

State Health Plan PPO Summary of Benefits*

For employees hired or rehired prior to April 1, 2010 [except MSPTA (T01)]

	In-network	Out-of-network
Diagnostic tests and radiation services		
X-rays, ultrasound, MRI and CAT scans	Covered – 100% after deductible	Covered – 90% after deductible
Lab and pathology tests		
Diagnostic tests		
Radiation therapy		
Diagnostic mammography		
Position emission tomography (PET) scans		
Emergency medical care		
Ambulance services	Covered – 100% after deductible	
Emergency room	Covered – \$50 copay** (waived if admitted)	
Hearing care		
Audiometric exam	Participating Covered – 100%	Non-participating Not covered when provided by a nonparticipating provider in Michigan.
Hearing aids (standard only)		
Hearing aid evaluation and conformity test		
Hearing aid ordering and fitting		
Medical hearing clearance exam	Covered – \$15 copay**	Covered – 90% after deductible
Hospital care		
Chemotherapy	Covered – 100% after deductible	Covered – 90% after deductible
Inpatient care	Covered – 100% after deductible	Covered – 90% after deductible
	Unlimited days	
Inpatient and outpatient consultations	Covered – 100% after deductible	Covered – 90% after deductible
Hospital care (alternatives)		
Home health care	Covered – 100% after deductible (participating provider only)	
Hospice care	Covered – 100% (BCBSM or Medicare-certified hospice program)	
Skilled nursing care	Covered – 100% after deductible (120 days per admission period. 730 days for UAW members.)	
Urgent care visit	Covered – \$15 copay**	Covered – 90% after deductible

*Limitations apply. Refer to benefit details in this booklet.

** No deductible

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	In-network	Out-of-network
Human organ transplants – Contact HOTP at 800-242-3504 for additional criteria and information		
Bone marrow	Covered-100% in designated facilities when pre-approved	
Kidney, cornea and skin	Covered – 100% after deductible	Covered – 90% after deductible
Liver, heart, lung, pancreas and other specified organs	Covered – 100% in designated facilities only	
Maternity services provided by a physician or certified nurse midwife		
Prenatal and postnatal care	Covered – 100% after deductible	Covered – 90% after deductible
Delivery and nursery care		
Other services		
Acupuncture	Covered – 90% after deductible	
Allergy testing and therapy	Covered – 100% after deductible	Covered – 90% after deductible
Anesthesia	Covered – 100% after deductible	
Cardiac rehabilitation	Covered – 100% after deductible	Covered – 90% after deductible
Chiropractic/spinal manipulation	Covered – \$15 copay**	Covered – 90% after deductible
Durable medical equipment; prosthetic and orthotic appliances and supplies	Covered – 100% through SUPPORT program	Covered – 90% of approved amount (member responsible for difference)
Home hemophilia	Covered – 100% after deductible	Covered – 90% after deductible
Medical injections	Covered – 100% after deductible	Covered – 90% after deductible
Observation care	Covered – 100% after deductible	
Office consultations	Covered – \$15 copay**	Covered – 90% after deductible
Office visit		
Osteopathic manipulation therapy		
Outpatient hospital and home visits		
Private duty nursing	Covered – 90% after deductible	
Wig, wig stand, adhesives	\$300 lifetime max. through the SUPPORT program (Additional wigs covered for children due to growth.)	
Outpatient physical, speech and occupational therapy		
Facility	Covered – 100% after deductible	
Physician's office	Covered – 100% after deductible	Covered – 90% after deductible
Surgical services		
Pre-surgical consultations	Covered – 100% after deductible	Covered – 90% after deductible
Surgery		
Voluntary sterilization		

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	In-network	Out-of-network
Preventive services (limited to \$1,500 per calendar year per person)		
Digital rectal exam*	Covered – 100% Beginning at age 50	Covered – 90% after deductible
Fecal occult blood screening*	Covered – 100% Beginning at age 50; one per calendar year	Not covered
Flexible sigmoidoscopy exam*	Covered – 100% one every five years	Not covered
Health maintenance exam	Covered – 100% one per calendar year	Not covered
Hepatitis C screening	Covered – 100% one per calendar year (no age limit)	Not covered
Immunizations: <ul style="list-style-type: none"> • Chickenpox • Diphtheria, pertussis (whooping cough) tetanus and Hemophilus B (DPT/HIB) • Diphtheria, pertussis and tetanus (DPT) • Diphtheria, pertussis (DT) • Diphtheria, tetanus, acella pertussis and polio (DTaP/IPV) • Hemophilus B (HIB) • Hepatitis A • Hepatitis B • Human Papilloma Virus (HPV) • Measles, Mumps, Rubella (MMR) • Polio 	Covered – 100% Age 19 and over	Not covered
Pap smear screening – laboratory services only*	Covered – 100% one per calendar year	Not covered
Prostate specific antigen (PSA) screening	Covered – 100% one per calendar year	Not covered
Tuberculosis test	Covered – 100% one per calendar year	Not covered
Urinalysis	Covered – 100% one per calendar year	Not covered
Colonoscopy exam and related anesthesia services*	Covered – 100% one every 10 years	Covered – 90% after deductible
Double contrast barium enema*	Covered – 100% Beginning at age 50; one every 5 to 10 years	Covered – 90% after deductible
Mammography screening*	Covered – 100%	Covered – 90% after deductible
	One per calendar year, no age restrictions	
Meningitis	Covered – 100%	Covered – 90% after deductible

*Limitations apply. Refer to benefit details in this booklet.

** No deductible

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Custom Certificate - Effective 11/01/2003

ASC HEALTH PLAN SOM-PPO - STATE OF MICHIGAN ACTIVE EMPLOYEES

Medical Services , Form # 1748

BI3 Doc # 8829 ,

PRODUCT AND DEVELOPMENT SERVICE DEPARTMENT COVERAGE SPECIFICATIONS

EFFECT ON COVERAGE

1. PANEL DEDUCTIBLE REQUIREMENT

B. Coverage Under ASC Health Plan SOM-PPO (Active)

Under ASC Health Plan SOM-PPO: Active Employees (Form Number 1748), most panel services are subject to an annual deductible requirement of \$200 per member, not to exceed \$400 for a family.

The following services are NOT subject to the panel deductible.

- services subject to a fixed-dollar copayment, namely:
 - office visits,
 - clinic visits
 - urgent care visits,
 - osteopathic manipulation,
 - office consultations,
 - medical hearing exams;
 - second and third opinion surgical consultations, and
 - facility fee for hospital emergency room treatment

(NOTE:

In addition to not being subject to the panel deductible, hospital emergency treatment will also have no copayment requirement. Section 3.B. of this ASC Health Plan removes the fixed copayment. The result of these changes is that BCBSM will pay 100% of the approved amount for hospital emergency treatment.)

- services for the initial exam to treat a medical emergency or an accidental injury in the outpatient department of a hospital, or urgent care center
- hospice care benefits
- wig benefits (which are covered as part of the Prosthetic and Orthotic benefit)
- specific preventive care services (NOTE: Section 6.B. of this ASC Health Plan addresses the preventive care services covered under this plan.)

Further, unlike the Community Blue certificate, deductible amounts for panel and non-panel services are kept separate and distinct. Amounts applied toward the annual deductible for non-panel services will NOT count toward the deductible for panel services. Also, deductible amounts for panel services will NOT apply toward the deductible for non-panel services.

Another departure from Community Blue is that under this plan, there is a fourth quarter carryover provision for the panel deductible requirement. As a result, amounts applied to the panel deductible for services performed during the last quarter of the year will also count towards the member's panel deductible for the following year. This fourth quarter carryover provision will be implemented with the inception of this ASC Health Plan. Therefore, the first carryover will occur for services performed between October 1 and December 31, 2002.

Also, this ASC Health Plan allows a one-time prior deductible credit whereby amounts applied to an annual deductible requirement under any other State of Michigan coverage can be applied to the panel deductible requirement described above for employees who transfer into a group number/suffix that's affected by this ASC Health Plan.

2. NON-PANEL DEDUCTIBLE REQUIREMENT

B. Coverage Under ASC Health Plan SOM-PPO (Active)

Under ASC Health Plan SOM-PPO: Active Employees (Form Number 1748), the annual deductible requirement for non-panel services is \$500 per member, not to exceed \$1,000 for a family. The same services excluded from the non-panel deductible under the Community Blue certificate are also excluded from the non-panel deductible under this ASC Health Plan. In addition, this ASC Health Plan includes provisions that allow:

- a.) covered dental surgery performed by a dentist (specialty code 19) to also be excluded from the non-panel deductible. However, this service will be subject to the panel deductible requirement. (NOTE: A covered dental surgery is one that meets the criteria for reimbursement under the account's hospital/medical-surgical coverage.);
- b.) the non-panel deductible to be waived if the member does not live in an area where panel providers are readily accessible as defined by the account and the member has an approved request on file with BCBSM attesting to this fact. However, these services will be subject to the panel deductible requirement, unless the particular service performed does not contribute to the panel deductible (i.e., office visits).

In essence, the non-panel deductible is not imposed when:

- a panel provider refers the patient to a non-panel provider;
- the patient receives services for the initial exam to treat a medical emergency or an accidental injury in the outpatient department of a hospital or urgent care center
- the patient receives services from a provider specialty that is not represented/included on BCBSM's PPO panel. (NOTE: A listing of the provider specialties that are not represented on BCBSM's PPO panel is identified in Section 1.B. of this ASC Health Plan.);
- the patient has a dental surgical procedure that's covered under the account's hospital/medical-surgical coverage (this ASC Health Plan) and the procedure is performed by a dentist (specialty code 19), or
- the member does not live in an area where panel providers are readily accessible as defined by the account and the member has an approved request on file with BCBSM attesting to this fact (NOTE: Section 32.B. of this ASC Health Plan provides specific details about this provision. Also, attached to this ASC Health Plan is a copy of the waiver policy, along with the form members must complete.)

Unlike the Community Blue certificate, deductible amounts for panel and non-panel services are kept separate and distinct. Amounts applied toward the annual deductible for non-panel services will NOT count toward the deductible for panel services. Also, deductible amounts for panel services will NOT apply toward the deductible for non-panel services.

Further, under this ASC Health Plan, the non-panel deductible does not include a fourth quarter carryover provision or a prior deductible credit.

3. FIXED DOLLAR COPAYMENT

B. Coverage Under ASC Health Plan SOM-PPO (Active)

Under ASC Health Plan SOM-PPO: Active Employees (Form Number 1748), there is no fixed dollar copayment for emergency room services. Instead, we pay 100% of our approved amount, whether the treatment is performed by a panel or non-panel hospital.

However, there is a \$10 copayment for each of the following when performed by a panel provider:

- Office visits
- Office consultations
- Clinic visits
- Urgent care visits
- Second and third surgical opinion consultations
- Medical hearing exams
- Osteopathic manipulation

NOTE:

Benefits osteopathic manipulation have been added to the account's coverage via Section 8.B. of this ASC Health Plan. Benefits for second and third surgical opinions have been added via Section 10.B. of this ASC Health Plan.

4. MEMBER PERCENTAGE (%) COPAYMENT.

B. Coverage Under ASC Health Plan SOM-PPO (Active)

As noted in Section 7.B. of this ASC Health Plan, mental health and substance abuse treatment are not covered by BCBSM under this Plan and therefore, this plan does not include any copayment provisions related to these services.

However, private duty nursing remains covered and will be subject to a 10% member copayment. (NOTE: Private duty nurses are not a part of BCBSM's PPO panel and as a result, these claims are always treated as if the services were performed by a panel provider.)

With respect to the remaining covered services, the following percentage (%) copayment amounts will be imposed:

Panel Services

- 10% for durable medical equipment
- 10% for prosthetic and orthotic appliances
- 10% for private duty nursing services
- 10% for chiropractic manipulation
- 10% for acupuncture (NOTE: Benefits for acupuncture has been added to the account's coverage via Section 26.B. of this ASC Health Plan.)

ALL other covered services performed by a panel provider will be paid at 100% of our approved amount.

Non-Panel Services

- 10% member copayment for most other covered services performed by a non-panel provider, including office visits, urgent care visits and office consultations

NOTE:

If the member does not live in an area where panel providers are readily accessible as defined by the account and the member has an approved request on file with BCBSM attesting to this fact, then BCBSM will waive the non-panel copayment (and deductible) requirement(s). However, these services will be subject to the panel copayment requirement, unless the particular service performed does not have a panel copayment (i.e., chest xray). Section 32.B. of this ASC Health Plan provides further details about this provision.

5. OUT-OF-POCKET MAXIMUMB. Coverage Under ASC Health Plan SOM-PPO (Active)

Under ASC Health Plan SOM-PPO: Active Employees (Form Number 1748), there are annual out-of-pocket maximums for both panel and non-panel services.

- For PANEL services, the annual out-of-pocket maximum is \$1,000 per member, not to exceed \$2,000 for a family.
- For NON-PANEL services, the annual out-of-pocket maximum is \$2,000 per member, not to exceed \$4,000 for a family.

As is the case under Community Blue, the annual deductible(s) do not contribute to the annual out-of-pocket maximums, and neither do the fixed dollar copayments nor the copayment for private duty nursing. (NOTE: As explained elsewhere in this ASC Health Plan, mental health and substance abuse services are covered by another carrier and therefore, there are no copayment provisions in this ASC health Plan for those services.)

Also, unlike the Community Blue certificate, the out-of-pocket maximums for panel and non-panel services are kept separate and distinct. Amounts applied toward the annual out-of-pocket maximum for non-panel services will NOT count toward the annual out-of-pocket maximum for panel services, or visa versa.

6. PREVENTIVE SERVICESB. Coverage Under ASC Health Plan SOM-PPO (Active)

Like the Community Blue Certificate, preventive care services covered under this ASC Health Plan fall into one of two categories: those subject to an annual preventive care benefit maximum and those that are not.

The annual preventive care benefit maximum is \$500 per member for the 2003 calendar year. However, beginning January 1, 2004, the annual preventive care benefit maximum will be \$750 per member. (Each member enrolled in this ASC Health Plan also has an overall lifetime maximum of five million dollars and the preventive care maximums of \$500 and \$750 will contribute to this overall limit.)

Preventive services covered under the preventive care maximum will only be payable when performed by a panel provider. Also, BCBSM will pay 100% of its approved amount: deductible and copayment requirements will NOT be imposed.

The following services will contribute to the annual preventive care benefit maximum. There are no age limits for any of these services, except for colorectal screening and well baby/child care visits.

- Health Maintenance Examination:
covered once per calendar year
- Colorectal Screening covered beginning at age 50 years. Benefits include:
 - an annual fecal occult blood test
 - flexible sigmoidoscopy once every five years
 - colonoscopy once every ten years

NOTE:

Additional colorectal screening procedures (contrast barium enema and digital rectal exam) are also covered, but are not subject to the annual preventive care maximum. Details about these additional services are explained later on this is same section of the ASC Health Plan.

