

State of Michigan Employees



**STATE CATASTROPHIC
HEALTH PLAN**

**STATE CATASTROPHIC
HEALTH PLAN**

Your Benefit Guide



**Blue Cross
Blue Shield**
of Michigan

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

Welcome

Welcome to the State Catastrophic Health Plan, a self-insured benefit plan administered by Blue Cross Blue Shield of Michigan under the direction of the Michigan Department of Civil Service.

MDCS is responsible for implementing State Catastrophic Health Plan benefits and future changes in benefits. BCBSM will provide certain services on behalf of MDCS through an administrative-service-only contract. Your benefits are not insured with BCBSM, but will be paid from funds administered by MDCS.

This benefit book is designed to help you understand your State Catastrophic Health Plan coverage. Please take the time to read it. Make sure you understand what services are covered and when you're responsible for out-of-pocket costs.

If you have any questions about your State Catastrophic Health Plan coverage after reading this book, please call the State of Michigan Customer Service Center. The number is **1-800-843-4876**. Our customer service representatives are available Monday through Friday from 8:30 a.m. to 4:45 p.m., excluding holidays.

This document is not a contract. Rather, it is intended to be a summary description of benefits. Every effort has been made to ensure the accuracy of this information. However, if statements in this description differ from the applicable coverage documents, then the terms and conditions of those documents will prevail.

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How to reach us

You can call, write or visit the Blue Cross Blue Shield of Michigan State of Michigan Customer Service Center when you have benefit and claims handling questions.

To help us serve you better, here are some important tips to remember:

- Have your ID card handy so you can provide your contract and group numbers. If you're writing, include this information in your letter.
- To ask if a particular service is covered, please have your physician provide you with the five-digit procedure code. If your planned procedure does not have a code, please obtain from your provider a complete description of the service. Please also include the diagnosis.
- To inquire about a claim, please provide the following:
 - Patient's name
 - Provider's name (such as the doctor, hospital or supplier)
 - Date the patient was treated
 - Type of service (for example, an office visit)
 - Charge for the service
- When writing to us, please send copies of your bills, other relevant documents and any correspondence you have received from us. Make sure you keep your originals.
- Include your daytime telephone number on all of your letters.

Calling

Our customer service hours are Monday through Friday from 8:30 a.m. to 4:45 p.m. We are closed on holidays.

In and outside Michigan	1-800-843-4876
Hearing and speech impaired customers	
Area codes 248, 313, 586, 734 and 810	(313) 225-6903
Area codes 231, 616 and 989 ...	(616) 977-8494 or 1-877-977-8494
Area code 517	1-800-231-6921
Special servicing numbers	
Anti-fraud hotline	1-800-482-3787
Blue Health Line SM	1-800-811-1764
Hearing-impaired customers	TTY# 1-800-240-3050
BlueSafe SM hotline.....	1-877-BLUESAFE (258-3723)
BlueCard [®]	1-800-810-BLUE (2583)
Human Organ Transplant Program	1-800-242-3504

Writing

Please send all correspondence to:

**State of Michigan Customer Service Center
Blue Cross Blue Shield of Michigan
P.O. Box 80380 — WRAP
Lansing, MI 48908-0380**

Visiting

Our Customer Service Center is open Monday through Friday from 8:30 a.m. to 5 p.m. We are closed on holidays.

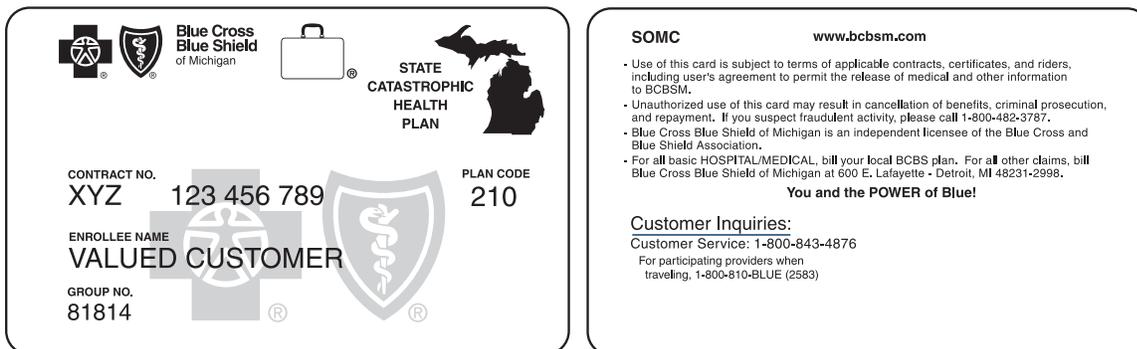
**BCBSM State of Michigan Customer Service Center
1405 S. Creyts Road
Lansing MI**

Surfing the net

Blue Cross Blue Shield of Michigan Home Page www.bcbsm.com
Anti-fraud www.bcbsm.com/antifraud

Your ID card

Your BCBSM ID card is your key to receiving quality health care. Your card will look similar to the one below.



The numbers on your personal ID card will be different from the ones illustrated above.

The suitcase tells providers about your travel benefits.

Line 1: **CONTRACT NO.** This is your identification number, which is the subscriber's Social Security number. The subscriber is the person who signed and submitted the application for State Catastrophic Health Plan coverage.

The alpha prefix preceding the contract number identifies the type of coverage you have (XYZ).

PLAN CODE identifies you as a Blue Cross Blue Shield of Michigan member.

Line 2: **ENROLLEE NAME** is the same as the subscriber. All communications are addressed to this name.

Line 3: **GROUP NO.** tells us you are a BCBSM group subscriber. Your Blue Cross Blue Shield of Michigan ID card is issued once you enroll for coverage. It lets you obtain services covered under the State Catastrophic Health Plan. Only the subscriber's name (the subscriber is the person who signed and submitted the application for State Catastrophic Health Plan coverage) appears on the ID card. However, the cards are for use by all covered members.

Here are some tips about your ID card:

- Carry your card with you at all times to help avoid delays when you need medical attention.
- If you or anyone in your family needs a card, please call the State of Michigan Customer Service Center at **1-800-843-4876** for assistance.
- Call the State of Michigan Customer Service Center at **1-800-843-4876** if your card is lost or stolen. You can still receive service by giving the provider your contract number to verify your coverage.

Only you and your eligible dependents may use the cards issued for your contract. Lending your card to anyone not eligible to use it is illegal and subject to possible fraud investigation and termination of coverage.

