Yes** ☐ **No**
2. Are you covering a spouse or dependents under this employer or union plan? If yes, name of spouse: _____ Name(s) of dependent(s): _____	☐ **Yes** ☐ **No**
3. Do you work? **Does your spouse work?**	☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No**
4. Do you have other drug coverage, including other private insurance,workers compensation, VA benefits or state pharmaceutical assistance programs? If yes, please provide: Company name: _____ Name of other drug plan: _____ ID # for coverage: _____	☐ **Yes** ☐ **No**
5. Are you a resident of a long-term care facility, such as a nursing home? If yes, please provide: Name of facility: _____ Facility street address: _____ City: _____ State: _____ ZIP code: _____ Phone number: _____	☐ **Yes** ☐ **No**

This enrollment application is part of your <Prescription Blue Group PDP> enrollment kit. Other important materials you should review before joining this plan are included with this form:

- A Pre-Enrollment Checklist
- A cover letter with important deadlines and information (such as the date your enrollment form is due and where to send it)
- A Summary of Benefits booklet
- A Centers for Medicare & Medicaid Services Stars Ratings flier (measures how well Medicare Advantage plans perform in several areas)

Please contact <Prescription Blue Group PDP> Customer Service at **1-866-684-8216** (TTY users call **711**) if you need information in an accessible format or language other than what is listed below.

Select one if you want us to send you information in a language other than English.
☐ Spanish ☐ Other

Select one if you want us to send you information in an accessible format.
☐ Large print ☐ Audio CD

Customer Service hours are 8:30 a.m. to 5 p.m., Eastern time, Monday through Friday (October 1 through March 31, 8 a.m. to 9 p.m., Eastern time, seven days a week). You can also visit us at **www.bcbsm.com/medicare**.

Important: Please read and sign below.

By completing this enrollment application, I agree to the following:

<Prescription Blue Group PDP> is a Medicare drug plan and has a contract with the Federal government. I understand that this prescription drug coverage is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare Part A or Part B coverage. It is my responsibility to inform <Prescription Blue Group PDP> of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time-if I am currently in a Medicare Prescription Drug Plan, my enrollment in <Prescription Blue Group PDP> will end that enrollment.

I understand that if I leave this plan and don't have or get other Medicare prescription drug coverage or creditable prescription drug coverage (as good as Medicare's) I may have to pay a late enrollment penalty in addition to my premium for Medicare prescription drug coverage in the future.

<Prescription Blue Group PDP> serves a specific service area. If I move out of the area that <Prescription Blue Group PDP> serves, I need to notify the plan so I can disenroll and find a new plan in my new area. I understand that I must use network pharmacies except in an emergency when I cannot reasonably use <Prescription Blue Group PDP> network pharmacies. Once I am a member of <Prescription Blue Group PDP>, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from <Prescription Blue Group PDP> when I receive it to know which rules I must follow in order to receive coverage.

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with <Prescription Blue Group PDP>, he/she may be paid based on my enrollment in <Prescription Blue Group PDP>.

Counseling services may be available in my state to provide advice concerning Medicare supplemental insurance or other Medicare Advantage or Prescription Drug plan options,medical assistance through the State Medicaid Program and the Medicare Savings Program.

Release of Information: By joining this Medicare prescription drug plan, I acknowledge that <Prescription Blue Group PDP> will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that <Prescription Blue Group PDP> will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes that follow all applicable federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under State law where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under state law to complete this enrollment and 2) documentation of this authority is available upon request by <Prescription Blue Group PDP> or by Medicare.

Please sign below. By signing below, you have read the above information and you acknowledge you received a cover letter with this form as well as a Summary of Benefits, Star rating flyer.			
Signature:		Today's date:	
If you are the authorized representative, you must sign above and provide the following information:			
Name			
Address			
City		State	ZIP code
Phone number	Relationship to enrollee		

Please send your completed enrollment application to:

Prescription Blue Group PDP
P.O. Box 44828
Detroit, Michigan 48244-0828

OR

Fax to: 1-866-533-5810

PRIVACY ACT STATEMENT
The Centers for Medicare & Medicaid Services (CMS) collects information from Medicare plans to track beneficiary enrollment in Medicare Advantage (MA) or Prescription Drug Plans (PDP), improve care, and for the payment of Medicare benefits. Sections 1851 and 1860D-1 of the Social Security Act and 42 CFR §§ 422.50, 422.60, 423.30 and 423.32 authorize the collection of this information. CMS may use, disclose and exchange enrollment data from Medicare beneficiaries as specified in the System of Records Notice (SORN) "Medicare Advantage Prescription Drug (MARx)", System No. 09-70-0588. Your response to this form is voluntary. However, failure to respond may affect enrollment in the plan.

PDP Opt-Out Cover Letter

Prescription Blue℠ Group PDP

Blue Cross Blue Shield of Michigan

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

<MAIL DATE>

Dear <Retiree>:

As a Medicare-eligible group member, the <Group Name> group is offering you a prescription drug plan called **Prescription Blue Group PDP**, through Blue Cross Blue Shield of Michigan. We know choosing health care coverage is a big decision. We're here to help you. This letter will help you understand some important information about Prescription Blue Group PDP and how enrollment in this plan works.

What is a Medicare Prescription Drug Plan?

Medicare Prescription Drug Plans are drug plans that are approved by Medicare and administered by private insurance companies. Medicare Prescription Drug Plans provide all of your drug coverage under Part D.

Prescription Blue Group PDP combines Part D benefits with coverage by <GROUP NAME>.

What does this mean for me?

Because one or more members on your contract recently became eligible for Prescription Blue Group PDP, **we will automatically submit an application for enrollment in Prescription Blue Group PDP for each Medicare eligible member on your contract**. If you receive a request for additional information, please make sure you reply by the date indicated in that information so we can complete your enrollment.

If you or your dependents **do not want the coverage** offered through the <Group Name> group, please make sure you read the enclosed opt-out form and provide all requested information, including your signature. You would then mail the opt-out form using the enclosed postage-paid envelope by <mail file create + 25 days>. Again, **only return the opt-out form if you or your Medicare-eligible dependents *do not* want the prescription drug coverage from <Group Name>.**

Prescription Blue is a PDP plan with a Medicare contract. Enrollment in Prescription Blue depends on contract renewal.

OPT-OUT FORM

<GROUP NAME> Prescription Blue Group PDP

If you wish to decline coverage, complete all sections below and return to BCBSM. Please print.

Name of contract holder	
BCBSM contract no.	**Medicare ID no.**

Important: *You can only be enrolled in one Medicare prescription drug plan or Medicare Advantage medical plan that includes Medicare Part D drug coverage (MAPD) at a time. If you are already enrolled in a Medicare prescription drug plan, or if you are covered through your spouse's prescription drug plan, you must decide which plan you wish to keep. If you do not use this form to notify us that you are enrolled in another plan, we will enroll you in* **<GROUP NAME>** *Medicare prescription drug plan and Medicare will automatically cancel your other Medicare prescription drug plan coverage.*

- ❑ **I decline Medicare prescription drug coverage for myself (the contract holder) and understand this will result in cancellation of all prescription benefits for me and all dependents currently covered by <GROUP NAME>.**
- ❑ **I want to join <GROUP NAME>'s Prescription Blue Group PDP, but wish to remove the following Medicare-eligible dependents from my contract.**

Dependent's last name	Dependent's first name	Date of birth	Dependent's signature
			X
			X
			X
			X

Please sign

Once you or your representative have checked one box above and provided any requested information, please complete the information below, sign, and date.

X_____ _____

Contract holder's signature **Date**

(___) _____

Daytime phone no.

If you are signing as the contract holder's authorized representative, please complete the section below.

The following is authorized to act on behalf of the individual above under the laws of the State in which the individual resides. If signed by an authorized individual, this signature certifies that: 1) this person is authorized under State law to complete this opt-out form and 2) documentation of this authority is available upon request.

Name of representative	**Daytime phone no.**
Address	**Relationship to retiree**

For office use only

BCBSM Rec'd date:		Confirm date		BCBSM Rep name	
Please check one	❑ Opt-out confirmed ❑ Opt-out reversed (Member will be enrolled) ❑ Enroll contract holder/remove dependent				
Comments:					

PDP Opt-Out Enrollment Form

Enrollment request for <GROUP NAME> <Group Number> <BCBSM ID #>

Prescription Blue℠ Group PDP

Blue Cross Blue Shield of Michigan

Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

Please contact <Prescription Blue Group PDP> if you need information in another language or format.

Please provide the following information. Please print.				
☐ Mr. ☐ Ms. ☐ Mrs.	First name	Middle initial	Last name	
Birth date (mm/dd/yyyy)	Sex ☐ Male ☐ Female	Phone number	Alternate phone number	
Permanent residence street address (*cannot be a post office box*)			City	State
ZIP code	County	Email address (optional)		
Mailing address (*if different from your permanent residence address*)				
Street address	City	State	ZIP code	
Optional information				
Emergency contact name				
Relationship to you	Telephone number			

Please provide your Medicare insurance information		
Please take out your red, white and blue Medicare card to complete this section. • Fill out this information as it appears on your Medicare card -OR- • Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.	Name (as it appears on your Medicare card)	
	Medicare Number:	
	Is Entitled To:	Effective Date:
	HOSPITAL (Part A)	
	MEDICAL (Part B)	
	You must have Medicare Part A or Part B, or both to join a Medicare Advantage plan.	

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-NEW. The time required to complete this information is estimated to average 20 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

IMPORTANT
Do not send this form or any items with your personal information (such as claims, payments, medical records, etc.) to the PRA Reports Clearance Office. Any items we get that aren't about how to improve this form or its collection burden (outlined in OMB 0938-1378) will be destroyed. It will not be kept, reviewed, or forwarded to the plan. See page 4 to send your completed form to the plan.

S5584_Grp21PDPEnrollFrm_C FVNR 0920
OMB No. 0938-1378
Expires: 07/31/2023

DN 15180 SEP 20

Please respond to all questions	
1. Are you the retiree? If yes, retirement date (month/day/year): _____ If no, name of retiree: _____	☐ **Yes** ☐ **No**
2. Are you covering a spouse or dependents under this employer or union plan? If yes, name of spouse: _____ Name(s) of dependent(s): _____	☐ **Yes** ☐ **No**
3. Do you work? **Does your spouse work?**	☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No**
4. Do you have other drug coverage, including other private insurance,workers compensation, VA benefits or state pharmaceutical assistance programs? If yes, please provide: Company name: _____ Name of other drug plan: _____ ID # for coverage: _____	☐ **Yes** ☐ **No**
5. Are you a resident of a long-term care facility, such as a nursing home? If yes, please provide: Name of facility: _____ Facility street address: _____ City: _____ State: _____ ZIP code: _____ Phone number: _____	☐ **Yes** ☐ **No**

This enrollment application is part of your <Prescription Blue Group PDP> enrollment kit. Other important materials you should review before joining this plan are included with this form:

- A Pre-Enrollment Checklist
- A cover letter with important deadlines and information (such as the date your enrollment form is due and where to send it)
- A Summary of Benefits booklet
- A Centers for Medicare & Medicaid Services Stars Ratings flier (measures how well Medicare Advantage plans perform in several areas)

Please contact <Prescription Blue Group PDP> Customer Service at **1-866-684-8216** (TTY users call **711**) if you need information in an accessible format or language other than what is listed below.