- Gynecological Examination:

- covered once per calendar year
- Routine Pap Smear:
covered once per calendar year
- Fecal Occult Blood Screening:
covered once per calendar year
- Well Baby and Child Care Visits:
 - six visits per year up to 24 months (2nd birthdate) (NOTE: This means that benefits are available for a total of 12 visits up to age 24 months.)
 - two visits per year, age 24 months to 36 months (3rd birthdate)
 - two visits per year, age 36 months to 48 months (4th birthdate)
 - one visit each birth year, age 48 months (4 years) through 15 years (16th birthdate)
- Immunizations (childhood and otherwise; no age limit):
covered once per calendar year
- Flu Shots:
covered once per calendar year
- Hepatitis C Screenings:
covered once per calendar year
- Prostate Specific Antigen Screening:
covered once per calendar year
- Specific Routine Laboratory and Radiology Services:
 - Chemical Profile
 - Complete Blood Count or any of its components
 - Urinalysis
 - Chest X-ray
 - EKG

Each routine laboratory and radiology procedure is covered once per year.

This ASC Health Plan also includes benefits for routine mammograms and additional colorectal screening procedures. However, neither of these services is subject to the preventive care benefit maximum referenced above. Instead, BCBSM will pay these claims up to the member's overall lifetime benefit maximum of five million dollars whether performed by a panel or non-panel provider, but subject to the following limits.

- Routine mammograms (which includes digital mammograms) are covered once per calendar year and will be administered according to the medical guidelines set forth by the American Cancer Society.
- Double contrast barium enema and digital rectal exam are covered as part of the Colorectal Screening benefit. Beginning at age 50 years, BCBSM will cover:
 - a double contrast barium enema once every five to ten years or more often if the family history dictates
 - a digital rectal exam when performed at the same time as any other covered colorectal screening procedure.

Routine mammograms and these additional colorectal screening procedures are subject to the member's annual deductible and member copayment requirements.

7. MENTAL HEALTH AND SUBSTANCE ABUSE

B. Coverage Under ASC Health Plan SOM-PPO (Active)

Under ASC Health Plan SOM-PPO: Active Employees (Form Number 1748), benefits are NOT included for mental health and substance abuse services. The account has elected to have these types of claims/benefits administered by another carrier.

8. OSTEOPATHIC MANIPULATION

B. Coverage Under ASC Health Plan SOM-PPO (Active)

Under ASC Health Plan SOM-PPO: Active Employees (Form Number 1748), osteopathic manipulation is covered.

When performed by a panel provider, the member is responsible only for a \$10 fixed copayment.

When performed by a non-panel provider, the service is subject to the member's annual deductible and the 10% copayment.

9. OUTPATIENT DIABETES MANAGEMENT PROGRAM

B. Coverage Under ASC Health Plan SOM-PPO (Active)

Under ASC Health Plan SOM-PPO: Active Employees (Form Number 1748), the outpatient diabetes management program is

included and covered. Under the program, BCBSM pays for the following services when related to the care and treatment of diabetes.

- self-management training
- durable medical equipment
- medical supplies
- prescription drugs

These benefits are consistent with those provided under Rider ODMP (Form Number 2592) and are subject to the annual panel deductible when performed by a panel provider. When performed by a non-panel provider, covered services are subject to the non-panel deductible and the 10% copayment.

10. PRE-SURGERY CONSULTATIONS (2ND AND 3RD Opinions)

B.Coverage Under ASC Health Plan SOM-PPO (Active)

Under ASC Health Plan SOM-PPO: Active Employees (Form Number 1748), pre-surgery consultations (second and third opinions) are covered.

When performed by a panel provider, the member is only responsible for a \$10 fixed copayment. However, when performed by a non-panel provider, the resulting claim is subject to the non-panel deductible and the 10% copayment.

11. SPECIFIED ORGAN TRANSPLANTS

B.Coverage Under ASC Health Plan SOM-PPO (Active)

Under ASC Health Plan SOM-PPO: Active Employees (Form Number 1748), the specified organ transplant program is included and covered. Benefits are consistent with those described in Rider SOT-PE (Form Number 9909), which means that:

- BCBSM pays for specific organ transplants, subject to a lifetime maximum of one million dollars per member for each covered organ. (See Rider SOT-PE for a listing of the covered organs.)
- The lifetime maximum of one million dollars per organ does not contribute to the overall lifetime maximum of five million dollars that applies to most other covered services under this ASC Health Plan.
- The program includes benefits for anti-rejections drugs, organ acquisition costs, and travel meals and lodging expenses related to the transplant
- Member cost-sharing requirements (deductible and copayments) are not imposed.

12. SPECIFIED ONCOLOGY CLINICAL TRIALS

B.Coverage Under ASC Health Plan SOM-PPO (Active)

Under ASC Health Plan SOM-PPO: Active Employees (Form Number 1748), specified oncology clinical trials are included and covered. BCBSM will pay for pre-approved specified bone marrow and/or peripheral blood stem cell transplants and related services to treat stages II and III breast cancer and/or all stages of ovarian cancer during the approved clinical trials. These benefits are consistent with those provided under Rider SOCT (Form Number 5401).

Since the services must be pre-approved, providers who perform them are considered panel. As such, we impose only the panel cost-sharing requirements that are applicable to the specific procedure performed. However, in instances where the particular service would have been subject to a percentage copayment (%), the group has elected to NOT impose it.

So, essentially, only the panel deductible and fixed copayments will be imposed.

BCBSM's reimbursement for SOCT services is applied to the member's overall lifetime maximum of five million dollars.

13. RADIOLOGY SERVICES

B.Coverage Under ASC Health Plan SOM-PPO (Active)

Under ASC Health Plan SOM-PPO: Active Employees (Form Number 1748), the Radiology Management Program is NOT included. Therefore, precertification is not required in any instance.

14. COVERED RADIOLOGY PROCEDURES

B.Coverage Under ASC Health Plan SOM-PPO (Active)

In addition to the radiology procedures BCBSM typically covers, ASC Health Plan SOM-PPO: Active Employees (Form Number 1748) includes benefits for the following radiology procedures.

- Cholangiography and/or pancreatography; additional set intraoperative, radiological supervision and interpretation
- Venography
- Joint survey: single view
- Xeroradiography
- Subtraction in conjunction with contrast studies
- Venous Thrombosis imaging: unilateral and bilateral

15. COVERED LABORATORY PROCEDURES

B.Coverage Under ASC Health Plan SOM-PPO (Active)

In addition to the radiology procedures BCBSM typically covers, ASC Health Plan SOM-PPO: Active Employees (Form Number 1748) includes benefits for the following laboratory procedures.

- General health panel
- Collagen cross links
- Etiocholanolone
- Helicobacter Pylori

16. COVERED SURGICAL PROCEDURES

B.Coverage Under ASC Health Plan SOM-PPO (Active)

Under ASC Health Plan SOM-PPO: Active Employees (Form Number 1748), the following surgical services are covered for diabetes and peripheral vascular disease:

- Paring or cutting of benign hyperkeratotic lesion
- Debridement of nails by any method

In addition, numerous other surgical procedures (beyond those typically paid by BCBSM) are covered under this ASC Health Plan. The business requirements contain a complete listing of the procedures that will be payable when this plan is implemented on January 1, 2003. However, on a continuous basis, as new procedures are added to the listing of covered procedures for the state of Michigan account, they will be identified as such in BCBSM's maximum fee screen and other internal documents available to claims and servicing staffs - such as the Professional Claims Benefit Manual, online reference (GBR), etc.).

An example of the additional payable surgical procedures includes:

- Blepharoplasty
- Chemical cauterization of granulation tissue
- Application of splints
- Strapping
- Windowing of cast
- Endoscopic retrograde cholangiopancreatography with ablation of tumors, polyps, or other lesions
- Small intestinal endoscopy, with placement of percutaneous jejunostomy tube, or replacement of gastrostomy to jejunostomy

17. DURABLE MEDICAL EQUIPMENT (including Medical Supplies)

B.Coverage Under ASC Health Plan SOM-PPO (Active)

Under ASC Health Plan SOM-PPO: Active Employees (Form Number 1748), benefits are available for:

- Slings
- Needles and Syringes for other conditions in addition to diabetes
- Lights to treat Seasonal Affective Disorder (SAD)

18. SPEECH AND LANGUAGE THERAPY

B.Coverage Under ASC Health Plan SOM-PPO (Active)

Under ASC Health Plan SOM-PPO: Active Employees (Form Number 1748), benefits are included for developmental speech therapy for children under six years old.

While speech therapy rendered for a medical condition will be subject to the combined benefit maximum of 60 visits, that will not be the case for developmental speech therapy.

Developmental speech therapy will be paid on an unlimited basis. When performed by a panel provider, covered services are subject to the annual panel deductible. However, when performed by a non-panel provider, covered services are subject to the non-panel deductible and the 10% copayment.

19. INDEPENDENT LICENSED PHYSICAL THERAPISTS

B.Coverage Under ASC Health Plan SOM-PPO (Active)

Under ASC Health Plan SOM-PPO: Active Employees (Form Number 1748), independent licensed physical therapists are included among the covered PT providers. When physical therapy is rendered in the office of the licensed therapist, it too will be subject to the combined benefit maximum of 60 visits per member, per calendar year.

This benefit is consistent with those provided under Rider PTS (Form Number 6217).

20. CARDIAC REHABILITATION

B.Coverage Under ASC Health Plan SOM-PPO (Active)

Under ASC Health Plan SOM-PPO: Active Employees (Form Number 1748), benefits are included for cardiac rehabilitation. When performed by a panel provider, covered services are subject to the annual panel deductible. However, when performed by a non-panel provider, covered services are subject to the non-panel deductible and the 10% copayment.

21. CERTIFIED NURSE SERVICES

B.Coverage Under ASC Health Plan SOM-PPO (Active)

Under ASC Health Plan SOM-PPO: Active Employees (Form Number 1748), benefits are included for services performed by certified nurse practitioners, certified registered nurse anesthetists, or certified nurse midwives. Since these provider specialties are not part of BCBSM's PPO panel, the claims for these providers will be processed as if the services were performed by a panel provider and will be subject only to the panel deductible.

For certified nurse practitioners (CNPs), benefits are available for all covered except those provided in an inpatient hospital setting.

In the case of certified registered nurse anesthetists (CNRAs), benefits are available only for anesthesia services performed in a hospital setting (inpatient or outpatient) or in an approved ambulatory surgical facility.

In the case of certified nurse midwives (CNMs), benefits are available only for: 1.) normal vaginal deliveries, but only when performed in an inpatient hospital setting or in a birthing center that's affiliated with a hospital, 2.) pre-natal care, and 3.) post natal care including a pap smear during the six-week visit.

The benefits described above are consistent with those described in Rider CNP (Form Number 3687), Rider CRNA (Form Number 5385), and Rider CNM (Form Number 6600).

22. WEIGHT LOSS PROGRAMS

B.Coverage Under ASC Health Plan SOM-PPO (Active)

Under ASC Health Plan SOM-PPO: Retirees (Form Number 1750), benefits are included for weight loss programs and services, but subject to a lifetime benefit maximum of \$300 per member. BCBSM will pay 100% of the approved amount for covered services. Deductible and copayment amounts will NOT be imposed.

23. CONTRACEPTIVE DEVICES AND CONTRACEPTIVE INJECTIONS

B.Coverage Under ASC Health Plan SOM-PPO (Active)

Under ASC Health Plan SOM-PPO: Active Employees (Form Number 1748), benefits are included for:

- prescription contraceptive devices obtained in the physician's office;
- contraceptive injections, and
- implantable contraceptive capsules, insertion, removal and reinsertion

When performed by a panel provider, covered services are subject to the annual panel deductible. However, when performed by a non-panel provider, covered services are subject to the non-panel deductible and the 10% copayment.

24. INFERTILITY TREATMENT

B.Coverage Under ASC Health Plan SOM-PPO (Active)

Under ASC Health Plan SOM-PPO: Active Employees (Form Number 1748), benefits are included for infertility treatment, but only in the scope of the benefits provided under the member's coverage. (For example, since office visits are covered, office visits which report a diagnosis of infertility will also be payable.)

In essence, a diagnosis of infertility will be paid rather than denied, but only if the service itself is a covered benefit.

25. PROSTHETIC AND ORTHOTIC DEVICES (P&O)

B.Coverage Under ASC Health Plan SOM-PPO (Active)

Under ASC Health Plan SOM-PPO: Active Employees (Form Number 1748), benefits are included for:

- Orthotic shoes and shoe inserts whether or not they are attached to a brace
 - Since P&O suppliers are not part of the PPO panel, this service will be subject only to the panel cost-sharing requirements: the panel deductible will be imposed, along with the 10% member copayment.
- Hair prostheses, with wig stand and adhesives (hair pieces and hair implants are not payable)
 - Benefits are limited to a lifetime benefit maximum of \$300 per member and are subject to the following benefit criteria.
 - must be prescribed by a physician
 - can be obtained from sources other than a medical supplier
 - covered only when the hair loss is the result of either: a.) chemotherapy, or b.) alopecia or a disease that

When the patient is a child (age 19 years or less) with hair loss resulting from either of the above conditions, the lifetime benefit maximum is not imposed. Rather, we will pay these claims on an unlimited basis until the child turns age 19 years.

Whether the patient is an adult or child, we will pay 100% of the approved amount for this service. Deductible and copayment amounts will NOT be imposed.

26. ACUPUNCTURE

B. Coverage Under ASC Health Plan SOM-PPO (Active)

Under ASC Health Plan SOM-PPO: Active Employees (Form Number 1748), benefits are included for acupuncture, but only when performed by or supervised by a Doctor of Medicine (MD) or a Doctor of Osteopathy (DO).

Also, benefits are subject to an annual benefit maximum of 20 visits per member.

Covered services are subject to the panel and non-panel deductible and copayment requirements described earlier in this ASC Health Plan.

27. SKILLED NURSING CARE

B. Coverage Under ASC Health Plan SOM-PPO (Active)

Under ASC Health Plan SOM-PPO: Active Employees (Form Number 1748), the benefit maximum for skilled nursing services is determined by which bargaining unit represents the member.

- For UAW, skilled nursing services are limited to a benefit maximum of 730 days per admission.
- For MPES, MSEA, MCO, 31-M, AFSME and UTEA, skilled nursing services are limited to a benefit maximum of 120 days per admission

Members who are not represented by a union are also eligible for up to 120 days of skilled nursing care per admission.

28. AMBULANCE SERVICES

B. Coverage Under ASC Health Plan SOM-PPO (Active)

Under ASC Health Plan SOM-PPO: Active Employees (Form Number 1748), benefits are included for water ambulance services.

29. HOME INFUSION THERAPY

B. Coverage Under ASC Health Plan SOM-PPO (Active)

Under ASC Health Plan SOM-PPO: Active Employees (Form Number 1748), home infusion therapy is covered.

For the period of January 1, 2003 to October 31, 2003, the benefit is administered as part of the group's coverage for durable medical equipment, home health care and prescription drugs. The providers who perform the services are not required to be a part of BCBSM's home infusion therapy program.