Explanation of benefits

You'll receive an *Explanation of Benefit Payments* form each time we process a claim under your contract number. **The EOBP is not a bill.** It's a statement that helps you understand how your benefits were paid. It tells you:

- The family member who received services
- Who provided the service, the payments made and any amount saved by using a participating provider under *Summary of Balances*
- *Helpful Information* about BCBSM programs
- Service Dates, charges, payments and any balance you may owe under *Detail on Services*

Please check your EOBPs carefully. If you see an error, please contact your provider first. If they cannot correct the error, call the State of Michigan Customer Service Center at **1-800-843-4876**. Our customer service representatives are available 8:30 a.m. to 4:45 p.m. Monday through Friday, excluding holidays.

If you think your provider is intentionally billing us for services you did not receive or that someone is using your BCBSM ID card illegally, contact our anti-fraud hotline at **1-800-482-3787**.

Your call will be kept strictly confidential. By working together, we can help keep health care costs down.

We've included a sample *Explanation of Benefit Payments* form on the following page.

Sample of Explanation of Benefit Payments

EXPLANATION OF BENEFIT PAYMENTS

THIS IS NOT A BILL

Statement Date: 10/11/03

81814-400
SMITH, JOHN
123 ELM LANE
GRAND RAPIDS MI 49512

Group Name: STATE OF MICHIGAN
Group Number: 81814-400
Subscriber Name: SMITH, JOHN
Contract Number: 123454321
Coverage: HOSPITAL/PHYSICIAN

Patient Name or Initial: SUSAN
Patient Birth Month/Year: 09/61



An independent licensee of the Blue Cross and Blue Shield Association.

Your Customer Service Phone Number is:
NATIONWIDE TOLL-FREE 1-800-843-4876

Send Written Inquiries to this Address:
BLUE CROSS BLUE SHIELD OF MICHIGAN
P.O. BOX 80380
LANSING MI 48908-0380

See your Health Care Benefits Certificate or Benefits Guide for details on contract coverage.

Summary of Balances (See Detail on Services)

Name of Hospital, Physician or Provider	Total Provider Charges	(-) Less BCBSM Paid	(-) Less Participating Provider Savings	(-) Less Other Insurance Paid	(=) Equals Your Balance*
DOE, B MD	184.00	60.14	117.18	0.00	6.68
Totals	\$ 184.00	\$ 60.14	\$ 117.18	\$ 0.00	\$ 6.68

*Note: The amount in the 'Equals Your Balance' column includes any copayments, deductibles, sanctions and non-covered charges.

Helpful Information

What sets the Michigan Blues apart from some other insurers? The others may drop you when you get sick - or charge you higher premiums. We think that's unfair. The Blues have never done it, and never will.

Detail on Services
Contract Number: 123454321
Patient: SUSAN

Service Date (from to): 10/03/03	Total Charge	\$ 184.00
Claim Received on: 10/08/03	Amount approved by BCBSM for this service	66.82
Provider Name: DOE J MD	Minus deductible	6.68
Provider Status: PARTICIPATING	BCBSM processed on 10/09/03 and paid provider	60.14
Referring Provider:	Savings because provider participates with BCBSM	+ 117.18
Service Type: SURGERY	Total Covered	\$ 177.32
Procedure: SHAVE SKIN LESION	Your Balance: (Highlighted Amounts)	\$ 6.68
Procedure Code: 11300		
Claim Number: 32818712345		

Eligibility guidelines

You're eligible to enroll in the State Catastrophic Health Plan on the first day of the bi-weekly payroll period following your first day of employment or submission of your enrollment form, whichever is later if:

- You are a State employee
- You have an appointment of at least 720 hours

You are not eligible to enroll if you have a non-career appointment.

Applying for coverage

You may apply for health care coverage when you meet State Catastrophic Health Plan requirements for eligibility. Your employer will provide you with an application form and you may enroll yourself and your eligible dependents before or within 31 days after your eligibility date.

An eligible employee who is not enrolled but is covered by the enrollment of a spouse or parent may enroll before or within 31 days after termination of the spouse's or parent's coverage. The effective date of coverage is the first day of the pay period after the date of termination or after enrollment, whichever is later.

Dependent coverage

Your dependent's State Catastrophic Health Plan is also effective the same day as yours.

Eligible dependents include your spouse and any of your unmarried children until the day before they turn 19. In addition to being unmarried, children must meet the following conditions to be considered eligible. They must be:

- Your children by birth, legal adoption or legal guardianship who are in your custody and dependent on you for support. You'll need to provide proof of dependency.
- Your children by birth, or legal adoption or legal guardianship who do *not* reside with you, but are your legal responsibility for the provision of medical care (for example, children of divorced parents).

In the case of legal adoption, a child is eligible for coverage as of the date of placement. Placement occurs when you become legally obligated for the total or partial support of the child in anticipation of adoption. A sworn statement with the date of placement or a court order verifying placement is required.

Continuing coverage for dependent children

Under certain circumstances, you can continue coverage for dependent children past the age of 19. If your coverage is still active but your dependent child no longer meets the eligibility criteria outlined above, your dependent child can remain on your coverage if he or she is:

- Unmarried and between 19 and 25 **and**
- Regularly attending school and dependent on the employee for support, as defined by IRS regulations

This coverage will continue until the day before the child turns 25 if he or she remains eligible. Coverage for these dependents will be the same as yours.

Continuing coverage for incapacitated children

Incapacitated children are those who are unable to earn a living because of mental retardation or physical disability and must depend on their parents for support and maintenance.

If your enrolled dependent is an incapacitated child, your coverage for this child will continue beyond age 19 as long as he or she became incapacitated before age 19, continues to be incapacitated and your coverage does not terminate for any other reason.

To ensure uninterrupted coverage for your incapacitated child, you must apply for continuation within 31 days after the child turns 19. To apply for continuation coverage, contact your personnel office for a BCBSM application form.

Mail the completed form to:

**Blue Cross Blue Shield of Michigan
State of Michigan Customer Service Center
P.O. Box 80380
Lansing, MI 48908-0380**

Dependent exclusions

You cannot claim a dependent on your coverage if he or she is:

- In the armed forces
(Individuals who are called to active military duty are eligible for coverage under TRICARE, formerly CHAMPUS, effective with the date of active duty orders.)
- Already covered on another State of Michigan Health Plan
No person can be covered on more than one State of Michigan Health Plan.

Dual eligibility

If you and your spouse are both covered by State Health Plans (retiree or active, including State-sponsored HMO options), you may:

- Maintain separate coverage through your individual plans
- Enroll in one plan, with one of you as a dependent

If you choose to maintain separate coverage, your child or children can only be listed on one plan, not both. This applies even if you are divorced.

