



STATE HEALTH PLAN PPO

Michigan State Police Troopers Association

Active and Retired Members



YOUR BENEFIT GUIDE



Blue Cross
Blue Shield
of Michigan

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

STATE HEALTH PLAN PPO – YOUR COVERAGE FOR A LIFETIME

This easy-to-read benefits guide is designed to provide State Health Plan PPO benefit information for employed or retired members and their dependents of the Michigan State Police Troopers Association. It is intended to be a general summary of your coverage, and is not a legal contract. Please check each section of this booklet carefully for an explanation of your benefits. Services are covered as benefits depending on medical necessity, appropriateness of setting, and according to Blue Cross Blue Shield of Michigan guidelines.

REFERENCE TERMS

Throughout this benefit book the terms **We, Us** and **Our** are used when referring to **Blue Cross Blue Shield of Michigan**. The terms **You** and **Your** are used when referring to any person covered under the **State Health Plan PPO**.

This guide replaces any prior descriptions of benefit information you may have received. Please discard any prior descriptions of your benefits.

ONE GUIDE FOR ALL

ACTIVE OR RETIREE

This benefit book contains information on health care eligibility and benefits for actively employed and retired members and their dependents of the Michigan State Police Troopers Association. Most of the eligibility guidelines are the same, whether you are active or retired. However, there are a few instances where there is a slight variation for our retired employees.

We have indicated retiree-only guidelines by outlining the information in blue.

NON-MEDICARE ELIGIBLE RETIREES

Your benefits are the same as the active employees if you or your covered dependents are not eligible for Medicare coverage. Please refer to the sections for non-Medicare eligible members for information pertaining to eligibility, health care benefits and selecting a medical provider.

MEDICARE ELIGIBLE RETIREES

When you become eligible for Medicare, your health care benefits do not change, but Medicare becomes your primary health care carrier and the State Health Plan PPO becomes secondary. Medicare will process your claims first. Blue Cross Blue Shield of Michigan processes your claims after Medicare. Therefore, you must be sure that your providers are Medicare participating providers. Since Medicare does not cover some preventive benefits, you must continue to see a BCBSM participating provider for preventive services that are not covered by Medicare.

If you are eligible for Medicare, please refer to the sections on Medicare coverage to understand its impact on your health care plan.

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SECTION 1: HOW TO REACH US

CUSTOMER SERVICE INFORMATION

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 are 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 most 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**

BlueHealthConnection® **1-800-775-BLUE (2583)**

Hearing-impaired customers	TTY# 1-800-240-3050
BlueSafe SM hotline	1-877-BLUESAFE (258-3723)
BlueCard [®]	1-800-810 BLUE (2583)
SUPPORT program	1-800-321-8074
Human Organ Transplant Program	1-800-242-3504
BCBSM Integrated Medical and Surgical Services	1-800-482-4040
(Skilled nursing facility preauthorization 8 a.m. – 5 p.m.)	
Mental Health Precertification Unit	1-800-342-5891
MI HR.....	1-877-766-MIHR (6447)
Medicare	1-800-MEDICARE (633-4227)
State of Michigan Office of Retirement Services	
Lansing area	(517) 322-5103
Toll free.....	1-800-381-5111

Writing

Please send correspondence to:

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

For durable medical equipment, prosthetic and orthotic services, and medical supplies, send claims to:

**SUPPORT Program
P. O. Box 82060
Rochester, MI 48308-2060**

For specific eligibility information and assistance, active employees may contact:

**Department of Civil Service
MI HR Service Center
P. O. Box 30002
Lansing, MI 48909**

For specific eligibility information and assistance, retired employees may contact:

Office of Retirement Services
P. O. Box 30171
Lansing, MI 48909-7671

Visiting

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

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/contact.shtml
BlueHealthConnection www.bcbsm.com
State of Michigan www.michigan.gov

SECTION 2: GENERAL INFORMATION

YOUR IDENTIFICATION CARD

Your BCBSM ID card is your key to receiving quality health care benefits. Your card will look similar to one of these:



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

Line 1: **Contract Number** is your identification number.

Alpha prefix preceding the contract number identifies the type of coverage you have (PPO).

Plan Code identifies you as a Michigan Blue Cross Blue Shield of Michigan member.

Line 2: **Enrollee Name** is same as subscriber. All communications are addressed to this name.

Line 3: **Group Number** tells us you are a BCBSM group subscriber.

Your BCBSM ID card is issued once you enroll for coverage. It lets you obtain services covered under your health care plan. Only the subscriber's name appears on the ID cards. However, the cards are for use by all covered members on your contract.

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 if your card is lost or stolen. Our customer service representatives are available 8:30 a.m. to 4:45 p.m. Monday through Friday, excluding holidays. 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.

Preventing Fraud

Blue Cross Blue Shield of Michigan tries to prevent fraudulent use of your ID card. Only you and eligible members listed on your application card are covered for services.

Providers may ask for identification other than the BCBSM ID card. Checking the identification of the cardholder is one way of preventing unauthorized use of your card.

- If you suspect health care fraud against BCBSM, let us know.
- If your health care coverage is through BCBSM, call our Anti-Fraud Hotline at 1-800-482-3787. Your call is strictly confidential.
- Write us at the following address:

***Anti-Fraud Unit, Mail Code B759
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226***

- Contact us online at www.bcbsm.com/antifraud/contact.shtml

SECTION 3: ELIGIBILITY

START OF ELIGIBILITY

Active employees

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

- You are a State employee and
- You have an appointed position of at least 720 hours

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

Retirees

You are eligible as a retiree for State Health Plan PPO coverage on the day your pension begins. This is known as your “eligibility date.”

You can continue your coverage without interruption if you receive an immediate pension benefit under the State Police Retirement Act.

You can also enroll in the State Health Plan PPO if you were previously enrolled in a State-sponsored Health Maintenance Organization and you received an immediate pension benefit.

APPLYING FOR COVERAGE

Active employees

You may apply for health care coverage when you meet the State Health Plan PPO requirements for eligibility. You may enroll yourself and your eligible dependents before or within 31 days after your eligibility date (hire date) via MI HR Self-Serve or you may contact the MI HR Service Center.

Retirees

To apply for State Health Plan PPO coverage or to ensure uninterrupted coverage, you will need to submit a retiree Group Insurance Application to the Office of Retirement Services. The form (form number R329M) is available on the ORS Web site, or you may contact the ORS to request one.

You must decide within 31 days after your eligibility date whether you will enroll in the plan. If you choose not to enroll within this timeframe, your coverage, and that of your eligible dependents, will not be effective until six months after the first day of the month in which the ORS receives your completed application.

The six-month waiting period can be waived, and coverage can begin within 31 days after your completed application is received, if:

- You get married:
Within 31 days of your marriage, send a letter of notification to the ORS that includes your new spouse's name, date of birth, Social Security number and Medicare information. Include a copy of your marriage license
- You need to enroll in the plan because you or your dependents are losing coverage from another group plan

If you would like to receive waiver consideration for your six-month waiting period, please submit your application with a letter from the employer that states:

- Who was covered under the plan
- Why coverage is ending
- The date the coverage ends

Submit your application to ORS.

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, or
- 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 covered by one of the parent's plans, not both. This applies even if you are divorced.

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

- Continues to meet eligibility requirements, and
- Was covered as a dependent of the departing employee or was enrolled separately as an employee and
- Notifies MI HR 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.

MAKING CHANGES TO YOUR COVERAGE

Active employees

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 of 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 of the insurance will be the first day of the next pay period after notification to MI HR Service Center.

Or, you may newly enroll in health coverage if you lose insurance coverage because 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 you 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, or stopped attending 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.

Retirees

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 get married or divorced
- An eligible child is born, adopted or you gained legal guardianship.

- 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

To make mid-year enrollment changes, notify the ORS, in writing within 31 days of the date of the event. The changes in coverage will be effective retrospectively to the qualifying event after the ORS receives the written request for change and documentation of the qualifying event.

Submit your enrollment changes to ORS.

Open Enrollment Period

During open enrollment, you can:

- Enroll in the State Health Plan PPO if you are not already enrolled
- Add eligible dependents

To Add a Dependent to Your Contract

When you become a State Health Plan PPO member, your eligible dependent family members may be added to your contract.

To add a dependent to your contract, you must notify MI HR within 31 days* of the date any change occurs (date of the event), so we can adjust our records.

The following chart shows the coverage effective date when we are notified within 31 days of the qualifying event.

<i>When adding...</i>	<i>Effective coverage date is...</i>
<i>Spouse</i>	First day of your pay period after notification.
<i>Newborn</i>	Date of birth.
<i>Adopted child</i>	Date of placement. Placement occurs when the member becomes 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.
<i>Child under legal guardianship</i>	Date of the legal guardianship.

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

To Change Your Address

If you change your address, or if your address is incorrect in our records, please notify MI HR if you are an active employee or ORS if you are a retiree. This will ensure that you will continue to receive any notices BCBSM sends to you. Remember to include your group and contract numbers whenever you contact us.

Terminating coverage

Active employees

The cancellation effective date will be the last day of the last payroll period of eligibility, or when the entire group contract is discontinued.

Retired employees

You can voluntarily cancel your State Health Plan PPO coverage or your dependent's coverage at any time by writing to the ORS.

Include your signature and Social Security number.

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

Dependent coverage

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 will need to provide proof of dependency.
- Your children by birth, 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).
- Step children for whom you have physical custody (i.e. step children living with you at least 50 percent of the time as stated in a current divorce decree) and for whom you provide 50 percent of their support.

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.

Dependent exclusions

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

- In the armed forces
No person will be considered a dependent while in the armed forces of any country. Individuals who are called to active military duty are eligible for coverage under TRICARE, effective with the date of active duty orders.
- Already covered on another State of Michigan health plan
No person can be covered by more than one State of Michigan health plan.

Terminating dependent coverage

Active employees

Your dependent's coverage will automatically terminate:

- When your dependent no longer meets the definition of an eligible dependent.
Note: You must immediately notify MI HR if you divorce or if a child becomes ineligible.
Ex-spouses are not eligible for coverage as of the date of divorce.
- 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 are notified more than 31 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 promptly report any membership changes to MI HR so these changes can be reflected on your records. ***If you fail to give timely notice, you may be held responsible for any payments made by State of Michigan and BCBSM on behalf of your ineligible dependent after the date of the event.***

Under certain circumstances, you can continue coverage for dependent children past the age of 19. For more information, please read the following section on Continuing Coverage for Dependent Children.

See the chart below for information about removing dependents.

<i>Dependent</i>	<i>Reason for Removal</i>	<i>Effective Date</i>
<i>Spouse</i>	Divorce	Date of the divorce
<i>Child</i>	Marriage	Date of marriage
	Reaches 19 or 25 and is no longer eligible for coverage	The day prior to the child turning 19 or 25
<i>Any dependent</i>	Death	First day following the date of death

*If we are notified more than 31 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 MI HR promptly so these changes can be reflected on your records.

If you fail to give timely notice of a divorce, you may be liable for any payments made by State of Michigan and BCBSM on behalf of your ex-spouse subsequent to the date of your divorce.

Retirees

Your dependent's coverage will automatically terminate on the last day of the last month for which you made any required dependent premium contribution and:

- When your dependent no longer meets the definition of an eligible dependent
Note: You must immediately notify ORS if you divorce. **Ex-spouses are not eligible for coverage effective the date of divorce.**
- When the entire group or the group dependent contract is discontinued
- When your coverage terminates

Under certain circumstances, you can continue coverage for dependent children past the age of 19. For more information, please read the following section on *Continuing Coverage for Dependent Children*.

See the chart below for information about removing your dependents. Remember, if a dependent child is no longer eligible, you must notify ORS promptly.

Dependent	Reason for Removal	Effective Date
Spouse	Divorce	Date of the divorce
Child	Marriage	Date of marriage
	Reaches 19 or 25 and is no longer eligible for coverage	The end of the month in which the child turning 19 or 25
Any dependent	Death	First day following the date of death

*If we are notified more than 31 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 ORS promptly so these changes can be reflected on your records.

If you fail to give timely notice of a divorce, you may be liable for any payments made by State of Michigan and BCBSM on behalf of your ex-spouse subsequent to the date of your divorce.

CONTINUING HEALTH CARE COVERAGE

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

Continuing coverage for dependent children

Active employees

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 in the section entitled “Dependent Coverage” your dependent child can remain on your coverage if he or she is:

- Unmarried and between the ages of 19 and 25, and
- Regularly attending an accredited school and dependent on the employee for 50 percent or more of financial support.

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).

Retirees

If your coverage is still active but your dependent child no longer meets the eligibility criteria outlined in the section Dependent Coverage, your dependent child can remain on your coverage if he or she is:

- Unmarried and between the ages of 19 and 25, and
- Regularly attending an accredited school and dependent on the retiree for 50 percent or more of financial support.

This coverage will continue until the end of the month in which 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 a mental or physical impairment 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 coverage before the end of the month in which the child turns 19.

Active employees

To apply for continuation coverage, either contact a MI HR representative or the State of Michigan Customer Service Center for a BCBSM application form. Mail the completed form to the State of Michigan Customer Service Center.

Retirees

To apply for continuation coverage, either contact an ORS representative or the State of Michigan Customer Service Center for an application card. Mail the completed form to the State of Michigan Customer Service Center.

Continuing coverage under COBRA

Active employees

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
- 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
- Children who no longer meet dependent eligibility requirements under the State Health Plan PPO
- Surviving dependents who will lose group coverage in the case of your death

State Health Plan PPO 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 (directly to the COBRA program) the full monthly premium plus a two-percent administrative fee. (You must notify MI HR of a divorce, legal separation or when a dependent child is no longer eligible.)

MI HR Service Center will contact the Michigan Department of Civil Service, Employee Benefits Division to send the COBRA form (CS-1767) to your dependent. The COBRA 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. For further information on your rights to continue State-sponsored insurance, see the MDCS Web site, www.michigan.gov/mdcs and look under the section Employee Benefits.

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

Continuing coverage under COBRA

Retirees

Your dependents may also be eligible for continuing coverage under the federal law known as COBRA. COBRA requires the State of Michigan to offer eligible dependents of retirees continued group insurance coverage. COBRA applies to:

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

If your eligible dependents choose COBRA, they may continue State of Michigan coverage for up to 36 months by paying the full monthly premium directly to the State of Michigan.