However, beginning November 1, 2003, the benefits contained in this plan for home infusion therapy will be identical in every respect to those that BCBSM standardly offers under Rider HIT – including the fact that:

- 1.) the services must be billed using the appropriate procedure codes that are consistent with the home infusion therapy program, and
- 2.) the services must be performed by providers with whom BCBSM has contracted.

30. COORDINATED CARE MANAGEMENT (CCM) PROGRAM

B. Coverage Under ASC Health Plan SOM-PPO (Active)

ASC Health Plan SOM-PPO: Active Employees (Form Number 1748) includes the Coordinated Care Management (CCM) Program.

CCM is a disease management program designed to prevent or minimize the impact of an illness. Members will be eligible if they:

- have an appropriate diagnosis;
- are active non-Medicare members, dependents and surviving spouses, and/or
- are primary in the State Health Plan Advantage Program

If the member is eligible, the CCM nurse care manager assesses the needs of the patient and develops a program of health care services. When the patient, the physician and nurse care manager agree to the services and, program goals they are designed to achieve, a treatment plan is developed. The nurse care manager then helps the member obtain the services and assesses the patient's progress towards the goals.

CCM may pay for services that are not ordinarily covered as part of the patient's coverage.

Participation in the CCM Program is strictly VOLUNTARY.

31. SUBROGATION PROVISIONS

B. Coverage Under ASC Health Plan SOM-PPO (Active)

ASC Health Plan SOM-PPO: Active Employees (Form Number 1748) includes the following provision regarding subrogation.

"In the event that a participant receives services that are paid by the State Health Plan Advantage (SHPA), or is eligible to receive future services under the SHPA, the SHPA shall be subrogated to the participant's rights of recovery against and is entitled to receive all sums recovered from, any third party who is or may be liable to the participant, whether by suit, settlement, or otherwise, to the extent of recovery for health related expenses.

A participant shall take such action, furnish such information and assistance, and execute such documents as the SHPA may request to facilitate enforcement of the rights of the SHPA and shall take no action prejudicing the rights and interest of the SHPA."

NOTE:

It is important to mention that the group will NOT have Rider SUBRO-2. Rather, only the subrogation provision cited above will apply to members enrolled in this ASC Health Plan.

32. ACCESS WAIVER POLICYB. Coverage Under ASC Health Plan SOM-PPO (Active)

As referenced in Sections 2.B. and 4.B. of this ASC Health Plan, the non-panel deductible and non-panel copayments are waived if the member does not live in an area where panel providers are readily accessible as defined by the account and the member has an approved request on file with BCBSM attesting to this fact.

Although BCBSM will administer the provisions of this waiver, the account has established the guidelines that will be used.

Access waivers submitted by the member will be approved if BCBSM determines that the access to its PPO provider panel is not within the following guidelines established by the State Health Plan PPO standards.

- Two primary care physicians within 15 miles of the member's home
- Two specialty care physicians within 20 miles of the member's home
- One hospital within 25 miles of the member's home

NOTE:

By design, PPO coverage does not require, but encourages the member to select a primary care physician. For the purposes of this Access Waiver policy, the primary physician is the panel physician who is in the best position to refer patients to specialists or coordinate any necessary hospital care.

The Access Waiver policy includes a few other provisions regarding non-panel cost-sharing requirements and when it's appropriate to waive them. However, in those instances, BCBSM's existing PPO policy already encompasses the waiver scenarios as described in the State Health Plan PPO standards.

The Access Waiver Policy also includes a provision to reimburse the member at 100% after deductible for services received from a non-participating facility.

A copy of the Access Waiver Policy is attached to this ASC Health Plan. (Please see Attachment A)

All other benefits, terms and conditions of this ASC Health Plan are the same as those described in BCBSM's Community Blue Group Benefits Certificate.

Attachment A**STATE HEALTH PLAN PPO**ACCESS WAIVER POLICY

Members receive maximum reimbursement of benefits when services are obtained from Community Blue network providers under the State Health Plan PPO. When services are obtained from a provider who is not part of the network, Blue Cross Blue Shield (BCBSM) will pay a portion of the approved amount. The remainder, or sanction amount, will be the member's out-of-pocket cost, in addition to any deductible or copayment required by the State Health Plan PPO. Out-of-pocket costs will be even higher if the member selects a provider who does not participate with BCBSM.

BCBSM has a statewide network of Community Blue providers that includes more than 19,000 physicians and more than 144 hospitals. Although not required, members are encouraged to select one physician from the network to coordinate all their health care needs. These "primary care" physicians are in the best position to refer patients to specialists or coordinate any necessary hospital care. The type of primary care physician a member selects is a personal choice. The State Health Plan PPO considers a primary care physician to be an internist, family practitioner or general practitioner. Other physician types are considered specialists.

Members may choose to obtain services from a provider who is not part of the network. In these situations, members will be sanctioned with out-of-pocket costs unless they have a referral from a Community Blue PPO provider. Sanctions are set at a level that gives members some limited flexibility to leave the network by choice without undue financial hardship, but retains sufficient deterrent to make the network effective. However, a member's choice is not an issue related to access.

In certain limited situations members may have little choice but to utilize the services of a non-network provider. Therefore,

special provisions have been incorporated into the program to waive the sanction requirement. Situations in which the sanction requirement will be waived are as follows:

- Emergency Care

The sanction will be waived for verified emergency care when rendered by non-network providers or non-participating providers.

- Specialty Care

Sanctions do not apply to services rendered by non-network providers if the services are not reasonably available from Community Blue network providers within State Health Plan PPO access standards.

Sanctions also do not apply if members are referred out-of-network. Out-of-network services are paid at the in-network level when a Community Blue PPO physician refers the member to BCBSM approved providers and completes a "TRUST Preferred Provider Organization (PPO) Program Referral Form".

If hospitalization is recommended following a referral, the out-of-network physician must contact the Community Blue PPO Physician. If admission to a non-network hospital is necessary, the Community Blue PPO physician must complete a "Physician to Hospital/Hospital to Hospital" referral form.

- Out-of-state Care

BlueCard PPO, a Blue Cross Blue Shield Association program, allows members to receive services at in-network benefit levels out of state. BlueCard PPO refers members to the nearest Blue PPO provider or Blue participating provider if there are no PPO providers within State Health Plan PPO access standards.

Members who are referred to out-of-state providers receive services at in-network benefit levels. However, members who choose to receive services from a non-network provider out-of-state without a referral will be sanctioned with out-of-pocket costs.

Although the State Health Plan PPO has a statewide network of providers and special provisions have been incorporated in the program to waive sanctions as described above, members may request an "Access Waiver", which is a request to waive a sanction. Access Waiver requests will be approved if BCBSM determines that access to Community Blue PPO providers is not within the following State Health Plan PPO standards:

- Two primary care physicians within 15 miles of the member's home
- Two specialty care physicians within 20 miles of the member's home
- One hospital within 25 miles of the member's home

BLUE CROSS BLUE SHIELD OF MICHIGAN

STATE HEALTH PLAN PPO

REQUEST FOR WAIVER OF OUT-OF-NETWORK COSTS

I, _____

(Contract Holder's Name)

request waiver of the out-of-network out-of-pocket cost when any member on my State Health Plan PPO receives services from providers who are not in the Blue Preferred network.

I am making this request because there is no available internist, family practitioner or general practitioner in the Community Blue PPO network within 15 miles of my home, and the non-network physician named below is located within 15 miles of my home.

Provider's Name

Provider's Address

Provider's Specialty

Contract Holder's Name

BCBSM Contract Number

Contract Holder's Street Address

City State Zip

Contract Holder's Signature

Date

Witness' Signature*

Date

*Any adult age 18 or older can sign as a witness.

Blue Cross Blue Shield of Michigan is an independent licensee of the Blue Cross and Blue Shield Association.

Show Back Matter Text

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Standard Certificate - Effective 08/01/2010

VISION CARE GROUP BENEFIT CERTIFICATE SERIES A80

Vision Services and Hearing , Form # 4770

BI3 Doc # 2918 ,

Section 1: Information About Your Contract

ELIGIBILITY

Who Is Eligible to Receive Benefits

You, your spouse (this does not include a person who marries a member who has coverage as a surviving spouse) and your children listed on your contract are eligible. You will need to complete an application for coverage.

BCBSM will review your application for coverage to determine if you, your spouse and your dependents are eligible for coverage. This determination is based upon the terms of your benefit plan, which include this certificate and any underwriting policies that are in effect at the time of your application.

NOTE:

If you, your group or someone applying for coverage on your behalf commits fraud or makes an intentional misrepresentation of material fact in completing the application, your coverage may be rescinded as described on Page 1.4 under Rescission.

Children are covered through the end of the calendar year in which they turn 26 years of age if, and as long as, the subscriber continues to be covered under this certificate and the children are related to you by birth, marriage, legal adoption or legal guardianship.

NOTE:

Your child's spouse and your grandchildren are not covered under this certificate.

Disabled, unmarried children may remain on your contract beyond the end of the calendar year in which they turn age 26 if all of the following apply:

- They are diagnosed as totally and permanently disabled due to a physical condition or mental retardation and are incapable of self-sustaining employment.
- They receive more than half of their support from you.
- The disability began before their 19th birthday.

NOTE:

Physician certification, verifying the child's disability and that it occurred prior to the child's 19th birthday, must be submitted to us by the end of the calendar year in which the child turns age 26.

You may also request group coverage for yourself or your dependents within 60 days of either of the following events:

- Your Medicaid coverage or your dependents' CHIP coverage (Children's Health Insurance Program) is terminated due to loss of eligibility.
- You or your dependent becomes eligible for premium subsidies.

You must notify your employer or group if there is a change in your family such as birth, divorce, death, etc. We must receive notice from your employer or group within 30 days of the change so that any contract changes take effect as of the date of the event. Any change in rates resulting from contract changes will take effect as of the effective date of the contract change.

If a dependent becomes ineligible for coverage under your contract, as in the case of a divorce, that dependent may be eligible for his or her own contract. However, we must be notified within 30 days of the change in order to provide continuous coverage.

CANCELLATION

How to Cancel Coverage

Send your written request to cancel coverage to your employer or group. We must receive it from your employer or group

within 30 days of the requested cancellation date. Your coverage will then be canceled on the next business day after we receive notification.

Automatic Cancellation

We will automatically cancel your coverage if:

- Your group does not qualify for coverage under this certificate
- Your group does not pay its bill on time
- You are serving a criminal sentence for defrauding BCBSM
- You no longer qualify to be a member of your group
- Your group changes to a non-BCBSM health plan
- We no longer offer this coverage
- You misuse your coverage
 - Misuse includes illegal or improper use of your coverage such as:
 - Allowing an ineligible person to use your coverage
 - Requesting payment for services you did not receive
- You fail to repay BCBSM for payments we made for services that were not a benefit under this certificate, subject to your rights under the appeal process
- You are satisfying a civil judgment in a case involving BCBSM
- You are repaying BCBSM funds you received illegally
- You no longer qualify as a dependent

Your coverage will end on the last day covered by the last payment made by your group, employer, or remitting agent.

Rescission

We will rescind your coverage if you, your group or someone seeking coverage on your behalf has:

- Performed an act, practice, or omission that constitutes fraud, or
- Made an intentional misrepresentation of material fact to BCBSM or another party, which results in you or a dependent obtaining or retaining coverage with BCBSM or the payment of claims under this or another BCBSM certificate.

NOTE:

Your coverage may be rescinded back to the effective date of your contract after we have provided you with prior notice, if required under the law. You will be required to repay BCBSM for its payment for any services you received during this period.

CONTINUATION OF BENEFITS

Consolidated Omnibus Budget Reconciliation Act

COBRA is a federal law that affects all employers with 20 or more employees. It extends the opportunity for continued group coverage to all qualified beneficiaries when such coverage is lost due to a qualifying event. This group continuation option must be selected within 60 days of the qualifying event. It provides the following coverage at the covered member's expense:

- 18 months of coverage for an employee who is terminated, other than for gross misconduct, or whose hours are reduced
- Coverage is extended to 29 months for all qualified beneficiaries if one member is determined by the Social Security Administration to be disabled at the time of the qualifying event or within 60 days thereafter
- 36 months of coverage for qualified beneficiaries in case of the death of the employee, divorce, legal separation, loss of dependency status, or employee entitlement to Medicare

COBRA coverage can be terminated because:

- The 18, 29 or 36 months of COBRA coverage end
- The required premium is not paid on time
- The employer terminates its group health plan
- The qualified beneficiary is entitled to Medicare coverage
- The qualified beneficiary obtains coverage under a group health plan unless the new health plan has pre-existing condition limitations that apply to the qualified beneficiary

Please contact your employer for more details about COBRA.

Section 2: What You Must Pay

This section explains the copayments you must pay for covered vision services.

Eye Exam

- Your copayment is \$5.
 - No copayment is required for a second examination by a physician when recommended by an optometrist.

Prescription Glasses

- Your copayment is \$7.50
 - You pay one copayment for both lenses and frames.
 - No copayment for eyeglasses obtained from a nonparticipating provider, but you are responsible for charges in excess of our payment.

Contact Lenses

- Your copayment is \$7.50 for medically necessary contact lenses
 - No copayment for prescribed but not medically necessary contact lenses is required but you are responsible for charges in excess of our payment.

Participating Providers

We pay participating providers the approved amount minus your copayment for covered services.

Nonparticipating Providers

We pay fixed dollar amounts for contacts, eyeglass lenses and frames obtained from nonparticipating providers. These amounts are listed at the end of [Section 3](#). The amounts can be less than what we pay for services of participating providers.

NOTE:

Because nonparticipating providers often charge more than our maximum payment level, our payment may be less than the amount charged by the provider.

Section 3: Coverage for Vision Care Services

This section describes covered vision services to detect, improve or correct vision problems.

Frequency

We pay for the following once in any period of 24 consecutive months:

- One eye examination
- One pair of eyeglass lenses with or without frames; or one pair of contact lenses.

Eye Exam

We pay for an eye exam by a physician or optometrist to determine the need for lenses to correct or improve eyesight. The examination must include the following:

- History
- Testing of visual acuity
- External examination of the eye
- Binocular measure
- Ophthalmoscopic examinations
- Tonometry (test for glaucoma) when indicated
- Medication for dilating the pupils and desensitizing the eyes for tonometry, if necessary
- Summary of findings

If an optometrist recommends an examination by a physician, we pay for this examination.

The examination by the physician must be within 60 days following the optometrist's examination.

Lenses

We pay for eyeglass lenses when prescribed or dispensed by a physician, optometrist or optician.

- Lenses may be molded or ground, glass or plastic.
- Lenses must be equal in quality to the first-quality lens series made by American Optical; Bausch & Lomb or Tillyer and Univis.
- The lens blank must meet Z80.1 or Z80.2 standards of the American National Standards Institute.
- The lenses must be colorless or have Rose tints #1 or #2 if therapeutically necessary. The provider may charge you for additional tinting other than for necessary Rose tints #1 or #2.

- The lens blank of a standard lens must not exceed 65 mm in diameter. The provider may charge you for the difference in cost between standard and oversize lenses.