Should you or your spouse separate from State service, take a leave of absence, or be laid off, the departing employee may be enrolled as a dependent on the remaining employee's State Catastrophic Health Plan coverage, providing the remaining employee:

- Continues to meet eligibility requirements
- Was covered as a dependent of the departing employee or was enrolled separately as an employee
- Notifies his or her personnel office of his or her intent to transfer enrollment prior to the departure of the spouse from State service

Once you return to work, you must wait until the State's next open enrollment period before you may transfer your coverage back into your own name.

Changing coverage

You can make mid-year enrollment changes to your coverage based on a family status change. These changes occur if you or your dependents lose or need coverage because:

- You move outside your health maintenance organization's service area
- You get married or divorced
 - You may enroll a new spouse within 31 days of your marriage; the effective date will be the first day of the pay period in which you were married if you notify your Human Resource office during the first pay period. If notification is received within 31 days of the marriage but after the first pay period, the effective date of the insurance is the first day of the next pay period after the Human Resource office received notification.
 - Or you may newly enroll in health coverage if you lose insurance coverage as a result of a divorce. (Note: a former spouse's eligibility for State-sponsored insurance coverage will end on the date of your divorce.)
- An eligible child is born, adopted or moves into your home
 - You may add a new dependent to your insurance coverage within 31 days of acquiring that dependent through birth, adoption, or legal guardianship. The effective date will be the date of birth, adoption, legal guardianship or move.
- Your spouse begins or ends employment
- Your spouse changes from part-time to full-time (or vice versa) or takes an unpaid leave of absence resulting in a significant change in your coverage
- There is a significant change in your or your spouse's coverage through your spouse's non-State of Michigan employer plan
- Your dependent 19- to 25-year-old child has returned to school

New dependents who are not enrolled within 31 days of the qualifying event can be enrolled during the next open enrollment period.

The effective date for any other family status change will be the first day of the payroll period following the family status change or after enrollment, whichever is later.

Open enrollment period

During open enrollment, you can:

- Enroll in the State Catastrophic Health Plan if you're not already enrolled
- Add eligible dependents

Canceling coverage

The cancellation effective date will be the last day of the last payroll period in which a premium is paid.

Your coverage under the State Catastrophic Health Plan will automatically terminate:

- When you are no longer eligible
- On the last day of the last payroll period for which you made a required premium contribution
- When the entire group contract is discontinued

Canceling dependent coverage

Your dependent's coverage will automatically terminate:

- When your dependent no longer meets the definition of an eligible dependent
(You must immediately notify your personnel office if you divorce. Ex-spouses are not eligible for coverage.)
- When your dependent becomes eligible for coverage as an employee
- When the entire group or the group dependent contract is discontinued
- When your coverage terminates

If we're notified more than 30 days after the date of the event, the change to your contract will be delayed, which may cause errors when your claims are processed. Please remember to report any membership changes to your personnel office promptly so these changes can be reflected on your records. If you fail to give timely notice, you may be liable for any payments made by BCBSM on behalf of your dependent for medical services that have been provided subsequent to the date of the event.

Continuing health care coverage

When your enrollment or your dependent's enrollment in the State Catastrophic Health Plan has been canceled, you or your dependents may be eligible for continuation or conversion of certain benefits.

Continuing coverage under COBRA

If your coverage is terminated, you and your dependents may be eligible for continuing coverage under the federal law known as COBRA. You can continue coverage for up to 18 months if your coverage is terminated because:

- You were suspended
- Your work hours were reduced (this includes PT/PI furloughs)
- You were terminated (this includes deferred retirement) unless the termination was for gross misconduct

Dependents can continue coverage for up to 36 months if they are:

- Spouses who lose coverage because of divorce or legal separation
- Children who no longer meet dependent eligibility requirements under the State Catastrophic Health Plan
- Surviving dependents who will lose group coverage in the case of your death

State Catastrophic Health Plan coverage will automatically continue for dependents who are to receive an immediate monthly pension benefit from the State of Michigan upon your death. If your dependents are *not* going to receive a monthly pension benefit following your death, their coverage will end 30 days following your death.

COBRA notification and application

To continue coverage under any of the above qualifying events, you or your dependents must pay the full monthly premium, including the share that was paid by the State, directly to the COBRA program. (You'll need to notify your personnel office of a divorce, legal separation or when a dependent child is no longer eligible. For all other qualifying events, your personnel office will notify you and your dependents of the right to continue coverage.)

In any case, to arrange COBRA payments, please submit an *Application for Continuation of Insurance Benefits* (form MDCS-1499), to the Michigan Department of Civil Service. The form must be submitted within 60 days from the date of your qualifying event or the date

coverage ends, whichever is later and whichever applies. The form is available at the State of Michigan's Web site, www.michigan.gov.

The address for the Employee Benefits Division is:

**Michigan Department of Civil Service
Employee Benefits Division
400 S. Pine
Lansing, MI 48933**

The continuation opportunity will end if an application is not submitted on a timely basis or the full COBRA premium is not paid.

Continuing coverage while on layoff

If you're on layoff, you can also continue State Catastrophic Health Plan coverage for up to 36 months by paying the full monthly premium (including the share that was paid by the State) directly to the State.

For the first two pay periods after layoff, you can pre-pay your share of the bi-weekly premium by having it deducted from your last paycheck. The State will contribute its share.

To continue coverage after the pre-paid period, submit an *Application for Continuation of Insurance Benefits* (form MDCS-1499) to the Employee Benefits Division within 60 days of the date your coverage ends.

After you return to work, please complete an *Enrollment Application* (form MDCS-1696) to ensure immediate re-enrollment in the State Catastrophic Health Plan. The form can be obtained from your personnel office or the State of Michigan's Web site, www.michigan.gov.

Continuing coverage while on a leave of absence

If you're on a leave of absence, you can continue State Catastrophic Health Plan coverage for you and your dependents for up to 18 months by paying the full monthly premium (including the share that was paid by the State) directly to the State.

However, if you're receiving wage replacement benefits under the State's Long Term Disability Plan, a health insurance premium rider will cover your premium in full for up to a maximum of six months — but only while the LTD benefit is being paid.

Please remember to submit an *Application for Continuation of Insurance Benefits* (form MDCS-1499) to the Employee Benefits Division within 60 days of the qualifying event or the date your coverage ends, whichever is later.

To ensure immediate re-enrollment in the State Catastrophic Health Plan after you return to work, please complete an *Enrollment Application* (form MDCS-1696). The form can be obtained from your personnel office or the State of Michigan's Web site, www.michigan.gov.