COBRA notification and application

To continue coverage under any of the above qualifying events, you or your dependents must pay (directly to the COBRA program) the full monthly premium plus a two percent administrative fee. (You must notify ORS of a divorce, legal separation or when a child is no longer eligible).

ORS will send the Application for Continuation of Insurance Benefits (CS – 1767) to you. You must complete and submit this application to the Employee Benefit Division within 60 days of the qualifying event or the date coverage ends, whichever is later. For more information on your rights to continue State-sponsored insurance, see the MDCS Web site, at www.michigan.gov/mdcs and look under the section Employee Benefits.

This 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 a leave of absence

If you are on a leave of absence, you can continue State Health Plan PPO coverage for you and your dependents by paying the full monthly premium.

Your Human Resource Office will send you an Application for Continuation of Insurance Benefits (CS-1767). You must submit this completed application to the Employee Benefits Division within 60 days of the qualifying event or the date the coverage ends, whichever is later.

If you are 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 six months — but only while the LTD benefit is being paid, as long as Employee Benefits Division receives a completed application (CS-1767).

When you return to work, please notify the MI HR Service Center to reinstate your active coverage.

Continuing coverage while on layoff

If you are on layoff, you can also continue State Health Plan PPO coverage for up to 36 months by paying the full monthly premium.

Your Human Resource Office will send you an Application for Continuation of Insurance Benefits (CS-1767). This completed application must be sent to the Michigan Department of Civil Service, Employee Benefits Division within 60 days of the date your coverage ends.

When you return to work, please notify MI HR Service Center to have your active coverage reinstated.

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, or
- 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 BCBSM within 30 days from the date you are no longer eligible for State Health Plan PPO coverage or within six months before COBRA coverage ends.

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

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's rules help ensure that coverage is portable. This means that, once a person has coverage, he or she can use it to reduce or eliminate any exclusion periods due to pre-existing conditions that might otherwise apply when changing coverage. When your coverage through your employer ends, you will receive a certificate of coverage.

Medicare - eligible members

Your health coverage continues when you or your covered dependents become eligible for Medicare by providing you Medicare Supplemental benefits. These benefits supplement Medicare so that you enjoy the same covered services as non-Medicare members.

You become eligible for Medicare coverage at age 65. If you are disabled or if you have end stage renal disease (ESRD), you will be eligible for Medicare at an earlier age. To limit your out-of-pocket expenses regardless of your age, you should enroll in Part A and Part B if you and/or your covered dependents are recognized by Social Security as being disabled or diagnosed with end stage renal disease.

Remember, if you do not enroll in Part B of Medicare, your State Health Plan PPO coverage will be adjusted as if Medicare coverage were in place. The State Health Plan PPO will not reimburse that portion of expenses normally covered by Medicare. This may result in limited or no payment, or retroactive adjustment to claims.

More information is available in Section 7, *Medicare Coverage for Eligible Members*, and from Medicare through your local Social Security office. You can also visit www.medicare.gov.

SECTION 4: CHOOSING A PROVIDER

This section provides information to help you understand and use your BCBSM coverage. You will find information about:

- Network providers
- Non-network providers
- Medicare participating providers
- Medicare non-participating providers
- BlueCard PPO program
- Care out of the country

The State Health Plan PPO is designed to provide you with the highest level of benefits and the lowest out-of-pocket costs when you choose PPO providers. You also have the freedom to receive care from a non-network provider, but with higher out-of-pocket costs.

NETWORK PROVIDERS

The State Health Plan PPO uses a network of physicians, hospitals and other health care specialists who have signed agreements with us to accept our approved amount as payment in full for covered services. When you use PPO providers, your out-of-pocket costs for covered services are limited to the *deductible and copayments* listed in Section 5.

When you need medical care, find a State Health Plan PPO provider by calling the State of Michigan Customer Service Center and asking for assistance in locating a PPO provider in your area, or visit www.bcbsm.com.

Using the BCBSM Web site

When you visit www.bcbsm.com:

1. Click on "Members & Groups"
2. Click on "Physician Search"
3. From the Site Search Menu, click on the provider type you are looking for:
 - "Physician Search"
 - "Hospitals & Facilities"
 - "Community Blue PPO Urgent Care Locations"

When you are searching for a physician, follow these steps on the Physician Search site.

Step 1 Choose a plan.

Click "SOM State Health Plan PPO" on the drop-down menu.

Step 2 Select from the following options. To narrow your search, select more than one:

Option A: Locate Specific Physician — Type the physician's name.

Option B: Get a List of Physicians — Choose a specialty from the drop-down menu or choose a hospital from the drop-down menu.

Option C: Locate a Physician Near You — Type the number of miles you are willing to travel and your address.

Option D: Locate a Physician by County or ZIP — Choose a county from the drop-down menu or type your ZIP code.

Step 3 Click on "Search" — Physicians will appear in alphabetical order.

For additional information about a physician, select one of the following from the drop-down menu to the right of the individual physician list:

"Physician Details"

"Driving Directions"

"Map to Physician"

If you are searching for a hospital or facility:

1. Click on "Hospital & Facilities" from the Site Search menu sidebar.
2. Click on the region on the map or the name of the region in which you are interested.
3. Click the facility type on the drop-down menu.
4. Click "Community Blue PPO" as the plan type on the drop-down menu.
5. Click the county on the drop-down menu.
6. Click on "Search" — the hospitals and facilities will appear in alphabetical order.

If you are searching for an urgent care location:

1. Click "Community Blue PPO Urgent Care Locations" on the Site Search menu sidebar.
2. Select the region on the map or the name of the region in which you are interested.
3. Select the county. The urgent care locations will appear in alphabetical order.

With the State Health Plan PPO, you do not have to choose just one provider for your care and you do not have to notify us if you decide to change physicians. Just remember to select your provider from the State Health Plan PPO directory and you will stay in-network. If you would like to verify if a provider is in the State Health Plan PPO network, please call the State of Michigan Customer Service Center at 1-800-843-4876.

To receive medical benefits at the in-network level, your care must be received from a State Health Plan PPO provider. You do not need to use a State Health Plan PPO provider for the following services; however, you must follow any coverage requirements outlined in this booklet:

- Services where there is no network available (see Section 5)
- Services covered under a separate prescription drug, dental, vision or hearing plan

Change in Network Status

Your physician is your partner in managing your health care. However, physicians retire, move or otherwise cease to be affiliated with our PPO network. Should this happen, your physician should notify you that he or she is no longer in the State Health Plan PPO network.

If you have difficulty choosing another physician, please contact our State of Michigan Customer Service Center for assistance. If you wish to continue care with your current physician, a Customer Service representative will explain the financial costs to you when services are performed by a physician who is no longer in the State Health Plan PPO network.

NON-NETWORK PROVIDERS

When you receive care from a provider who is not in the PPO network, without a referral from a PPO provider, your care is considered out-of-network. Before choosing a non-network provider, you should verify if the service would be covered. ***Preventive care services are not covered out-of-network.***

Blues Participating Providers

If you choose to receive services from a non-network provider, you can still limit your out-of-pocket costs if the provider participates in our Traditional plan.

If you use a Blues participating provider outside the State Health Plan PPO network:

- The provider will bill us directly for your services.
- You will not be billed for any differences between our approved amount and the provider's charges.
- You will be responsible for out-of-network costs.

You can locate a Blue participating provider in Michigan by logging onto the BCBSM Web site at ***www.bcbsm.com/directories***.

Nonparticipating Providers

Nonparticipating providers have **not** signed agreements with BCBSM. If you receive services from a nonparticipating provider, you are usually required to pay the provider directly and may be required to submit a claim to us for payment.

When you use a provider **who does not participate** with BCBSM:

- You will receive payment directly from BCBSM (The amount you receive from BCBSM may be significantly less than the amount a nonparticipating provider charges you.)
- You are responsible for paying the provider
- You are responsible for any difference between our payment and the provider's charges

Note: If you choose to go to a non-participating hospital or facility when you have adequate access to a network hospital, the State Health Plan PPO will not cover the charges.

Medicare Participating Providers

When you select hospitals, doctors or other medical providers, always ask if they accept assignment of Medicare claims. This means they will not bill you for the difference between their charge and the Medicare-approved amount. These providers will also file your Medicare claims for you.

Medicare Non-participating Providers

Providers that do not accept Medicare assignment will cost you more and you may have to file claims for supplemental benefits.

You may be asked to sign a private contract. A private contract is a written agreement between you and a doctor who has decided not to participate in the Medicare program.

If you sign a private contract with your doctor

- You will have to pay whatever this doctor or provider charges you for the services you receive. Medicare's limiting charge will not apply.
- No claims should be submitted to Medicare, and Medicare will not pay if one is submitted. If the claims is submitted to BCBSM, BCBSM will only pay 20 percent of our approved cost.

BLUECARD PPO PROGRAM

When you need medical care **outside of Michigan**, you can receive in-network benefits by using the BlueCard PPO program. Simply call the toll-free number below and you'll be directed to the nearest BlueCard PPO provider. BlueCard PPO providers bill their local Blue Plan for any covered services you receive. The local Blue Plan does not reduce its payments to the BlueCard PPO providers by the out-of-network deductible and/or copayments. You are responsible only for the in-network deductible and copayments (if any) listed in Section 5 and for services not covered by your plan.

To take advantage of your BlueCard program, just follow these three steps:

1. Call **1-800-810-BLUE (2583)** any day of the week. You will be given the name of the nearest **PPO** physician or hospital.

Note: If you need emergency medical care, please seek care immediately from the nearest hospital or physician.

2. Show your BCBSM ID card and remind the provider you are covered under the BlueCard program and to **include the alpha prefix** on all claims.
3. Pay applicable deductibles and copayments required by your plan.

You won't be expected to pay any out-of-network copayments or deductibles if:

- You are referred to a non-network provider by a BlueCard participating PPO provider
- You receive treatment for an accidental injury or a medical emergency

Important: You may need to submit itemized receipts directly to us if you receive services from a non-network provider. **Also, BlueCare does not include prescription drugs and dental services.**

Care Out of the Country

The State Health Plan PPO will only pay for services for emergency and unexpected illness for residents of the United States traveling in foreign countries.

Note: Coverage applies only if the hospital is accredited and the physician is licensed.

Most hospitals and doctors in foreign countries will ask you to pay the bill. Try to get itemized receipts, preferably written in English. When you submit your claim, tell us if the charges are in U.S. or foreign currency. Be sure to indicate whether payment should go to you or the provider. We will pay the approved amount for covered services at the rate of exchange in effect on the date you received your services, minus any deductibles or copayments that may apply.

SECTION 5: HOW YOUR STATE HEALTH PLAN PPO WORKS

State Health Plan PPO gives you the choice of receiving care from a PPO physician or outside the PPO network from any physician. The choice is always yours.

- When a PPO physician provides or refers your hospital and/or medical services, it is called “in-network.”
- When a PPO physician does not provide or refer your services, it is called “out-of-network.”

Each person enrolled in a State Health Plan PPO plan is entitled to a **lifetime benefit maximum of \$5 million**. Within this maximum each member has:

- Up to **\$3,500** annually for outpatient substance abuse treatment
- Up to **\$750** annually for all preventive care services (not covered out-of-network)

Here’s a diagram that shows how State Health Plan PPO works.

When you use any State Health Plan PPO physician	When you choose a non-network physician who is	
<p>Your plan may require:</p> <ul style="list-style-type: none"> • A deductible • A percentage copayment for some services • A flat-dollar copayment for selected office services • A copayment for private duty nursing <p>You have:</p> <ul style="list-style-type: none"> • No balance billings* • No claim forms to file* <p>You’re in-network</p>	<p>A Blue participating provider</p> <p>You pay:</p> <ul style="list-style-type: none"> • An out-of-network deductible • An out-of-network percentage copayment for some services <p>You have:</p> <ul style="list-style-type: none"> • No balance billings* • No claim forms to file* <p>You’re out-of-network</p>	<p>A non-participating provider</p> <p>You pay:</p> <ul style="list-style-type: none"> • An out-of-network deductible • An out-of-network percentage copayment for some services <p>You have:</p> <ul style="list-style-type: none"> • Balance billings* • Claim forms to file* <p>You’re out-of-network</p>

* If you self-refer to a nonparticipating provider, you may be balanced billed and/or have to file your own claims.

IN-NETWORK GUIDELINES

To receive benefits at the in-network level, a PPO provider must provide or refer your hospital or medical care. The following lists those exceptions where we will pay services at the in-network level if they are received from a non-network provider.

Referrals

Referral care services are services received from a provider not in the PPO network, **but coordinated by your PPO physician.**

Important: A referral from your PPO provider does not guarantee payment. To be covered, the service must be a covered benefit and you must have a completed and signed written referral from your PPO physician.

Emergency Care

When you think emergency care is needed, go to the nearest medical facility. The initial exam to treat a life-threatening medical emergency or accidental injury is covered only at the in-network level for approved diagnoses.

Note: Follow-up care is not considered emergency care.

PPO Network Exceptions

The following types of services are covered at the in-network level of benefits when performed by a Blues participating provider:

- Ambulance providers
- Ambulatory surgery facilities
- Certified Nurse Practitioners and Certified Nurse Midwives
- Certified Registered Nurse Anesthetists
- Dentist (limitations apply)
- Freestanding End Stage Renal Disease facilities
- Freestanding Extracorporeal Shock Wave Lithotripsy facilities
- Freestanding outpatient physical therapy facilities
- Home Health Care through an approved agency
- Home Infusion Therapy Providers
- Hospice programs
- Independent Licensed Physical Therapists
- Optometrist

- Private Duty Nursing providers
- Skilled Nursing facilities
- Urgent care centers

IN-NETWORK DEDUCTIBLE

When you receive services in-network you must pay an in-network deductible of **\$200** per member or **\$400** per family before payment will be made for benefits. This deductible is required each calendar year.

Any amount you pay toward your in-network deductible during the fourth quarter (October through December) will carry over and be applied to your in-network deductible during the following year.

Reminder: When one individual has met the in-network deductible, benefits are payable for that individual. In-network services for the remaining family members will be paid when the full family deductible has been met.