We pay for the following special lenses:

- Myodisc
- Lenticular myodisc
- Lenticular aspheric myodisc
- Aphakic
- Lenticular aphakic
- Lenticular aspheric aphakic

We do not pay for aphakic lenses for aphakia (lack of natural lens). These may be covered by your hospital-medical-surgical plan.

We pay for prism, slab-off prism and special base curve lenses when medically necessary.

Lens Insertion Fee

If you do not receive new frames, we pay to have new lenses inserted in your old frames.

Frames

We pay the provider's acquisition cost up to \$14.75, plus a dispensing-fee, for standard eyeglass frames.

- If you select more expensive frames, the provider may charge you the difference between the usual retail charge for covered frames and the more expensive frames.

Contact Lenses

- Suitability Exam

A contact lens suitability examination determines whether you can wear contact lenses. The exam may include:

- Biomicroscopic evaluation
- Lid evaluation
- Ophthalmoscopy
- Tear test
- Pupil evaluation
- Fluorescein evaluation
- Cornea evaluation
- Lens tolerance tests

The fee for the examination is included in our dispensing fee if you get contact lenses.

If it is determined that contact lenses would not be suitable, we pay for the examination.

- Contact Lenses

We pay the approved amount minus your copayment for medically necessary contact lenses. Contact lenses are considered medically necessary if:

- They are the only way to correct vision to 20/70 in the better eye; or
- They are the only effective treatment to correct keratoconus, irregular astigmatism or irregular corneal curvature.

If prescription contact lenses are not needed for the above reasons, we pay up to \$35 per pair.

Nonparticipating Providers

If you receive services from a nonparticipating provider, we pay the following:

- Vision testing examination
 - 75 percent of the approved amount, after it has been reduced by your \$5 copayment.

- Eyeglass Lenses

Single Vision \$13 per pair

Bifocal \$20 per pair

Trifocal \$24 per pair

Special Lenses 50 percent of the provider's charge or 75 percent of the average amount paid to participating providers, whichever is less.

Additional Charges

Plastic Lenses \$3 per pair
 Rose Tints #1 and #2 \$3 per pair
 Prism Lenses \$2 per pair

- Eyeglass Frames
 - Provider's charge up to \$14
- Contact Lenses
 - Medically Necessary \$96 per pair
 - Prescribed, but not Medically Necessary \$35 per pair
 - If only one lens is needed, we pay one half of the amount per pair.

Section 4: Vision Care Services Not Covered

We do not pay for the following:

- Additional charges for:
 - Lenses tinted darker than Rose Tint #2
 - Anti-reflective and photosensitive lenses
 - Oversize lenses
 - Sunglasses
- Medical-surgical treatment
- Medications administered during any service except an eye exam
- Services or materials ordered before coverage began
- Services not prescribed by a physician or optometrist
- Special services, such as orthoptics, vision training, low (subnormal) vision aids, aniseikonic lenses and tonography
- Replacement of broken or lost lenses or frames
- Services covered by worker's compensation laws
- Services received at a medical clinic provided or maintained by an employer
- Services received as a result of an eye disease, defect or injury due to an act of war, declared or undeclared
- Services available at no cost to you or for which no charge would be made in the absence of BCBSM coverage
- Charges for lenses or frames ordered while you were eligible for benefits but delivered more than 60 days after coverage ends
- Charges for completing insurance forms
- Aphakic lenses when the patient lacks a natural lens
- Charges for experimental or poor quality services
- Medically unnecessary services, glasses or contact lenses, unless otherwise specified in this certificate
- Charges for cosmetic contact lenses (contacts that are nonprescribed and do not correct visual acuity)

Section 5: How Vision Benefits are Paid**Paying a Participating Provider**

- The participating provider submits a claim to us for the services you receive.
- We pay the provider directly for the covered services.

A participating provider may bill you when:

- You receive a service not covered by your contract
- We deny a claim from a participating provider that was submitted more than 180 days after the date of service because you did not furnish needed information.

Paying a Nonparticipating Provider

You should expect to pay charges to a nonparticipating provider at the time you receive the services. You should then submit a claim to us.

- If we approve the claim, we will send payment to you.

NOTE:

Because nonparticipating providers often charge more than our maximum payment level, our payment may be less than the amount charged by the provider.

Out-of-State Providers

- An out-of-state provider may require you to pay for services at the time they are provided. If so, submit an itemized statement to us for the services. We will pay you the approved amount.
- An out-of-state provider may submit a claim. If so, the provider will be paid the approved amount.

BlueCard? Program

If you receive covered services in another state from a BlueCard participating provider, the Host Plan will pay the provider the amount required under its contract with the provider less any deductible or copayment required under your BCBSM certificate. After the Host Plan pays the provider, BCBSM reimburses the Host Plan the amount required under the BlueCard Program.

If the provider is not a BlueCard participating provider, we will pay for out-of-state services as described above.

If your certificate requires a deductible, that amount will apply to services received outside of Michigan. If your certificate requires a copayment, your copayment for services received outside of Michigan will be calculated using the designated payment level.

NOTE:

Your deductible and copayment requirements are based on your certificate and remain the same regardless of which Host Plan processes your claim for services.

The BlueCard Program will not apply if:

- The services are not a benefit under this certificate
- This certificate excludes coverage for services performed outside of Michigan or
- The services are performed by a vendor or provider who has a contract with BCBSM for those services

BlueCard Worldwide? Program

The BlueCard Worldwide Program assists BCBSM members traveling or living outside of the United States in obtaining medical care services; provides access to a worldwide network of health care providers; and includes claims support services.

BlueCard Worldwide Professional Services

- Subscribers are responsible for payment of all professional services at the time the services are rendered.
- Subscribers must provide copies of the itemized bill and proof of payment with the claim form. BCBSM will only pay for covered services.

Section 6: General Conditions of Your Contract

This section lists and explains certain general conditions that apply to your contract. These conditions may make a difference in how, where and when benefits are available to you.

Assignment

The services provided under this certificate are for your personal benefit and cannot be transferred or assigned. Any attempt to assign this contract will automatically terminate all your rights under it. No right to payment from us, claim or cause of action against us may be assigned by you to any provider. We will not pay any provider except under the terms of this contract.

Care and Services That Are Not Payable

We do not pay for the following care and services:

- Those for which you legally do not have to pay or for which you would not have been charged if you did not have coverage under this certificate
- Those payable by government-sponsored health care programs, such as Medicare, for which a member is eligible. These services are not payable even if you have not signed up to receive the benefits provided by such programs. However, care and services are payable if federal laws require the government-sponsored program to be secondary to this coverage.
- Any services not listed in this certificate as being payable

Changes in Your Family

We must be notified by your employer or group within 30 days of any changes in your family. This requires you to complete an enrollment/change of status form with your employer or group. Any coverage changes will then take effect as of the date of the event. Changes include marriage, divorce, birth, death, adoption, or the start of military service. An enrollment/change of status form should be completed when you have a change of address.

Changes to Your Certificate

BCBSM employees, agents or representatives cannot agree to change or add to the benefits described in this certificate.

- Any changes must be in writing and approved by BCBSM and the Michigan Commissioner of Financial and Insurance Regulation.
- We may add, limit, delete or clarify benefits by issuing a rider. Keep any riders you receive with this certificate.

Coordination of Benefits

We will coordinate the benefits payable under this certificate pursuant to the Coordination of Benefits Act, Public Act No. 64 of 1984 (starting at MCLA 550.251). To the extent that the services covered under this certificate are also covered and payable under another group health care plan, we will combine our payment with that of the other plan to pay the maximum amount we would routinely pay for the covered services.

Coverage Under Previous Contracts

This certificate replaces any previous contracts for vision coverage you had with us.

Experimental Treatment

Services That Are Not Payable

We do not pay for experimental treatment (including experimental drugs or devices) or services related to experimental treatment, except as explained under "Services That Are Payable" below. In addition, we do not pay for administrative costs related to experimental treatment or for research management.

NOTE:

This certificate does not limit or preclude the use of antineoplastic or off-label drugs when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.

How BCBSM Determines If a Treatment Is Experimental

The BCBSM medical director is responsible for determining whether the use of any service is experimental. For example, the service may be determined to be experimental when:

- Medical literature or clinical experience is inconclusive as to whether the service is safe or effective for treatment of any condition, or
- It has been shown to be safe and effective treatment for some conditions, but there is inadequate medical literature or clinical experience to support its use in treating the patient's condition, or
- Medical literature or clinical experience has shown the service to be unsafe or ineffective for treatment of any condition, or
- There is a written experimental or investigational plan by the attending provider or another provider studying the same service, or
- It is being studied in an on-going clinical trial, or
- There is a written informed consent used by the treating provider in which the service is referred to as experimental or investigational or other than conventional or standard treatment.

NOTE:

The medical director may consider other factors.

When available, the following sources will be considered in evaluating whether a treatment is experimental under the above criteria:

- Scientific data, such as controlled studies in peer-reviewed journals or medical literature
- Information from the Blue Cross and Blue Shield Association or other local or national bodies
- Information from independent, nongovernmental, technology assessment and medical review organizations
- Information from local and national medical societies, other appropriate professional societies, organizations, committees or governmental bodies
- Approval, when applicable, by the Food and Drug Administration (FDA), the Office of Health Technology Assessment (OHTA) and other governmental agencies
- Accepted national standards of practice in the medical profession
- Approval by the Institutional Review Board of the hospital or medical center

NOTE:

The medical director may consider other sources.

Services That Are Payable

We do pay for experimental treatment and services related to experimental treatment when all of the following are met:

- BCBSM considers the experimental treatment to be conventional treatment when used to treat another condition (i.e., a condition other than what you are currently being treated for).
- The treatment is covered under your certificates when it is provided as conventional treatment.
- The services related to the experimental treatment are covered under your certificates when they are related to conventional treatment.
- The experimental treatment and related services are provided during a BCBSM-approved oncology clinical trial (check with your provider to determine whether a clinical trial is approved by BCBSM).

NOTE:

This certificate does not limit or preclude the use of antineoplastic or off-label drugs when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.

Limitations and Exclusions

- This section of your certificate does not provide coverage for services not otherwise covered under your certificates.
- Drugs or devices provided to you during a BCBSM-approved oncology clinical trial will be covered only if they have been approved by the FDA, regardless of whether the approval is for treatment of the member's condition, and to the extent they are not normally provided or paid for by the sponsor of the trial or the manufacturer, distributor or provider of the drug or device.

Illness or Injuries Resulting From War

Services are not payable for the treatment of an illness or injuries resulting from declared or undeclared military acts of war.

Improper Use of Contract

If you allow any ineligible person to receive benefits (or try to receive benefits) under your contract, we may:

- Refuse to pay benefits
- Cancel your contract
- Begin legal action against you and
- Refuse to cover your vision care services at a later date

Notification

When we need to notify you, we mail the notice to your employer or remitting agent or to your most recent address we have in our records, as applicable. This fulfills our obligation to notify you.

Other Coverage

In certain cases, we may have paid for vision care services for you or your covered dependents that should have been paid by another person, insurance company or organization. In these cases:

- You grant us a lien or right of reimbursement on any money or other valuable consideration you or your covered dependents or representatives receive through a judgment, settlement, or otherwise. You grant us the lien or right of reimbursement regardless of 1) whether the money or other valuable consideration is designated as economic or non-economic damages, 2) whether the recovery is partial or complete, and 3) who holds the money or other valuable consideration or where it is held.
- You agree to inform us when you hire an attorney to represent you, and to inform your attorney of our rights under this certificate
- You must do whatever is necessary to help us recover the money we paid to treat the injury that caused you to claim damages for personal injury.
- You must not settle a personal injury claim without first obtaining our written consent if we paid for the treatment you received for that injury.
- You agree to cooperate with us in our efforts to recover money we paid on behalf of you or your dependents.
- You acknowledge and agree that this certificate supercedes any made whole doctrine, collateral source rule, common fund doctrine or other equitable distribution principles.

Personal Costs

We will not pay for:

- Care, services, supplies or devices that are personal or convenience items
- Charges to complete claim forms

Physician of Choice

You may continue to receive services from the physician of your choice.

Refunds of Premium

If we determine that we must refund a premium, we will repay up to a maximum of two years of payments.

Release of Information

You agree to permit providers to release information to us. This can include medical records and claims information related to services you may receive or have received.

We agree to keep this information confidential. Consistent with our Notice of Privacy Practices, this information will be used and disclosed only as authorized by law.

Reliance on Verbal Communications

Verbal verification of a member's eligibility for coverage or availability of benefits is not a guarantee of payment of claims. All claims are subject to a review of the diagnosis reported, medical necessity verification, the availability of benefits at the time the claim is processed as well as to the conditions, limitations, exclusions, maximums, deductibles and copayments under your coverage.

Right to Interpret Contract

During claims processing and internal grievances, BCBSM reserves the right to interpret and administer the terms of this certificate and any riders that amend it. BCBSM's final adverse decisions regarding claims processing and grievances are subject to your right to appeal under applicable law.

Services Before Coverage Begins or After Coverage Ends

Unless otherwise stated in this certificate, 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, except for eyeglasses and contact lenses ordered before, but received within 60 days after coverage ends.

Time Limit for Legal Action

Legal action against us may not begin later than two years after we have received a complete claim for services. No action or lawsuit may be started until 30 days after you notify us that our decision under the claim review procedure is unacceptable.

Unlicensed Provider

Benefits are not payable for vision care services provided by persons who are not legally qualified or licensed to provide such services.

What Laws Apply

This certificate will be interpreted under the laws of the state of Michigan.

Workers Compensation

We do not pay for the treatment of work-related injuries covered by workers compensation laws or for work-related services you receive through a medical clinic or a similar facility provided or maintained by an employer.

Section 7: The Language of Vision Care

This section explains the terms used in your certificate.

Acquisition Cost

The actual cost of lenses and frames to the provider.

Approved Amount

The lower of the billed charge or our maximum payment level for the covered service. Copayments and/or deductibles, which may be required of you, are subtracted from the approved amount before we make our payment.

BCBSM

Blue Cross Blue Shield of Michigan.

BlueCard? Program

A program that allows Blue Cross Blue Shield members to receive health care services in other states and have claims processed by the Host Plan, subject to Blue Cross and Blue Shield Association policies.

BlueCard Worldwide? Program

A program that provides access to a network of inpatient facilities and medical assistance services worldwide, including referrals to professional providers for all Blue Cross Blue Shield of Michigan members whose claims are eligible for processing through the BlueCard Program.

Certificate

This book, which describes your benefit plan, and any riders that amend the certificate.

Claim for Damages

A lawsuit against, or demand to, another person or organization for compensation for an injury to a person.

Contact Lenses

Contact lenses prescribed by a physician or optometrist to correct or improve vision. They are fitted directly to the patient's eye.

Contract

This certificate and any related riders, your signed application for coverage and your BCBSM ID card.

Copayment

The portion of the approved amount that you must pay for a covered service.

Dispensing Fee

The amount we pay a participating provider for dispensing eyeglass lenses and frames.