Select one if you want us to send you information in a language other than English.
☐ Spanish ☐ Other

Select one if you want us to send you information in an accessible format.
☐ Large print ☐ Audio CD

Customer Service hours are 8:30 a.m. to 5 p.m., Eastern time, Monday through Friday (October 1 through March 31, 8 a.m. to 9 p.m., Eastern time, seven days a week). You can also visit us at **www.bcbsm.com/medicare**.

Coordination of Part D Benefits

Blue Cross Blue Shield of Michigan

600 E. Lafayette Blvd.
Detroit, MI 48226-2998

<Date>

<FIRST NAME LAST NAME>
<ADDRESS>
<CITY, STATE ZIP CODE>

Dear <FIRST NAME>:

The Centers for Medicare & Medicaid Services have told us you may have other prescription drug coverage in addition to the coverage you have with Blue Cross Blue Shield of Michigan OR you may have indicated you have other prescription drug coverage when you completed your Blue Cross enrollment application. CMS requires us to make sure that your other prescription drug coverage is accurate so we can process your prescription drug claims correctly.

Your other prescription drug coverage is printed in Section A on the back of this letter. If the information is correct, you do not need to do anything.

If the information is not correct:

- **In Section A**: Fill in any missing or incomplete information. If you no longer have this coverage, fill in the date it ended.
- **In Section B**: Add any additional prescription drug coverage you have that isn't listed in Section A.

Once you've made your corrections, please sign and date the bottom of the back page and return it to us in the enclosed, postage-paid envelope within 30 days, or mail to:

Blue Cross Blue Shield of Michigan
1000 Town Center, Mail Code: TC1515
Southfield, MI 48075

If you have questions, please call the number on the back of your Blue Cross ID card. TTY users please call 711.

Thank you for your assistance.

Sincerely,

COB & Recoveries
Enclosure

OVER

Medicare Plus Blue, and Prescription Blue are PPO and PDP plans with Medicare contracts. Enrollment in Medicare Plus Blue, and Prescription Blue depends on contract renewal.

Internal Use Only

Member name: _____ Group: _____

Plan ID: _____ Accrete date: _____ Effective date: _____ ID: _____

SECTION A: Please make any corrections to the information listed below. If you no longer have the coverage listed, please fill in the date your coverage ended (shown as "term date").

Insurer name: _____ Effective date: _____ Term date: _____

Address: _____ BIN: _____ PCN: _____

Policy #: _____ Group #: _____ Policy holder name: _____

<Internal Use Only content> _____

Insurer name: _____ Effective date: _____ Term date: _____

Address: _____ BIN: _____ PCN: _____

Policy #: _____ Group #: _____ Policy holder name: _____

<Internal Use Only content> _____

Insurer name: _____ Effective date: _____ Term date: _____

Address: _____ BIN: _____ PCN: _____

Policy #: _____ Group #: _____ Policy holder name: _____

<Internal Use Only content> _____

SECTION B: If you have other prescription drug coverage in addition to your Blue Cross plan, please check the type of coverage and fill in the requested information.

☐ Worker's compensation ☐ Veteran Affairs ☐ TRICARE ☐ TRICARE for Life

☐ Liability insurance (e.g., slip and fall)

☐ Employer coverage

- ☐ Active employee
  If you or your spouse is an active employee with insurance coverage, how many people are employed through the employer? ☐ Less than 20 ☐ 20-99 ☐ 100 or more
- ☐ Retiree (If retired, please provide retirement date: _____)

☐ Involved in Auto Accident

Date of Auto Accident _____

For each type of insurance checked in Section B, please provide the following (use an additional sheet if necessary). You'll find this information on your prescription drug card:

Insurance company: _____ Phone: _____

Policy or contract number: _____ Effective date _____

Rx BIN or Rx group number _____ Rx PCN number _____

Signature: _____ **Date**: _____

PPO Enrollment Reminder Letter (Online Enrollment)

600 E. Lafayette Blvd.
Detroit, MI 48226-2998
bcbsm.com/medicare

Blue Cross Blue Shield Blue Care Network of Michigan

<Member name>
<Street address>
<City, ST ZIP>

<Date>

Call us at **1-800-284-6994** to talk about enrolling in Medicare Advantage.
TTY: **711**.

Dear <Group Name>Retiree:

Your open enrollment deadline is a few days away.

Your group open enrollment period ends <Date>. This is your annual opportunity to review or make changes to your coverage. Changes made during open enrollment become effective January 1, <Year>. During Medicare open enrollment, you can:

- Change Medicare Advantage plans if offered by your employer group
- Add or cancel coverage for yourself, your spouse or dependent children

You must notify us of your decision by <Date>.

Open enrollment takes place online at www.bcbsmgroupmedicareplan.com.

When you visit this site and log in, a customized site displays your plan options. You can review benefits, select a plan or waive coverage**.** [<Company name> pays for a portion of your benefits; you'll be able to see those details after you log in.]

To get started, have your Medicare Beneficiary Identity number ready. That's the number you received directly from Medicare. Use the account and password you created from the notice you received in the mail, *Welcome to Coverage for Employees*.

You can also call us at **1-800-284-6994** to enroll or ask for more information. **NOTE: An individual can only enroll in one Medicare Advantage plan at a time.** [<Company name> holds special retiree meetings to share additional information and answer questions. For dates and locations and to RSVP, call **1-800-284-6994**. TTY users call **711**.]

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Medicare Plus Blue℠ and BCN Advantage℠ are PPO and HMO-POS plans with Medicare contracts. Enrollment in Medicare Plus Blue and BCN Advantage depends on contract renewal.

You must elect benefits or waive coverage before <date>.

We're here to help. If you have questions about your group plan**,** please call **1-800-284-6994** Monday through Friday from 8 a.m. to 5 p.m. Eastern time. TTY users call **711**.

Again, thank you for considering a Medicare Advantage plan from Blue Cross. We look forward to supporting your health care needs.

Sincerely,

Susan Schram -

Susan Schram
Director, Medicare Employer Group Sales and Development

PDP Enrollment Reminder Letter (Online Enrollment)

600 E. Lafayette Blvd.
Detroit, MI 48226-2998
bcbsm.com/medicare

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

<Member Name>
<Street Address>
<City, ST ZIP>

Call us at **1-800-284-6994 (TTY:711)** to enroll in your group Medicare prescription drug plan.

<Date>

Dear <Retiree Name>:

It's easy to sign up for Blue Cross' Medicare prescription drug coverage.

You are approaching the enrollment deadline for our Medicare prescription drug plan, Prescription Blue℠ Group PDP, which is being offered to you by <Group Name>. When you enroll in a Medicare prescription drug plan with Blue Cross Blue Shield of Michigan, you're choosing a company that's already served generations of Michiganders. If you don't contact us to confirm your enrollment, your group retiree prescription drug benefits may end and you may not be able to re-enroll in the group plan.

Benefits of our prescription drug plan

- Money-saving generic and brand-name drug options
- A network that includes most Michigan retail and national chain pharmacies
- A frequently updated online directory to find pharmacies in our network
- A mobile app to locate pharmacies in our network
- Preferred pharmacies that may save you money

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Prescription Blue is a PDP plan with a Medicare contract.
Enrollment in Prescription Blue depends on contract renewal.

How to sign up

The fastest, easiest way to review benefit information and enroll yourself or your Medicare-eligible spouse or dependent is to visit the website below:

www.bcbsmgroupmedicareplan.com
or call
1-800-284-6994
8 a.m. to 5 p.m. Eastern time
Monday through Friday
TTY users call 711

*[If a NEW group, use: **If you want to receive benefits from Prescription Blue, you must respond by <Date>.**]*
*[If aging-in or retiring into Medicare, use: **We must receive your application no later than one day before <eligible date>.**]*

Important information: You can enroll in a stand-alone employer group Part D prescription drug plan *and* a separate employer group Medicare Advantage medical-only plan without a loss of coverage in either plan. Enrolling in <a/an> <Group Name> Medicare plan that combines medical and drug benefits in a single package will automatically disenroll you from a stand-alone Part D prescription drug plan.

We're here to help you easily transition to your new prescription drug plan. If you have questions about Prescription Blue Group PDP, call 1-800-284-6994 from 8 a.m. to 5 p.m. Eastern time Monday through Friday. TTY users call 711.

Thank you for considering Prescription Blue Group PDP. We look forward to supporting your prescription drug needs.

Sincerely,

Susan Schram

Susan Schram
Director, Medicare Employer Group Sales and Development

Online Enrollment Platform Access form

In 2019, Blue Cross began processing enrollments for employer group waiver plans (EGWP) through an Online Enrollment Platform. Properly staged retirees being offered Medicare Advantage insurance will have the ability to access this Online Enrollment Platform to preview pre-enrollment materials as well as enroll in the offered Medicare Advantage plans.

As the Group Administrator, you'll need access to the Online Enrollment Platform to perform your job responsibilities. In most cases access will occur during the implementation of the new group to Medicare Advantage.

There's a simple access form used to submit a request for administrative access to the system. The form can be obtained from your Medicare Advantage Representative or your Sales Support representative. After you complete the form, it should be emailed to MAOpimpliaisons@bcbsm.com.