The in-network deductible **does not** apply to:

- Preventive care services
- Services for the initial exam to treat a medical emergency or an accidental injury. Services must be provided in the outpatient department of a hospital, urgent care center or physician's office
- Services subject to a fixed dollar copayment (i.e., office visits)
- Hospice care benefits
- Human Organ Transplant Program (includes both solid organ transplants and bone marrow transplants)

In-Network Copayments

You are required to pay the following **fixed dollar** copayments, which do not apply toward your deductible or copayment maximum:

- **\$10** for office visits, which includes urgent care visits, office consultations and medical hearing examinations
- **\$10** for osteopathic manipulations

After you have met your in-network deductible, you will be responsible for the following percent copayments:

- **10 percent** of the approved amount for durable medical equipment, prosthetic and orthotic appliances, private duty nursing, chiropractic and acupuncture services

The in-network percent copayment **does not** apply to:

- Hospice care benefits
- Preventive care services
- Services for the initial exam to treat a medical emergency or an accidental injury. Services must be provided in the outpatient department of a hospital, urgent care center or physician's office
- Services subject to a fixed dollar copayment

In-Network Copayment Maximum

After you have paid **\$1,000** per member or **\$2,000** per family in-network and out-of-network percent copayments, you do not need to pay any further **in-network copayments** for the rest of that year.

The following **cannot** be used to meet your copayment maximum:

- Deductibles (in-network and out-of-network)
- Fixed dollar copayments
- Charges for non-covered services
- Charges in excess of our approved amount
- Private duty nursing
- Mental health care copayments

OUT-OF-NETWORK GUIDELINES

When you receive services from providers who are not in the PPO network (out-of-network), you will be required to pay out-of-network deductibles and copayments. Preventive care services are not covered out-of-network.

Out-of-Network Deductible

Your coverage requires you to pay a **\$500** per member or **\$1,000** per family deductible before payment will be made for out-of-network benefits. This deductible is required each calendar year.

When one individual has met the out-of-network deductible, benefits are payable for that individual. Out-of-network services for the remaining family members will be paid when the full family deductible has been met.

Out-of-network deductibles will be waived if you do not have adequate access to a PPO provider. Adequate access is defined by how far you live from PPO providers and hospitals. The State Health Plan PPO access standards in Michigan are:

- Two family care physicians within 15 miles of your home
- Two specialty care physicians within 20 miles of your home
- One hospital within 25 miles of your home

If you feel that you do not have adequate access based on the above guidelines, you must contact the State of Michigan Customer Service Center.

Note: Deductibles are not required for in-network office visits.

The out-of-network deductible **does not** apply to:

- The initial exam to treat a medical emergency or an accidental injury. Services must be provided in the outpatient department of a hospital, urgent care center or physician's office
- Referrals to a non-network provider by a PPO provider
- Ambulance providers
- Ambulatory surgery facilities
- Certified nurse practitioners and certified nurse midwives
- Certified registered nurse anesthetists
- Freestanding End Stage Renal Disease facilities
- Freestanding Extracorporeal Shock Wave Lithotripsy facilities
- Freestanding outpatient physical therapy facilities
- Home health care through an approved agency
- Hospice programs
- Independent licensed physical therapists
- Optometrist
- Private duty nursing providers
- Skilled nursing facilities
- Urgent care centers

Out-of-Network Percent Copayments

After you have met your out-of-network deductible, you are responsible for the copayment of **10 percent** of the approved amount for general services.

Out-of-network copayments will be waived if you do not have adequate access to a PPO provider. Adequate access is defined by how far you live from PPO providers and hospitals.

The State Health Plan PPO access standards in Michigan are:

- Two family care physicians within 15 miles of your home
- Two specialty care physicians within 20 miles of your home
- One hospital within 25 miles of your home

If you feel that you do not have adequate access based on the above guidelines, you must contact the State of Michigan Customer Service Center.

Out-of-Network Copayment Maximum

After you have paid **\$2,000** per member or **\$4,000** per family in out-of-network copayments for general services, you do not need to pay any further out-of-network copayment for the rest of that year.

The following **cannot** be used to meet your out-of-network copayment maximum:

- Deductibles, in-network or out-of-network
- Fixed dollar copayments
- In-network percent copayments
- Charges for non-covered services
- Charges in excess of our approved amount
- Private duty nursing
- Mental health care copayments

SECTION 6: STATE HEALTH PLAN PPO HOSPITAL AND PHYSICIAN COVERAGE

This section explains your State Health Plan PPO benefits. Please check each section of this booklet carefully for a complete explanation of your benefits.

Important: Unless otherwise indicated, all services described in this section are subject to both in-network and out-of-network deductibles and copayments listed in Section 5. Remember, preventive care services are not covered out-of-network.

Medical Necessity

A service must be medically necessary in order to be payable by your health care coverage. Medical necessity for the 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 intensified 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 investigative by Blue Cross Blue Shield of Michigan.
- The treatment is not determined to be medically inappropriate by the Utilization Management and Quality Assessment Programs.

Important: 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 Blue Cross Blue Shield member either at the time of admission or within 30 days after you have been discharged.
- When you fail to provide the hospital with information that identifies your coverage.

Services Before Coverage Begins or After Coverage Ends

Unless otherwise stated in this booklet, we will not pay for any services, treatment, care or supplies provided before your coverage under this certificate becomes effective or after your coverage ends.

If your coverage begins or ends while you are an inpatient at a facility, our payment will be based on the facility's contract with us. Our payment may cover:

- The services, treatment, care or supplies you receive during the entire admission or
- The services, treatment, care or supplies you receive while your coverage is in effect.

In addition, if you have other coverage when you are admitted to or discharged from a facility, your other carrier may be responsible for paying for the care you receive before the effective date of your BCBSM coverage or after it ends.

Pain Management

Blue Cross Blue Shield of Michigan considers pain management an integral part of a complete disease treatment plan. We provide coverage for the comprehensive evaluation and treatment of diseases, including the management of symptoms such as pain that may be associated with these diseases. Your health care benefits provide for such coverage and are subject to contract limitations.

Payment of Benefits

Under your 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 and it is the lesser of the billed charge or maximum payment amount allowed for covered services. Applicable deductibles and copayments are deducted from our approved amount.

HOSPITAL INPATIENT BENEFITS

Room and Board

Your benefits include the cost of a semi-private room; use of specialty care units such as intensive, burn or cardiac care; meals and special diets; and general nursing care. However, the cost of a private room is not covered. If you request a private room, your coverage will pay the cost of a semi-private room. You will be required to pay the difference.

General Medical Care Days

You have an **unlimited** number of inpatient days for the diagnosis and treatment of general medical conditions. The following types of admissions are also considered general medical care:

- **Maternity and nursery care** – Includes delivery room costs and routine nursery care for a newborn during an eligible mother's hospital stay. After the hospital stay, the newborn is covered as a dependent child, but **only if you add the child to your coverage within 30 days of birth.**

Note: Under federal law, we generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. However, the attending physician may, after consulting with the mother, discharge the mother or the newborn earlier. We also may not require a provider to obtain authorization for prescribing a length of stay not in excess of the 48/96-hour minimum.

- **Cosmetic surgery** – Includes correction of birth defects, conditions resulting from accidental injuries or traumatic scars and the correction of deformities resulting from certain surgeries, such as breast reconstruction following a mastectomy.
- **Dental surgery** – Includes removal of impacted teeth or multiple extractions only when a concurrent hazardous medical condition, such as a heart condition exists. The inpatient stay must be considered medically necessary to safeguard the life of the patient during the dental surgery.

Hospital Services and Supplies

The following services and supplies are covered when they are needed during a hospital admission:

- **Anesthesia** – Administration, cost of equipment, supplies and the services of a hospital anesthesiologist when billed as a hospital service
- **Blood services** – Blood derivatives, whole blood, blood plasma and supplies used for administering the services
- **CAT, PET and MRI scans** – Scans of the head and body when required for eligible diagnoses and when performed in a facility approved by BCBSM
- **Diagnostic radiology** – Ultrasound and X-rays required for the diagnosis of an illness or injury
- **Diagnostic tests** – EKGs, EMGs, EEGs, thyroid function tests and nerve conduction studies required in the diagnosis of an illness or injury
- **Drugs** – Medicines prescribed and given during a hospital admission
- **Durable medical equipment** – Items such as oxygen tents, wheelchairs and other hospital equipment used during the hospital stay
- **Laboratory and pathology tests** – Laboratory tests and procedures required to diagnose a condition or injury when billed as a hospital service
- **Medical and surgical supplies** – Gauze, cotton and solutions used during the hospital admission
- **Prosthetic and orthotic appliances** – Items that are surgically implanted in the body, such as heart valves
- **Special treatment rooms** – Operating, delivery and recovery rooms
- **Therapeutic radiology** – Radiological treatment by X-ray, isotopes or cobalt for a malignancy

HOSPITAL OUTPATIENT BENEFITS

The following services are covered when performed in the outpatient department of a PPO hospital or, where noted, in a freestanding facility approved by BCBSM.

Emergency Medical Care in the Emergency Room

Your benefits include the initial exam and treatment of accidental injuries or conditions determined by BCBSM to be medical emergencies (see Glossary for definitions).

The following are not considered emergency care:

- Routine care for minor medical problems such as headaches, colds, slight fever and back pain
- Follow-up care

Note: The exam, diagnosis and treatment of illness or injury by a physician is payable when you are seen in the physician's office or in a non-hospital urgent care center.

Pre-Admission Testing

Testing must be performed in the outpatient department of a hospital within seven days before a scheduled hospital admission or surgery. These tests must be medically necessary at the time of admission and must not be duplicated during the hospital stay.

Chemotherapy

Treatment is payable in a hospital, in the outpatient department of a hospital, or in a physician's office. Your benefits include the administration and cost of drugs (except those taken orally) when ordered by a physician for the treatment of a specific type of malignant disease, approved by the Food and Drug Administration (FDA) for use in chemotherapy and provided as part of a chemotherapy program.

Hemodialysis

Hemodialysis services are covered to treat acute kidney failure and End Stage Renal Disease (ESRD). You can receive treatment in the outpatient department of a PPO hospital or in a freestanding facility approved by BCBSM. You can also receive dialysis services in the home if the owner of the patient's home gives the hospital prior written permission to install the equipment.

Your physician must arrange for home hemodialysis and all services must be billed by a PPO hospital or in a freestanding facility approved by BCBSM that has an approved hemodialysis program. Also, to be eligible for home dialysis, the member must meet BCBSM's homebound criteria. Benefits include cost of the equipment, installation, training and necessary hemodialysis supplies.

Important: Dialysis services for the treatment of ESRD are coordinated with Medicare. It is important that individuals with ESRD apply for Medicare coverage regardless of age. Blue Cross Blue Shield of Michigan is the primary payer for up to 33 months, which includes the three-month waiting period, if the member is under 65 and is eligible for Medicare solely because of ESRD.

ALTERNATIVES TO HOSPITAL CARE

As alternatives to hospital care, your coverage provides the following benefits.

Home Hemophilia Program

Your benefits include all medications and medical supplies needed for in-home treatment for hemophilia, including syringes, needles and the antihemophilic factor. Your physician must prescribe all services and all services and supplies must be billed by a PPO hospital. Your benefits also include training the patient or a family member on how to inject the antihemophilic factor, when the training is provided through an approved facility.

Home Health Care

To receive benefits under the Home Health Care program, a physician must prescribe and submit a detailed treatment plan to the home health care agency. The Home Health Care agency must be BCBSM approved.

Once the agency accepts the patient into its program, the following services are covered when billed by the agency:

- Home health aide services if the patient is receiving skilled nursing care or physical or speech therapy and the health care agency has identified a need for the patient to have these services
- Social services and nutritional guidance when requested by the patient's physician
- Physical, speech and occupational therapy (up to a combined maximum of 60 visits per member per calendar year; this benefit maximum renews each calendar year)
- Nursing care when supervised by a registered nurse employed by the home health care agency

Important: We do not pay for general housekeeping services, for transportation to or from a hospital or other facility, for elastic stockings, sheepskin or comfort items such as lotion, mouthwash, body powder, etc., for physician services and for custodial or non-skilled care.

Skilled Nursing Care

Care in a skilled nursing facility is covered when the patient is suffering from or gradually recovering from an illness or injury and is expected to improve. In addition, we require written

confirmation of the need for skilled care from the patient's physician. Once prescribed, your coverage will provide benefits for the period necessary for the care and treatment of the patient, up to a maximum of 730 days per calendar year. All services must be provided by a BCBSM approved skilled nursing facility (see Glossary for definition).

To obtain preauthorization, your physician or skilled nursing facility must contact the **BCBSM Integrated Medical and Surgical Services department at 1-800-482-4040**. The department is open 8 a.m. to 5 p.m. Eastern Standard Time Monday through Friday.

Your coverage **does not** pay for:

- Custodial care
- Care for senility or mental retardation
- Care for substance abuse
- Care for long-term mental illness

Hospice Care

Hospice is an agency that is primarily involved in providing care to terminally ill individuals and can be used as an alternative to hospitalization. A patient is considered terminally ill when the attending physician has certified in writing that life expectancy is six months or less.

You may apply for hospice care benefits only after discussion with and referral by your attending physician. Your request must be in writing to the hospice agency and **all hospice services must be arranged through an approved hospice provider**.

- **Electing Hospice Benefits** – When the patient elects to enter into the program, the hospice benefits will replace the patient's State Health Plan PPO benefits for conditions related to the terminal illness. The hospice benefits will be more specific to the patient's needs and may include alternative services that provide more appropriate care. However, medical services unrelated to the terminal illness are covered according to your State Health Plan PPO coverage. The patient may cancel, in writing, all hospice benefits at any time. When services are canceled, the patient's regular coverage resumes.
- **Levels of Care** – The hospice program provides four levels of care:
 - **Routine home care** that consists of services provided to patients who are living at home and are not receiving continuous home care (see next item). Benefits include counseling, home health care and physical therapy. Such care must not exceed eight hours per day.
 - **Continuous home care** that consists of nursing care services provided to patients during crisis periods to enable them to stay at home. Such care is covered up to 24 hours per day during periods of crisis.