Effective Date

The day your coverage begins under this contract. This date is established by BCBSM.

Exclusions

Situations, conditions or services that are not covered by the subscriber's contract.

Experimental Treatment

Treatment that has not been scientifically proven to be as safe and effective for treatment of the patient's conditions as conventional treatment. Sometimes it is referred to as "investigational" or "experimental services."

First Priority Security Interest

The right to be paid before any other person from any money or other valuable consideration recovered by:

- Judgment or settlement of a legal action
- Settlement not due to legal action
- Undisputed payment

This right may be invoked without regard for:

- Whether plaintiff's recovery is partial or complete
- Who holds the recovery
- Where the recovery is held

Frames

Standard frames into which two lenses may be fitted.

Group

A collection of subscribers under one contract. Generally, all members of a group are employed by the same employer. One employer, however, may have different segments or categories of employees working for the same employer. A group can also include participants of a trust fund that has been established to purchase health care coverage pursuant to collective bargaining agreements.

Lenses

Glass or plastic lenses prescribed by a physician or optometrist to correct or improve vision. They are fitted into frames.

Lien

A first priority security interest in any money or other valuable consideration recovered by judgment, settlement or otherwise up to the amount of benefits, costs and legal fees BCBSM paid as a result of the plaintiff's injuries.

Medically Necessary

Medical necessity is the determination by physicians or optometrists acting for BCBSM, based on criteria and guidelines developed by physicians and optometrists for BCBSM, that the service is appropriate and necessary for the condition.

NOTE:

In the absence of established criteria, medical necessity will be determined by physicians or optometrists according to accepted standards and practices.

Member

Any person eligible for health care services under this certificate. This means the subscriber and any eligible dependent listed on the application. The member is the "patient" when receiving covered services.

Nonparticipating Provider

A physician, optometrist or optician who has not signed an agreement with BCBSM to participate in our vision care plan.

Off-Label

The use of a drug or device for clinical indications other than those stated in the labeling approved by the federal Food and Drug Administration.

Ophthalmologist

A licensed doctor of medicine or osteopathy who, within the scope of his or her license, performs eye exams and prescribes corrective lenses.

Optician

A person or organization that makes corrective lenses prescribed by a physician or optometrist. The optician must be licensed in the state where the service is performed.

Optometrist

A person licensed to practice optometry in the state where the service is provided.

Participating Provider

A physician, optometrist or optician who has signed an agreement with BCBSM to participate in our vision care plan. The provider accepts direct payment from BCBSM and accepts our payment plus your copayment as payment in full for covered services.

Physician

A licensed doctor of medicine (M.D.) or osteopathy (D.O.) who, within the scope of his or her license, performs vision testing examinations and prescribes corrective lenses. An ophthalmologist is a physician. Physicians may also be referred to as "practitioners."

Plaintiff

The person who brings the lawsuit or claim for damages. The plaintiff may be the injured party or a representative of the injured party.

Practitioner

A physician (a doctor of medicine or osteopathy) or a professional provider (a doctor of medicine or osteopathy) or other professional provider who participates with BCBSM or who is on a BCBSM PPO panel. Practitioner may also be referred to as "participating" or "panel" provider.

Professional Provider

One of the following:

- Doctor of Medicine
- Doctor of Osteopathy
- Other providers as identified by BCBSM

Professional providers may also be referred to as "practitioners."

Provider

A physician, optometrist or optician that provides services related to vision care.

Remitting Agent

Any individual or organization that has agreed, on behalf of the subscriber to:

- Collect or deduct premiums from wages or other sums owed to the subscriber; and
- Pay the subscriber's BCBSM bill

Rider

A document that amends a certificate by adding, limiting, deleting or clarifying benefits.

Right of Reimbursement

The right of BCBSM to make a claim against you, your dependents or representatives if you or they have received funds from another party responsible for benefits paid by BCBSM.

Subrogation

The assumption by BCBSM of your right, or the right of your dependents or representatives, to make a legal claim against or to receive money or other valuable consideration from another person, insurance company or organization.

Subscriber

The person who signed and submitted the application for coverage.

We, Us, Our

Used when referring to Blue Cross Blue Shield of Michigan.

You and Your

Used when referring to any person covered under a subscriber's contract.

Section 8: How to Reach Us

This section lists phone numbers and addresses to help you get information quickly. You may call us or visit our BCBSM Customer Service center.

To Call

Most of our BCBSM Customer Service lines are open for calls from 8:30 a.m. to noon and from 1 p.m. to 5 p.m., Monday through Friday. Please have your ID card with your group and contract numbers ready when you call.

Area code 248, 313, 586, 734, 810 or 947

Detroit.....313-225-8100

Southeast Michigan toll-free.....800-637-2227

Area code 231, 269 or 616

West Michigan toll-free.....800-972-9797

Area code 517 or 989

Central Michigan toll-free.....800-258-8000

Area code 906

Upper Peninsula toll-free.....800-562-7884

To Visit

BCBSM Customer Service centers are located throughout Michigan. Check the following list or visit our Web site at www.bcbsm.com to find the center nearest you. The centers are open Monday through Friday.

Detroit

600 E. Lafayette Blvd., Detroit 48226

Downtown, three blocks north of Jefferson at St. Antoine

Open from 8:30 a.m. to 5 p.m.

Flint

4520 Linden Creek Parkway, Suite A, Flint 48507

Open from 8:30 a.m. to 5 p.m.

Grand Rapids

86 Monroe Center, NW., Grand Rapids 49503

Open from 9 a.m. to 5 p.m.

Holland

151 Central Ave., Holland 49423

Open from 9 a.m. to 5 p.m.

Lansing

1403 Creyts Road, Lansing 48917

One-quarter mile south of I-496, Creyts Road exit

Open from 8:30 a.m. to 5 p.m.

Marquette

415 S. McClellan Ave., Marquette 49855

Up on the hill

Open from 8:30 a.m. to 5 p.m.

Portage

8175 Creekside Drive, Suite 100, Portage 49024

Open from 9 a.m. to 5 p.m.

Southfield

27000 W. 11 Mile Road, Southfield 48034

East of Inkster Road on the first floor of Tower 300

Open from 8:30 a.m. to 4:30 p.m.

Traverse City

1769 S. Garfield, Traverse City 49686

Across from Cherryland Center

Open from 9 a.m. to 5 p.m.

Utica

6100 Auburn Road, Utica 48317

Diagonally across from the AAA building

Open from 8:30 a.m. to 5 p.m.

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Standard Rider - Effective 06/30/1998
RIDER PCO-MHS
Medical Services , Form # 4890
BI3 Doc # 88222 ,

PRODUCT AND DEVELOPMENT SERVICES DEPARTMENT COVERAGE SPECIFICATIONS

EFFECT ON COVERAGE

1. PRECERTIFICATION CARVE-OUT - MENTAL HEALTH SERVICES

B. Effect of adding this Rider

Rider PCO-MHS carves out the precertification functions for psychiatric and substance abuse admissions from Green Spring Health Services. A third party other than Green Spring performs this function. Criteria other than Blue Chip will be applied.

LIMITATIONS AND EXCLUSIONS:

Rider PCO-MHS will NOT be available to:

- members with Blue Preferred Plus coverage
- members with Point of Services coverage
- members with HMO/BCN coverage

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Standard Rider - Effective 02/01/1995
 RIDER HMN - HOSPITAL MEDICAL NECESSITY
 Medical Services , Form # 5227
 BI3 Doc # 1534 ,

IMPORTANT Keep This Rider With Your Certificate

Rider HMN HOSPITAL MEDICAL NECESSITY AMENDS ALL BCBSM GROUP BENEFIT CERTIFICATES WHICH PROVIDE HOSPITAL CARE SERVICES (Excluding Dental Care, Vision Care and Prescription Drug Program Certificates)

Rider HMN amends the certificates named above to include and define the term medical necessity for hospital services.

This rider is effective when you, your employer, or remitting agent is notified.

Blue Cross Blue Shield of Michigan

An Independent Licensee of the Blue Cross and Blue Shield Association.

Your certificate is amended as follows:

SECTION 1 : Definitions

Acute Care

Medical care that requires a wide range of medical, surgical, obstetrical and/or pediatric services. It generally requires a hospital stay of less than 30 days.

Appropriate

The type, level and length of care or services needed to provide safe and adequate diagnosis and treatment. For inpatient hospital stays, acute care must be required for the patient's condition because safe and adequate care cannot be provided in an outpatient or other less intensive medical setting.

Hospital

A facility which is licensed and accredited as a hospital and provides inpatient diagnostic and therapeutic services 24 hours every day for acutely ill medical, surgical and obstetric patients. The facility provides a professional staff of licensed physicians and nurses to supervise the care of the patients.

Medical Necessity

A determination which allows for payment of covered hospital services when all of the following conditions are met:

- The service is for the diagnosis or treatment of an injury, condition or disease.
- The service or treatment is appropriate for the injury, condition or disease.
- The service is not mainly for the convenience of the member or health care provider.
- The treatment is not generally regarded as experimental or investigational by BCBSM.
- The service is considered to be the generally accepted standard of practice by the BCBSM Medical Director or his/her agents.

Service

Care, procedures and supplies performed or given by a properly licensed health care provider to diagnose or treat medical conditions.

SECTION 2: What We Pay

Subject to the remaining terms and conditions of your certificate, we will pay our approved amount for covered hospital services that are medically necessary.

SECTION 3: Limitations and Exclusions

- We will not pay for inpatient hospital services that can be provided safely in an outpatient or office location.
- You may have to pay for medically necessary hospital services if you do not inform the hospital, either at the time of your admission or within 30 days after your discharge, that you are a BCBSM member.

GENERAL

Until further notice, all the terms, definitions, limitations, exclusions, and conditions of your certificate and related riders remain in full force and effect, except as provided in Rider HMN.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN

Richard E. Whitmer

President and Chief Executive Officer

Form No, 5227 Bureau Approved 2/95

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Custom Rider - Effective 01/01/2003
ASC PLAN MODIFICATION 1717 - STATE OF MICHIGAN
Medical Services , Form # 5368
B13 Doc # 8894 ,

**PRODUCT DEVELOPMENT SERVICE DEPARTMENT
COVERAGE SPECIFICATIONS
EFFECT ON COVERAGE**

1. HEARING CARE

B. Effect Of Adding This Modification

This modification **WAIVES** the 36-month frequency limit in instances where the member's hearing loss changes significantly. As a result, when a significant hearing loss occurs, BCBSM will pay for a binaural hearing aid and the related covered services even in cases where it's been less than 36 months since the patient obtained his/her last hearing aid.

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Standard Rider - Effective 09/01/1992

RIDER RAPS - REIMBURSEMENT ARRANGEMENT FOR PROFESSIONAL SERVICES

Medical Services , Form # 7469

BI3 Doc# 2232 ,

IMPORTANT Keep This Rider With Your Certificate

Rider RAPS REIMBURSEMENT ARRANGEMENT FOR PROFESSIONAL SERVICES AMENDS ALL BCBSM GROUP, NON-GROUP, AND GROUP CONVERSION BENEFIT CERTIFICATES

Rider RAPS amends the certificates named above to provide a payment arrangement for services rendered by professional providers.

It does not amend Master/Major Medical Supplemental Certificates, Dental Care, Vision Care or Prescription Drug Program Certificates.

This rider is effective when you, your employer, or remitting agent is notified.

Blue Cross Blue Shield of Michigan

An Independent Licensee of the Blue Cross and Blue Shield Association.

Your certificate is amended as follows:

SECTION 1: Definitions**Approved Amount**

The lower of the billed charge or our maximum payment level for the covered service.

BCBSM

Blue Cross and Blue Shield of Michigan.

Medically Necessary

A service must be medically necessary in order to be covered. The definition of medically necessary applies to physician services.

- Medical necessity for payment of physician services
 - Determination by physicians acting for BCBSM, based on criteria and guidelines developed by physicians for BCBSM who are acting for their respective provider type and/or medical specialty, that:
 - the covered service is accepted as necessary and appropriate for the patient's condition. It is not mainly for the convenience of the member or physician.
 - in the case of diagnostic testing, the results are essential to and are used in the diagnosis and/or management of the patient's condition.

NOTE:

In the absence of established criteria, medical necessity will be determined by physicians according to accepted standards and practices.

Physician

The term includes those providers listed under the definition Professional Provider.

Non-participating Provider

Any provider who has not signed an agreement with us to accept our payment for covered services as payment in full. A non-participating provider, however, may agree to accept our payment as payment in full on a per claim basis.

Participating Provider

Any provider who has signed an agreement with us to accept our payment for covered services as payment in full.

Professional Provider

A doctor of medicine (M.D.), doctor of osteopathy (D.O.), chiropractor (D.C.), podiatrist (D.P.M.), and fully licensed psychologist.

We, Us, Our

Used when referring to Blue Cross and Blue Shield of Michigan.

You and Your

Used when referring to any person covered by the subscriber's contract.

SECTION 2: Payment Arrangement for Professional Provider Services

We will pay the approved amount for each medically necessary covered service, less any deductibles and/or copayments that may be required in the amended certificates and related riders.

- **Participating Provider**

A participating provider will submit a claim to us for the services you receive. We will pay the provider directly for covered services that are medically necessary. The provider will accept our payment as payment in full.

A participating provider may bill you in the following limited situations:

- you receive a service not covered by your contract, or
- you receive a service determined not to be medically necessary and you agree, in writing before the service is provided, to pay for it, or
- we deny a claim for a covered service because you failed to give the provider information necessary to file the claim in a timely manner.

- **Non-participating Provider**

When you receive services from a non-participating provider, you should expect to pay the charges at the time you receive care. It is then your responsibility to submit a claim to us. If we approve the claim, we will send the payment directly to you. Because non-participating providers may charge more than the approved amount, our payment to you may sometimes be less than the amount charged by the provider.

In those instances when a non-participating provider agrees to participate on a "per claim" basis, the provider will:

- submit a claim to us for the service or services you receive, and
- accept our payment as payment in full for medically necessary covered services.

GENERAL

Until further notice, all the terms, definitions, limitations, exclusions, and conditions of your certificate and related riders remain in full force and effect, except as otherwise provided in Rider RAPS.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN

Richard E. Whitmer

President and Chief Executive Officer

Form No. 7469 (A) Bureau Approved 9/92

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Standard Rider - Effective 02/01/2008

RIDER HC (A) - HEARING CARE

Medical Services , Form # 7572

BI3 Doc # 2247 ,

IMPORTANT

KEEP THIS RIDER WITH YOUR CERTIFICATE

RIDER HC (A) HEARING CARE

AMENDS

ALL BCBSM GROUP BENEFIT CERTIFICATES

(excluding Prescription Drug, Dental Care, Vision Care, Master Medical and Medicare supplemental benefit certificates)

Rider HC (A) amends the certificates named above to provide coverage for hearing aids and certain other hearing care services every 36 months.

This rider is effective when you, your employer or remitting agent is notified.