Continuing coverage when you retire

If you retire before the end of a given month, and your pension is to begin the first day of the next month, your coverage as an active employee continues to the end of that month. Your coverage as a retiree begins the first day of the next month, when your pension begins.

Continuing coverage under BCBSM group conversion

BCBSM's individual coverage, called group conversion, is available to you and your eligible dependents either:

- As an alternative to COBRA when you first become eligible for COBRA
- At the end of the COBRA eligibility period **if** you made all the required payments during that period

Benefits for you and your eligible dependents will change under group conversion coverage, but there will be no interruption of coverage provided you pay the initial and subsequent bills. You and your dependents must be Michigan residents for at least six months out of each year to be eligible for this type of coverage.

To ensure continuous coverage, please submit a written request for group conversion coverage to Blue Cross within 30 days from the date you are no longer eligible for State Catastrophic Health Plan coverage or within six months before COBRA coverage ends.

For additional information on how to apply for BCBSM conversion coverage, please call our Direct Billed Servicing department at **1-800-848-5101**. Customer service representatives are available Monday through Friday, 8:30 a.m. to 5 p.m.

Certificate of creditable coverage

The Health Insurance Portability and Accountability Act of 1996 requires all health plans to provide a certificate of creditable coverage to any individual who loses health coverage. The certificate rules help ensure that coverage is portable, which means that once a person has coverage, he or she can use it to reduce or eliminate any pre-existing condition exclusion periods that might otherwise apply when changing coverage. When your coverage through your employer ends, you will receive a certificate of coverage.

Catastrophic Benefits

The State Catastrophic Health Plan provides benefits covering certain hospital, surgical and medical expenses that you or your enrolled family members may incur in connection with the treatment of an injury, disease or illness, only after all other benefits have been exhausted.

Under the State Catastrophic Health Plan, covered services and supplies are called benefits. The payment allowed for benefits is called the approved amount. Blue Cross Blue Shield of Michigan determines the approved amount. Applicable deductibles are deducted from the approved amount.

Benefits are payable after you have met a policy year deductible equal to one month of the subscriber's base pay (excluding overtime, hazard pay, night shift premium, on call pay, etc.). The maximum policy year deductible amount for a family is one and a half month's base pay. The benefit period runs from October 1 through September 30.

General Features

The State Catastrophic Health Plan is a hospitalization only plan. It is designed to provide benefits only after any other benefits available have been paid for the effective treatment of **non-occupational** injuries, illness and diseases. A "non-occupational illness, injury, or disease" is an illness, disease or accidental injury to the body that is not caused by nor caused during any work for pay nor in any way results from an illness, disease or injury which does.

Coverage is provided only for those excess hospital services and supplies furnished to an individual **while covered and only after the member has incurred excess covered expenses each plan year equal to one month of the subscriber's base pay (excluding overtime, hazard, night shift premium, on call pay, etc.)** This is the member's individual policy year deductible requirement. **The maximum deductible for a family (two or more members) is one and a half month's base pay.**

Facilities

Coverage is provided for services rendered by an accredited hospital.

Professional Providers

Coverage is provided for services performed in the hospital setting by a laboratory technician, radiologist and other individual practitioner, including a physician who is defined under the State Catastrophic Health Plan as a person who is legally licensed in the state of practice and who is operating within the scope of his or her license or certificate and who is a:

- Doctor of Medicine (MD) including a Psychiatrist
- Doctor of Osteopathy (DO)
- Doctor of Chiropractic-Podiatry (DSC or DPM)
- Dentist (DDS or DMD)
- Psychologist (PhD)
- Social Worker at the master's degree level (MSW or CSW)

Cost Management and Special Features

Your plan includes several important Cost Management Programs such as the Precertification of Hospital Admissions, as described in the following pages.

For these programs and other cost containment efforts to be truly effective, our *State Catastrophic Health Plan members must take an active part in the management of their own health care*. Plan members can do this, in part, by:

- Keeping a record of health complaints and medications to share with the health care professionals who treat you
- Examining lifestyle for prevention of serious health problems, eating the right foods, getting enough exercise and dealing effectively with stress
- Asking questions about treatment or medication orders

In addition, Blue Cross Blue Shield of Michigan cost containment efforts include:

- Cost avoidance policies that have been established to encourage the efficient delivery of health care and to discourage unnecessary services
- An ongoing review of paid claims to verify membership and the medical necessity of services

- Aggressive anti-fraud efforts that have been implemented that lead to recovery or avoidance of fraudulent payments

Those aware of any illegal activity involving the State Catastrophic Health Plan are encouraged to use the anti-fraud hotline, **1-800-842-3787**.

- Special reimbursement agreements with health care facilities and professionals, which control increases in costs and limit any out-of-pocket expenses for members

Precertification of Hospital Admissions (PRECERT)

This PRECERT program helps you and your physician use your health benefits in a cost-effective way. This is accomplished by establishing, before an admission, whether an inpatient hospital is the proper setting, and what is an appropriate length of stay.

PRECERT allows your physician to request a review by the Plan Administrator (BCBSM) at least two weeks before admitting you to a hospital for a non-emergency admission. (If a two-week notice is not possible, your physician can call for an immediate review of the requested admission.)

When your physician's admission request is received, BCBSM will:

- Determine if your admission is appropriate for your condition; and,
- Determine the number of days for which benefits should be paid if the admission is approved; and,
- Send written notice of the decision to you, your physician and the hospital within one working day of BCBSM's receipt of complete information

Your physician can appeal decisions about any non-approval or the number of days assigned for approved admissions by submitting additional information with the appeal request. A review will then be made by a panel of physicians, excluding the physician who made the initial decision.

If additional days are required for medical reasons after you are admitted to a hospital, the hospital and your physician can request additional days beyond those initially approved. This extension (or precertification) should be requested at least 48 hours before the end of the initially approved length-of-stay period.

Emergency admissions and maternity admissions do not require advance precertification. However, your physician must notify BCBSM within one working day of the admission so that a length-of-stay decision can be made.

PRECERT will *not* be required when you and/or your dependent are enrolled in Medicare.

PRECERT will assist you in the effective use of your benefits because you'll know, in writing, what is covered before your hospital admission. Call the toll-free BCBSM Healthline at **1-800-811-1764** for more details.

Catastrophic Hospital Benefits

The State Catastrophic Health Plan covers inpatient and outpatient hospital care in accredited hospitals for each enrolled member. Coverage includes admissions for surgery and general medical conditions.