- **Inpatient respite care** that consists of short-term inpatient services to allow the home care provider short periods of relief. Such care must be provided in an approved facility on a non-routine or occasional basis and in increments of five days or less in any 30-day period.
- **General inpatient care** that consists of services for pain control and acute and/or chronic symptom management that cannot be provided in other less intensive settings.
- **Hospice Services** – The following benefits are payable under the hospice program up to the dollar maximum amount that is reviewed and adjusted annually.
 - Nursing care when provided by or under the supervision of a registered nurse
 - Medical social services by a qualified social worker, provided under the supervision of a physician
 - Counseling services for the patient and caregivers, when care is provided in the home and for family bereavement after the patient’s death
 - Medical appliances and supplies to provide comfort to the patient and when approved by us
 - Durable medical equipment when furnished by the hospice program for the patient’s home
 - Physical, speech and occupational therapy when provided to control symptoms and maintain the patient’s daily activities and basic functional skills

Important: There is a separate dollar maximum for services provided by a physician who is not part of the hospice team.

BLUEHEALTHCONNECTION[®] PROGRAM

BlueHealthConnection is an integrated health care management program that provides the information, assistance and decision-making tools you need to take charge of your personal health care needs. It gives you access to:

- Nurse health coaches 24 hours per day, seven days a week.
- Guided self-management tools such as Web-based information, self-help handbooks and videos.
- Outreach programs by telephone or mail to assist you in understanding the use of services available through BlueHealthConnection.
- Integrated case and disease management for members with chronic illnesses like diabetes and heart disease or acute illness.
- A Health Risk Appraisal (HRA), an online tool developed by doctors and leading health researchers that helps you pinpoint your specific health issues and risks.

Note: Integrated case and disease management is a voluntary program designed to help manage the health care of members with acute or chronic medical conditions, regardless of setting. The candidates for this program must meet the eligibility criteria listed below.

Eligibility for Integrated Case and Disease Management (ICDM)

BCBSM decides who is eligible for ICDM based on the following factors:

- Candidate's diagnosis
- Admission status
- Clinical status
- Scope of contractual benefits available to the candidate
- Availability of community services to the candidate and his or her family
- Personal and family support available to the candidate
- Substantial probability of lasting improvement in the candidate's clinical status within 12 months

Candidates for ICDM may be identified based on BCBSM claims data. In addition, BCBSM will consider referrals of candidates from such sources as:

- Attending physicians
- Hospitals
- Candidate or candidate's family
- Employer group

When a member is accepted as a candidate for ICDM, a personal treatment plan is developed. The treatment plan describes the goals, expected outcomes, type and limited duration of services to be provided to the member under ICDM. It may include medically necessary services that BCBSM determines should be provided because of the member's condition as specified in the plan, even if those services are not covered under the patient's hospital and professional certificates. (Such services are referred to as non-contractual services.)

The member's physician must order all services described in the treatment plan. ***BCBSM will pay only for the services, equipment and supplies specifically described in the signed treatment plan, which is a binding contract between the member and BCBSM.***

Termination of ICDM

BCBSM may terminate the treatment plan and the member's participation in ICDM if:

- The member is no longer eligible to receive benefits under his or her BCBSM health care plan.
- The member voluntarily withdraws from the program.
- The member meets the treatment plan goals. (Termination in these cases occurs when the case manager determines that the goals have been met. As a result, termination may occur well before any expiration period described in the treatment plan is reached.)
- The member fails to meet the treatment plan goals within the time period specified in the treatment plan.
- The time period described in the member's treatment plan expires.
- The member (or his or her representative), treating physician or case manager determines that the member's participation in case management will no longer result in measurable improvement in the member's clinical status.

Limitations and Exclusions of the ICDM Program

- Benefits provided under the ICDM program are applied to the lifetime maximum of your certificate, except where specifically waived by BCBSM.
- Services described in the treatment plan will be provided only as long as the plan is in effect.
- Coverage for non-contractual services under ICDM will only be provided for the specific conditions identified in the treatment plan. Treatment for other conditions remains subject to the terms of your underlying benefits plan(s).
- BCBSM does not pay for any services provided by a relative of the patient.

HUMAN ORGAN TRANSPLANTS

The following types of human organ transplants are covered when received in a BCBSM-approved transplant facility, designated transplant facility, or designated cancer center.

Please call the customer service number in Section 1 for questions you have about cornea, kidney or skin transplants. Call the BCBSM Human Organ Transplant Program at 1-800-242-3504 for any questions you have about bone marrow or specified human organ transplant surgery.

Organ and Tissue Transplants

Benefits are payable for services performed to obtain, test, store and transplant only the following human tissues and organs:

- Cornea
- Kidney
- Skin

We will pay for covered services for donors if the donor does not have transplant benefits under any health care plan.

Note: To determine donor benefits please call the customer service number in Section 1.

Hematopoietic Transplants

Your transplant benefits include transplants of the bone marrow, peripheral blood stem cells or umbilical cord blood. Benefits are payable for up to a maximum of two single transplants per member per condition.

Note: There is no travel benefit associated with this coverage.

Services are paid in full when received at a BCBSM-approved transplant facility, and designated transplant facility or designated cancer center [approved by National Cancer Institute (NCI)] and requires preauthorization or pre-approval from BCBSM's Human Organ Transplant Program (HOTP). Please verify with HOTP if your diagnosis is covered.

Benefits for ***allogeneic*** transplants are payable only when the bone marrow, peripheral blood stem cells or umbilical cord blood of another person is transplanted into the patient. This includes syngeneic transplants, a procedure using the bone marrow, peripheral blood stem cells or umbilical cord blood from a patient's identical twin to transplant into the patient.

We cover the following services:

- Blood tests on immediate family members (mother, father, sister or brother) for evaluation as donors (if tests are not covered by the potential donor's health coverage)
- Search of the National Bone Marrow Donor Program Registry for a donor (A search will begin only when the need for a donor is established.)
- Infusion of colony stimulating growth factors
- Harvesting (including peripheral blood stem cells pheresis) and storage of the donor's bone marrow, peripheral blood stem cell and/or umbilical cord blood:
 - If the donor is an immediate relative (mother, father, sister or brother) and has four of the six important HLA genetic markers as the patient.
 - ***Donors outside of the immediate family must match five of the six important HLA genetic markers with the patient.*** This provision does not apply to transplants for Sickle Cell Anemia (ss or sc) or Beta Thalassemia.

Note: Harvesting and storage will be covered if it is not covered by the donor's health coverage. In a case of Sickle Cell Anemia (ss or sc) or Beta Thalassemia, the donor must be an HLA-identical sibling.

- High dose chemotherapy and/or total body irradiation
- Infusion of bone marrow, peripheral blood stem cells and/or umbilical cord blood
- T-cell depleted infusion
- Donor lymphocyte infusion
- Hospitalization

Autologous Transplants

Benefits include transplants of the patient's own bone marrow (autologous) or transplanting the patient's own peripheral blood stem cells.

We cover the following services:

- Infusion of colony stimulating growth factors
- Harvesting (including peripheral blood stem cells pheresis) and storage of bone marrow and peripheral blood stem cells
- High dose chemotherapy or total body irradiation
- Infusion of bone marrow and peripheral blood stem cells
- Hospitalization

Your coverage **does not** pay for:

- Services **not** medically necessary
- Services provided by persons or entities that are not legally qualified or licensed to provide such services
- Services rendered to a donor when the donor's health care coverage will pay for such services
- Any services related to, or for, allogeneic transplants when the donor does not meet the HLA genetic marker matching requirements
- An autologous tandem transplant for any condition other than germ cell tumors of the testes
- An allogeneic tandem transplant
- The routine harvesting and storage of a newborn's umbilical cord blood for possible use at some unspecified time in the future
- Services that are experimental or investigational

Specified Oncology Clinical Trials

Benefits are payable for bone marrow and peripheral blood stem cell transplants, their related services, and FDA-approved antineoplastic drugs to treat stages II, III and IV breast cancer and all stages of ovarian cancer when they are provided pursuant to an approved phase II or III clinical trial. This benefit does not limit or preclude coverage of antineoplastic drugs when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.

In order for services to be payable as eligible benefits:

- The inpatient admission to a hospital and the length of stay at the hospital **must** be medically necessary (in those cases requiring inpatient hospital treatment) and **pre-approved**. A request for an admission and length of stay must be pre-approved by BCBSM **before** the admission occurs. **(NO retroactive approvals will be granted.)**

Note: A pre-approval is good only for one year after it is issued. However, pre-approval services, admissions or lengths of stay will not be paid if you no longer have this coverage at the time services occur.

If your condition or proposed treatment plan changes after pre-approval is granted, your provider must submit a new request for pre-approval. Failure to do so will result in the transplant, related services, admission and length of stay not being covered.

- The proposed services **must** be medically necessary and rendered in a designated cancer center or in an affiliate of a designated center. The designated cancer center must submit its written request for pre-approval to BCBSM Human Organ Transplant Program.

A designated cancer center is a site approved by the National Cancer Institute (NCI) as a cancer center, comprehensive cancer center, clinical cancer center or an affiliate of one of these centers. The names of the approved centers and their affiliates are available to you and your physician upon request. An affiliate cancer center is a health care provider that has contracted with an NCI-approved cancer center to provide treatment.

- The patient must be an eligible BCBSM member with hospital/medical/ surgical coverage.

Covered Services

Covered services are payable when directly related to a transplant covered under this benefit.

When **pre-approved** by BCBSM, the following services are covered:

- Autologous transplants
 - Infusion of colony stimulating growth factors
 - Harvesting (including peripheral blood stem cell phereses) and storage of bone marrow and/or peripheral blood stem cells

- Purging or positive stem cell selection of bone marrow or blood stem cells
- High dose chemotherapy and/or total body irradiation
- Infusion of bone marrow and/or peripheral blood stem cells
- Hospitalization
- Allogeneic transplants
 - Blood tests to evaluate donors (if not covered by the potential donor’s insurance)
 - Search of the National Bone Marrow Donor Program Registry for a donor (A search will begin only when the need for a donor is established.)
 - Infusion of colony stimulating growth factors
 - Harvesting (including peripheral blood stem cell phereses) and storage of the donor’s bone marrow, peripheral blood stem cells or umbilical cord blood (We will cover harvesting and storage even if the donor’s insurance does not cover it.)
 - High dose chemotherapy or total body irradiation
 - Infusion of bone marrow, peripheral blood stem cells and/or umbilical cord blood
 - T-cell depleted infusion
 - Donor lymphocyte infusion
 - Hospitalization

Travel, Meals and Lodging

We will pay up to a total of \$5,000 for travel, meals and lodging expenses directly related to pre-approved services rendered during an approved clinical trial. The expenses must be incurred during the period that begins on the date of pre-approval and ends 180 days after the transplant. However, these expenses will not be paid if your coverage is no longer in effect. We will pay the expenses of an adult patient and one companion (or two companions if the patient is under age 18).

Within the \$5,000, the following amounts apply to the combined expenses of the patient and eligible companion(s):

- Up to \$60 per day for travel
- Up to \$50 per day for lodging
- Up to \$40 per day for meals

Note: This travel, meal, lodging benefit only applies to those members preauthorized under the SOCT benefit and who have either breast or ovarian cancer.

What's Not Covered

Your coverage **does not** pay for:

- A hospital admission or a length of stay at a hospital that has not been **pre-approved**
- Services that have not been **pre-approved**
- Services that **are not** medically necessary
- Services provided by persons or entities that are not legally qualified or licensed to provide such services
- Services rendered to a donor when the donor's health care coverage will pay for such services
- The routine harvesting and storage of a newborn's umbilical cord blood for possible use at some unspecified time in the future
- More than two single transplants per member for the same condition
- Items, such as investigational drugs that are normally covered by other funding sources (e.g., investigational drugs funded by a drug company)
- Non-health care related services and/or research management (such as administrative costs)
- Transplants performed at a center that is not a designated cancer center or its affiliate
- Items not considered directly related to travel, meals, and lodging expenses. They include, **but are not limited to**, dry cleaning, clothing, laundry services, kennel fees, entertainment (cable televisions, movie rentals, books, magazines), car maintenance, toiletries, security deposits, toys, alcoholic beverages, flowers, cards, stationery, stamps, household products, household utilities, including cell phone charges, maid, baby-sitter or day care services.
- Experimental or investigational services not included in this benefit
- Any other services, admissions or lengths of stay related to any of the above exclusions

Specified Human Organ Transplants

Your benefits include coverage for specified human organ transplants performed during the transplant benefit period, as described below, when the transplant is preauthorized by BCBSM and received at a BCBSM-designated transplant facility. (A **designated facility** is one that BCBSM determines to be qualified to perform a specific organ transplant.)

Benefits apply only to transplants of the:

- Liver
- Partial liver (a portion of the liver from a cadaver or living donor)
- Heart

- Lung(s)
- Lobar lung (a portion of a lung from a cadaver or living donor to a recipient)
- Heart-lung(s)
- Pancreas
- Simultaneous pancreas-kidney
- Small intestine (small bowel, a procedure in which the patient's small intestine is removed and replaced with the small intestine of a cadaver)
- Combined small intestine-liver

All covered human organ transplant services, except anti-rejection drugs and other transplant-related prescription drugs, must be provided during the **benefit period** that begins five days before the transplant surgery and ends one year after the surgery.

Benefits are limited to a **\$1 million** lifetime maximum per member for each covered human organ transplant type.

Note: During the **benefit period**, the deductible and copayments do not apply to the specified organ transplants and related procedures described in this section.

When directly related to the transplant, we will pay for the following medically necessary services:

- Facility and professional services.
- Anti-rejection drugs and other transplant-related prescription drugs during and after the benefit period. Payment will be based on the BCBSM approved amount. Our payment for the drugs is limited only by the \$1 million lifetime maximum.
- Medically necessary services needed to treat a condition arising out of the organ transplant surgery if the condition occurs during the benefit period, and is a direct result of the organ transplant surgery. We will pay for any medically necessary service needed to treat a condition as a direct result of the organ transplant surgery, if it is a benefit under any of our certificates.
- Up to \$10,000 for travel, meals and lodging. This includes:
 - Cost of transportation to and from the designated transplant facility for the patient and one companion eligible to accompany the patient (or two companions if the patient is under age 18 or if the transplant involves a living related donor).
 - Reasonable and necessary costs of lodging for the companion(s) eligible to accompany the patient.
 - Reasonable and necessary costs of meals up to a combined maximum of \$40 per day for the patient and companion(s) eligible to accompany the patient.

- The cost of acquiring the organ, which includes surgery to obtain the organ, storage of the organ and transportation of the organ. Also payment for covered services for a donor if the donor does not have transplant services under any health care plan. The total payment for all services combined for each organ transplant type will not be more than the \$1 million lifetime maximum.