Blue Cross Blue Shield of Michigan

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

Your certificate is amended as follows:

SECTION 1: Definitions

Approved Amount

The lower of the billed charge or our maximum payment level for the covered service.

Audiologist

A professional who is licensed or legally qualified in the state in which services are provided to perform audiometric and other procedures to assist in the diagnosis, treatment and management of individuals with hearing loss or balance problems. They may dispense and fit hearing aids as part of a comprehensive rehabilitative program.

Audiometric Examination

A procedure to evaluate the patient's hearing and measure hearing loss.

Binaural Hearing Aids

Two electronic devices worn by the patient to amplify sound and improve hearing in both ears.

Conformity Test

A follow-up visit to the physician-specialist, audiologist or hearing aid dealer who prescribed the hearing aid to verify that the patient received the prescribed hearing aid and to evaluate its effectiveness.

Ear Mold

A device made of soft rubber, plastic or nonallergenic materials, vented or nonvented, that is fitted to the outer ear canal and pinna of the patient.

Hearing Aid

An electronic device worn by the patient to amplify sound and improve the patient's hearing. A hearing aid may include an ear mold, if necessary.

Hearing Aid Evaluation Test

A series of subjective and objective tests to determine what model and make of hearing aid should be prescribed to improve

the patient's hearing.

Hearing Aid Dealer

A person licensed to perform audiometric examinations, hearing aid evaluation tests and conformity tests and to sell prescribed hearing aids.

Medical Evaluation

A procedure performed by a physician to evaluate the cause of hearing loss and to determine if the hearing loss can be improved with a hearing aid.

Monaural Hearing Aid

A single electronic device worn by the patient to amplify sound and improve hearing in one ear.

Nonparticipating Providers

Physicians and other health care professionals or facilities that have not signed a participation agreement with BCBSM to accept the approved amount as payment in full for covered services.

Participating Providers

Physicians and other health care professionals or facilities that have signed a participation agreement with BCBSM to accept the approved amount as payment in full for covered services.

Per Claim Participation

Available to some nonparticipating providers when they elect to accept the approved amount for specific covered services as payment in full.

Physician-specialist

A licensed doctor of medicine or osteopathy who is also board certified or board eligible as an otologist, otolaryngologist or otorhinolaryngologist. A physician-specialist determines whether a patient has a hearing loss and whether such loss can be offset by a hearing aid.

Provider

A physician-specialist, audiologist or hearing aid dealer who provides services or supplies relating to a possible hearing loss.

SECTION 2: What You Must Pay

You must obtain a medical evaluation (sometimes called a medical clearance examination) performed by a physician-specialist before you receive your hearing aid. The medical evaluation is not a benefit under the hearing care program, so you must pay for this examination unless your medical coverage provides for office visits.

If a physician-specialist is not accessible, your primary care doctor may perform the medical evaluation.

If you select a digitally-controlled programmable hearing device, you may be responsible for charges that exceed the cost of a covered hearing aid.

Outside of Michigan, the Blue Cross and Blue Shield plan in a particular state may not contract with providers for hearing care services. In that case you may be responsible for charges that exceed BCBSM's approved amount.

SECTION 3: What We Pay

Participating Providers

In Michigan and outside of Michigan where Blue Cross and Blue Shield plan contracts with providers for hearing care services, we pay the approved amount for hearing aids and related covered services only when obtained from participating providers.

Nonparticipating Providers

We do not pay for services performed by nonparticipating providers unless both the following occur:

- The services are performed outside of Michigan.
 - The local Blue Cross and Blue Shield plan does not contract with providers for hearing care services
- In this case, we pay the approved amount for hearing aids and related covered services when obtained from nonparticipating providers. Your provider may participate with BCBSM on a per claim basis.

If the provider will not submit a claim for your covered services, you may submit a detailed receipt to BCBSM. We will pay you the approved amount.

SECTION 4: Covered Services

We pay the approved amount for:

- An audiometric examination that
 - Is performed by a participating physician-specialist, audiologist or hearing aid dealer
 - Includes tests for measuring hearing perception relating to air conduction, bone conduction, speech reception threshold and speech discrimination
 - Includes a summary of findings
- A hearing aid evaluation test and a conformity test
 - Prescribed by a physician
 - Performed by a participating physician-specialist, audiologist, or hearing aid dealer
- A monaural or binaural hearing aid that must be
 - Designed to be worn in the ear, in the ear canal, behind the ear (including air conduction and bone conduction types) or on the body
 - Prescribed by a participating physician-specialist, audiologist, or hearing aid dealer based on the most recent audiometric examination and hearing aid evaluation test
 - The make and model prescribed by the participating physician-specialist, audiologist, or hearing aid dealer
 - Dispensed by a participating hearing aid dealer when services are obtained in Michigan

SECTION 5: Limitations and Exclusions

We will pay for the audiometric examination, hearing aid evaluation, conformity tests and a hearing aid once every 36 months. We will consider providing additional hearing care benefits if a physician-specialist sends us documentation of severe hearing loss that has occurred within 36 months. An example of severe hearing loss would be when a person wearing the hearing aid cannot distinguish normal speech 25 percent of the time.

The following are not payable:

- Services performed by nonparticipating providers in Michigan and outside of Michigan where the Blue Cross and Blue Shield plan contracts with providers for hearing care services
- Medical or surgical treatment
- Drugs or other medications
- The trial and testing of different makes and models of hearing aids when the tests are not supported by the results of the most recent audiometric examination
- A medical evaluation by a physician-specialist to determine possible hearing loss
- Hearing aids ordered while you are a BCBSM member, but delivered more than 60 days after coverage ends
- Charges for audiometric examinations, hearing aid evaluation tests, conformity tests and hearing aids that are not necessary, according to professionally accepted standards of practice, or which are not prescribed by the physician-specialist
- Charges for spare hearing aids
- Replacement of hearing aids that are lost or broken, unless you have not used this benefit for at least 36 months
- Replacement parts for and repairs of hearing aids
- Any charges that exceed our approved amount for covered hearing aids if you obtain digitally-controlled programmable hearing devices
- Examinations related to medical-surgical procedures such as tonsillectomies or myringotomies
- Two hearing aids ordered on different dates. These are not considered binaural hearing aids.
- Hearing aids that do not meet Food and Drug Administration and Federal Trade Commission requirements

GENERAL

Until further notice, all of the terms, definitions, limitations, exclusions and conditions of your certificate and related riders remain in full force and effect, except as otherwise provided in Rider HC (A).

BLUE CROSS BLUE SHIELD OF MICHIGAN

Daniel J. Loepp

President and Chief Executive Officer

Form No. 7572

Bureau Approved 02/08

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Custom Rider - Effective 04/01/2005
ASC PLAN MODIFICATION 2441 - STATE OF MICHIGAN
Medical Services , Form # 8241
BIS Doc # 75896 .

PRODUCT DEVELOPMENT AND MANAGEMENT DEPARTMENT COVERAGE SPECIFICATIONS EFFECT ON COVERAGE

1. DURABLE MEDICAL EQUIPMENT, PROSTHETIC & ORTHOTIC AND MEDICAL SUPPLIES

B. Effect Of Adding This Modification

Under this modification, BCBSM will only administer benefits for DME, P&O and medical supplies that meet one or more of the following parameters.

- Services rendered by out-of-state providers
- Home infusion therapy services
- Optical-related services
- Fee-for-service items
- Services reported in any location except location 4 (NOTE: Location 4 is the patient's home.)

Benefits for services that do not meet the above parameters will be administered by another carrier selected by the account.

Benefits that have a DME, P&O or medical supply component (such as outpatient diabetes management, etc.) are also subject to the same parameters cited earlier. If these claims meet one or more of the criteria, then BCBSM will be responsible for the claim. However, if the services do not meet either of the criteria, then the account's selected vendor will be responsible for the claim.

2. CASE MANAGEMENT

B. Effect Of Adding This Modification

This modification REMOVES the coordinated care management program and REPLACES it with BlueHealth Connection.

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Custom Rider - Effective 10/01/2005

ASC PLAN MODIFICATION 2595 - STATE OF MICHIGAN ACTIVE EMPLOYEES

Medical Services , Form # 8507

B13 Doc # 79525 ,

PRODUCT DEVELOPMENT AND MANAGEMENT DEPARTMENT COVERAGE SPECIFICATIONS

EFFECT ON COVERAGE

1. CHIROPRACTIC CARE

B. Effect Of Adding This Modification

This modification **REMOVES** the previous member cost-sharing provisions for ALL chiropractic care (including physical therapy and xrays) and **REPLACES** it with the following:

- Chiropractic office visits and spinal manipulations performed by a **PANEL** provider will be subject to a \$10 member copayment for each covered procedure. The panel deductible will **NOT** be imposed. When chiropractic office visits and spinal manipulations are performed on the same day by the same **PANEL** provider, and both services are payable however, only one \$10 copay is applicable. The 24 visit maximum remains in place.
- Physical therapy traction procedures and xrays performed by a **PANEL** provider will continue to be paid at 100% of the approved amount after the panel deductible has been met.
- Chiropractic office visits, spinal manipulations, physical therapy traction procedure, and xrays performed by a **PANEL** provider will be subject to the non-panel deductible (\$500/\$1000) and 10% member copayment that typically applies to most other non-panel services.

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Custom Rider - Effective 10/01/2008
ASC PLAN MODIFICATION 4258 - STATE OF MICHIGAN
Medical Services , Form # 858A
B13 Doc # 2001349 ,

EFFECT ON COVERAGE

1. Emergency Room Visits

B. Effect of Adding this Modification

This modification IMPOSES a \$50 copayment for facility only emergency room visits whether performed by a panel or non-panel provider. The \$50 copayment is waived if the patient is admitted to any hospital within 72 hours of the emergency.

2. Fixed Dollar Copayment

B. Effect of Adding this Modification

This modification INCREASES the copayment to \$15 for the following benefits when rendered by a panel provider:

- Office Visits
- Office Consultations
- Chiropractic Office Visits
- Chiropractic Spinal Manipulation
- Urgent Care Visits
- Medical Eye Exams
- Medical Hearing Exams

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Custom Rider - Effective 01/01/2006
ASC PLAN MODIFICATION 2723 - STATE OF MICHIGAN
Medical Services , Form # 8709
B13 Doc # 81004 ,

**PRODUCT DEVELOPMENT AND MANAGEMENT
DEPARTMENT COVERAGE SPECIFICATIONS
EFFECT ON COVERAGE**

1. PREVENTIVE SERVICES

B.Effect Of Adding This Modification

This modification:

- **INCREASES**the annual preventive care maximum to \$1500 per member
- **EXCLUDES**colonoscopies and childhood immunizations, (through age 16) from the annual benefit maximum; and
- **ALLOWS**colonoscopies and childhood immunizations, (through age 16) to be covered when performed by a non-panel provider
(All other preventive services are not covered when performed by a non-panel provlder)

2. PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY

B.Effect Of Adding This Modification

This modification **INCREASES**the benefit limit for Physical, Occupational and Speech Therapy to 90 visits per member, per calendar year.

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Custom Rider - Effective 01/01/2009
ASC PLAN MODIFICATION 4398 - STATE OF MICHIGAN
Medical Services , Form # 998A
B13 Doc # 2002034 ,

COVERAGE SPECIFICATIONS

EFFECT ON COVERAGE

1. Panel Deductible Requirement

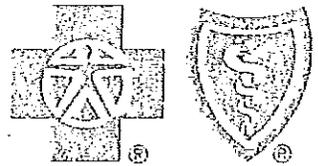
B.Effect Of Adding This Modification

This modification INCREASES the panel deductible to \$300 per member, not to exceed \$600 for a family.

2. Non-Panel Deductible

B.Effect Of Adding This Modification

This modification INCREASES the non-panel deductible to \$600 per member, not to exceed \$1,200 for a family.



Your Benefit Guide

STATE HEALTH PLAN

PPO

STATE HEALTH PLAN

State of Michigan Employees

Welcome

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

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

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

Your copayments are as follows:

Benefit	Copayment as of Oct. 1, 2008
In-network office visits: <ul style="list-style-type: none">• Physician office visit• Office consultations• Chiropractic spinal manipulations• Chiropractic office visit• Urgent care visit• Medical hearing exam• Medical eye exam	\$15
Emergency room	\$50 (waived if admitted)

Your deductibles are as follows:

Deductible as of Jan 1, 2009	In-network	Out-of-network
Individual	\$300	\$ 600
Family	\$600	\$1200

If you have any questions about your State Health Plan PPO coverage after reading this book, please call the BCBSM State of Michigan Customer Service Center. The toll free number is 800-843-4876. Our customer service representatives are available Monday through Friday from 8 a.m. to 6 p.m., excluding holidays.

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

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How to reach us

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

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

- Have your ID card handy so you can provide your contract and group numbers. If you 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 a.m. to 6 p.m. We are closed on holidays.

In and outside Michigan.....800-843-4876

Special servicing numbers

Anti-fraud hotline800-482-3787
Hearing-impaired customers..... TTY# 800-240-3050
BlueSafeSM hotline877-BLUESAFE (258-3723)
BlueCard[®]800-810 BLUE (2583)
BlueHealthConnectionSM800-810 BLUE (2583)
Human organ transplant program.....800-242-3504
Conversion coverage servicing department.....888-642-2276

Writing

Please send all correspondence to:

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

Visiting

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

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

Additional walk-in offices:

Alpena

135 W. Chisholm St.

Detroit

500 E. Lafayette Blvd.

Flint

4520 Linden Creek Parkway
Suite A

Grand Rapids

86 Monroe Center NW

Holland

259 Hoover Blvd., Suite 160

Jackson

1000 N. Wisner St., Suite 5

Mt. Pleasant

1620 S. Mission

Marquette

415 S. McClellan Ave.

Muskegon

The Pointes
1034 E. Sternberg Road

Portage

2255 W. Centre Ave.

Port Huron

2887 Kraft Rd., Suite 200

Saginaw

4300 Fashion Square Blvd., Suite 100

Southfield

27000 W. 11 Mile Road

Traverse City

1769 S. Garfield Ave.

Utica

6100 Auburn Road

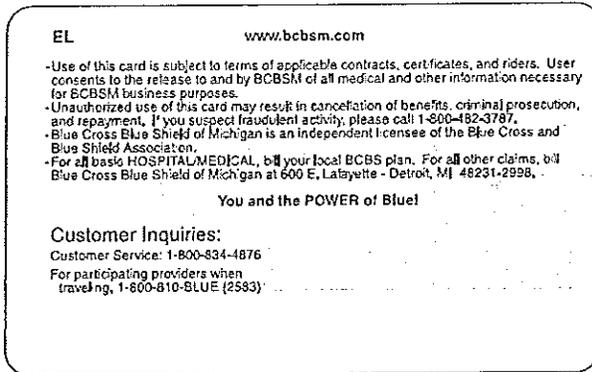
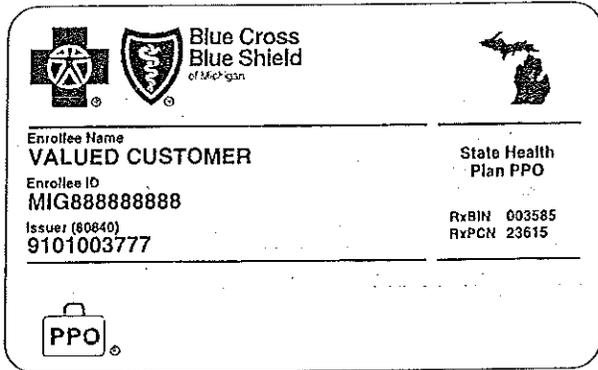
Internet access

Blue Cross Blue Shield of Michigan Home Page
Anti-fraud

bcbsm.com
bcbsm.com

Your ID card

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



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

The suitcase tells providers about your travel benefits.