Inpatient hospital benefits

Inpatient hospital benefits cover up to 365 days per admission of inpatient hospital care including the following services and supplies:

- Anesthesia when administered by an employee of the hospital
- Birthing center service
- Bone marrow transplants
- Cardiac rehabilitation
- Cardiology
- CT scans
- Chemotherapy for the treatment of malignant and non-malignant disease
- Dental and related anesthesia expenses in a hospital when a concurrent hazardous health condition exists
- Accidental dental is covered for initial emergency treatment only. Routine restorative dental services are non-payable.
- Diagnostic and therapeutic x-rays, EKGs, cobalt isotopes, radiation therapy, CAT, PET and MRI scans
- Drugs, biologicals and solutions

- Foot care, including orthotics
- General nursing services
- Hemophilia
- Hospital-billed ambulance service charges up to the approved amount for a trip to or from the hospital
- Hyperalimentation
- Injections like tetanus shots, rabies, chemotherapy, etc. covered for trauma or payable diagnosis
- IV therapy
- Laboratory and pathology examinations
- Lithotripsy
- Meals and special diets
- MRA
- Newborn admission
- Non-experimental transplant of a human organ or body tissue
 - Transplants of artificial organs are not covered. This benefit also covers those hospital, surgical, laboratory and x-ray expenses incurred by the person donating an organ or tissue to you or your enrolled family member, if the donor is not covered for the procedure by any other medical plan. These donor expenses are payable to the same extent as though that person's expenses were incurred by you.
- Obstetrical services including delivery
 - Inpatient examinations of the newborn are a benefit when performed by a physician other than the anesthesiologist or the delivering provider.
- Oxygen and other gas therapy
- Photo therapy for the treatment of psoriasis
- Private room — covered if it meets the guidelines for medical necessity
- Prosthetics and orthotics
- Respiratory and inhalation therapy
- Semi-private room

- Temporal Mandibular Jaw Joint surgery — the follow-up is not covered
- Use of operating, delivery and other treatment rooms
- Veterans Affairs providers — covered as the primary carrier if the condition is not payable as primary under the VA benefit

Outpatient hospital benefits

Outpatient hospital benefits cover the following services, supplies and charges:

- Anesthesia
- Cardiac rehabilitation
- Cardiology
- Chemotherapy
- CT scans
- Dental and related anesthesia expenses in a hospital when a concurrent hazardous health condition exists
- Diagnostic laboratory, x-ray and EKG services
- Drugs
- Emergency medical care — The initial exam and treatment of accidental injuries or conditions in an emergency room are covered when determined by BCBSM to be medical emergencies

This includes both professional and facility services. Treatment must occur within 48 hours of the injury or 72 hours of the medical emergency.

Routine care for minor medical problems such as headaches, colds, slight fevers and back pain is not considered emergency care. Also, follow-up care is not considered emergency care.

- Foot care, including orthotics
- Hemophilia
- Hemodialysis
- Hyperbaric O2 treatments
- Hyperalimentation

- Injections, like tetanus shots, rabies, chemotherapy, etc. — covered for trauma or payable diagnosis
- IV therapy
- Lithotripsy
- Maternity services on an outpatient basis if an emergency
- MRAs, MRIs and Pet scans
- Observation beds
- Photo therapy for the treatment of psoriasis
- Preadmission testing **must** be performed within seven days before a scheduled hospital admission or surgery

These tests must be medically appropriate, valid at the time of admission and must not be duplicated during the hospital stay.

- Prosthetics and Orthotics
- Surgery
- Termination of pregnancy

Inpatient Substance Abuse Treatment Benefits

The amount of benefits payable for inpatient substance abuse treatment room and board charges and any miscellaneous fees depends on where these services are provided as explained below:

- Residential Care Facility charges are covered at 100 percent for the standard length of the treatment program in that facility, not exceeding the 28 day maximum.*
- Acute Care (Hospital) Facility bed use charges are covered at 67 percent of the semi-private room and board charge and miscellaneous fees are covered 100 percent.
- Detoxification as a part of an effective treatment program is covered at 100 percent.

* *A new 28-day benefit period can be re-established after 60 days from discharge with a limit of two such admissions per calendar year.*

[If your confinement is solely for the acute care treatment of a life-threatening medical complication of alcoholism or substance abuse (such as cirrhosis of the liver, delirium tremens or hepatitis), you will be covered under the “Inpatient Hospital Benefit.”]

Medical and Surgical Care Benefits

The following services are covered if performed in a hospital:

- Accidental dental (covered for initial emergency treatment only; routine restorative dental services are non-payable)
- Anesthesia and oxygen
- Blood (excluding storage and transportation charges)
- Cataract surgery and first lens implant(s)
- Chemotherapy
- Diagnostic and therapeutic EKG, x-ray, radium, isotope and radiation therapy
- Diagnostic laboratory and x-ray examinations including CAT and MRI scans
- Emergency care coverage provides payment for the initial examination and treatment of accidental injuries and conditions determined by BCBSM to be medical emergencies (Treatment must occur within 48 hours of the injury or 72 hours of the medical emergency. Please see the ***Glossary*** for definitions of these terms.)
- Hemodialysis
- Inpatient consultations
- Inpatient medical care
- Professional ambulance service up to a maximum of \$25 per trip
- Surgery
- Technical surgical assistance when an intern, resident or house office is not available or qualified

The State Catastrophic Health Plan covers those hospital and professional medical expenses you or your enrolled family members incur to receive a non-experimental transplant of a human or body tissue. Transplants of artificial organs are not covered.

This benefit also covers those hospital, surgical, laboratory and x-ray expenses incurred by the person donating an organ or tissue to you or your enrolled family member, if the donor is not covered for this procedure by any other medical plan. These donor expenses are payable to the same extent as though that person's expenses were incurred by you.