Your coverage **does not** pay for:

- Services that are not BCBSM benefits
- Living donor transplants other than partial liver, lobar lung and kidney transplants that are part of a simultaneous pancreas-kidney transplant
- Pancreatic islet cell transplants (pancreatic cells that manufacture and secrete insulin)
- Anti-rejection drugs that do not have Food and Drug Administration marketing approval
- Transplant surgery and related services that are not performed in a BCBSM designated transplant facility. You must pay for the transplant surgery and related services you receive in a non-designated facility.
- Transportation, meals and lodging costs under circumstances other than those related to the initial transplant surgery and hospitalization
- Items not considered directly related to travel, meals and lodging expenses. They include, but are not limited to, dry cleaning/clothing/laundry services, kennel fees, entertainment (cable, movie rentals, televisions, books, magazines), car maintenance, toiletries, security deposits, toys, alcoholic beverages, flowers/cards/stationery/stamps, household products, household utilities including cell phone charges, maid/babysitter/day care services.
- Services prior to your organ transplant surgery, such as expenses for evaluation and testing, if not covered by your hospital/medical/surgical coverage
- Experimental transplant procedures

INPATIENT MENTAL HEALTH CARE AND SUBSTANCE ABUSE

Mental health is payable by BCBSM using a traditional network and is not subject to PPO guidelines. All services must be provided in BCBSM-approved hospitals and in approved day- and night-care centers. A mental health treatment admission can include individual and group therapy sessions and family counseling when provided through an approved facility.

Fully licensed psychologists with hospital privileges can be directly reimbursed for the following inpatient services:

- Psychological testing
- Individual psychotherapeutic treatment

- Family counseling for members of a patient's family
- Group psychotherapeutic treatment
- Inpatient consultations when your physician requires assistance of a consulting psychologist in diagnosing or treating your mental health condition

Note: Inpatient mental health care admissions are covered only if they meet Severity of Illness and Intensity of Service criteria. If you are not sure that the criteria will be met, please have your physician call BCBSM's Mental Health Precertification Unit at 1-800-342-5891 for guidance.

(Inpatient) substance abuse treatment

Only licensed facilities may provide substance abuse treatment. We will pay for 28 calendar days of a treatment plan. Any treatment days beyond the 28 days are not covered. You qualify for additional in-patient substance abuse treatment only after a 60-day renewal period. Only two admissions, up to 28 days each per calendar year are covered (no dollar maximum).

In-patient treatment and charges for room, board and miscellaneous fees are covered as follows

- **Residential care facility:** 100 percent of reasonable and customary charges for the standard length of treatment program offered by the facility.
- **Acute care hospital** using acute care beds: 67 percent of semi-private room and board charges and 100 percent of covered miscellaneous fees for the standard length treatment program offered by the facility.

Charges for detoxification are payable at 100 percent of reasonable and customary levels for semi-private room and board and miscellaneous fees.

In the event the patient's physician requires, as part of the treatment plan, that the patient be admitted to an acute care hospital rather than a residential care facility, requests for payment of more than 67 percent will be evaluated on a case-by-case basis.

Note: Inpatient substance abuse treatment admissions are covered only if they meet Severity of Illness and Intensity of Service criteria. If you are not sure that the criteria will be met, please have your physician call BCBSM's Substance Abuse Precertification Unit at 1-800-324-5891 for guidance.

OUTPATIENT (IN-OFFICE) MENTAL HEALTH AND SUBSTANCE CARE

Outpatient psychiatric services are covered when rendered by an MD, DO, fully and limited licensed psychologist, MSW, CSW, LPC and outpatient mental health care facilities. Network guidelines are not applicable. Benefits for services rendered by limited licensed psychologists, MSWs, CSWs and LPCs are limited to psychological therapy sessions with the exception of psychological testing which the LLP may be eligible to perform.

You have a 10 percent copayment for services rendered by participating providers. If you choose to receive services from a nonparticipating provider, you will be financially responsible for the difference between the provider's charges and the BCBSM approved amount.

Outpatient substance abuse treatment

Outpatient substance abuse treatment is payable in the outpatient department of a Blue participating hospital or in an approved freestanding facility.

You have an annual dollar maximum of **\$3,500** for outpatient substance abuse services.

The following mental health services are not payable:

- Services provided by practitioners not designated as eligible providers
- Hypnotherapy
- Guided imagery
- Marital counseling
- Psychodrama
- Sex therapy, including therapy for sexual dysfunction or therapy related in any way to gender identity disorders or intersex surgery
- Art therapy
- Recreation therapy
- Behavior modification, including habitual behaviors such as compulsive gambling
- Counseling for vocational, academic or educational purposes
- Court-ordered psychotherapy, including substance abuse treatment
- Phone consultations or therapeutic phone sessions
- Music therapy

PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY

Benefits are payable when provided in:

- The outpatient department of PPO and participating hospitals
- Participating outpatient physical therapy facilities

In addition, physical therapy services are payable when provided in the physician's office or the office of an independent licensed physical therapist.

Physical, occupational and speech therapy services provided for rehabilitation are payable for up to a **combined** maximum of 60 visits per calendar year. The 60-visit maximum renews each calendar year and is a combined in- and out-of-network benefit maximum for all outpatient locations (hospital-based, freestanding facility or physician's office).

Important: Payment for therapy is based on the diagnosis and the location. Ask your physician or therapist to call BCBSM to verify if the prescribed therapy will be rendered in a payable location before receiving physical therapy treatment.

Your therapy **must**:

- Be prescribed by the patient's attending physician
- Require the assistance and supervision of the appropriate licensed therapist
- Be designed to improve or restore the patient's functioning level after a loss in musculoskeletal functioning due to an illness or injury
- Be given for a condition that is capable of significant improvement in a reasonable and generally predictable period of time

Your coverage **does not** pay for:

- Long-standing, chronic conditions such as arthritis
- Health club membership or spa membership
- Developmental conditions or learning disabilities for members over the age of six years
- Congenital or inherited speech abnormalities for members over the age of six years
- Inpatient hospital admissions principally for speech or language therapy
- Massage therapy
- Sensory integration
- Cognitive therapy without any language based therapy

DURABLE MEDICAL EQUIPMENT, PROSTHETIC AND ORTHOTIC AND SUPPLIES THROUGH THE SUPPORT PROGRAM

You have coverage under the SUPPORT Program for medical equipment and supplies. SUPPORT stands for Select Utilization of Providers for Prosthetic, Orthotic and Rehabilitative Technology.

Medical equipment and supplies obtained in Michigan

The program is available only in Michigan and applies to items prescribed by a physician that you purchase or rent from an independent medical supplier for use at home. It does not apply to items you use during a hospital stay or receive from your doctor.

If you use the SUPPORT network, you pay nothing for covered items.

If you are Medicare-eligible, and you use a supplier that participates with ***Medicare and the SUPPORT network***, you will ***pay nothing*** for covered items. However, if you obtain items from a supplier that participates with Medicare, but does not participate with the SUPPORT network, you will be responsible for the entire amount not covered by Medicare.

If you choose not to use the SUPPORT network, you will be responsible for additional out-of-pocket costs. For services provided by a non-network supplier you will be responsible for ***20 percent*** of the approved amount plus the difference between the supplier's charge and the approved amount.

Medical equipment and supplies obtained outside Michigan

The SUPPORT network does not apply beyond Michigan. For medical equipment and supplies elsewhere in the United States, you can minimize your out-of-pocket expenses by using suppliers that participate with the local Blue Cross Blue Shield plan.

If you are Medicare-eligible, and you use a supplier that does not participate with the local Blue Cross Blue Shield plan, you will be required to pay for the prescribed products, then file a claim with Medicare. You will be responsible for the entire amount not covered by Medicare.

If you are Medicare-eligible, and you use a supplier that participates with the local Blue Cross Blue Shield plan, you will be required to pay for the prescribed products, then file a claim with BCBSM. BCBSM will only reimburse you 20 percent of the BCBSM-approved amount.

Covered items through a medical supplier

Types of equipment, supplies and services include:

- Durable medical equipment used in your home, such as hospital beds, wheelchairs, walkers, canes and oxygen equipment

- Medical supplies such as glucometer strips, colostomy supplies, adult disposable diapers, surgical stockings
- Orthotic devices such as leg braces, back braces and ankle or wrist supports
- Prosthetic devices such as artificial limbs and mastectomy supplies
- Respiratory equipment such as oxygen concentrators and apnea monitors

The items you obtain through SUPPORT can be delivered to your home at no charge or you can go to any retail SUPPORT outlet.

Diabetic supplies and medications

Some diabetic supplies are covered under SUPPORT, while others are covered under your prescription drug benefit. Diabetic supplies covered under SUPPORT include:

- Blood-testing strips used with glucometers
- Glucometers to test blood sugar
- Insulin pump and supplies
- Lancets and lancing device used with glucometers

Using the SUPPORT network

The SUPPORT network is composed of independent suppliers coordinated by Wright & Filippis in alliance with BCBSM. For help finding a SUPPORT provider, call the SUPPORT program at 1-800-321-8074. They will give you the name, address and phone number of a SUPPORT provider in your area. They will also answer any questions you may have about the SUPPORT program.

Medical equipment and supplies from doctors' offices and hospitals

If you obtain medical equipment and supplies from a physician's office or hospital, keep in mind that these benefits are then covered under your medical or inpatient hospital benefits by BCBSM, not the SUPPORT Program, and are subject to different cost-sharing requirements for those benefits.

In addition to applicable exclusions and limitations listed elsewhere in this booklet, SUPPORT Program coverage is subject to the following:

- Items primarily for your comfort or convenience are not covered
- Items such as air purifiers, air conditioners and exercise equipment are not covered
- Many individual DME services have quantity restrictions or limitations, depending on the service provided.
- DME that is not reasonable and necessary in the care or treatment of illness or injury is not covered. Some of these items include safety equipment, exercise equipment or home (or vehicle) modifications such as lifts, elevators and ramps.

Wigs

Members have a **lifetime maximum of \$300** for wigs, wig stands and supplies, such as adhesives. This benefit is for those who need wigs because of cancer or alopecia. Additional replacements for children due to growth are available.

The SUPPORT network does not apply to wig purchases. Wigs may be purchased at any supplier, and should be submitted to the SUPPORT program for claim processing at: P.O. Box 82060, Rochester, MI 48308-2060.

PHYSICIAN BENEFITS

Your coverage provides the following physician benefits.

Medical Necessity

Medical necessity for **physician services** is determined by physicians acting for their respective provider types and/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 members or physicians.
- The covered service is reasonably expected to improve the patient's condition or level of functioning. In the case of diagnostic testing, the results are used in the diagnosis and management of the patient's care.
- In the absence of established criteria, medical necessity will be determined by physician or professional review according to generally accepted standards and practices.
- The Blue Cross Blue Shield of Michigan determination of medical necessity for **payment** purposes is based on standards of practice established by physicians.

Preventive Services

Your coverage pays for the preventive services listed below when you go to network providers. You have no out-of-pocket cost when you receive these services from network providers. Preventive care services received out-of-network or from nonparticipating providers are not covered.

The annual dollar maximum for preventive services is **\$750** per member.

- **Annual gynecological exam** — One per calendar year
- **Fecal occult blood screening***— Beginning at age 50, one per calendar year

- **Flexible sigmoidoscopy exam*** — Beginning at age 50, one every five years
- **Health maintenance exam** — One per calendar year. Includes a comprehensive history and physical exam. It also includes the following laboratory and radiology procedures when performed as a routine screening:
 - Chemical profile
 - Complete blood count
 - Urinalysis
 - Chest X-ray
 - EKG
- **Hepatitis C screenings** — One per calendar year. Covered for those at risk
- **Immunizations** — Includes annual flu shots, age 17 and older
- **Pap smears** — Laboratory services only for one routine Pap smear per calendar year
- **Prostate Specific Antigen screening*** — One per calendar year
- **Well-baby and child care** — Number of visits as follows:
 - Six visits per year through age 1
 - Two visits per year, age 2 through 3
 - One visit per year, age 4 through 15

Note: Well child visits are based on the date of birth.

If you are Medicare-eligible, please note that preventive exams, well baby care, child care, immunizations, Hepatitis C screening and annual routine Pap smear are not covered by Medicare. Therefore, make sure you go to a BCBSM participating provider.

Preventive care services — other

The following preventive care services are **not** subject to the \$750 preventive care maximum.

You will be responsible for additional out-of-pocket cost when you receive services from an out-of-network provider unless otherwise specified.

* American Cancer Society guidelines apply.

These services are covered based on the guidelines below.

- **Childhood immunizations** – Includes flu shots through age 16
- **Mammography screening** – Includes one screening per member per calendar year, regardless of age. (Digital mammography is covered and paid at the same rate as standard film mammography.)
- **Colonoscopy*** – Beginning at age 50:
 - One colonoscopy every 10 years
 - Double contrast barium enema every 5 - 10 years, or if family history dictates more often
 - Digital rectal exam (at the time of each colorectal screening)

If you are Medicare-eligible, please note that childhood immunizations are not covered by Medicare. Therefore, make sure you go to a BCBSM participating provider for this service.

Prescribed Contraceptive Devices

Your benefits include coverage for physician-prescribed contraceptive devices, such as diaphragms, intrauterine devices or contraceptive implants designed to prevent pregnancy. Contraceptive devices are subject to your plan's in- and out-of-network deductible, and your out-of-network copayment.

Contraceptive Injections

Administration of injectable contraceptive medications, as well as the cost of the medication, is payable under your medical-surgical coverage when provided by your physician. Contraceptive medication you obtain from a pharmacy is not covered under your medical-surgical coverage. When your physician injects contraceptive medication you purchased from a pharmacy, only the administration is payable under your medical-surgical coverage.

Office Visits

The exam, diagnosis and treatment of illness or injury by a physician is payable when you are seen in the physician's office, outpatient clinic or outpatient department of a hospital. Injections are covered with an eligible diagnosis.

You are responsible for a **\$10** fee for office visits, office consultations, osteopathic manipulations, and urgent care visits rendered by a network provider. **You are responsible for the deductible when you receive these services in an outpatient clinic or outpatient department of a hospital.** You will be responsible for additional out-of-pocket costs when you receive services from an out-of-network provider unless otherwise specified.

* American Cancer Society guidelines apply.