Enrollee Name is the subscriber. All communications are addressed to this name.

Enrollee ID. This is your identification number. The subscriber is the person who signed and submitted the application for State Health Plan PPO coverage.

- The alpha prefix preceding the contract number identifies the type of coverage you have PPO.

Your Blue Cross Blue Shield of Michigan ID card is issued once you enroll for coverage. It lets you obtain services covered under the State Health Plan PPO. Only the subscriber's name appears on the ID card. However, the cards are for use by all covered members.

Here are some tips about your ID card:

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

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

Explanation of benefits

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

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

Please check your EOBPs carefully. If you see an error, please contact your provider first. If they cannot correct the error, call the BCBSM State of Michigan Customer Service Center.

If you think your provider is intentionally billing us for services you did not receive or that someone is using your BCBSM ID card illegally, contact our anti-fraud toll free hotline. Your call will be kept strictly confidential. By working together, we can help keep health care costs down.

Eligibility guidelines

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 submission of your enrollment form, whichever is later if:

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

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

Applying for coverage

You may apply for health care coverage when you meet State Health Plan PPO requirements for eligibility. You may enroll yourself and your eligible dependents before or within 31 days after your eligibility date.

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

Changing coverage

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

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

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

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

Open enrollment period

During open enrollment, you can:

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

Canceling coverage

The cancellation effective date will be the last day of the last payroll period in which a premium is paid. Your coverage under the State Health Plan PPO will automatically terminate:

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

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:

- Your child by birth, legal adoption, or legal guardianship.
- 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.
- Step-child for whom you have physical custody (i.e., the step-child lives with you at least 50 percent of the time as stated in a current divorce decree) and for whom you provide at least 50 percent of their support.
- Foster child placed in your home by a state agency or the court.
- Your children from the age of 19 until the age of 25 who are enrolled in an accredited educational institution and for whom you provide at least 50 percent of their support.

Continuing coverage for dependent children

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

- Unmarried and between 19 and 25 and
- Enrolled in an accredited educational institution and for whom you provide at least 50 percent of their 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.

Continuing coverage for incapacitated children

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

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

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

Mail the completed form to:

Blue Cross Blue Shield of Michigan
Attn: Senior Medical Analyst — Mail Code B419
600 E. Lafayette Blvd.
Detroit, MI 48226

Dependent exclusions

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

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

Canceling dependent coverage

Your dependent's coverage will automatically terminate:

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

If we are notified more than 30 days after the date of the event, the change to your contract will be delayed, which may cause errors when your claims are processed. Please remember to report any membership changes to the MI HR Service Center promptly so these changes can be reflected on your records.

If you fail to give timely notice, you may be liable for any payments made.

Eligibility guidelines by BCBSM on behalf of your dependent for medical services that have been provided subsequent to the date of the event.

Qual eligibility

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

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

If you choose to maintain separate coverage, your child or children can only be listed on one plan, not both. This applies even if you are divorced. Should you or your spouse separate from State service, take a leave of absence, or be laid off, the departing employee may be enrolled as a dependent on the remaining employee's State Health Plan PPO coverage, providing the remaining employee:

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

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 under COBRA

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

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

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

- Spouses who lose coverage because of divorce or legal separation
- Children who no longer meet dependent eligibility requirements under the State 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 the full monthly premium, including the share that was paid by the State, directly to the COBRA program. (Notify the MI HR Service Center of a divorce, legal separation or when a dependent child is no longer eligible. For all other qualifying events, you and your dependents will be notified of the right to continue coverage.)

In any case, to arrange COBRA payments, please submit an *Application for Continuation of Insurance Benefits* (form CS-1767), to the Michigan Civil Service Commission. The form must be submitted within 60 days from the date of your qualifying event or the date coverage ends, whichever is later and whichever applies.

The address for the Employee Benefits Division is:

Michigan Civil Service Commission
Employee Benefits Division
P.O. Box 30002
Lansing, MI 48933

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 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 (including the share that was paid by the State) directly to the State. For the first two pay periods after layoff, you can pre-pay your share of the bi-weekly premium by having it deducted from your last pay check. The State will contribute its share.

To continue coverage after the pre-paid period, submit an *Application for Continuation of Insurance Benefits* (form CS-1767) to the Employee Benefits Division within 60 days of the date your coverage ends.

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 for up to 18 months by paying the full monthly premium (including the share that was paid by the State) directly to the State. However, if you 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 a maximum of six months — but only while the LTD benefit is being paid.

Please remember to submit an *Application for Continuation of Insurance Benefits* (form CS-1767) to the Employee Benefits Division within 60 days of the qualifying event or the date your coverage ends, whichever is later.

Continuing coverage when you retire

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

Continuing coverage under BCBSM group conversion

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

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

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

To ensure continuous coverage, please submit a written request for group conversion coverage to BCBSM within 30 days from the date you are no longer eligible for State Health Plan PPO coverage or within 60 months before COBRA coverage ends.

For additional information on how to apply for BCBSM conversion coverage, please call our individual coverage servicing department at 888-642-2276. Customer service representatives are available Monday through Friday, 8 a.m. to 6 p.m.

Certificate of creditable coverage

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

Choosing a network provider

To receive care with the lowest out-of-pocket costs, choose providers from the BCBSM Community Blue/Blue Preferred PPO Network. The network is made up of physicians, hospitals and other health care specialists who have signed agreements with BCBSM to accept our approved amount as payment in full for covered services.

When you receive services from a PPO network provider, your out-of-pocket costs are limited to in-network deductibles and copayments. You do not have to choose just one provider, and you do not have to notify us when you change physicians.

To find PPO providers, call the BCBSM State of Michigan Customer Service Center, and ask for assistance in locating PPO providers in your area. Or visit bcbsm.com.

What happens if your PPO physician leaves the network

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 will notify you that he or she is no longer in the PPO network. If you have difficulty choosing another physician, please contact the BCBSM 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 PPO network.

Non-network providers

When you receive care from a provider who is not part of the PPO network, without a referral from a PPO provider, your care is considered out-of-network. For most out-of-network services, you have a 10 percent copayment and a higher deductible. Some services, such as your preventive care services, are not covered out-of-network.

They are not PPO, but they are still Blue

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 BCBSM's Traditional plan. When you use BCBSM participating providers:

- You will not have to submit a claim. The provider will bill us directly for your services.
- You will not be billed for any differences between our approved amount and their charges.

Remember, some services, such as your preventive care services, are not covered out-of-network.

Nonparticipating providers

Nonparticipating providers are providers who are not in the PPO network and do not participate in any BCBSM plan. If you receive services from a nonparticipating provider, in addition to the out-of-network deductible and copayments, you may also be responsible for any charge above BCBSM's approved amount. That is because providers who do not participate with the BCBSM may choose not to accept our approved amount as payment in full for covered services. You may also be required to file your own claim.

When you use nonparticipating providers, we will send you our approved amount, less the out-of-network deductible and copayments. You are responsible for paying the provider. Some services, such as your preventive care services, are not covered when you use nonparticipating providers.

Non-PPO hospitals and facilities

If you choose to go to a non-PPO hospital or facility when you have adequate access to a network hospital, the State Health Plan PPO will pay 90 percent after your deductible. You will be responsible for the difference.

Nonparticipating hospitals and facilities

If you choose to go to a nonparticipating hospital when you have adequate access to a network hospital, the State Health Plan PPO will not cover the charges.

Exceptions to the rule

Out-of-network deductibles and 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 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

BlueCard PPO

When you need medical care outside of Michigan, you can receive in-network benefits by using the BlueCard® PPO program. BlueCard PPO providers bill their local Blues Plan for any covered services you receive and will accept the approved amount or negotiated price as payment in full. You are only responsible for applicable in-network deductibles and copayments and for services not covered by the State Health Plan PPO.

If you need emergency medical care, please seek care immediately from the nearest hospital or physician. Otherwise, just follow these steps:

1. Call 800-810-BLUE (2583) any day of the week. You will be given the name of the nearest PPO physician or hospital.
2. Show your BCBM ID card to the provider. Remind him or her to include the MIG alphabetical prefix on all of your claims.
3. Pay the applicable deductibles and copayments required by the State Health Plan PPO.

If you are in one of the few areas without Blues PPO or participating providers, you will not be expected to pay any out-of-network copayments or deductibles. However, you may need to submit itemized receipts directly to us if you receive services from a non-network provider.

BlueCard does not include prescription drugs, dental, vision and hearing 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. In addition, coverage applies only if:

- The hospital is accredited.
- 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.

Your State Health Plan PPO benefits

Under the State Health Plan PPO, covered services and supplies are called benefits. The payment allowed for benefits is called the approved amount. BCBSM determines the approved amount. Applicable deductibles and copayments are deducted from the approved amount.

Payment of your State Health Plan PPO benefits is based on a fiscal year beginning October 1 and ending September 30. Your deductible is based on a calendar year beginning January 1 and ending December 31.

Dollar maximums

Covered services are limited to a lifetime dollar maximum of \$5 million per member. This does not include human organ transplants, which have a separate dollar maximum. The dollar maximum for human organ transplants is \$1 million per transplant.

Out-of-pocket costs

For most covered services, you are required to pay a portion of the approved amount through deductibles and copayments.

Deductibles

Deductibles are out-of-pocket costs you are required to pay before benefits are payable for covered services. There are different amounts for individuals and families. When one individual has met the deductible, benefits are payable for covered services for that individual. Services for the remaining family members will be paid when the full family deductible has been met.

Deductible amounts are determined by whether you receive services in- or out-of-network. Deductibles are applied to one or the other, but not both. Your in- and out-of-network deductibles are noted below.

Deductibles are required each year.

Deductible	In-network	Out-of-network
Individual	\$300	\$ 600
Family	\$600	\$1200

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 the following year.

Copayments

After you have met your deductible, you are responsible for copayments with one exception. There are no required deductibles for in-network office visits. There is a deductible for office visits out-of-network. Only the 5 copayment applies to in-network office visits. As with deductibles, copayment amounts are determined by whether you receive services in- network or out-of-network. Copayments are applied to one or the other, but not both.

Copayments	In-network*	Out-of-network*
Fixed-dollar	\$15 for office visits: <ul style="list-style-type: none"> • Physician office visit • Office consultations • Chiropractic office visit • Chiropractic spinal manipulations • Urgent care visits • Medical hearing exams • Medical eye exams 	Not applicable. There is no fixed-dollar copayment for out-of-network services
	\$50 for emergency room care (waived if admitted)	
Percentage	10% for: <ul style="list-style-type: none"> • Private duty nursing • Acupuncture 	10% for most services including office visits

*Services without a network are covered at the in-network level.

Annual copayment maximums

You are only required to pay a certain amount in copayments each year:

Out-of-pocket maximum	In-network	Out-of-network
Individual	\$1000	\$2000
Family	\$2000	\$4000

However, certain copayments and other charges cannot be used to meet your copayment maximum. These copayments and other charges are:

Fixed-dollar copayments	Charges in excess of our approved amount
Private duty nursing copayments	
Deductibles	
Charges for noncovered services	

Medical necessity for hospital services

Unless otherwise specified, a service must be medically necessary in order to be covered by the State Health Plan PPO. 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 that 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 investigational by BCBSM.
- The treatment is not determined to be medically inappropriate by the Utilization Management and Quality Assessment programs.

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

- When you do not inform the hospital that you are a BCBSM member 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

Pain management

BCBSM 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 intractable pain that may be associated with these diseases. Your health care benefits provide for such coverage and are subject to contract limitations.

Hospital coverage

What you pay for covered services		
In-network	Out-of-network	Nonparticipating
Annual in-network deductible	10% after annual out-of-network deductible	100%

Inpatient hospital benefits

Your coverage includes the following inpatient hospital services for unlimited days at a PPO network hospital:

- **Room and board** – Includes:
 - The cost of a semi-private room
 - The use of special units such as intensive, burn or cardiac care
 - Meals and special diets
 - General nursing care

The cost of a private room is not covered. If you request a private room, your coverage will pay for the cost of a semi-private room and you will be required to pay the difference.

- **General medical care days** — You have an unlimited number of inpatient days available for the diagnosis and treatment of general medical conditions. This includes admissions for:
 - **Maternity and nursery care** — Includes delivery room costs, birthing center services, 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 31 days of birth.

Under federal law, BCBSM generally cannot restrict benefits for any hospital length of stay in connection with childbirth for the mother or 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. BCBSM also cannot 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, deformities resulting from certain surgeries, such as breast reconstruction following mastectomies.
- **Dental surgery** — Includes removal of impacted teeth or multiple extractions only when a concurrent hazardous medical condition, diagnosed by a physician, exists. The inpatient stay must be considered medically necessary to safeguard the life of the patient during the dental surgery.
- **Diagnostic and radiology services** — The following diagnostic and radiology services are covered during a hospital admission:
 - **CAT and MRI scans** — Includes scans of the head and body when required for eligible diagnoses and when performed in a facility approved by BCBSM.
 - **Diagnostic tests** — Includes EKGs, EMGs, EEGs, thyroid function tests and nerve conduction studies required in the diagnosis of an illness or injury.
 - **Therapeutic radiology** — Includes radiological treatment by X-ray, isotopes or cobalt for a malignancy.
 - **Diagnostic radiology** — Includes ultrasounds and X-rays required for the diagnosis of an illness or injury.

- **Hospital services and supplies** — The following services and supplies are covered during a hospital admission when needed:
 - **Anesthesia** — Includes administration, cost of equipment, supplies and the services of a hospital anesthesiologist when billed as a hospital service.
 - **Blood services** — Includes blood derivatives, blood plasma and supplies used for administering the services as well as the cost of drawing and storing self-donated blood intended for scheduled surgery.
 - **Laboratory and pathology tests** — Includes laboratory tests and procedures required to diagnose a condition or injury when billed as a hospital service.
 - **Drugs** — Includes biologicals and medicines prescribed and given during a hospital admission.
 - **Durable medical equipment** — Includes items such as oxygen tents, wheelchairs and other hospital equipment used during the hospital stay.
 - **Medical and surgical supplies** — Includes gauze, cotton and solutions used during the hospital admission.
 - **Prosthetic and orthotic appliances** — Includes items surgically implanted in the body, such as heart valves.
 - **Special treatment rooms** — Includes operating, delivery and recovery rooms.