You will receive email notification from our vendor Interserv when your account has been created.

interserv
SYSTEMS

26533 Evergreen Road, Suite 400, Southfield, MI 48076
248.356.8585 • techsupport@interservsystems.com

Online Enrollment System User Access/Change Request

Submitted For: ☐ Carrier Employee ☐ Employer Group ☐ Agent/TPA

Type of Access/Change: ☐ New User ☐ Change Profile ☐ Reinstatement ☐ Termination

User Legal Name (First and Last)**:** _____

User Job Title: _____

User Email: _____ **User Phone:** _____

User Department Name/Agency/Group Name: _____

User Privileges

☐ Member Support ☐ Read-Only

Member Support Privileges (Check all that apply if selected above)

☐ Enrollment ☐ Withdrawal ☐ Termination ☐ Reinstatement

☐ **Reporting Access** (Available with both Member Support and Read-Only access)

Company Access

☐ All Customers ☐ Restricted

If Restricted, Please indicate groups for access: _____

_____

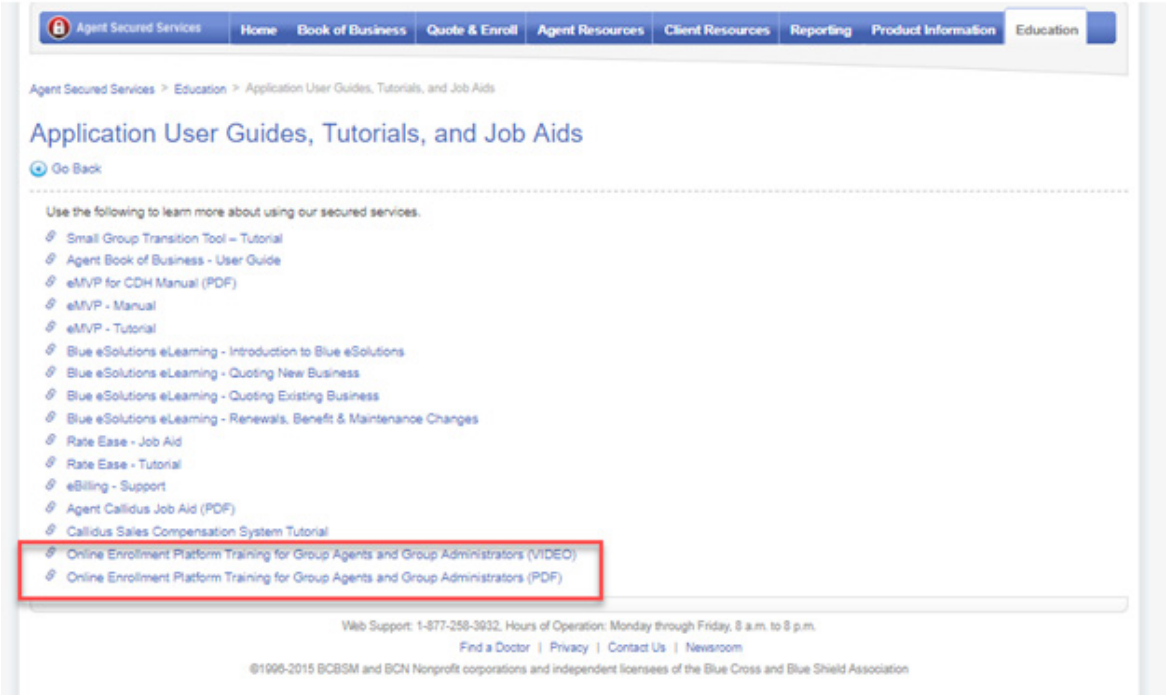
_____

Email completed applications to MA Ops Liaison (**maopimpliaisons@bcbsm.com**) for processing.

Online Enrollment Platform Training

A video training session and a PDF overview are available on the Group Secured Services portal. Please note, you will need to log in to the portal to access the video and PDF.

To watch the training video log in and navigate to Membership and Group Tools area where you will find the video and the training PDF.



Employer Group Authorization Agreement For Automatic ACH Transactions Medicare Advantage Premium Payments

Blue Cross Blue Shield Blue Care Network of Michigan

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

Employer Group

Authorization Agreement For Automatic ACH Transactions Medicare Advantage Premium Payments

This form constitutes an agreement of written authorization (hereafter referred to as "agreement") by the company or an authorized representative acting on the company's behalf (hereafter referred to as "company") for automated payment (debit to your account) for recurring ACH transactions to be initiated by **Blue Cross Blue Shield of Michigan**. This written authorization is maintained by Blue Cross for reference in the event of a dispute as evidence of authorization. Both parties agree that this agreement constitutes authorization to debit the company's bank account.

Both parties agree to be bound by National Automated Clearing House Association (NACHA) Operating Rules as they pertain to all ACH transactions initiated by **Blue Cross** that credit or debit the **company** bank account listed below, and acknowledge that the origination of ACH transactions to the listed account must comply with provisions of U.S. law.

Please complete below			
Company name			
Company group number with Blue Cross	Authorization applies to all divisions: ☐ Yes ☐ No If "no," only applies to division(s), list:		
Billing address	City	State	ZIP code
Company representative telephone number	Company representative email		

Bank information			
Company name on bank account	Bank name		
Bank account number	Bank routing number	Type of account ☐ Checking ☐ Savings	
Billing address	City	State	ZIP code

This business bank account must be enabled for ACH transactions. Please verify with your bank that ACH debit transactions are permitted on this account. Contact your Service Consultant if you need our ACH company ID to permit ACH debit transactions on this account.

I authorize Blue Cross Blue Shield of Michigan to initiate ACH debits on the bank account indicated above according to the terms of this agreement.

This authorization is to remain in full force and effect until either party has received written notification from an authorized signatory.

Receiver Authorized Signer _____ Date _____

I am an authorized signer, or otherwise have authority to act, on the account identified in this statement.

Print Name _____ Title _____

Please mail this form to:
Blue Cross Blue Shield of Michigan
P.O. Box 44256
Detroit, MI 48244-0256

Or Fax to: 1-866-533-5810

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BCN Advantage℠ HMO-POS

Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

SECTION 1:
BCN Advantage℠ HMO-POS Group Overview

BCN Advantage is a Medicare Advantage plan

Medicare Advantage plans are offered by health care plans that contract with the federal government to provide comprehensive coverage through doctors, hospitals and other health providers. Blue Care Network of Michigan contracts with the Centers for Medicare & Medicaid Services to provide health care services to Medicare beneficiaries through its BCN Advantage plan. BCN Advantage includes the benefits offered by Original Medicare and offers additional covered services.

Members can expect to receive:

- All Medicare-covered services
- Preventive and wellness care (for example, an annual physical exam)
- Focused care for chronic conditions
- Prescription drug coverage (group option)

BCN Advantage benefits

BCN Advantage provides coverage worldwide for medical emergencies and urgently needed care. It also covers renal dialysis and care that is approved and coordinated by BCN Advantage or the primary care physician. When traveling outside of Michigan in the United States, BCN Advantage members receive care through BlueCard®, a Blue Cross and Blue Shield Association* program that gives members access to physicians in the United States wherever a Blue plan is offered.

Eligibility

BCN Advantage is available to Medicare beneficiaries who are eligible for health care benefits through an employer or group. It replaces Original Medicare.

To be eligible, group members must meet the following conditions:

- The individual is a U.S. citizen or lawfully present in the United States; and
- Permanently resides in the service area of the Medicare Advantage plan; and
- Their permanent residence is in Michigan at least 6 months of the year; and
- Be enrolled in Medicare Part A and Part B
- Meet the qualifications of the sponsoring employer or union group
- Have a valid Medicare Beneficiary Identifier number

NOTE: Members must obtain a valid Medicare Beneficiary Identifier (MBI) number from CMS which is required for enrollment

NOTE: BCN Advantage also allows groups to enroll those who have been diagnosed with end-stage renal disease (ESRD).

Medicare-eligible members who don't sign up for both Part A and Part B when first eligible can do so during General Enrollment, which takes place between January 1 and March 31 each year. Members may have to pay a higher Medicare premium for late enrollment.

Enrolling retirees

Each person must enroll using the Online Enrollment Platform (www.bcbsmgroupmedicareplan.com), contacting the Online Enrollment Support Call Center (1-800-284-6994) for telephonic enrollments, or completing, signing and dating a separate Employer Group Enrollment Form. The BCN Advantage HMO-POS Application must be dated no later than the last day of the month before the coverage effective date. Groups can add Medicare Advantage members retroactively, however, retroactive enrollment of

a member is allowed only in limited circumstances as defined by CMS guidelines for Medicare Advantage groups.

Forced enrollment

A group can elect to move all its retirees to BCN Advantage, but CMS requires that:

- All beneficiaries be notified of the group's intent to enroll them in BCN Advantage
- All beneficiaries, spouses and dependents complete enrollment forms
- Any beneficiary be allowed to opt out of BCN Advantage

A retiree who chooses not to be part of BCN Advantage must be advised in writing of any consequences for opting out of the group's benefits. The notice must be provided no less than 21 calendar days prior to the effective date of the beneficiary's enrollment into the plan.

Eligible Dependents

Groups can extend coverage to their retirees' non-Medicare dependents. If a retiree wants coverage extended to a spouse or dependent who is not Medicare eligible, the group must open an active segment to cover the non-Medicare dependent. The following dependents are eligible for coverage subject to applicable BCNA dependent eligibility requirements:

Coverage for eligible dependents include:

- Legally married spouse
- Dependent children (this includes disabled children)
- Principally supported children
- Surviving spouse - only if available under the group's eligibility rules and approved by BCNA
- Domestic partners are eligible only when the group includes the domestic partner – same and opposite gender rider in their coverage

Medicare Eligible members and dependents complete the BCN Advantage Employer Group Enrollment Form or enroll using the Online Enrollment Platform. If a group extends eligibility to non-Medicare eligible dependents a Enrollment Change of Status form should be completed. Self-funded groups operate under different rules.

BCN Advantage and Blue Care Network

These are the activities BCN provides for BCN Advantage:

- Wellness, disease management and case management programs
- Processing of claims
- Administering utilization and quality management programs

Care must be provided by BCN Advantage doctors

The BCN Advantage network is a subset of the BCN network. The network includes primary care physicians, specialists, hospitals and providers who are licensed or certified by Medicare and the state to provide health care services. A Medicare physician may be contracted with BCN and not be a BCN Advantage provider.

BCN Advantage physicians manage and coordinate care for members. Members can select any primary care physician from the BCN Advantage network who is accepting new patients. A member needs to identify his or her primary care physician on the BCN Advantage enrollment form.
Services received from physicians who aren't in the BCN Advantage network may not be covered. We en-

courage members to build long term relationships with their primary care physicians. However, members who want to change their primary care physicians have that option.

Members can change physicians by:	
	Using the primary care physician selection feature on our website: www.**bcbsm.com/find a doctor**
	Mailing a completed Enrollment/Change of Status Form to: Blue Care Network — C300 P.O. Box 5043 Southfield, MI 48086 5043
	Calling our Customer Service number **1-800-450-3680 TTY users: 711**

Behavioral health services

BCN Advantage manages the behavioral health benefit (mental health and substance abuse care) for BCN Advantage members.

Members should call 1-800-431-1059 (TTY, 711) when they need behavioral health services.