General Exclusions

Unless it is specifically stated otherwise in this booklet, **the State Catastrophic Health Plan will not provide benefits to cover the following services, supplies or charges:**

- 1) Acupuncture
- 2) Air and water ambulance services
- 3) Allergy injections
- 4) Charges for ambulatory surgical facilities
- 5) Charges for anti-rejection drugs in a non-hospital setting
- 6) Blood storage and transportation charges
- 7) Charges that are determined to be beyond the BCBSM approved amount
- 8) Professional fee for certified nurse midwife home delivery
- 9) Charges for services rendered to improve cognition (memory, perception), concentration and or attentiveness, organizational and problem-solving skills, academic skills and impulse control or other behaviors for which behavior modification is being sought
- 10) Benefits payable by other individual, group or third party plans
- 11) Care and services received under another certificate offered by BCBSM or another Blue Cross Blue Shield Plan
- 12) Charges for services rendered by a Christian Science Practitioner and charges for services rendered at a Christian Science Sanitarium
- 13) Charges which are submitted for coverage under the Catastrophic Health Plan after the final claim filing deadline which is 15 months from the date of service (or from the date of an “Explanation of Medicare Payment”)

This deadline shall not apply if you are legally incapacitated.
- 14) Contraceptive care management and IUDs
- 15) Coordinated care management

- 16) Charges for hospital and physician services for cosmetic surgery and related services except when necessary to improve and restore bodily function or to correct a deformity from disease, trauma, birth or growth defects, or prior therapeutic processes
- 17) Charges for counseling for sexual dysfunctions that are other than medical
- 18) Charges for services and supplies for which no charge would be made if the family member did not have coverage or for which no family member is legally required to pay
- 19) Charges for services or supplies not specifically mentioned as covered in your plan coverage documents
- 20) CT scan or MRI if performed in a mobile unit
- 21) Charges for custodial care, rest therapy and care in nursing or rest home facilities

Custodial care is care that consists of services and supplies, including room and board and other institutional services, furnished to an individual, whether disabled or not, primarily to assist in the activities of daily living.
- 22) Services for which a charge is not customarily made
- 23) Dental surgery other than for the removal of impacted teeth or multiple extractions when the patient must be hospitalized for the surgery because a concurrent medical condition exists
- 24) Outpatient diabetes management program
- 25) Charges for diagnostic testing for infertility
- 26) Dialysis services after 33 months of ESRD treatment
- 27) Durable medical equipment
- 28) Charges for a hospital admission that begins **before** the effective of coverage by the State Catastrophic Health Plan
- 29) Hospital admissions that begin **after** the coverage termination date
- 30) Medical services or supplies provided or furnished **before** the effective date of coverage or **after** the coverage termination date

- 31) Charges for services and supplies provided while a family member is not enrolled, except as may be specifically mentioned in this booklet
- 32) Charges for services or supplies that have not exceeded the required policy year deductible amount per person, which is one month of the subscriber's base pay (excluding overtime, hazard pay, night shift premium, on call pay, etc.), up to a maximum of one and a half months of the subscriber's base pay for a family
- 33) Charges for services, care, devices or supplies that are considered experimental or still under clinical investigation by health professionals
- 34) Charges for or related to any eye surgery done mainly for cosmetic or recreational purposes **or** to correct refractive errors, except as specifically mentioned in this document
- 35) Fourth quarter carryover charges
- 36) Charges for gender reassignment or any treatment leading to (or in connection with) gender reassignment surgery
- 37) Charges for services and supplies for which a government prohibits the provision or payment of benefits (such as the prohibition by certain Canadian provinces of payment of benefits for hospital expenses)
- 38) Charges for services and supplies that are paid for or provided under any law of a government, except for services and supplies furnished by an institution or facility of the State of Michigan or a political subdivision thereof if payment would be legally required in the absence of coverage

This exclusion will also not apply where the payment of benefits is provided under a plan specifically established by government for its own civilian employees and their dependents.

- 39) All home based services
- 40) Home health care
- 41) Hospice

- 42) Hospitalization principally for:
 - Observation
 - Diagnostic evaluation
 - Physical therapy
 - X-ray or lab tests
 - Reduction of weight by diet control (with or without medication)
 - Basal metabolism test
 - Electrocardiography
- 43) Charges for immunizations or any other preventive services and supplies, except as may be specifically mentioned in this booklet
- 44) Charges from an independent lab
- 45) Services from institutions that do not meet the definition of a hospital
- 46) Charges for in vitro fertilization, artificial insemination or embryo transfer procedures
- 47) Medically necessary services received on an inpatient basis that can be provided safely in an outpatient or office location
- 48) Charges for mental health care
- 49) Benefits for any expenses incurred during an inpatient or outpatient hospital confinement due to a mental or nervous condition (including the treatment of alcoholism or substance abuse) after it has been determined that such a condition is not subject to a favorable modification
- 50) Charges for services and supplies that are furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any member in the armed forces of a government
- 51) Care and services available at no cost to you in a veteran, marine or other federal hospital or any hospital maintained by any state or governmental agency
- 52) Treatment of a condition caused by military action or war, declared or undeclared
- 53) Care and services payable by government-sponsored health care programs, such as Medicare or TRICARE, formerly CHAMPUS, for which a member is eligible

- 54) Services and supplies that are not medically necessary according to accepted standards of medical practice
- 55) Services for which the patient is not obligated to pay or services without cost
- 56) Treatment of occupational injury or disease that the State of Michigan is obligated to furnish or otherwise fund
- 57) Office visits, office consultations and home office visits
- 58) Outpatient substance abuse services
- 59) Outpatient audiology testing
- 60) Outpatient clinic fees
- 61) Charges for services and supplies received by members or their dependents outside of the United States, except in the case of temporary absence due to travel
- 62) Charges for patient education, whether or not such services are provided in a physician's office or facility that also provides medical, psychiatric or rehabilitation services
- 63) Charges for services or supplies for personal comfort or convenience or personal hygiene, including charges for telephone, radio, television, barber or beauty service
- 64) Charges for physical therapy in a freestanding facility or office setting
- 65) Premarital or pre-employment exams
- 66) Private duty nursing
- 67) Charges for private hospital rooms in excess of a semi-private rate for room and board, except as specifically mentioned in this document.
- 68) Separate charges for the professional services of a resident physician, intern or other employee of a hospital whether made by the individual or by the hospital (Such charges are already a part of the hospital's billed facility charge.)
- 69) Charges for psychiatric treatment of mental deficiency or retardation except services necessary to diagnose and evaluate the mental deficiency or retardation
- 70) Charges for services or supplies not recommended, approved or performed by, or upon the direction of persons who are not legally qualified or licensed to provide such services

- 71) Charges for research services
- 72) Outpatient or office respiratory therapy
- 73) Charges for the reversal of a voluntary sterilization procedure
- 74) Routine hospital outpatient care requiring repeated visits for the treatment of chronic conditions
- 75) Charges for services that are for screening procedures, routine (not diagnostic or treatment) purposes including routine periodic physical, premarital examination or similar examinations or tests not required in, and directly related to the diagnosis of an illness or injury, vision or dental examinations, except as may be specifically mentioned in this booklet
- 76) Charges for skilled nursing care
- 77) Charges for sleep studies in an outpatient facility
- 78) Charges for Specified Oncological Clinical Trials (SOCT)
- 79) Charges for telephone consultations, missed appointments and psychotherapy training
- 80) Treatment of Temporomandibular Joint Syndrome and related jaw-joint problems by any method other than as specified in this benefit book
- 81) Charges for an organ or tissue transplant procedure if you or your family member is the donor if the recipient is not also covered under the State Catastrophic Health Plan or other State Health Plan for a State of Michigan member
- 82) Charges for travel, meals and lodging for covered transplants
- 83) Transportation and travel except as specified in this benefit book
- 84) Charges for voluntary sterilization even if performed in-patient following delivery
- 85) Weight loss (other than surgery) facility fees
- 86) Charges for any services or supplies relating to any injury, illness or disease that are work or employment related and for which Worker's Compensation payments are being made

Any exclusion mentioned above will not apply to the extent that coverage is specifically provided by name in this booklet, or if coverage of a charge is required under any law that applies to that coverage. This list of exclusions is not meant to be all-inclusive.