Allergy Services

The State Health Plan PPO pays for allergy testing, survey testing and therapeutic injections when performed by or under the supervision of a physician. Benefits are not payable for fungal or bacteria skin tests, such as those given for tuberculosis or diphtheria, self-administered or over-the-counter medications, psychological testing, evaluation or therapy for allergies, or environmental studies.

Chiropractic Services

Chiropractic services are covered when performed by a licensed chiropractic provider. You are responsible for the annual in-network deductible and a 10 percent copayment for services rendered by a PPO provider. You will additional out-of-pocket costs for services rendered by a non-participating provider.

Your benefits include the following chiropractic services:

- **New patient office visits** – one every 36 months. A new patient is one who has not been seen by the same provider in 36 months.
- **Office visits** – one per member every calendar year for established patients.
- **Chiropractic traction** – number of payable visits is determined by your physical therapy benefit.
- **Chiropractic manipulation** – limited to one per day, up to a maximum of 24 medically necessary visits each calendar year.

Maternity Care

Your benefits include delivery and pre-and post-natal services. The initial inpatient exam of the newborn is a benefit when performed by a physician other than the anesthesiologist or the delivering physician.

Note: Maternity care benefits also are payable when provided by a certified nurse midwife approved by BCBSM. Delivery must be in a hospital or BCBSM-approved birthing center.

Surgical Services

Surgical benefits include the physician's surgical fee, medical care given by the surgeon before and after surgery while the patient is in the hospital, and visits to the attending physician for the usual care before and after surgery. Surgery is covered inpatient and outpatient, in the physician's office and in **approved** ambulatory surgical facilities.

- **Multiple surgeries** performed on the same day and by the same physician are paid according to national standards recognized by BCBSM. You may have additional out-of-pocket costs for similar surgeries performed on the same day.

Reminder: PPO and Blues participating providers accept our approved amount as payment in full. However, nonparticipating providers may bill you for the difference.

- **Cosmetic or reconstructive surgery** is covered only for the correction of birth defects, for conditions resulting from accidental injuries or traumatic scars, and for correction of deformities resulting from certain surgeries, such as breast reconstruction following a mastectomy.
- **Breast reconstruction surgery** is covered for:
 - Reconstruction of the breast on which the mastectomy was performed
 - Surgery and reconstruction of the other breast to produce a symmetrical appearance
 - Prosthesis and treatment of physical complications at all stages of the mastectomy, including lymphedemas
- **Cataract surgery and first lens implants** are covered.
- **Dental surgery** performed on an inpatient basis is covered only for the removal of impacted teeth or multiple extractions. The patient must be hospitalized for the surgery because a concurrent medical condition, diagnosed by a physician, exists. The inpatient admission for the dental surgery must be considered medically necessary to safeguard the life of the patient.

Benefits are limited to services performed by an MD or DO, including anesthesia services, and services billed by the facility.

Dental procedures performed by a DDS must be billed to the dental program.

- Voluntary sterilization for both male and female patients is covered regardless of medical necessity. Reverse sterilization is not covered.

Your surgical services also include:

- **Technical surgical assistance (TSA)** – TSA is a covered benefit for certain major surgeries that require surgical assistance by another physician. TSA is covered inpatient and outpatient and in an approved ambulatory surgery facility.
- **Anesthesia** – Services for giving anesthesia are payable to a physician other than the operating or assisting physician, and to a certified registered nurse anesthetist. We do not pay for local anesthesia.

Temporomandibular Joint Syndrome (TMJ) or Jaw-Joint Disorder

Benefits for TMJ or jaw-joint disorder are limited to surgery directly to the jaw joint, X-rays (including MRIs) and arthrocentesis (injection procedures). Other than the exceptions noted, benefits are not payable for reversible or irreversible medical or dental treatment of the mouth, teeth, jaw, jaw joint, skull and the muscles/nerves/tissue related to the jaw joint.

These exclusions include (but are not limited to): crowns, inlays, caps restorations, grindings, orthodontics, dentures, partial dentures or bridges.

If you are not sure that your prescribed treatment will be covered, ask your physician to contact BCBSM for approval before treatment begins.

Note: Irreversible treatment of the mouth, teeth, or jaw is intended to bring about permanent change to a person's bite or position of the jaws. It includes but is not limited to dentures, bridges, crowns, caps, inlays, restorations, grinding and orthodontics.

Reversible treatment of the mouth and jaw is not intended to result in permanent alteration of the bite or position of the jaws; it is directed at managing the patient's symptoms.

Inpatient Medical Care

Medical supervision by a physician is payable while you are in the hospital or in a skilled nursing care facility.

Hospital and Office Consultations

Medical consultations are payable when your physician requires assistance in diagnosing or treating a condition or because special skill or knowledge of the consulting physician is required.

You are responsible for the annual in-network deductible for services received in a hospital setting rendered by a network provider. For services rendered in an office setting by a PPO network provider you are responsible for a copayment of **\$10** and for services rendered by a BCBSM participating provider you are responsible for a **10 percent** copayment after you have satisfied your out-of-network deductible. You will have additional out-of-pocket cost for services rendered by a non-participating provider.

Diagnostic and Radiation Services

Physician services are payable to diagnose disease, illness, pregnancy or injury through:

- **Diagnostic radiology** – X-rays, ultrasound, radioactive isotopes, and Resonance MRI, PET and CAT scans of the head and body when performed for an eligible diagnosis.
- **Laboratory and pathology tests**
- **Diagnostic tests** – EKGs, EMGs, EEGs, thyroid function tests, nerve conduction and pulmonary function studies.
- **Radiation therapy** – Radiological treatment by X-ray, isotopes or cobalt for a malignancy.
- **Mammography (diagnostic)** – Is considered medically necessary when an abnormality or clinical finding suggest further evaluation or treatment might be necessary.
- **Colonoscopy** (diagnostic)** – Is considered medically necessary when an abnormality or clinical finding suggest further evaluation or treatment might be necessary.

Note: Complex radiology such as CAT, MRI and PET scans must be performed in BCBSM-designated facilities. You or your physician may call BCBSM for a list of designated facilities.

Other Covered Services

Your coverage includes the following services.

Durable Medical Equipment (DME), Prosthetic & Orthotic (P&O) and medical supplies

(If use is for the home, see information on the SUPPORT Program.)

Benefits include rental or purchase (whichever is less expensive) and repair of durable medical equipment when prescribed by a physician. The prescription must include a description of the equipment and a diagnosis. For rental equipment, a new prescription must be written when the current prescription expires.

Important: We do not pay for exercise and hygienic equipment, for comfort and convenience items, for self-help devices, such as elevators, for deluxe equipment, such as motorized wheelchairs unless medically necessary and required so the patient can operate the equipment themselves, and for experimental or investigational equipment.

If the service is rendered in a physician's office, you are responsible for the copayments and deductibles.

Private Duty Nursing

Nursing services are covered in your home when medically necessary. You are responsible for **10 percent** of the BCBSM-approved amount after deductible. Services must be prescribed by a physician and provided by a registered or licensed practical nurse who is not related to or living with the patient. The attending physician must complete a Certification Statement each month stating that the patient is required to have private duty nursing care. BCBSM's medical policy criteria for private duty nursing also applies.

Professional Ambulance Services

Ambulance services are covered to transport a patient if the destination is the nearest medical facility capable of treating the patient's condition. The service must be medically necessary, prescribed by a physician (when used for transferring a patient) and provided in a vehicle qualified as an ambulance and part of a licensed ambulance operation.

Air or water ambulance is covered when no other means of transport is available or the patient's condition requires air or **water** transport rather than ground ambulance. For air ambulance, the provider must be licensed as an air ambulance service and is not a commercial air carrier.

Your coverage **does not** pay for:

- Transportation for the convenience of the patient or the patient's family, or for the preference of the physician
- Ambulance services provided by a fire department, rescue squad or other carrier whose fee is a voluntary donation

What's Not Covered

Your State Health Plan PPO coverage **does not** cover:

- Pre-marital or pre-employment exams
- Care and services available at no cost to you in a veterans, marine or other federal hospital or any hospital maintained by any state or governmental agency
- Medically necessary services received on an inpatient basis that can be provided safely in an outpatient or office setting
- Custodial care, rest therapy and care in nursing or rest home facilities
- 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
- Treatment of temporomandibular joint syndrome (TMJ) and related jaw-joint problems by any method other than as specified in this benefit book
- Medical services or supplies provided or furnished while coverage is not in effect (that is before the effective date of coverage or after the coverage termination date)
- Health care services provided by persons who are not legally qualified or licensed to provide such services
- Routine hospital outpatient care requiring repeated visits for the treatment of chronic conditions
- Hospitalization principally for observation, diagnostic evaluation, physical therapy, X-ray or lab tests, reduction of weight by diet control (with or without medication) or basal metabolism tests
- Items for the personal comfort or convenience of the patient
- Services and supplies that are not medically necessary according to accepted standards of medical practice
- Services provided through a medical clinic or similar facility provided or maintained by an employer
- Treatment of occupational injury or disease that the employer is obligated to furnish or otherwise fund
- Care and services received under another certificate offered by Blue Cross Blue Shield of Michigan or another Blue Cross Blue Shield plan
- Care and services payable by government-sponsored health care programs, such as Medicare or TRICARE, for which the member is eligible. These services are not payable even if you have not signed up to receive the benefits provided by such programs.
- Cosmetic surgery and related services solely for improving appearances, except as specified in this booklet

- Treatment of a condition caused by military action or war, declared or undeclared
- Services, care, devices or supplies considered experimental or investigational
- Services for which a charge is not customarily made; services for which the patient is not obligated to pay or services without cost
- Services rendered for gender assignment
- Tests other than those identified in the benefit section that are not required in, and related to the diagnosis of an illness or injury
- Dialysis services after 33 months of ESRD treatment
- Services that are not included in your plan coverage documents
- Transportation and travel except as specified in this booklet
- Services covered under any other Blue Cross or Blue Shield contract or under any other health care benefits plan
- Screening services, unless otherwise stated, excluding mammograms
- Deductibles or copayments paid by the member under any other certificate
- Physical therapy services, except for traction, performed by a chiropractor
- Services, care, supplies or devices not prescribed by a physician
- Services provided during non-emergency medical transport
- Reverse sterilization

HEARING CARE BENEFITS

Your hearing care coverage is designed to identify hearing problems and provide benefits for corrective hearing devices.

If you are Medicare-eligible, please note that hearing exams and hearing aid devices are not covered by Medicare. Therefore, make sure you go to a BCBSM participating provider for these services.

Choosing your hearing provider

When you need hearing care, it is important to find out whether your provider participates with BCBSM; hearing benefits are covered only when you receive services from a participating provider.

The types of eligible hearing providers include:

- Audiologists
- Otologists
- Otolaryngologists
- Hearing aid dealers

To locate a Blues participating hearing care provider in Michigan, call the ***State of Michigan Customer Service Center at 1-800-843-4876***.

Out-of-state providers who participate with their local Blues Plans are paid the BCBSM-local Plan's approved amount. Out-of-state providers who do not participate with their local Blues Plans are paid the BCBSM-approved amount.

Covered hearing services

1. ***Audiometric examination*** — Measures hearing ability, including tests for air and bone conduction, speech reception and speech discrimination
2. ***Conformity test*** – Evaluates the performance of a hearing aid and its conformity to the original prescription after it has been fitted
3. ***Hearing aid evaluation*** — Determines what type of hearing aid should be prescribed to compensate for loss of hearing
4. ***Ordering and fitting of the hearing aid*** — Includes in-the-ear, behind-the-ear, and basic hearing aids worn on the body, with ear molds, if necessary, as well as dispensing fees for the normal services required for fitting the hearing aid

Note: A medical evaluation is required with the purchase of each hearing aid for children under the age of 18. A medical evaluation is required once, lifetime, for adults. Medical evaluations are covered benefits under your medical coverage, not your hearing coverage.

Time limitation

Hearing care benefits are payable once every 36 months unless significant hearing loss occurs earlier and is certified by your physician. Tests to determine if there is significant hearing loss are also covered.

What is not covered under your hearing care benefit

Your hearing care coverage **does not** cover:

- A hearing aid ordered while the patient is a member, but delivered more than 60 days after the patient's coverage terminates
- Additional charges for digital-controlled programmable hearing devices (sometimes called "deluxe" hearing aids) that exceed the amount BCBSM pays for a basic hearing aid
- Additional charges for eye-glass type hearing aids (sometimes called "deluxe" hearing aids) that exceed the amount BCBSM pays for a basic hearing aid
- Additional charges for unusual or cosmetic equipment such as canal, one-half shell or low profile hearing aids (sometimes called "deluxe" hearing aids) that exceed the amount BCBSM pays for a basic hearing aid
- Hearing aids that do not meet Food and Drug Administration and Federal Trade Commission requirements
- Repairs and replacement of parts including batteries and ear molds
- Replacement of hearing aids that are lost or broken, unless this occurs after 36 months, when benefits are renewed
- Your medical evaluation examination to determine possible loss of hearing
- Hearing care services and supplies provided by a nonparticipating provider in Michigan

SECTION 7: MEDICARE COVERAGE FOR ELIGIBLE MEMBERS

Medicare is a federal health care program that provides you with health care benefits if you are age 65 or older, or have End Stage Renal Disease (ESRD) or certain disabilities. When enrolled in Medicare, you are called a “beneficiary.” You must apply for Medicare through your local Social Security Administration office. ***The Social Security Administration is the sole authority for determining your Medicare eligibility.***

Medicare coverage has two parts:

- ***Hospital insurance (Part A)*** – helps pay your inpatient hospital care and certain follow-up care after you leave the hospital. It is provided at no cost to you.
- ***Medical insurance (Part B)*** – helps pay for physicians’ services, medical services and other medically necessary services and supplies. You must pay a monthly premium, which is adjusted annually. You are notified of new premium rates before each new-year.

Medicare eligibility and enrollment

Generally, you become eligible for Medicare coverage at age 65. Once enrolled in Medicare, your PPO coverage automatically becomes secondary to Medicare coverage. This means that Medicare is your primary carrier and BCBSM is your supplemental or secondary carrier.

When you enroll in the Medicare Plan, it is equally important to enroll in both parts A and B at the same time. Part A covers hospital services and Part B covers professional provider services. In fact, failure or delayed enrollment results in increases in Medicare Part B premiums as much as ten percent for each year you postpone enrollment when you are eligible.