The role of the PCP in referring members to specialists and other providers

Your PCP is the best resource for coordinating care for BCN Advantage members and can help them find an in-network specialist. However, BCN Advantage doesn't require a referral for members to make an appointment with an in-network specialist. Some in-network specialists may still need to confirm with a member's PCP that they need specialty care.

Partners in care

Some BCN Advantage services are provided through arrangements with third party vendors.

Services	Vendor	Phone Number
Outpatient durable medical equipment, prosthetics and orthotics	Northwood, Inc.	1-800-667-8496
Outpatient diabetic materials	J&B Medical Supply Company	1-888-896-6233
Outpatient laboratory services	JVHL (Joint Venture Hospital Labs)	1-800-445-4979

BCN Advantage Group Overview

BCN Advantage has standard packages for groups under 100 contracts. A package may consist of a medical coverage only plan, or it may be a combined medical and pharmacy plan.

Groups with 100 or more active employees that have a retiree segment can add riders to the BCN Advantage basic benefit, modifying the coverage.

Groups may also elect to offer ancillary coverage (dental or vision or both) in addition to a medical or medical and pharmacy benefit package. Benefit levels may vary based on available benefit plans.

BCN Advantage member minimum

In order to offer BCN Advantage, the group must enroll a minimum of five Medicare eligible members.

BCN Advantage and other plans

A group can offer both BCN Advantage and BCN 65 (a commercial HMO group Medicare plan), with the following qualification:

- BCN Advantage can only be offered in the counties where it is available.
- BCN 65 can be offered in counties outside the BCN Advantage service area. (For a map of the BCN Advantage service area, see the BCN Appendix).

BCN Advantage administration

Some things to know when moving your group to BCN Advantage:

- All new business paperwork requires a 45-day lead.
- All BCN Advantage groups renew January 1 regardless of the active segment's renewal date. Benefit changes must be submitted no later than November 1 of the previous year.
- A member's permanent residence must be in Michigan at least 6 months of the year.
- Employers may subsidize a member's enrollment in one of our individual plans by offering a stipend to cover monthly premiums.
- Standard underwriting guidelines apply regarding Michigan headquarter rules and Blue Cross Blue Shield Association guidelines.

Accommodating non-Medicare members on a contract

Non Medicare-eligible spouses or dependents can be enrolled in a group's active segment when the Medicare eligible member is enrolled in BCN Advantage.

Contact your representative

In general, CMS does not allow for mid-year changes to raise rates or decrease benefits. If you wish to make mid-year benefit changes, contact your Medicare Advantage representative.

For more information about available benefit options, contact BCN Advantage Sales and Marketing, your Medicare Advantage representative or contracted agent.

For customer service, please call 1-800-450-3680.

SECTION 2:
Group Coverage and Enrollment Agreement

The BCN Advantage Group Enrollment and Coverage Agreement is a contract between Blue Care Network and a group. It's signed by the group's decision maker, the group Medicare sales account representative or contracted agent and the BCN underwriter. The agreement states what coverage your group has selected and who's eligible for it.

To obtain the latest copy of the agreement, contact your Medicare sales account representative or contracted agent.

The BCN Advantage Group Enrollment and Coverage Agreement consists of these parts:
- BCN — Part A New Group, which sets forth the contractual obligations of each party
- Group Letter of Agreement, Part A New Group, which explains the link to the national BlueCard program covering services members receive away from home
- New Group Part B, which Describes the group
- New Group, Part C, which lists the products selected

Group invoice

BCN Advantage is a prepaid health care plan. Each invoice reflects the premium due for the next month, plus any retroactive adjustments. For example, the invoice you receive in March will show your premium for April.

Your monthly invoice provides information on who is covered under your group plan. It's important to review the invoice carefully each month.

Don't send member changes on the invoice, they will not be processed and will delay enrollment or disenrollment effective dates.

Autopay option

Groups can elect to pay premiums through our autopay program. There's no charge for the service. Autopay processing offers payment convenience and eliminates the possibility of a late or delinquent payment.

The premium deducted is the amount due based on the number of enrollees BCN has on record for the group at the time the invoice is generated. We send monthly statements showing the amount we deducted.

Enrollment requirements

If a group has an open enrollment period, CMS requires that members receive open enrollment information 15 days before the start of the open enrollment period. The group and BCN must work together to ensure the open enrollment period meets CMS compliance guidelines.

At renewal time, groups need to let BCN know:
- If the group will be having an open enrollment
- The open enrollment dates
- The plan choices that the member will have

SECTION 3:
Disenrollment Guidelines

Member disenrollment

A disenrollment is the termination of a member's BCN Advantage coverage following one or more months of active coverage. Disenrollment differs from a member opt-out or cancellation of coverage, which occur before a member is enrolled in the BCN Advantage plan. Disenrollments are effective on the first day of the month following the disenrollment request.

Disenrollment can be initiated by the member or the employer or union, and can be voluntary or involuntary.

BCN Advantage should be notified at least 30 days before the desired termination date.

Voluntary disenrollment

Members may elect to disenroll from BCN Advantage if they meet CMS requirements for disenrollment. The member must sign a Group Disenrollment Form.

Generally, beneficiaries may not select their effective date of disenrollment.

Subscribers or dependents who leave your group or who are no longer eligible for benefits can purchase their own benefits without a lapse in coverage. They may qualify for continuing, non-group coverage:

- BCN 65 — Individual coverage
- BCN Advantage — Individual coverage

Retroactive disenrollment

CMS does not allow Medicare Advantage plans to retroactively cancel group member coverage.

Involuntary disenrollment

A group may disenroll a member, but the individual must be told why he or she is being disenrolled, except in the case of member death. The disenrollment letter must also provide coverage options for the person based on whether they have prescription coverage or not.

These are valid reasons for disenrollment:

- Failure to pay the individual monthly premium that the group collects
- Leaving the plan's service area (includes incarceration)
- Losing entitlement to Medicare Part A or Part B (CMS may notify BCN Advantage of this situation)
- Abuse of BCN Advantage ID card (BCN Advantage will work with the group to investigate this situation)
- Improper conduct with providers or BCN Advantage staff (Member was abusive, unruly or uncooperative; BCN Advantage will work with the group to investigate the situation)
- Death

BCN Advantage cancellation of coverage

In the event your group discontinues BCN group benefits, CMS requires that a group notify members of its decision to discontinue BCN Advantage coverage at least 21 days before the end of coverage.

The member has the following special election periods to enroll in a Medicare Advantage plan:
• 90 days before the loss of coverage • 60 days after the loss of coverage for a Medicare Advantage plan with prescription drug coverage • 30 days after the loss of coverage of a Medicare Advantage plan with no prescription drug coverage

Disenrollment when a member dies

If the group is notified of a member's death, the group should inform BCBSM. However, federal guidelines do not permit BCNA to terminate a deceased member's BCN Advantage enrollment until we receive the CMS eligibility files, which report the member's date of death. BCN will terminate the member's enrollment upon receipt of the CMS file. The effective date of the contract termination for a deceased member is the first day of the month following the date of death.

If the group has paid a premium for the deceased member beyond the month of his or her date of death, the group will receive credit for premiums paid for the months subsequent to the member's death. No credit or proration is done for the month of death. The premium credit will be reflected on the monthly invoice following the cancellation process date by BCN.

Canceling a disenrollment

To request cancellation of a disenrollment, please contact your Medicare group service representative. Requests for cancellation of voluntary member disenrollment must be accompanied by a written request, with signature and date, from the member. Requests for cancellation of disenrollment can only be processed if they are received by BCN prior to the effective date of the disenrollment.

Re-enrolling a disenrolled member

If the member wishes to be reinstated after his or her disenrollment effective date, but within the same benefit year, he or she does not need to repeat the enrollment process. If the member's reinstatement occurs in the next benefit year, he or she must repeat the complete enrollment process.

Example
Disenrollment effective date: Oct. 31, 2021 Reinstatement date: Dec. 1, 2021 Does not need to repeat the enrollment process

Each employer or union determines the impact disenrollment has on members during the BCN Advantage plan design stage. The consequences vary from no employer- or union-sponsored retiree health care coverage (Medicare-only coverage) to no ancillary benefits (e.g., prescription drug, vision or dental coverage). During the disenrollment process, we will send retirees a letter confirming their disenrollment and explaining their coverage options.

Discontinuing your group coverage

Each employer or union determines the impact disenrollment has on members during the BCN Advantage plan design stage. If member disenrolls from Medicare Advantage plan, they may lose ancillary

dental or vision coverage included on their card. During the disenrollment process, we will send retirees a letter confirming their disenrollment and explaining their coverage options.

BCN Advantagerequires advanced written notice to cancel group MA coverage as set forth in the Group Enrollment & Coverage Agreement. Please consult your Medicare Advantage representative for additional information. If your group wishes to cancel one or more of its BCN Advantage plans, contact your Medicare Advantage representative. If a group discontinues group MA benefits, CMS requires members are notified of its decision to discontinue group MA coverage at least 21 days before the end of coverage. Per CMS rules, members must be given prospective notice that such an event is occurring and be provided with options for obtaining ongoing coverage. Your Medicare Advantage representative can assist you in planning a transition of group coverage that minimizes disruption to your members.

SECTION 4:
Member Enrollment Materials

We send prospective members a pre-enrollment kit, and new members a welcome kit. These materials explain how BCN Advantage works and provide information about plan benefits and tools to manage their plan. We recommend you inform members of their enrollment in the plan so they'll be prepared when they receive this information.

Pre-enrollment kit

We typically mail a pre-enrollment kit to prospective members approximately 60 days before the plan's effective date.

The pre-enrollment kit contains:

- Cover letter
- Benefits at a Glance
- CMS Star rating flier for plan
- Anti-Discrimination Notification
- Enrollment or opt-out forms
- Postage-paid return envelope

Please see the Appendix for samples of pre-enrollment kit materials.

NOTE: For groups that want to perform the open enrollment mailing of pre-enrollment materials to their retirees, the following steps and information must be documented as evidence that CMS guidelines were met.

- Pre-enrollment materials must be in retirees' hands 15 days before the start of the open enrollment period. Anything less is non-compliant per CMS time lines.
- The group needs to provide BCNA with a copy of the mail receipt, including but not limited to:
- Date and time the material was mailed
- Number of packages mailed
- Copy of a pre-enrollment kit packet provided to its membership
- Signed attestation letter with attached mailing list of membership

The attestation letter should include the following:

- "On (month, day, year), (number of pre-enrollment kits) were delivered by the group to (post office, UPS, other location) for delivery via (overnight, first class). The enclosed receipt is provided for verification. We (group name) attest that the enclosed pre-enrollment kit was mailed to each person on the attached mail file."
- The attestation letter must be signed by the group decision maker.