Medicare and Supplemental coverage

Medicare is a federal health care benefit program for people who are:

- Age 65 or older (except for certain pension recipients and spouses covered under the State Police Retirement System)
- Diagnosed with End Stage Renal Disease
- Under age 65 but have received a Social Security disability benefit for at least 24 months

Medicare will become primary for actively working employees and their enrolled dependents with End Stage Renal Disease after 33 months and the State Catastrophic Health Plan will act as a supplement to Medicare coverage.

Medicare coverage for inpatient and physician services

Medicare has two parts: Part A and Part B. Part A helps pay for inpatient hospital care and certain follow-up care after you leave the hospital. It's provided to you at no cost.

Part B helps pay for physician's services and other medical services and items. There is a monthly premium that you must pay for Part B coverage.

The State Catastrophic Health Plan supplements Part A by covering services that Medicare doesn't — as long as those services are benefits under the State Catastrophic Health Plan. It supplements Part B by covering 20 percent of Medicare's reasonable charge for services. You're still responsible for any applicable deductible and copayment.

If you don't enroll in Part B of Medicare, your State Catastrophic Health Plan coverage will be adjusted as if Medicare coverage were in place. The State Catastrophic Health Plan will not reimburse that portion of expenses normally covered by Medicare. This may result in limited payment or no payment.

Enrolling in Medicare

Enrollment in Medicare is handled in two ways: either you are enrolled automatically or you have to apply. Here's how it works:

Automatic enrollment

If you are not yet 65 and already getting Social Security you do not have to apply for Medicare. You will be enrolled automatically in both Part A and Part B effective the month you are 65. Your Medicare card will be mailed to you about three months before your 65th birthday.

If you are disabled and have been receiving disability benefits under Social Security for 24 months, you will be automatically enrolled in Part A and Part B beginning the 25th month of benefits. Your card will be mailed to you about three months before your entitlement.

Remember that if you don't enroll in Part B of Medicare, your State Catastrophic Health Plan coverage will be adjusted as if Medicare coverage were in place. The State Catastrophic Health Plan will not reimburse that portion of expenses normally covered by Medicare. This may result in limited payment or no payment.

Applying for Medicare

You should apply for Medicare three months before the month you turn 65. This is the beginning of your seven-month initial enrollment period. If you wait until you are 65, or in the last three months of your initial enrollment period, your Part B coverage will be delayed. You can apply for Medicare through your local Social Security Administration office.

If you do not enroll in Part B during your initial enrollment period, you will have to wait until the next general enrollment period to enroll. General enrollment periods are held January 1 through March 31 of each year, and Part B coverage starts on July 1 of that year. Your Part B premium will go up 10 percent for each 12-month period that you have been eligible for Part B but did not take it.

Remember that if you don't enroll in Part B of Medicare, your State Catastrophic Health Plan coverage will be adjusted as if Medicare coverage were in place. The State Catastrophic Health Plan will not reimburse that portion of expenses normally covered by Medicare. This may result in limited payment or no payment.

You can get more information on Medicare by logging on to the Medicare Web site at www.medicare.gov.

Subrogation

Occasionally, another person, insurance company or organization may be legally obligated to pay for health care services that we have paid. When that happens:

- Your right to recover payment from them is transferred to BCBSM
- You're required to do whatever is necessary to help BCBSM enforce their right of recovery

If you receive money through a lawsuit, settlement or other means for services paid under your coverage, you must reimburse BCBSM. However, this does not apply if the funds you receive are from additional health coverage you purchased in your name from another insurance company.

Filing claims

When you use your benefits, a claim must be filed before payment can be made. Blues participating providers should automatically file all claims for you. All you need to do is show your BCBSM ID card. However, if you receive services from nonparticipating providers, they may or may not file a claim for you.

To file your own claim, follow these steps:

1. Ask your provider for an **itemized** statement with the following information:
 - Patient's name and birth date
 - Subscriber's name, address, phone number and contract number (from your BCBSM ID card)
 - Provider's name, address, phone number and federal tax ID number
 - Date and description of services
 - Diagnosis (nature of illness or injury) and procedure code
 - Admission and discharge dates for hospitalization
 - Charge for each service
2. Include a copy of the Explanation of Benefit Payments from your primary insurer.
3. Make a copy of all items for your file. You'll also need to complete a claim form. To obtain a form, call the BCBSM State of Michigan Customer Service Center at **1-800-843-4876**.
4. Mail the claim form and itemized statement to the State of Michigan Customer Service Center.

Please file claims promptly because most services have a 15-month filing limitation.

You'll receive payment directly from BCBSM. The check will be in the subscriber's name and not the patient's name.

Glossary

Accidental injury is physical damage caused by an action, object or substance outside the body. This includes:

- Strains
- Sprains
- Cuts and bruises
- Allergic reactions
- Frostbite
- Sunburn and sunstroke
- Swallowing poison
- Medication overdosing
- Inhaling smoke, carbon monoxide or fumes

Acute care facility is a facility that offers a wide range of medical, surgical, obstetric and pediatric services. These facilities primarily treat patients with conditions that require a hospital stay of less than 30 days. The facility is **not** primarily for:

- Custodial, convalescent or rest care
- Care of the aged
- Skilled nursing care or nursing home care
- Substance abuse treatment

Approved amount is the BCBSM maximum payment level or the provider's billed charge for the covered service, whichever is lower. Deductibles and copays are deducted from the approved amount.

Approved facility is a hospital that provides medical and other services, and has been approved as a provider by BCBSM. Approved facilities **must** meet all applicable local and state licensing and certification requirements. Approved facilities must also be accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association.

Approved hospital is a hospital that meets all applicable local and state licensure and certification requirements, is accredited as a hospital by state or national medical or hospital authorities or associations, and has been approved as a provider by BCBSM or an affiliate of BCBSM.