If you do not enroll in Medicare Part B, your State Health Plan PPO coverage will be adjusted as if Medicare coverage were in place. The State Health Plan PPO will not reimburse that portion of expenses normally covered by Medicare. This may result in limited or no payment, or retroactive adjustments to claims.

Members with ESRD

If you or a dependent are disabled or diagnosed with end stage renal disease (ESRD), you may be entitled to Medicare benefits sooner than age 65. When you are approved for Medicare disability benefits, you must notify BCBSM. Your coverage will be converted to Medicare supplemental after the coordination period of 33 months.

It is important to accept both Part A and Part B coverage. If you are eligible for Medicare disability coverage and decline or delay enrollment in Part B, the health plan will only pay the remaining portion of your health services, had Medicare Part B been in place. You will have responsibility for the difference between the BCBSM payment and the provider’s charge.

For more information about Medicare, contact your local Social Security Administration office.

HOW YOUR SUPPLEMENTAL PPO COVERAGE WORKS

Your BCBSM Supplemental coverage is designed to ensure you receive the same level of health care coverage for those members with State Health Plan PPO. Your supplemental Plan also pays the Medicare annual deductible and Medicare coinsurance amounts for services covered under the State Health Plan PPO. You pay the deductible and copayments required by the State Health Plan PPO as well as services not covered by the State Health Plan PPO.

All benefits covered and paid by BCBSM, either as the primary or secondary carrier, are subject to the benefit limitations, dollar maximums and in-network deductible and copayment requirements outlined in this booklet.

SECTION 8: TO FILE A CLAIM

When you use your benefits, a claim must be filed before payment can be made. PPO and Blues participating providers should automatically file all claims for you. All you need to do is show your ID card. However, nonparticipating providers 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
 - Subscriber's name and contract number (from your ID card)
 - Provider's name, address, phone number, and federal tax ID number
 - Date and description of services
 - Diagnosis (nature of illness or injury)
 - Admission and discharge dates for hospitalization

Important: If you receive medical services out of the country, try to get all receipts itemized in English. Cash register receipts, canceled checks, or money order stubs may accompany your itemized statement, but may not substitute for an itemized statement.

2. Make a copy of all items for your files and send the original to us at the address listed in Section 1. It is important that you file claims promptly because most services have a two-year filing limitation.

Important: You will receive payment directly from us. The check will be in the subscriber's name, not the patient's name.

The example below shows the information we require in order to review your claim:

PHYSICIAN RECEIPT		
George S. Smith, M.D. 100 Market Street Hometown, State		
For professional services to: John Doe		
Date of Service	Charge	Diagnosis/Service
5-31-90	\$25.00	Anemia/Office Visit
6-11-90	\$15.00	Sprained Ankle/X-Ray, Ankle
5-22-90	\$ 8.00	Anemia/Complete Blood Count
6-5-90		
6-3-90	\$15.00	Sprained Ankle/X-Ray, Ankle
	\$ 8.00	Anemia/Complete Blood Count

**Include tax identification number for out-of-state physician.*

EXPLANATION OF BENEFIT PAYMENTS (EOBP)

After we process claims for services you receive, we send you an Explanation of Benefit Payments (EOBP). The EOBP is not a bill. It is a statement that helps you understand how your benefits were paid. At the top of the EOBP you'll find Blue Cross Blue Shield Customer Service numbers and an address to use for inquiries. Briefly the EOBP tells you:

- The family members who received services.
- The date services were provided ("claims processed from...to...").
- "Summary of Balances" includes the provider(s) of the services, detail about charges and payments, including the amount saved by using network providers.
- "Summary of Deductibles and Copayments" provides your deductible and copayment requirements as well as deductibles and copayments paid to date.
- "Helpful Information" includes messages and reminders.
- "Detail on Services" summarizes the BCBSM payment and shows your balance.

If you see an error, contact your provider first. If they cannot correct the error, call the Customer Service number on your EOBP.



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

EXPLANATION OF BENEFITS PAYMENTS

THIS IS NOT A BILL

Statement Date: 02/19/05

81816-100

Smith, John
123 Elm Lane
E Lansing
MI 48823

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
STATE OF MICHIGAN
P.O. BOX 80380
LANSING, MI 48908-0380

Group Name: STATE OF MICHIGAN
Group Number: 81816-100
Subscriber Name: SMITH, JOHN
Contract Number: 123454321
HOSPITAL/PHYSICIAN
Patient Name or Initial: SUSAN
Patient Birth Month/Year: 09/61

See your Benefits Guide for details on your 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 amounts in the 'Equals Your Balance' column includes any copayments, deductibles, sanctions, and non-covered charges.

Summary of Deductibles and Copayments

(These totals are based on our information to date and may not reflect all outstanding claims.)

Totals for: FAMILY		Totals for: SUSAN	
Deductible required for year:	\$400.00	Deductible required for year:	\$200.00
Deductible applied year to date:	\$400.00	Deductible applied year to date:	\$200.00
The family deductible requirement has been met.		The patient deductible requirement has been met.	
Copayment required for year:	\$4000.00	Copayment required for year:	\$2000.00
Copayment applied year to date:	\$396.68	Copayment applied year to date:	\$196.68

The family copayment requirement has not been met.

The patient copayment requirement has not been met.

Helpful Information

Generic prescription drugs are as safe and effective as their brand-name equivalents but can cost from 30 to 75 percent less. Generic drugs are approved by the Federal Food and Drug Administration because they meet the same standards for purity, strength and quality as brand-name drugs. The FDA requires a generic drug to have exactly the same active ingredients, be absorbed into the body at the same rate and manner, and produce the same results as a brand-name drug. Talk with your doctor to see if generic drugs are right for you. For more information, go to www.theunadvertisedbrand.com.

Details on Services	Contract Number:	123454321	Patient:	SUSAN
Service Date (From/To):	2/4/2005	Total Charge		\$184.00
Claim Received On:	2/7/2005	Amount approved by BCBSM for this service		\$66.82
Provider Name:	DOE B MD	Minus copayment		-6.68
Provider Status:	PARTICIPATING	BCBSM processed on 7/3/04 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			
Procedure Code:	11300	Your Balance (Highlighted Amount)		\$ 6.68
Claim Number:	41608712345			

COORDINATION OF BENEFITS

Coordination of Benefits (COB) is how health care carriers coordinate benefits when you are covered by more than one group health care plan. Under COB, carriers work together to make sure you receive the maximum benefits available under your health care plans. Your Blue Cross Blue Shield health care plan requires that your benefit payments be coordinated with those from another group plan for services that may be payable under both plans.

COB ensures that the level of payment, when added to the benefits payable under another group plan, will cover up to 100 percent of the eligible expenses as determined between the carriers. In other words, COB can reduce or eliminate out-of-pocket expenses for you and your family. COB also makes sure that the combined payments of all coverage will not exceed the approved cost for care.

HOW COB WORKS

If you are covered by more than one group plan, COB guidelines (explained below) determine which carrier pays for covered services first.

Your primary plan is the carrier that is responsible for paying first. This plan must provide you with the maximum benefits available to you under that plan.

Your secondary plan is the carrier that is responsible for paying after your primary plan has processed the claim. The secondary plan provides payments toward the remaining balance of covered services – up to the total allowable amount determined by the carriers.

Guidelines to Determine Primary and Secondary Plans

Contract Holder Versus Dependent Coverage – The plan that covers the patient as the employee (subscriber or contract holder) is primary and pays before a plan that covers the patient as a dependent.

Contract Holder (Multiple Contracts) – If you are the contract holder of more than one health care plan, your primary plan is the one of which you are an active member (such as an employee), and your secondary plan is the one of which you are an inactive member (such as a retiree).

Dependents (The “Birthday Rule”) – If a child is covered under both their mother’s and father’s plan, the plan of the parent (or legal guardian) whose birthday is earlier in the year is primary.

Children of Divorced or Separated Parents – For children of divorced or separated spouses, benefits are determined in the following order unless a court order places financial responsibility on one parent:

1. Plan of the custodial parent
2. Plan of the custodial parent's new spouse (if remarried)
3. Plan of non-custodial parent
4. Plan of non-custodial parent's new spouse

If the primary plan cannot be determined by using the guidelines above, then the "birthday rule" will be used to determine primary liability.

Filing COB Claims

Remember to ask your health care provider to submit claims to your primary carrier first. If a balance remains after the primary carrier has paid the claim, you or the provider can then submit the claim along with the primary carrier's payment statement to the secondary carrier. When you submit claims to Blue Cross Blue Shield of Michigan for reimbursement of the balance, please follow these steps:

1. Obtain an Explanation of Benefits (EOB) or payment statement from the primary carrier.
2. Ask your provider for an itemized receipt or a detailed description of the services, including charges for each service.
3. If you made any payments for the service, provide a copy of the receipt (not the original) you received from the provider.
4. Make sure the provider's name and complete address are on your receipts. If the provider is in Michigan, include the provider's Blue Cross Blue Shield of Michigan identification number (PIN). If the provider is located out of Michigan, include the provider's tax ID number.
5. Send these items to:

Blue Cross Blue Shield of Michigan

600 East Lafayette

Detroit, MI 48226-2998

Attn: COB Department, mail code B570

Please make copies of all forms and receipts for your own files, because Blue Cross Blue Shield cannot return the originals to you.

Updating COB Information – Your Responsibility

It is important to keep your COB records updated. If there are any changes in coverage information for you or your dependents, notify your employer immediately. We may periodically ask you to update your COB information. Please help Blue Cross Blue Shield serve you better by responding to requests for COB information quickly.

SUBROGATION

In certain cases, another person, insurance carrier or organization may be legally obligated to pay for health care services that BCBSM has paid. When this happens:

- Your right to recover payment from them is transferred to BCBSM.
- You are required to do whatever is necessary to help BCBSM enforce their right of recovery.
- If you receive payment 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 coverage you purchased in your name from another insurance company.

YOUR RIGHT TO FILE A GRIEVANCE

Most questions or concerns about how we processed your claim or request for benefits can be resolved through a phone call to one of our Customer Service Representatives. However, Michigan Public Act 350, as amended by Public Act 516 of 1996 and Public Act 250 of 2000, protects you by providing a grievance procedure, including a managerial-level conference, if you believe that we have violated Section 402 or 403 of Public Act 350. You will find the specific provisions of those two parts of the act at the end of this section.

A. Standard Grievance Procedure

Under the standard grievance procedure, we must provide you with our final written determination within 35 calendar days of our receipt of your written grievance. However, that timeframe may be suspended for any amount of time that you are permitted to take to file your grievance, and for a period of up to 10 days if we have not received information we have requested from a health care provider, for example your doctor or hospital. The standard grievance procedure is as follows:

- 1.** You or your authorized representative must send us a written statement explaining why you disagree with our determination on your request for benefits or payment.

Mail your written grievance to the address found in the top right hand corner of the first page of your Explanation of Benefits statement, or to the address contained in the letter we send you to notify you that we have not approved a benefit or service you are requesting.

We will respond to your grievance in writing. If you agree with our response, it becomes our final determination and the grievance ends.

- 2.** If you disagree with our response to your grievance, you may then request a managerial-level conference. You must request the conference in writing.

Mail your request to:

Conference Coordination Unit

Blue Cross Blue Shield of Michigan
P.O. Box 2459
Detroit, MI 48231-2459

You can ask that the conference be conducted in person or over the telephone. If in person, the conference can be held at our headquarters in Detroit or at a local customer service center. Our written proposed resolution will be our final determination regarding your grievance.

In addition to the information found above, you should also know:

- a. You may authorize in writing another person, including, but not limited to, a physician, to act on your behalf at any stage in the standard grievance procedure.
- b. Although we have 35 days within which to give you our final determination, you have the right to allow us additional time if you wish.
- c. You may obtain copies of information relating to our denial, reduction, or termination of coverage for a health care service for a reasonable copying charge.

B. Expedited Grievance Procedure

If a physician substantiates orally or in writing that adhering to the timeframe for the standard internal grievance would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, you may file a request for an expedited internal grievance. ***You may file a request for an expedited grievance only when you think that we have wrongfully denied, terminated, or reduced coverage for a health care service prior to your having received that health care service or if you believe we have failed to respond timely to a request for benefits or payment.***

The procedure is as follows:

You may submit your expedited grievance request by telephone. The required physician's substantiation that your condition qualifies for an expedited grievance can also be submitted by telephone.

Call: (313) 225-6800

We must provide you with our decision within ***72 hours*** of receiving both your grievance and the physician's substantiation.

In addition to the information found above, you should also know:

- a. You may authorize in writing another person, including, but not limited to, a physician, to act on your behalf at any stage in the expedited grievance procedure.
- b. If our decision is communicated to you orally, we must provide you with written confirmation within 2 business days.

SECTIONS 402 AND 403 OF PUBLIC ACT 350

What We May Not Do

The sections below provide the exact language in the law.

Section 402(1) provides that we may not do any of the following:

- Misrepresent pertinent facts or certificate provisions relating to coverage
- Fail to acknowledge promptly or to act reasonably and promptly upon communications with respect to a claim arising under a certificate.
- Fail to adopt and implement reasonable standards for the prompt investigation of a claim arising under a certificate.
- Refuse to pay claims without conducting a reasonable investigation based upon the available information.
- Fail to affirm or deny coverage of a claim within a reasonable time after a claim has been received.
- Fail to attempt in good faith to make a prompt, fair and equitable settlement of a claim for which liability has become reasonably clear.
- Compel members to institute litigation to recover amounts due under a certificate by offering substantially less than the amounts due.
- Attempt to settle a claim for less than the amount which a reasonable person would believe was due under a certificate, by making reference to written or printed advertising material accompanying or made part of an application for coverage.
- Make known to the member a policy of appealing from administrative hearing decisions in favor of members for the purpose of compelling a member to accept a settlement or compromise in a claim.
- Attempt to settle a claim on the basis of an application which was altered without notice to, knowledge or consent of, the subscriber under whose certificate the claim is being made.
- Delay the investigation or payment of a claim by requiring a member, or the provider of health care services to the member, to submit a preliminary claim and then requiring subsequent submission of a formal claim, seeking solely the duplication of a verification.
- Fail to promptly provide a reasonable explanation of the basis for a denial of a claim or for the offer of a compromise settlement.
- Fail to promptly settle a claim where liability has become reasonably clear under one portion of the certificate in order to influence a settlement under another portion of the certificate.