Enrollment documents

Enrollment documents are all the forms that constitute the terms and agreements between BCN Advantage and your group. All materials must be submitted to your Medicare sales account representative or your contracted agent at least 45 calendar days before the plan effective date.

Enrollment kits

All Medicare eligible retirees should receive an enrollment kit 15 days before the start of open enrollment.

The following items are included in the enrollment kit:

- Cover letter
- Service area map
- Anti-discrimination statement
- Listing of multi language interpreter services
- Information about Medicare's Five-Star Quality Rating System
- Group enrollment form
- Enrollment Change of Status form
- Other materials as applicable

Sample documents are included in the BCN Appendix. The group or union must inform retirees what they'll be required to pay.

Effective coverage dates

BCN Advantage coverage always starts on the first of the month, in accordance with CMS guidelines.

Annual Notice of Change

BCN Advantage sends existing members an Annual Notice of Change/Evidence of Coverage Notification to Members no later than 15 days before the beginning of the group's (employer or union) open enrollment. If the employer or union sponsor doesn't have an open enrollment period, the mailing is sent 15 days before the beginning of the plan year. All plans renew January 1 and the Annual Notice of Change notice will be in members hand by December 15

The CMS required mailings give members advanced notice of any benefit changes for the upcoming year.

CMS requires that BCN Advantage mail the following documents to each Medicare beneficiary upon enrollment and annually thereafter:

- A summary of benefits offered by BCN Advantage
- An explanation of coverage
- A provider directory flier, explaining how to access the directory online or how to get a directory from Customer Service
- A flier explaining how to access the drug list online or how to get the drug list from Customer Service (for members who have Medicare Advantage with Part D coverage) Flier explaining how to obtain more information about BCN Advantage
- Annual notice of coverage and evidence of coverage

BCN Advantage Member ID card

BCN Advantage members carry one card – see sample below – that replaces the red, white and blue Medicare card. Members need to use the BCN Advantage card when they seek medical services covered by this plan and prescription drugs at network pharmacies.

If members get covered services using the red, white and blue Medicare card while they are BCN Advantage members, Medicare will not pay for these services.

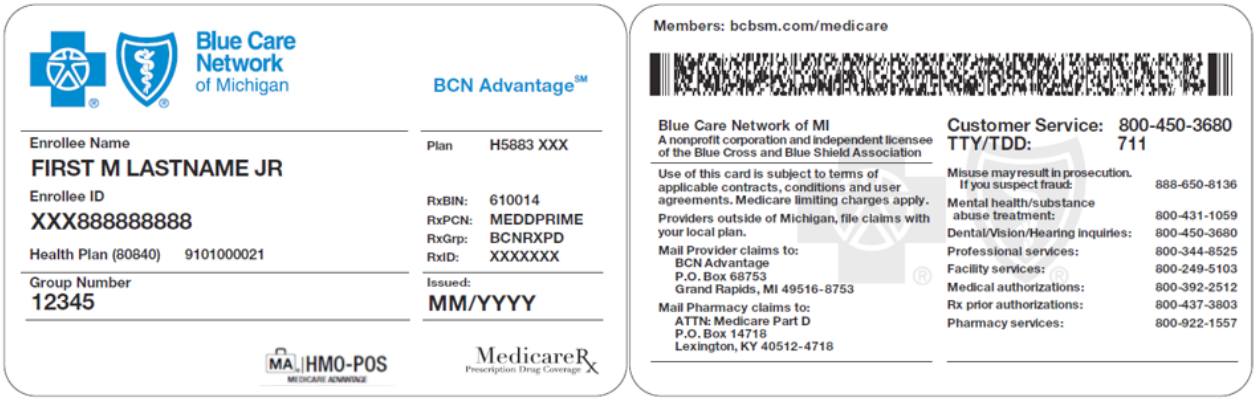
Dependent cards

The subscriber's dependents have the same contract number as the subscriber. They have BCN Advantage ID cards if they're Medicare eligible and Blue Care Network ID cards if they're not Medicare eligible. BCN Advantage tracks the number of dependents on the subscriber's contract; however, the ID cards (BCN Advantage or BCN) don't show dependent status.

Card design

The front of the BCN Advantage ID card contains the same information as the BCN ID card. The back of the BCN Advantage ID card includes information required by CMS. Members with Part D pharmacy coverage have a Medicare Rx logo on the front of their cards. Coordination of benefits survey
This assessment to members in January and participation is voluntary, free and confidential. The survey measures general health indicators and helps us determine how to best help your members and:

- Coordinate access to the appropriate services
- Understand members' medical conditions and help them stay as healthy and active as possible
- Better manage their health



Coordination of benefits survey

This assessment to members in January and participation is voluntary, free and confidential. The survey measures general health indicators and helps us determine how to best help your members and:

- Coordinate access to the appropriate services
- Understand members' medical conditions and help them stay as healthy and active as possible
- Better manage their health

SECTION 5:
Billing and Low-Income Subsidy Guidelines

BCN Advantage bills groups one month in advance. Invoices are typically mailed between the sixth and tenth day of each month. Adjustments to the billing schedule can be discussed with your Medicare sales account representative.

Note: The Payment Coupon accompanying the invoice has a unique PO Box Number for Medicare Advantage and differs from the commercial active invoice membership. If a group remits more than one payment to BCN, the group should pay each invoice (Medicare Advantage and/or Commercial) by a separate check and mail it with a copy of the payment coupon to the PO Box on the Payment Coupon.

Payment due dates

BCN Advantage health coverage is only offered on a prepaid basis. All premiums must be paid in full in advance of the coverage effective date.

Non-payment of premiums

A group is considered delinquent when we have not received the required payment by the billing due date. We will send a notice of delinquency. If we do not receive the premium payment by the requested date on the delinquency notice, we mail a final cancellation notice.

When a group's premiums are more than 30 days past due, BCN Advantage may immediately terminate coverage retroactive to the date through which premiums were paid in full. A group will be eligible for re-enrollment 12 months following the date of cancellation.

Returned checks (non-sufficient funds)

If a premium payment check is returned from the bank marked non-sufficient funds, the group must replace the check with certified funds within 10 days or coverage will be canceled. If the group submits another check within six months that is returned for non-sufficient funds, the group will be canceled and cannot be reinstated for one year.

If a group is more than one-month delinquent in submitting a premium payment and the check submitted for that payment is returned from the bank marked non-sufficient funds, the group will be canceled and cannot be reinstated for one year.

Part D Co-payment recovery

CMS requires that BCN Advantage bill members who were undercharged for prescription drugs. Occasionally, BCN Advantage's records may not reflect claims activity. This may happen when there's:

- A discrepancy in the member's enrollment information that had to be reconciled with CMS records
- A change from one drug plan to another, requiring a transfer of member information
- A retroactive change to the member's group coverage out of pocket costs

Part D records are reviewed annually.

Who's eligible for financial help

Medicare beneficiaries are eligible for Part D financial help if they have limited income and resources. The extra help can pay for part of their Part D monthly premiums or prescription co-payments.

Medicare beneficiaries can apply for this subsidy through their local Social Security office.

The federal government sends the subsidy to the prescription benefit provider

The low-income subsidy is paid to the entity that sponsors the benefit. If the group provides a commercial prescription benefit for its Medicare enrollees, CMS pays the subsidy directly to the group. If the group provides BCN Advantage's Part D prescription benefit, BCN Advantage receives the federal subsidy and sends it to the group, which distributes it to the eligible enrollees, as applicable.

NOTE: The group must distribute the federal subsidy to eligible enrollees within 45 days of receiving the funds, as required by CMS.

How the subsidy is applied

If the group pays 100 percent of the Part D premium for the Medicare enrollee, the group is entitled to retain the full subsidy. However, if the member pays any portion of the premium, the member must be reimbursed up to the amount of his or her contribution. Any remaining amounts belong to the group. Members pay the co-payments associated with the low-income subsidy level for which they qualify.

Explanation of benefits

BCN Advantage members who also have Part D prescription drug coverage through BCN receive an explanation of benefits statement each month reporting what they've paid in co-payments. When the annual co-payment total reaches a CMS specified amount, members have catastrophic coverage as provided by Part D.

Catastrophic coverage amounts, co-payment totals and limits are subject to change annually.

If a member gets an invoice

Occasionally, members may have to pay for a covered service. For example, if they need emergency care while traveling, they may be asked to pay at the time they receive care.

In the unlikely event one of your members needs to pay at the time of service, refer the member to Customer Service.

Members who pay for covered services can request reimbursement in writing within 12 months of the date of service to:

Member Reimbursement BCN Advantage
P.O. Box 68767
Grand Rapids, MI 49516 8767

The following information must be included:

- Itemized description of the service, identifying the provider, date of service, procedure and diagnosis codes, and associated provider fees
- Subscriber or dependent's name, address and telephone number
- Contract number as it appears on the BCN Advantage ID card
- Proof of payment (receipt or canceled check)
- Treatment record or emergency report
- Name and dosage of any prescription drugs, as well as the original prescription receipt

SECTION 6:
Member Guidelines and Updates

Address changes

Members who have a change in their permanent residential address should immediately notify:

- The Centers for Medicare & Medicaid Services (CMS)
- Their local Social Security Administration office
- Their group administrator
- BCN Advantage Member Services

Please advise members to contact CMS and their local Social Security Administration office to report a permanent residential address change. The address in the CMS file must be updated prior to contacting BCN Advantage Member Services. The group should then notify their or Support Service Representative of the address change for their BCN Advantage member(s). Once the Medicare sales account representative receives the address change, they will submit the change to the BCN service consultants. The BCN service consultants will verify that the CMS file has been updated before changing the permanent address on the Medicare Advantage file.

A mailing or alternate address can be updated without requesting a change through CMS. The group may update the member's retiree enrollment file in the alternate enrollment record.

It's important to confirm with your member what type of address change they are requesting. A permanent residential address change may impact their eligibility to remain enrolled in a Medicare Advantage plan. If a member moves away from the plan's service area, it may make them ineligible to remain in the plan.

The Medicare Advantage Service Center can be reached at 1-866-684-8216 from 8 a.m. to 8 p.m., Monday through Friday, with weekend hours October 1 through February 14. TTY users should call 711. Certain services are available 24/7 through our automated telephone response system.

The member may also need to log into the Online Enrollment Platform at:
www.bcbsmgroupmedicareplan.com to update their address.

BCNA Appendix

The Appendix includes additional resources, instructions, and examples of standard letters and forms.

Employer, Agent and Group Administrator Resources

Your Medicare Advantage representative and group service representative are your primary contacts for Medicare Advantage inquiries. They serve as your liaison to our internal operations departments and will respond to your inquiries. Below are types of inquiries and who you should contact to initiate a response to your call.