Blue Cross and Blue Shield Association is an association of independent Blue Cross and Blue Shield Plans that licenses individual Plans to offer health benefits under the Blue Cross Blue Shield name and logo. The Association establishes uniform financial standards but does not guarantee an individual Plan's financial obligations.

Blue Cross Blue Shield of Michigan is a nonprofit, independent company. BCBSM is one of many individual Plans located throughout the U.S. committed to providing affordable health care. It is managed and controlled by a board of directors comprised of a majority of community-based public and subscriber members.

Benefit is coverage for health care services available in accordance with the terms of your health care coverage.

COBRA is continuation coverage required by the Consolidated Omnibus Budget Reconciliation Act of 1986.

Copayment is the designated portion of the approved amount you are required to pay for covered services. This can be either a fixed dollar or percentage amount.

Covered Services are services, treatments or supplies identified as payable under the State Catastrophic Health Plan. Covered services must be medically necessary to be payable, unless otherwise specified.

Custodial care is care mainly for helping a person with activities of daily living such as walking, getting in and out of bed, bathing, dressing, eating or taking medicine. This care may be given with or without:

- Routine nursing care
- Training in personal hygiene and other forms of self-care
- Supervision by a physician

Deductible is the specified amount that you pay during each benefit period for services before your plan begins to pay.

Emergency first aid is the initial exam and treatment of conditions resulting from accidental injury.

End Stage Renal Disease is permanent and irreversible kidney failure that can no longer be controlled by medication or fluid and dietary restriction and, as such, requires a regular course of dialysis or a kidney transplant to maintain the patient's life.

Experimental or investigative is a service, procedure, treatment, device or supply that has not been scientifically demonstrated to be safe and effective based on a review of established criteria such as:

- Opinions of local and national medical societies, organizations, committees or governmental bodies
- Accepted national standards of practice in the medical profession
- Scientific data such as controlled studies in peer review journals or literature
- Opinions of the Blue Cross and Blue Shield Association or other local or national bodies

Hospital is a facility that provides inpatient diagnostic and therapeutic services for injured or acutely ill patients 24 hours every day. The facility also provides a professional staff of licensed physicians and nurses to supervise the care of patients.

Medical emergency is a condition that occurs suddenly, producing severe signs and symptoms, such as acute pain. A person would reasonably expect that this condition could result in serious bodily harm without prompt medical treatment.

Medical necessity, unless otherwise specified, is a service that must be medically necessary in order to be covered by the State Catastrophic Health Plan.

Medical necessity for payment of hospital services requires that all of the following conditions be met:

- The covered service is for the treatment, diagnosis or symptoms of an injury, condition or disease.

- The service, treatment or supply is appropriate for the symptoms and is consistent with the diagnosis.
 - “Appropriate” means the type, level and length of care, treatment or supply and setting are needed to provide safe and adequate care and treatment.
 - For inpatient hospital stays, acute care as an inpatient must be necessitated by the patient’s condition because safe and adequate care cannot be received as an outpatient or in a less intense medical setting.
- The services are not mainly for the convenience of the member or health care provider.
- The treatment is not generally regarded as experimental or investigational by BCBSM.
- The treatment is not determined to be medically inappropriate by the Utilization Management and Quality Assessment programs.

In some cases, you may be required to pay for services *even when they are medically necessary*. These limited situations are:

- When you don’t inform the hospital that you are a BCBSM member either at the time of admission or within 30 days after you’ve been discharged
- When you fail to provide the hospital with information that identifies your coverage

Medical necessity for payment of physician services is determined by physicians acting for their respective provider types or medical specialty and is based on criteria and guidelines developed by physicians and professional providers. It requires that:

- The covered service is generally accepted as necessary and appropriate for the patient’s condition, considering the symptoms. The covered service is consistent with the diagnosis.
- The covered service is essential or relevant to the evaluation or treatment of the disease, injury, condition or illness. It is not mainly for the convenience of the member or physician.

The BCBSM determination of medical necessity for payment purposes is based on standards of practice established by physicians.

Member is any person eligible for health care services under the State Catastrophic Health Plan. This includes the subscriber and any eligible dependents listed in BCBSM membership records.

Nonparticipating providers are providers that have **not** signed participation agreements with Blue Cross Blue Shield of Michigan agreeing to accept the BCBSM payment as payment in full. However, nonparticipating professional (nonfacility) providers may agree to accept the BCBSM-approved amount as payment in full on a per claim basis.

Occupational therapy is treatment consisting of specifically designed therapeutic tasks or activities that:

- Improve or restore a patient's functional level when illness or injury has affected muscles or joints
- Help the patient apply the restored or improved function to daily living

Participating providers are providers who have signed agreements with BCBSM to accept the BCBSM approved amount for covered services as payment in full.

Patient is the subscriber or eligible dependent (member) who is awaiting or receiving medical care and treatment.

Per claim is a provider's acceptance of the BCBSM approved amount as payment in full for a specific claim or procedure.

Physical therapy is treatment that is intended to restore or improve the patient's use of specific muscles or joints, usually through exercise and therapy. The treatment is designed to improve muscle strength, joint motion, coordination and general mobility.

Physical therapy is **not** covered when services are principally for the general good and welfare of the patient (for example, developmental therapy or activities to provide general motivation) and when there is no improvement expected in the patient's condition.

Physician is a medical doctor (MD), doctor of osteopathy (DO), doctor of Chiroprody-podiatry medicine (DSC or DPM), or a fully licensed psychologist (PhD).

Professional provider is a medical doctor (MD), doctor of osteopathy (DO), doctor of Chiroprody-podiatry medicine (DSC or DPM), dentist (DDS or DVD), a fully licensed psychologist, or social worker at the Master's degree level (MWS or CSW).

Provider is a person (such as a physician) or a facility (such as a hospital) that provides services or supplies related to medical care.

Routine services are procedures or tests that are ordered for a patient without direct relationship to the diagnosis or treatment of a specific disease or injury.

Skilled nursing facility is a facility that provides convalescent and short- or long-term illness care with continuous nursing and other health care services by or under the supervision of a physician and a registered nurse. The facility may be operated independently or as part of an accredited acute care hospital. It must meet all applicable local and state licensing and certification requirements.

Speech therapy is active treatment of speech, language or voice impairment due to illness, injury or as a result of surgery.

Subscriber is the person who signed and submitted the application for State Catastrophic Health Plan coverage.

We, Us, Our are used when referring to Blue Cross Blue Shield of Michigan.

You and Your are used when referring to any person covered under the State Catastrophic Health Plan.

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A nonprofit corporation and independent licensee
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