Section 402(2) provides that there are certain things that we cannot do in order to induce you to contract with us for the provision of health care benefits, or to induce you to lapse, forfeit or surrender a certificate issued by us or to induce you to secure or terminate coverage with another insurer, health maintenance organization or other person.

The things we cannot do under this section are:

- Issue or deliver to a person money or other valuable consideration.
- Offer to make or make an agreement relating to a certificate other than as plainly expressed in the certificate.
- Offer to give or pay, directly or indirectly, a rebate or part of a premium, or an advantage with respect to the furnishing of health care benefits or administrative or other services offered by the corporation except as reflected in the rate and expressly provided in the certificate.
- Make, issue or circulate, or cause to be made, issued or circulated, any estimate, illustration, circular or statement misrepresenting the terms of a certificate or contract for administrative or other services, the benefits thereunder, or the true nature thereof.
- Make a misrepresentation or incomplete comparison, whether oral or written, between certificates of the corporation or between certificates or contracts of the corporation and another health care corporation, health maintenance organization or other person.

What We Must Do

Section 403 provides that we **must**, on a timely basis, pay to you or a participating provider benefits as are entitled and provided under the applicable certificate. When not paid on a timely basis, benefits payable to you **will** bear simple interest from a date 60 days after we have received a satisfactory claim form at a rate of 12 percent interest per year. The interest **will** be paid in addition to the claim at the time of payment of the claim.

We **must** specify in writing the materials which constitute a satisfactory claim form no later than 30 days after receipt of a claim, unless the claim is settled within 30 days. If a claim form is not supplied as to the entire claim, the amount supported by the claim form **will** be considered to be paid on a timely basis if paid within 60 days after we receive the claim form.

SECTION 9: GLOSSARY – TERMS YOU SHOULD KNOW

Accidental Injury – 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 and medication overdosing; and inhaling smoke, carbon monoxide, or fumes.

Acute Care Facility – 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, rest care or care of the aged
- Skilled nursing care or nursing home care
- Substance abuse treatment

Allogeneic (Allogenic) Transplant – A procedure using another person’s bone marrow or peripheral blood stem cells to transplant into the patient (including syngeneic transplants when the donor is the identical twin of the patient).

Ambulatory Surgery Facility – A separate outpatient facility that is not part of a hospital, where surgery is performed and care related to the surgery is given. The procedures performed in this facility can be performed safely without overnight inpatient hospital care.

Approved Amount – The BCBSM Blue Shield of Michigan maximum payment level or the provider’s billed charge for the covered service, whichever is lower. Deductibles and copayments are deducted from the approved amount.

For prescription drugs, the approved amount is the lower of the billed charge or the sum of the drug cost plus the dispensing fee (and incentive fee, if applicable) for a covered drug or service. The drug cost and dispensing fee are set according to our contracts with the pharmacy. The approved amount is not reduced by rebates or other credits received directly or indirectly from the drug manufacturer. Copayments that may be required of you are subtracted from the approved amount before we make our payment.

Approved Facility – A hospital or clinic that provides medical and other services, such as substance abuse treatment, rehabilitation, skilled nursing care, or physical therapy. Approved facilities must meet all applicable local and state licensing and certification requirements. Approved facilities must be accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association. These facilities must also meet all applicable local and state licensing and certification requirements and have been approved as a provider by Blue Cross Blue Shield of Michigan.

Approved Hospital – 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 Blue Cross Blue Shield of Michigan or an affiliate of Blue Cross Blue Shield of Michigan.

Autologous Transplant – A procedure using the patient’s own bone marrow or peripheral blood stem cells for transplantation back into the patient.

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

Birth Year – A 12-month period of time beginning with a child’s month and day of birth.

Blue Cross and Blue Shield Association (BCBSA) – 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 (BCBSM) – A non-profit, independent company, one of many individual Plans located throughout the United States 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.

Clinical Trial – A study conducted on a group of patients to determine the effect of a treatment. It generally includes the following phases:

- **Phase I** - a study conducted on a small number of patients to determine what the side effect(s) and appropriate dose of treatment may be for a certain disease or condition.
- **Phase II** - a study conducted on a large number of patients to determine whether the treatment has a positive effect on the disease or condition as compared to the side effects of the treatment.
- **Phase III** - a study on a much larger group of patients to compare the results of a new treatment of a condition to a conventional or standard treatment. Phase III gives an indication as to whether the new treatment leads to better, worse or no change in outcome.

Colony Stimulating Growth Factors – Factors that stimulate the multiplication of very young blood cells.

Contracted Area Hospital – A BCBSM participating or network hospital located in the same area as a noncontracted area hospital.

Coordination of Benefits (COB) – A program that coordinates your health benefits when you have coverage under more than one group health plan.

COBRA – Continuation coverage required by the Consolidated Omnibus Budget Reconciliation Act of 1986.

Copayment – 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.

For prescription drugs, the copayment is the portion of the approved amount that you must pay for a covered drug or service. Your copayment amount is not reduced by any rebate or other credit received directly or indirectly from the drug manufacturer.

Note: A separate copayment is not required for covered disposable needles and syringes when dispensed at the same time as insulin or chemotherapeutic drugs.

Covered Services – Services, treatments or supplies identified as payable in your certificate and riders. Covered services must be medically necessary to be payable, unless otherwise specified.

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

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

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

Designated Cancer Center – A site approved by the National Cancer Institute (NCI) as a comprehensive cancer center, clinical cancer center, consortium cancer center or an affiliate of one of these centers.

Designated Facility – A facility that BCBSM determines to be qualified to perform a specific organ transplant.

Durable Medical Equipment – Equipment that is able to withstand repeated use, is primarily and customarily used to serve a medical purpose, and is not generally useful to a person in the absence of illness or injury. A physician must prescribe this equipment.

Emergency First Aid – The initial exam and treatment of conditions resulting from accidental injury.

End Stage Renal Disease (ESRD) – 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 Investigational – A service, procedure, treatment, device, or supply that has not been scientifically demonstrated to be safe and effective for treatment of the patient's condition. Blue Cross Blue Shield of Michigan makes this determination 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 Blue Shield Association or other local or national bodies

Freestanding Facility – A facility separate from a hospital that provides outpatient services, such as substance abuse treatment, rehabilitation, skilled nursing care, or physical therapy.

Freestanding Outpatient Physical Therapy Facility (OPT) – An independently owned and operated facility, separate from a hospital, that provides outpatient physical therapy services and occupational or functional occupational therapy or speech and language pathology.

Hematopoietic Transplant – A transplant of bone marrow, peripheral blood stem cells or umbilical cord blood.

High-Dose Chemotherapy (HDC) – A procedure that involves giving a patient cell destroying drugs in doses higher than approved by the FDA for therapy.

High Risk Patient – An individual who has an increased risk of mortality or morbidity according to standard criteria recognized by the oncology community.

HLA Genetic Markers – Specific chemical groupings that are part of many body cells, including white blood cells. Called human leukocyte antigens, these chemical groupings are inherited from each parent and are used to detect the constitutional similarity of one person to another. Close (or the degree of) identity is determined by tests using serologic (test tube) methods and/or molecular (DNA fingerprinting) techniques. An HLA identical match occurs when the six clinically important markers of the donor are identical to those of the patient.

Hospital – 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.

Independent Physical Therapist (IPT) – A licensed physical therapist that is not employed by a hospital, physician, or freestanding outpatient physical therapy facility and who maintains an office, separate from a hospital or freestanding outpatient physical therapy facility, with the equipment necessary to adequately provide physician-prescribed physical therapy.

Medical Emergency – A condition that occurs suddenly and unexpectedly. This condition could result in serious bodily harm or threaten life unless treated immediately. This is not a condition caused by accidental injury.

Medical Necessity – Unless stated otherwise, a service must be medically necessary in order to be covered. There are two definitions: one applies to physician services and one applies to hospital services. Reference these sections in this booklet for further information or for a complete description refer to your certificates and riders.

Member – Any person eligible for health care services under your plan. This includes you as the subscriber and any of your eligible dependents listed in Blue Cross Blue Shield of Michigan membership records.

Network Pharmacies – Pharmacies that have been selected for participation and have signed agreements to provide covered drugs through the Preferred Rx network (in Michigan) or MedImpact network (outside Michigan). Network pharmacies have agreed to accept the approved amount as payment in full for covered drugs or services provided to covered members.

Network Providers – Hospitals, physicians and other licensed facilities or health care professionals who have contracted with Blue Cross Blue Shield to provide services to members enrolled in a BCBSM Preferred Provider Organization (PPO) or Point of Service (POS) health care plan. Network providers have agreed to accept our approved amount as payment in full for covered services provided under these plans.

Noncontracted Area Hospital – A BCBSM nonparticipating and non-network hospital located in an area defined by BCBSM.

Non-Network Pharmacies – Pharmacies that are not in the Preferred Rx (in Michigan) or MedImpact (outside Michigan) networks. Non-network pharmacies have not agreed to accept the approved amount as payment in full for covered drugs or services provided to covered members.

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

Occupational Therapy – A rehabilitative service that uses specific activities and methods. The therapist is responsible for involving the patient in specific therapeutic tasks and activities to:

- Develop, improve or restore the performance of necessary neuromusculoskeletal functions affected by an illness or injury, or following surgery
- Help the patient learn to apply the newly restored or improved function to meet the demands of daily living or
- Design and use splints, orthoses (such as universal cuffs and braces) and adaptive devices (such as door openers, bath stools, large handle eating utensils, lap trays and raised toilet seats).

Out-of-Area Hospital – A BCBSM network or participating hospital that is more than 75 miles from a noncontracted area hospital. It is not in the same area as a contracted or noncontracted area hospital.

Out-of-Network Service – Under BCBSM’s PPO plans, an out-of-network service is a service not performed or referred by a PPO network provider. Under BCBSM’s Point of Service (POS) plans, an out-of-network service is a service not performed or authorized by the member’s primary care physician. This may also include services performed by another POS network provider, if authorization was not provided by the member’s primary care physician.

Participating Providers – Providers that have signed agreements with Blue Cross Blue Shield to accept the Blue Cross Blue Shield of Michigan-approved amount for covered services as payment in full.

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

Per Claim – A provider’s acceptance of the Blue Cross Blue Shield-approved amount as payment in full for a specific claim or procedure.

Peripheral Blood Stem Cell Transplant – A procedure where blood stem cells are obtained by pheresis and infused into the patient’s circulation.

Pheresis – Removal of blood from the donor or patient in order to separate and retain specific components of the blood (red cells, white cells, platelets, and stem cells).

Physical Therapy – 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.

Reminder: Physical therapy is not covered when services are principally for the general good and welfare of the patient (e.g., developmental therapy or activities to provide general motivation).

Physician – A medical doctor (MD), doctor of osteopathy (DO), doctor of podiatric medicine (DPM), doctor of dental surgery (DDS) or doctor of medical dentistry (DMD).

Pre-approval – A process that allows you or your provider to know if we will cover proposed services before you receive them. If pre-approval is not obtained before you receive certain services, they will not be covered.

Professional Provider – A medical doctor (MD), doctor of osteopathy (DO), doctor of podiatric medicine (DPM), doctor of dental surgery (DDS), doctor of medical dentistry (DMD) or a fully licensed psychologist.

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

Purging – A process that attempts to remove abnormal cells from a blood or bone marrow sample so that a clean sample with only normal blood producing cells is obtained.

Refractory Patient – An individual who does not achieve clinical disappearance of the disease after standard therapy.

Relapse – When a disease recurs after a period of time following therapy. This period of time is defined by evidence-based literature pertaining to the patient’s condition.

Rider – A legal document that amends a certificate by adding, limiting, or clarifying benefits.

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

Self-Management Training – An interactive, collaborative process involving patients with diabetes, their physicians and certified diabetes instructors. The training provides these members with the knowledge and skills needed to care for themselves on a day-to-day basis, manage diabetic crises and make any lifestyle changes needed to manage the disease successfully.

Skilled Nursing Facility – 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.

Specialty Hospital – A hospital, such as a children’s hospital, a chronic disease hospital, or a psychiatric hospital, that provides care for a specific disease or population group.

Speech Therapy – Active treatment of speech, language or voice impairment due to illness, injury or as a result of surgery.

Stem Cells – Primitive blood cells originating in the marrow but also found in small quantities in the blood. These cells develop into mature blood elements including red cells, white cells and platelets.

Subscriber – The person who signed and submitted the application for Blue Cross Blue Shield of Michigan coverage.

Substance Abuse – Taking alcohol or other drugs in amounts that can:

- Harm a person’s physical, mental, social, and economic well-being
- Cause the person to lose self-control
- Endanger the safety or welfare of others because of the substance’s habitual influence on the person

Syngeneic Transplant – A procedure using bone marrow, peripheral blood stem cells or umbilical cord blood from a patient’s identical twin to transplant into the patient.

T-Cell Depleted Infusion – A procedure in which T-Cells (immunocompetent lymphocytes) are eliminated from peripheral blood stem cells, bone marrow or umbilical cord blood.

Tandem Transplant – A procedure in which the patient is given chemotherapy followed by a blood stem cell (peripheral or umbilical cord blood) transplant or bone marrow transplant, and, if the patient’s cancer has not progressed, a second round of chemotherapy followed by a blood stem cell or bone marrow transplant. The second round of chemotherapy and transplant is usually performed within six months of the first transplant and if not, it must be approved by BCBSM. Tandem transplants are also referred to as dual transplants or sequential transplants. For purposes of transplant benefit coverage, a tandem transplant is considered to be one transplant.

Total Body Irradiation – A procedure that exposes most of the body to ionizing radiation to produce an anti-tumor effect that helps prevent rejection of a bone marrow, peripheral blood stem cell or umbilical cord blood transplant.

We, Us, Our – Used when referring to Blue Cross Blue Shield of Michigan.

You and Your – Used when referring to any person covered under the subscriber’s contract.

NOTES

This booklet is not a contract. It is intended as a brief description of benefits. Every effort has been made to ensure the accuracy of the information within. However, if statements in this description differ from the applicable coverage documents, then the terms and conditions of those documents will prevail.

Blue Cross Blue Shield of Michigan administers the program for your employer. Blue Cross Blue Shield of Michigan does not insure the coverage. Benefits and future changes in benefits are the responsibility of your employer. Information concerning members may be reviewed by your employer and Blue Cross Blue Shield of Michigan.

The coverage is provided pursuant to a contract entered into in the state of Michigan and shall be construed under the jurisdiction and according to the laws of the state of Michigan.