Inquiry type	Contact
General Inquiries: • Claims • Enrollment and pre-enrollment • Group benefits • ID cards • Membership eligibility • Pharmacy (MA-PD only) **Escalations:** • Membership eligibility • Enrollment inquiries	Medicare Advantage representative or Blue Cross contracted agent
Group specific: • Benefit changes • Coordinating or conducting open enrollment meetings and mailings • Pre-enrollment and other group-specific materials • Rates and rate renewals	Medicare Advantage representative or Blue Cross contracted agent
Online Enrollment Support	**Enrollment Support Call Center** 1-800-284-6994 8:00 a.m. to 5:00 p.m. Eastern (Monday-Friday) **Online Enrollment Platform (24/7)** www.bcbsmgroupmedicareplan.com Online chat assistance available 8:00 a.m. to 5:00 p.m. Eastern (Monday-Friday)
Programs or services offered through Blue Cross Health & Well-being	**Blue Cross Engagement Center** 1-800-775-2583 8:00 a.m. to 6:00 p.m. Eastern TTY users call 1-800-240-3050 8 a.m. to 8 p.m. Eastern time (Monday-Friday)
Report fraud	**BCBSM Anti-Fraud hotline** 1-888-650-8136 TTY users call 711 8:30 a.m. to 4:30 p.m. Eastern (Monday-Friday)
Membership and Billing Inquiries	**eBilling Web Support** **1-877-258-3932** **eMVP Processing Assistance** 1-866-676-4858

Member Resources

Provider directories

Members should always verify the providers they select participate in the BCN Advantage network. Hard-copy directories for Michigan-based providers are available to members; however, the most up-to-date provider listings are on our website at: https://www.bcbsm.com/index/find-a-doctor.html

NOTE: Find a doctor anywhere in the U.S. by visiting www.bcbsm.com and clicking on the "Find a doctor" box.

Group pharmacy directory

Visit the Group Pharmacy Directory link at: http://www.bcbsm.com/pharmaciesmedicare
BCN Advantage comprehensive formulary (list of covered prescription drugs) To access the Group Comprehensive Formularies as well as changes to the formularies,
visit: https://www.bcbsm.com/medicare/help/forms-documents/drug-lists.html

Online enrollment contacts

Retirees using the Online Enrollment Platform should contact the Enrollment Support Call Center to resolve issues concerning:

- Basic enrollment and pre-enrollment
- Benefits
- Claims status and information
- Address or other demographic info changes

Member service contacts

Retirees nor using the Online Enrollment Platform should contact Medicare Plus Blue Group Member Services to resolve issues concerning:

- Basic enrollment and pre-enrollment
- Benefits
- Claims status and information
- Grievances and appeals
- ID cards
- Address changes

If the member is not satisfied with the response from BCN Advantage Member Services, he or she has the right to escalate his or her concern within BCNA. Per CMS guidelines, members also have the right to file a grievance or appeal with Medicare. The Evidence of Coverage (EOC) provided to all members enrolled in an MA plan provides detailed step-by-step guidelines on how to submit an appeal.

Inquiry type	Contact
• Claims • Enrollment and pre-enrollment • Group benefits • ID cards • Membership eligibility • Grievances or appeals • Pharmacy (if the plan includes Part D prescription drugs) • Durable medical equipment • Prosthetic and orthotic devices	**Member Services** 1-866-684-8216 TTY users call 711 8:30 a.m. to 5:00 p.m. Eastern (Monday-Friday)
Online Enrollment Support	**Enrollment Support Call Center** 1-800-284-6994 8:00 a.m. to 5:00 p.m. Eastern (Monday-Friday) **Online Enrollment Platform (24/7)** www.bcbsmgroupmedicareplan.com Online chat assistance available 8:00 a.m. to 5:00 p.m. Eastern (Monday-Friday)
• Benefit changes • Premium rates • Premium rate renewals	Group administrator
Programs or services offered through Blue Cross Health & Well-being	**BlueHealth Connection** 1-800-775-2583 TTY users call 711 8:00 a.m. to 5:00 p.Blue Cross Engagement Center 1-800-775-2583 8:00 a.m. to 6:00 p.m. Eastern TTY users call 1-800-240-3050 8 a.m. to 8 p.m. Eastern time (Monday-Friday)
Report fraud	**Medicare Anti-Fraud hotline** 1-888-650-8136 TTY users call 711 8:30 a.m. to 4:30 p.m. Eastern (Monday-Friday)
Lab services	**Quest Diagnostics** www.questdiagnostics.com **Joint Venture Hospital Laboratories (JVHL)** www.jvhl.org
Exclusive discounts and Programs for members	https://www.blue365deals.com/ and https://www.bcbsm.com/index/members/discounts.html

Setting up automatic electronic (ACH) payments

If you don't want Medicare Advantage coverage
How to opt out of
Medicare Plus Blue℠ PPO Group coverage

<GROUP NAME> provides Medicare-eligible members with Medicare Plus Blue Group PPO, a Medicare Advantage plan. You will be automatically enrolled in the Medicare Plus Blue Group PPO plan, unless you notify Blue Cross Blue Shield of Michigan that you do not want this coverage.

How to opt out of Medicare Plus Blue Group PPO coverage
If you decide that you **do not** want to retain coverage under the **<GROUP NAME>** health care plan, complete the form on the back of this page, sign where requested and send it to Blue Cross Blue Shield of Michigan using the enclosed return envelope.

Important Information:

- Only return this form if you do not want to be covered by the Medicare Advantage plan offered through the **<GROUP NAME>**.
- When you, as the contract holder, decide to opt out of the Medicare Advantage plan, the dependents on your health care contract will no longer qualify for coverage. You will need to add their names to the form included here to confirm their removal from the Medicare Advantage plan offered through the **<GROUP NAME>**.
- Declining Medicare Plus Blue Group PPO coverage may affect other coverage your employer or union group offers, such as prescription drugs, vision or dental coverage. Before submitting this form, contact your employer or union group to find out what will happen to those benefits if you decline Medicare Advantage coverage.

Blue Cross Blue Shield of Michigan may contact you for verification of your coverage selection. Please make sure you provide your current phone number on the form below your signature.

Return the form in the enclosed postage-paid envelope to:

Medicare Plus Blue Group PPO
600 Lafayette East
Detroit, Michigan 48226
Mail Code: 1604

If you want to enroll in Medicare Plus Blue Group PPO coverage, do not return this form. However, if you receive a letter requesting additional information regarding your enrollment, please respond promptly so that we can complete the enrollment process. Once we receive your information, we will submit your enrollment request to the Centers for Medicare & Medicaid Services (CMS).

For questions about this form or the Medicare Plus Blue Group PPO plan, please call Customer Service, toll free at the telephone number below:

1-866-684-8216
Monday through Friday from 8:30 a.m. to 5 p.m., Eastern time,
(October 1 through March 31, 8 a.m. to 9 p.m., Eastern time,
seven days a week). **TTY users should call 711.**

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Page 1 of 2

Anti-discrimination statement

Discrimination is Against the Law

Blue Cross Blue Shield of Michigan and Blue Care Network comply with applicable Federal civil rights laws and does 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.

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Listing of multi-language interpreter services

Blue Cross Blue Shield Blue Care Network of Michigan

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

Multi-language Interpreter Services

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-684-8216 (TTY: 711).

Arabic: ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-684-8216 (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 1-866-684-8216 (TTY: 711)。

Syriac: ܙܘܗܪܐ: ܐܢ ܐܢܬ ܟܐ ܗܡܙܡܬ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܡܫܬܟܚܝܠܘܟ ܚܠܡܬ̈ܐ ܕܗܝܪܬܐ ܒܠܫܢܐ ܡܓܢܐܝܬ܀
ܩܪܝ ܥܠ ܡܢܝܢܐ: 1-866-684-8216 (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 1-866-684-8216 (TTY: 711).

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-866-684-8216 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-684-8216 (TTY: 711) 번으로 전화해 주십시오.

Bengali: মনে রাখবেন: যদি আপনার ভাষা বাংলা হয়, ভাষা সহায়তা পরিষেবা আপনি বিনামূল্যে পেতে পারেন। কল করুন 1-866-684-8216 (TTY: 711)।

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-684-8216 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-684-8216 (TTY: 711).

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-684-8216 (TTY: 711).

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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。
1-866-684-8216（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 1-866-684-8216 (телетайп: 711).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-866-684-8216 (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 1-866-684-8216 (TTY: 711).

BCN Advantage℠ HMO-POS

Blue Care Network of Michigan

Medicare and more

Blue Care Network of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

Group Enrollment and Coverage Agreement
New Group Part C

Group exec initials _____ Federal Tax ID Number _____ – _____

Group name (Full legal name)			
Group ID (Existing groups only)	Subgroup ID (Existing groups only)	Class ID (Existing groups only)	Requested effective date

Check one

- ☐ MA-Only (Hospital/Med/Surg only)
- ☐ MA w/commercial prescription drug plan
- ☐ MA -PD (Hospital/Med/Surg/Part D plan)

Blue Care Network Packaged Plan Menu Options

Hospital/Med/Surgical plans:

- ☐ Standard A Plan
- ☐ Standard B Plan
- ☐ Standard C Plan

☐ **Rx Option 1:**
$5 / 5 / 40 / 40 / 80 Preferred
$12 / 12 / 47 / 47 / 100 Standard
Mail order 2x copay

☐ **Rx Option 2:**
$10 / 10 / 30 / 30 / 60 Preferred
$20 / 20 / 40 / 40 / 80 Standard
Mail order 2x copay

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Prescription Drugs

☐ Part D (required for MA-PD plan

Mail order ☐ 1x copay ☐ 2x copay ☐ 2.5x copay

Copay options

- ☐ $2
- ☐ $4/$40/$80
- ☐ $5
- ☐ $5/$10
- ☐ $5/$15
- ☐ $5/$25/$50
- ☐ $5/$30
- ☐ $7/$15/$30
- ☐ $10/$20
- ☐ $10/$40
- ☐ $10/$20/$40
- ☐ $10/$25/$50
- ☐ $10/$30/$60
- ☐ $10/$35/$50
- ☐ $10/$40/$80
- ☐ $15/$50

Copay/Coinsurance options

- ☐ $5 Min/ $100 Max / or 50%
- ☐ $10 or 50%
- ☐ $10 or 50% / $20 or 50%
- ☐ $10/$40/$80/20%
- ☐ $10 or 50% / $20 or 50% / $40 or 50%
- ☐ $15 or 50% / $30 or 50% / $60 or 50%
- ☐ $15/$50/$80/20%
- ☐ $15/$50/50%
- ☐ $20/$40/$80/20%
- ☐ $20/$60/50%
- ☐ $20/$60/$80/20%
- ☐ $20/$75/$100/20%

Coinsurance options

- ☐ 20% ($5 / $100)
- ☐ 50% ($5 / $100)

Retail ☐ $5/$30 Mail ☐ $30

Max out of pocket for all prescription drugs: ☐ $500 ☐ $750 or ☐ N/A

Other Rx option

Blue Care Network Certificate/Rider Options	
s/b Hospital/Med/Surg ☐ BCNA **Rider/Summary:**	
Pulmonary rehab* ☐ $30	**Maximum out of pocket** ☐ $500 ☐ $1,000 ☐ $2,000 ☐ $2,500 ☐ $3,000 ☐ $6,700 ☐ Other
Supervised exercise therapy ☐ $30	**Ambulance** ☐ $25 ☐ $50 ☐ $100
Emergency room ☐ $25 ☐ $30 ☐ $35 ☐ $50 ☐ $65 ☐ $75 ☐ $80 ☐ $90	
Hearing aid ☐ Hearing aid-standard ☐ Hearing aid 1 ☐ Hearing aid 2	**Urgent care** ☐ $10 ☐ $15 ☐ $20 ☐ $25 ☐ $30 ☐ $35 ☐ $40 ☐ $50 ☐ $60
Healthy habit ☐ Healthy Habit Rx exclusion ☐ Healthy Habit tiered copay Rx coverage ☐ Healthy Habit sexual dysfunction and weight loss Rx 50% coinsurance ☐ Sexual dysfunction Rx exclusion	**Hospital admission** ☐ $250 per admission up to $750 per year
	s/b Imaging ☐ $100 ☐ $150
Fitness program ☐ SilverSneakers	**Deductible** ☐ $50 ☐ $100 ☐ $150 ☐ $200 ☐ $250 ☐ $500 ☐ $750 ☐ $1,000 ☐ $1,500
Office visits ☐ $5 ☐ $10 ☐ $15 ☐ $20 ☐ $25 ☐ $30 ☐ $35 ☐ $40 ☐ $45	
Referral physicians ☐ $20 ☐ $25 ☐ $30 ☐ $35 ☐ $40 ☐ $45 ☐ $50	**Coinsurance** ☐ 2% ☐ 5% ☐ 10% ☐ 20%
Skilled nursing ☐ Unlimited skilled nursing days	
Chiropractic care* ☐ $20	
Other benefits: _____ **Outpatient therapy*** ☐ $40	

***If referring physician's cost is higher, check this box

WF 3846 APR 20

			Group size requirements (# of vision contracts)
Vision	☐ Add/Change to ☐ Delete ☐ Maintain	Blue Vision ☐ 12-12-12, BVFL ☐ 24-24-24, BVFLE	2+
		Blue Vision Choice℠ (Voluntary) ☐ 12-12-24, BVFLL, BVC $10/$25	10+

Large Group GWC (continued) | **Federal Tax ID**

Blue Dental℠	**Non-voluntary – PPO (Non-PPO)**	**Single/Family deductible PPO (Non-PPO)**	**Annual max – PPO (Non-PPO)**	
☐ Add/change to ☐ Delete ☐ Maintain	☐ PPO Plus 100/80/50	☐ $50/$150	☐ $1000	☐ 50% Ortho (Lifetime max matches in-network annual max)
	☐ PPO Plus 100/80/50	☐ $50/$150	☐ $1250	
	☐ PPO 100/80/60 (80/60/40)	☐ $0/$0 ($50/$150)	☐ $1500	
	☐ PPO 100/80/50 (50/50/50)	☐ $0/$0 ($50/$150)	☐ $1000 ($800)	
	☐ PPO 100/80/50 (50/50/40)	☐ $0/$0 ($50/$150)	☐ $1200	
☐ Freestanding	☐ EPO 100/80/50	☐ $0/$0	☐ $1000	
	Voluntary – PPO (Non-PPO)	**Single/Family Deductible PPO (Non-PPO)**	**Annual max – PPO (Non-PPO)**	☐ 50% Ortho with $1000 max ☐ Waive waiting period (Proof of prior dental coverage required.) Voluntary dental plans require a minimum participation of 30% with 10+ dental contracts. Doesn't apply to groups enrolled in voluntary dental prior to 10/1/2011.
	☐ PPO Plus 100/80/50	☐ $50/$150	☐ $1000	
	☐ PPO 100/80/50 (80/50/40)	☐ $0/$0 ($50/$150)	☐ $1000 ($800)	
	☐ PPO 100/80/50 (80/50/40)	☐ $0/$0 ($50/$150)	☐ $1250 ($800)	
	☐ PPO 100/60/50 (50/50/40)	☐ $0/$0 ($50/$150)	☐ $1000 ($800)	
	☐ EPO 100/80/50	☐ $0/$0	☐ $1000	

The Group agrees with all terms as stipulated in this benefit change – Part C and in specified Blue Cross Blue Shield of Michigan certificates and riders.

Signature of group executive on behalf of the group and the group health plan:	Date
Signature of Blue Cross Representative	Date
Signature of agent:	Date
Signature of underwriter/group administration:	Date

Group Enrollment and Coverage Agreement

New Group - Part C *continued*

Group exec initials ☐ Federal Tax ID Number ☐ – ☐

Complete the applicable section for all new business or previously unenrolled segments.

Mail identification cards to: ☐ Individual ☐ Sub-group Send bill to: ☐ Group ☐ Sub-group ☐ Contract

Should BCN issue certificates of creditable coverage (HIPAA)? ☐ Yes ☐ No

Total group census	Enrolling	Not enrolling
Total employees:	Blue Cross enrolled – Active:	Enrolled, other carrier:
Total ineligible – part time:	Other:	Identify carrier:
Seasonal:	COBRA:	Covered by spouse/parent-BlueCross:
Other:	Retirees:	Not Blue Cross: _____
Identify segment:		Waiving coverage:
Total eligible employees:		

Effective date: _____	Sales office code:	Control code:
Billing cycle date:	Mail code:	SIC code:
Rate renewal date:	Territory code:	County code:
Inventory date:		

Distribution Underwriting Sales Office 1 Sales Office 2

WF 3846 APR 20

Enrollment Kit Cover Letter

2021

Get a peaceful,
easy feeling

We make it easy for you to choose our **BCN Advantage℠** plan. As a member, you'll get legendary Blue Cross coverage and the peace of mind and confidence that come with every card. This kit explains the benefits you get when you enroll. You'll see you get everything Original Medicare covers and much more.

Impressive benefits

- Preventive tests and annual physicals usually covered at 100%
- Personal concierge service to give you the assistance you deserve
- Simple to use with one card, one bill and your online member account

Huge provider network*

With BCN Advantage, if you visit an in-network specialist, you don't need a referral. The network includes:

- More than 5,500 primary care physicians
- More than 22,400 specialists
- More than 124 hospitals

Travel coverage

- Access to top doctors and hospitals whether you're at home or away
- Emergency and urgent care coverage anywhere in the world with your globally recognized member ID card**

BCN Advantage won't let you down

Simply complete the enclosed enrollment application. We'll help you make a seamless transition to BCN Advantage from your current plan, with no break in coverage. If you have questions, call **1-800-284-6994** from 8 a.m. to 5 p.m. Eastern time, Monday through Friday. TTY users should call **711**.

Sincerely,

Susan Schram

Susan Schram
Director, Medicare Employer Group Sales
and Development

**Source:* Facets/Portico, *May 2020*
***$50,000 lifetime limit may apply*

BCN Advantage HMO-POS Application

BCN Advantage℠ HMO-POS

Blue Care Network of Michigan

Medicare and more

Blue Care Network of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

2021 Employer Group/Union Enrollment Form

1 Complete the following information to enroll in BCN Advantage HMO-POS.

Name of employer group/union sponsoring this coverage:			
Employer group/union number (employer group/union sponsoring this coverage can provide this):			
☐ Mr. ☐ Mrs. ☐ Ms.	First name	Middle initial	Last name
Birth date / /	Sex ☐ Male ☐ Female	Daytime phone number ( )	Alternate phone number ( )
Permanent residence street address (No P.O. box)		City	State
ZIP code	County	Email address (optional)	
Mailing address (only if different from your permanent residence street address)			
Street address or P.O. Box			
City		State	ZIP code

Optional information

Emergency contact name	
Relationship to you	Phone number ( )

2 Please provide your Medicare insurance information.

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card.

  - OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

_____

Medicare number: _____

Is entitled to: Effective date:

HOSPITAL (Part A) _____

MEDICAL (Part B) _____

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

3 Please read and answer these important questions.

1. Do you have other drug coverage, including other private insurance, workers' compensation, VA benefits or state pharmaceutical assistance programs. ☐ **Yes** ☐ **No**

   If "yes," please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage:	ID # for this coverage:	Employer group/union # for this coverage:
_____	_____	_____

2. Are you a resident in a long-term care facility, such as a nursing home? ☐ **Yes** ☐ **No**

   If "yes," please provide the following information:

Name of facility			
Address			
City	State	ZIP code	Phone number

3. Are you enrolled in Medicaid? ☐ **Yes** ☐ **No**

   If "yes," please provide your Medicaid number: _____

4. Please enter the name and telephone number of your primary doctor:

   Name: _____

   Phone number: _____

   Are you a current patient of this doctor? ☐ **Yes** ☐ **No**

5. Are you the retiree of the employer group/union sponsoring this coverage? ☐ **Yes** ☐ **No**

   If "no," name of retiree you are getting coverage through: _____

6. Are you a surviving spouse? ☐ **Yes** ☐ **No**

7. Is this a Consolidated Omnibus Budget Reconciliation Act (COBRA) enrollment? ☐ **Yes** ☐ **No**

   If "yes,": Start date ___ /___ /___ End date ___ /___ /___

Medicare-eligible spouse must also complete an employer group/union application form. If the spouse or dependents are under age 65, are covered by the employer group/union and will receive Blue Care Network coverage, please complete the *Enrollment Change of Status* form.

Call the BCN Advantage Service Center at <**1-800-450-3680**> if you need information in an accessible format or to be referred to our foreign language line. Call center hours are <8 a.m. to 8 p.m. Eastern time, Monday through Friday.> TTY users call **711**.

4 Please read and sign.

By completing this enrollment application, I agree to the following:

- BCN Advantage HMO-POS is a Medicare Advantage plan and has a contract with the federal government. I need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan or prescription drug plan. It's my responsibility to tell you about any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year.
- BCN Advantage serves a specific area. If I move out of the area that BCN Advantage serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of BCN Advantage, I have the right to appeal plan decisions about payment or services if I disagree. I will read the *Evidence of Coverage* document (also known as a member contract or subscriber agreement) from BCN Advantage when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.
- I understand that beginning on the date BCN Advantage coverage begins, I must get all of my health care from BCN Advantage, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by BCN Advantage and other services contained in my BCN Advantage *Evidence of Coverage* document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR BCN ADVANTAGE WILL PAY FOR THE SERVICES.
- I understand that if I get help from a sales agent, broker or other individual employed by or contracted with BCN Advantage, he or she may be paid based on my enrollment in BCN Advantage.

Release of information:

By joining this Medicare health plan, I acknowledge that BCN Advantage will release my information to Medicare and other plans as needed for treatment, payment and health care operations. I also acknowledge that BCN Advantage will release my information including my prescription drug data to Medicare, which may release it for research or other purposes that follow all applicable federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this application means that I have read and understand the content of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under state law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Continued ▶

Signature	Date / /

If you are the authorized representative of the enrollee, you must sign above and provide the following information:

Name		Phone ( )	
Street address	City	State	ZIP code
Relationship to applicant			

Please note: Not all BCN providers are contracted with BCN Advantage. Please verify that the primary care physician listed in this form is contracted with BCN Advantage by calling <**1-800-450-3680**>. TTY users call **711**.

Please send your completed enrollment application to:

<BCN Advantage HMO-POS>
<Mail Code C300>
<P.O. Box 5043>
<Southfield, MI 48086>

BCN Advantage℠ HMO-POS

Blue Care Network of Michigan

Medicare and more

Blue Care Network of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

www.bcbsm.com/medicare

BCN Advantage Disenrollment Form

BCN Advantage℠ HMO
BCN Advantage℠ HMO-POS

Blue Care Network of Michigan
Medicare and more

Blue Care Network of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

If you request disenrollment, you must continue to get all medical care from BCN Advantage until the effective date of disenrollment. Contact us to verify your disenrollment before you seek medical services outside of BCN Advantage's network. We will notify you of your effective date after we get this form from you.

Last name: First name: Middle initial	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.
Medicare number:	

Birth date:	Sex: ☐ M ☐ F	Home phone number: ( )

Disenrollment reason (please check appropriate box):	
☐ I am moving out of the BCNA service area.	☐ I am returning to my previous Medigap coverage.
☐ I am joining coverage through my spouse.	☐ I am returning to my employer's coverage.
☐ Other: _____	☐ I am joining other creditable coverage.

Please carefully read and complete the following information before signing and dating this disenrollment form:

If I have enrolled in another Medicare Advantage or Medicare prescription drug plan, I understand Medicare will cancel my current membership in BCN Advantage on the effective date of that new enrollment. I understand that I might not be able to enroll in another plan at this time. I also understand that if I am disenrolling from my Medicare prescription drug coverage and want Medicare prescription drug coverage in the future, I may have to pay a higher premium for this coverage.

Your signature*: _____ **Date:** _____

*Or the signature of the person authorized to act on your behalf under the laws of the state where you live. If signed by an authorized individual (as described above), this signature certifies that (1) this person is authorized under state law to complete this disenrollment and (2) documentation of this authority is available upon request by BCN Advantage or by Medicare.

If you are the authorized representative, you must provide the following information (please print):

Name: _____

Address: _____

Phone number: ( ) _____

Relationship to enrollee: _____

Pre-Enrollment Letters (Online Enrollment)

BCN Advantage℠ HMO-POS

Blue Care Network of Michigan

Medicare and more

Blue Care Network of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

<Date>

Dear <Group Name> Retiree:

Thank you for your interest in the <Group Name> **BCN Advantage HMO-POS plan**. Here's the information you requested. It explains the coverage provided by BCN Advantage.

Before you or your Medicare-eligible spouse or dependent can take advantage of this plan, you need to follow these simple steps:

1. Complete the enclosed enrollment application.
2. Sign it.
3. Mail your signed, completed enrollment application. **We must receive your application no later than one day prior to your requested effective date.**

Please note that each individual enrolling must complete and sign his or her own enrollment application form. If you prefer to enroll online or by phone, or have any questions, visit **www.bcbsmgroupmedicareplan.com** or call **1-800-284-6994** Monday through Friday from 8 a.m. to 5 p.m. Eastern time. TTY users call 711.

NOTE: An individual can only be enrolled in one Medicare Advantage plan at a time. Enrolling in the <Group Name> BCN Advantage HMO-POS plan will automatically disenroll you from any other Medicare Advantage health plan or individual Part D Medicare prescription drug plan.

Thank you for choosing a Blue Cross Medicare Advantage plan.

Sincerely,

Krischa Winright
Senior Vice President, Business
Performance and Development
Senior Health Services

H5883_Grp19OptInCvrR1_MFVNR 0219

BCN Advantage is an HMO-POS plan with a Medicare contract.
Enrollment in BCN Advantage depends on contract renewal.

BCNA Enrollment Reminder Letter (Online Enrollment)

600 E. Lafayette Blvd.
Detroit, MI 48226-2998
bcbsm.com/medicare

Blue Cross Blue Shield Blue Care Network of Michigan

<Member name>
<Street address>
<City, ST ZIP>

<Date>

Call us at **1-800-284-6994** to talk about enrolling in Medicare Advantage.
TTY: **711**.

Dear <Group Name>Retiree:

Your open enrollment deadline is a few days away.

Your group open enrollment period ends <Date>. This is your annual opportunity to review or make changes to your coverage. Changes made during open enrollment become effective January 1, <Year>. During Medicare open enrollment, you can:

- Change Medicare Advantage plans if offered by your employer group
- Add or cancel coverage for yourself, your spouse or dependent children

You must notify us of your decision by <Date>.

Open enrollment takes place online at www.bcbsmgroupmedicareplan.com.

When you visit this site and log in, a customized site displays your plan options. You can review benefits, select a plan or waive coverage**.** [<Company name> pays for a portion of your benefits; you'll be able to see those details after you log in.]

To get started, have your Medicare Beneficiary Identity number ready. That's the number you received directly from Medicare. Use the account and password you created from the notice you received in the mail, *Welcome to Coverage for Employees*.

You can also call us at **1-800-284-6994** to enroll or ask for more information. **NOTE: An individual can only enroll in one Medicare Advantage plan at a time.** [<Company name> holds special retiree meetings to share additional information and answer questions. For dates and locations and to RSVP, call **1-800-284-6994**. TTY users call **711**.]

Y0074_19IntrSvEnrlRmndr_M FVNR 0419

Medicare Plus Blue℠ and BCN Advantage℠ are PPO and HMO-POS plans with Medicare contracts. Enrollment in Medicare Plus Blue and BCN Advantage depends on contract renewal.

You must elect benefits or waive coverage before <date>.

We're here to help. If you have questions about your group plan**,** please call **1-800-284-6994** Monday through Friday from 8 a.m. to 5 p.m. Eastern time. TTY users call **711**.

Again, thank you for considering a Medicare Advantage plan from Blue Cross. We look forward to supporting your health care needs.

Sincerely,

Susan Schram

Susan Schram
Director, Medicare Employer Group Sales and Development

New Member Welcome Letter

2021

Any time of year, you can find it here

Thank you for joining BCN Advantage℠. This welcome kit contains important plan information and other resources to help you get the most out of your benefits, including:

- Resource Guide — a guidebook to your plan and how to make it work for you
- Evidence of Coverage — the legal contract that explains your BCN Advantage benefits and amendments to the contract, called riders
- Comprehensive Drug Formulary — a list of the drugs covered when prescribed by your doctor
- Provider/Pharmacy Directory — a list of providers and pharmacies located near you

We update and mail many of these documents annually, but you can receive paperless documents instead. It's easy. First, register for our secure, members-only website. Have your member ID card handy.

- Go to **www.bcbsm.com/medicare**.
- Click on the LOGIN tab at the top right.
- Click on *Register now*.
- Complete the online form in three easy steps.

Next, sign up for paperless documents.

- Click on *Account Settings* at the top.
- Click on *Paperless Options* at the top left.
- Click *Change* to select paperless delivery of the documents you want to get online. You'll no longer receive paper copies. We'll send an email alert each time a new document is posted for you to review. You can change your delivery method back to paper at any time at the same site.

If you have questions, call Customer Service at **1-800-450-3680** from 8 a.m. to 8 p.m. Eastern time, Monday through Friday, with weekend hours October 1 through March 31. TTY users call **711**. Certain services are available 24/7 through our automated telephone response system. You can also visit our website at **www.bcbsmgroupmedicareplan.com**.

Sincerely,

Susan Schram

Susan Schram
Director, Medicare Employer Group Sales
and Development

Online Enrollment Platform Access form

In 2019, Blue Cross began processing enrollments for employer group waiver plans (EGWP) through an Online Enrollment Platform. Properly staged retirees being offered Medicare Advantage insurance will have the ability to access this Online Enrollment Platform to preview pre-enrollment materials as well as enroll in the offered Medicare Advantage plans.

As the Group Administrator, you'll need access to the Online Enrollment Platform to perform your job responsibilities. In most cases access will occur during the implementation of the new group to Medicare Advantage.

There's a simple access form used to submit a request for administrative access to the system. The form can be obtained from your Medicare Advantage Representative or your Sales Support representative. After you complete the form, it should be emailed to MAOpimpliaisons@bcbsm.com.

You will receive email notification from our vendor Interserv when your account has been created.

interserv
SYSTEMS

26533 Evergreen Road, Suite 400, Southfield, MI 48076
248.356.8585 • techsupport@interservsystems.com

Online Enrollment System User Access/Change Request

Submitted For: ☐ Carrier Employee ☐ Employer Group ☐ Agent/TPA

Type of Access/Change: ☐ New User ☐ Change Profile ☐ Reinstatement ☐ Termination

User Legal Name (First and Last): _____

User Job Title: _____

User Email: _____ **User Phone:** _____

User Department Name/Agency/Group Name: _____

User Privileges

☐ Member Support ☐ Read-Only

Member Support Privileges (Check all that apply if selected above)

☐ Enrollment ☐ Withdrawal ☐ Termination ☐ Reinstatement

☐ **Reporting Access** (Available with both Member Support and Read-Only access)

Company Access

☐ All Customers ☐ Restricted

If Restricted, Please indicate groups for access: _____

_____

_____

Email completed applications to MA Ops Liaison (**maopimpliaisons@bcbsm.com**) for processing.

Online Enrollment Platform Training

A video training session and a PDF overview are available on the Group Secured Services portal. Please note, you will need to log in to the portal to access the video and PDF.

To watch the training video log in and navigate to Membership and Group Tools area where you will find the video and the training PDF.