Outpatient hospital benefits

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

- **Pre-admission testing** — Testing must be performed within seven days before a scheduled hospital admission or surgery. These tests must be medically appropriate, valid at the time of admission and must not be duplicated during the hospital stay.
- **Professional ambulance services** — Ambulance services are covered if the destination is the nearest medical facility capable of treating the patient's condition.

The service must be:

- Medically necessary because transport by any other means would endanger the patient's health
- Prescribed by a physician (when used for transferring a patient)
- Provided in a vehicle qualified as an ambulance and part of a licensed ambulance operation

Air or water ambulance is also covered if it is medically necessary, ordered by the attending physician and the patient's emergent condition requires air or water transport rather than ground ambulance. The transport must be to the closest facility that can treat the patient. Air or water ambulance providers must be licensed to provide air or water ambulance services and not as a commercial air carrier.

Your coverage does not pay for transportation for the convenience of the patient, the patient's family or the preference of the physician.

- **Chemotherapy** — Treatment is payable in a hospital, in the outpatient department of a hospital, in a physician's office or in the patient's home. Benefits include the administration and cost of drugs when they are:
 - Ordered by a physician for the treatment of a specific type of disease
 - Approved by the Food and Drug Administration for use in chemotherapy
 - Provided as part of a chemotherapy program

Benefits also include three follow-up visits within 30 days of your last chemotherapy treatment to monitor the effects of chemotherapy.

- **Sterilization** — This benefit applies to both males and females. A medical reason is not required.
- **Termination of pregnancy**
- **Infertility treatment** — Infertility treatments are not included. This includes the following services:
 - Specific fertility treatments or procedures including inpatient and outpatient surgical procedures, labs and radiographs
 - Treatments and diagnostic tests for infertility problems
 - Artificial inseminations
 - Embryo transfer
 - Experimental/investigational fertility services
 - In vitro-fertilization
 - Reversal of voluntary sterilization
 - Services associated with excluded services
- **Hemodialysis** — Hemodialysis services are covered to treat acute kidney failure and end stage renal disease. Patients can receive treatment in the inpatient or outpatient department of a hospital, in a licensed facility or at home. (For more information on home hemodialysis services, see the Alternative to Hospital Care section of this book.)

Coverage for ESRD dialysis services is coordinated with Medicare. It is important that individuals with ESRD apply for Medicare coverage regardless of age. The State Health Plan PPO is the primary payer for up to 33 months, which includes a three-month waiting period, if the member is under 65 and eligible for Medicare solely because of ESRD.

- **Physical, occupational and speech therapy** — Your physical, occupational and speech therapy services are payable when provided in the outpatient department of a participating hospital.

Services are limited to a combined maximum of 90 visits per calendar year.

- **Physical therapy** is the use of specific activities or methods to treat disability when there is a loss of neuromusculoskeletal function due to an illness, injury or following surgery. It must require the assistance and supervision of the appropriate licensed therapist and be:

- » Prescribed by the patient's attending physician
- » Designed to improve or restore the patient's functioning level after a loss in musculoskeletal functioning due to an illness or injury
- » Provided for a condition that is capable of significant improvement in a reasonable and generally predictable period of time

Examples of covered services are:

- » Therapy prescribed to restore musculoskeletal functioning
- » Therapy used in conjunction with a treatment program to accelerate the healing of an acute injury or illness involving the muscles or joints

Physical therapy is also covered when provided in:

- » Outpatient participating physical therapy facilities
- » Physicians' offices
- » Independent licensed physical therapists' offices
- » In the home if part of a home health care treatment plan

- **Occupational therapy** is a rehabilitative service that uses specific activities or methods to:
 - » Develop, improve or restore the performance of necessary neuromusculoskeletal functions affected by an illness, injury or following surgery
 - » Help the patient learn to apply the newly restored or improved function to meet the demands of daily living
- **Speech and language pathology services** are rehabilitative services that use a specific activity or method to treat speech, language, and swallowing or voice impairment due to an illness, injury or following surgery.

Your benefit covers therapy for:

- » Nondevelopmental speech disorders, which are characterized by a communicative loss caused by trauma or organic conditions such as aphasia following a stroke or dysphonia resulting from vocal cord surgery
- » Severe congenital and developmental speech disorders, which are characterized by severe communicative deficits as a result of congenital (present at or existing from birth) and developmental conditions, for children age 6 and under

Your coverage for physical, occupational and speech therapy does not pay for:

- » Long-standing, chronic conditions such as arthritis
- » Massage therapy
- » Health club membership or spa membership
- » Developmental conditions or learning disabilities for members over the age of 6
- » Congenital or inherited speech abnormalities for members over the age of 6
- » Inpatient hospital admissions principally for speech or language therapy

Other outpatient hospital benefits

What you pay for covered services		
In-network	Out-of-network	Nonparticipating
\$50 (waived if admitted)	\$50 (waived if admitted)	\$50 (waived if admitted)

- **Emergency medical care** — The initial exam and treatment of accidental injuries or conditions in an emergency room are covered when determined by BCBSM to be medical emergencies. This includes both professional and facility services. Treatment must occur within 48 hours of the injury or 72 hours of the medical emergency.

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

What you pay for covered services		
In-network	Out-of-network	Nonparticipating
\$15	10% after annual out-of-network deductible	100%

- **Urgent care services** — Non-emergent treatment is covered under the health plan as a benefit and includes services at independent urgent care clinics, after-hour physician group practices and some PPO hospitals and their affiliated urgent care locations.

Medical necessity for physician services

Unless otherwise specified, a service must be medically necessary to be covered by the State Health Plan PPO. Medical necessity for physician services is determined by physicians acting for their respective provider types or medical specialty and is based on criteria and guidelines developed by physicians and professional providers. It requires that:

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

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

Physician and other professional services

Preventive services

What you pay for covered services		
In-network	Out-of-network	Nonparticipating
\$0 up to the yearly dollar maximum of \$1,500	100%	100%

Your coverage pays for the preventive services listed below when they are received from in-network PPO providers.

- **Health maintenance exam** — This 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
- **Annual gynecological exam** — Covered one per calendar year
- **Pelvic/gynecological exam screening** — Covered one per calendar year
- **Pap smears** — Covers laboratory services for one routine Pap smear per calendar year
- **Well-baby and child care**
- **Colorectal screenings** — One every 10 years
- **Prostate specific antigen screening** — One per calendar year
- **Fecal occult blood test** — Every year beginning at age 50
- **Flexible sigmoidoscopy** — Every five years beginning at age 50
- **Hepatitis C screenings** — There is no age limit.
- **Immunizations** — Age 17 and over

What you pay for covered services		
In-network	Out-of-network	Nonparticipating
\$0	10%	100%

- **Colonoscopy** — One every 10 years
- **Double contrast barium enema** — Every five to 10 years beginning at age 50
- **Digital rectal exam** — One every five to 10 years beginning at age 50
- **Mammography (annual screening)** — One per calendar year, no age limit
- **Flu shots** — There is no age limit on flu shots. Also covered when given by a visiting nurse agency or health department. Flu Mist is not covered.
- **Pneumococcal shot** — One per lifetime. There is no age limit. Also covered when given by a visiting nurse agency or a health department.
- **Childhood Immunizations** — Birth to age 16
- **Hepatitis B shot**

Surgical services

What you pay for covered services		
In-network	Out-of-network	Nonparticipating
Annual in-network deductible	10% after annual out-of-network deductible	Annual out-of-network deductible plus the difference between the BCBSM approved amount and the provider's charge

Surgery is covered inpatient and outpatient, in the physician's office and in ambulatory surgical facilities.

Multiple surgeries (two or more surgical procedures performed by the same physician during one operative session) are subject to the following payment limitations:

- When surgeries are through **different** incisions, the State Health Plan PPO pays the approved amount for the more costly procedure and one half of the approved amount for the less costly procedure.
- When surgeries are through the same incision they are considered related and the State Health Plan PPO pays the approved amount only for the more difficult procedure.

Participating providers accept these approved amounts as payment in full. However, nonparticipating providers may bill you for the difference.

Cosmetic or reconstructive surgery is covered only for the correction of the following:

- Birth defects
- Conditions resulting from accidental injuries
- Deformities resulting from certain surgeries, such as breast reconstruction following mastectomies

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

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.

Cataract surgery and first lens implants are covered.

Voluntary sterilization for both male and female patients is covered regardless of medical necessity.

Termination of pregnancy is also covered.

Additional surgical services covered

- **Technical Surgical Assistance** — TSA is a covered benefit for certain major surgeries that require surgical assistance by another physician. TSA is covered inpatient and outpatient, and in approved ambulatory surgery facilities.
- **Anesthesia** — Services for giving anesthesia are payable to a physician other than the operating or assisting physician, and to certified registered nurse anesthetists. We do not pay for local anesthetics.
- Some medical surgeries performed by a DDS

Inpatient medical care

What you pay for covered services		
In-network	Out-of-network	Nonparticipating
Annual in-network deductible	10% after annual out-of-network deductible	Annual out-of-network deductible plus the difference between the BCBSM approved amount and the provider's charge

When you receive inpatient or skilled nursing care, you are covered for an unlimited number of medical care visits by a physician for general medical conditions that are not related to surgery or maternity care.

Inpatient consultations

What you pay for covered services		
In-network	Out-of-network	Nonparticipating
Annual in-network deductible	10% after annual out-of-network deductible	Annual out-of-network deductible plus the difference between the BCBSM approved amount and the provider's charge

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

Emergency care

What you pay for covered services		
In-network	Out-of-network	Nonparticipating
\$50*	\$50*	\$50*

* Waived if admitted.

Your coverage provides payment for the initial examination of accidental injuries and conditions determined by BCBSM to be medical emergencies. Initial examination must occur within 48 hours of the injury or 72 hours of the medical emergency. Services in addition to the initial examination will be subject to in-network deductible and coinsurance. Nonparticipating providers may bill you the difference for additional services.

Diagnostic and radiation services

What you pay for covered services		
In-network	Out-of-network	Nonparticipating
Annual deductible	10% after annual deductible	Annual out-of-network deductible plus the difference between the BCBSM approved amount and the provider's charge

Your benefits include physician services for diagnostic and radiation services to diagnose and treat disease, illness, pregnancy or injury through:

- Diagnostic radiology that includes X-rays, ultrasound, radioactive isotopes, and MRI and CAT scans of the head and body when performed for an eligible diagnosis at a BCBSM approved facility
- Laboratory and pathology tests
- Diagnostic tests, which include EKGs, EMGs, EEGs, thyroid function tests, nerve conduction and pulmonary function studies
- Radiation therapy, which includes radiological treatment by X-ray, isotopes or cobalt for a malignancy

Mammograms are covered if requested by your physician because of the suspected or actual presence of a disease or when required as a postoperative procedure.

Digital mammography is covered.

Allergy testing

What you pay for covered services		
In-network	Out-of-network	Nonparticipating
Annual in-network deductible	10% after annual out-of-network deductible	Annual out-of-network deductible plus the difference between the BCBSM approved amount and the provider's charge

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

Acupuncture

What you pay for covered services		
In-network	Out-of-network	Nonparticipating
10% after annual in-network deductible	10% after annual out-of-network deductible	Annual out-of-network deductible plus the difference between the BCBSM approved amount and the provider's charge

Your acupuncture benefit covers up to a maximum of 20 treatments in a calendar year. These services are covered when performed by a licensed physician (MD or DO), or supervised and billed by a licensed physician (MD or DO), or under the supervision of a licensed physician (MD or DO).

Acupuncture is covered only for the treatment of the following conditions:

- Sciatica
- Neuritis
- Postherpetic neuralgia
- Tic douloureux
- Chronic headaches such as migraines
- Osteoarthritis
- Rheumatoid arthritis
- Myofascial complaints such as neck and lower back pain

Dental work

What you pay for covered services		
In-network	Out-of-network	Nonparticipating
Annual in-network deductible	10% after annual out-of-network deductible	Annual out-of-network deductible plus the difference between the BCBSM approved amount and the provider's charge

Certain dental work or oral surgery, limited to the following, is also covered:

- Treatment of jaw fractures, dislocations and wounds
- Treatment of cysts, tumors or other diseases of the tissues of the oral structures
- Other incision/excision procedures of the gums (periodontics) and tissues of the mouth when not done in conjunction with tooth repair or extraction
- Charges for dental services, office visits and appliance therapy related to the above procedures

Treatment for Temporomandibular Joint Syndrome or jaw-joint disorder

What you pay for covered services		
In-network	Out-of-network	Nonparticipating
Annual in-network deductible	10% after annual out-of-network deductible	Annual out-of-network deductible plus the difference between the BCBSM approved amount and the provider's charge

Benefits for TMJ or jaw-joint disorder are limited to:

- Surgery directly to the jaw joint
- X-rays (including MRIs)
- Trigger point injections
- Arthrocentesis (injection procedures)

Some symptom management services, such as office visits, reversible appliance therapy and physical medicine (diathermy, hot and cold applications) and medications are also covered.

Your TMJ benefit does not cover irreversible TMJ services with the exception of surgery directly related to the jaw joint as noted above.

Foot care

What you pay for covered services		
In-network	Out-of-network	Nonparticipating
Annual in-network deductible	10% after annual out-of-network deductible	Annual out-of-network deductible plus the difference between the BCBSM approved amount and the provider's charge

Certain services to the foot and ankle are covered:

- Cutting or removal of corns, calluses and/or trimming of nails.
- Application of skin areas and other hygienic and preventive maintenance care when related to diabetes or peripheral heart disease.

Radial keratotomy

What you pay for covered services		
In-network	Out-of-network	Nonparticipating
Annual in-network deductible	10% after annual out-of-network deductible	Annual out-of-network deductible plus the difference between the BCBSM approved amount and the provider's charge

Radial keratotomy is covered only when all of the following criteria are met:

- The patient is at least 18 years old.
- The patient has myopia of -2.00 diopters (spherical equivalent or greater).
- The patient has had a stable refractive error (+ or - .50 diopter) for at least one year.
- The patient is unable to wear glasses or contact lenses satisfactorily due to occupational, recreational or psychological reasons.

Maternity care

What you pay for covered services		
In-network	Out-of-network	Nonparticipating
Annual in-network deductible	10% after annual out-of-network deductible	Annual out-of-network deductible plus the difference between the BCBSM approved amount and the provider's charge

You have coverage for obstetrical services including delivery and pre- and post-natal care visits. Inpatient examinations of the newborn are a benefit when performed by a physician other than the anesthesiologist or the delivering provider.

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

Physician office services

What you pay for covered services		
In-network	Out-of-network	Nonparticipating
\$15 copayment in physician's office, urgent care, office consultations, and medical hearing exam Annual in-network deductible for outpatient and home services	10% after annual out-of-network deductible	Annual out-of-network deductible plus the difference between the BCBSM approved amount and the provider's charge

The exam, diagnosis and treatment of an injury, illness or disease by a physician is payable when you are seen in:

- A physician's office
- Outpatient clinic
- Outpatient department of a hospital
- The home
- Urgent care setting

Chiropractic services

What you pay for covered services
In-network
\$15

Chiropractic services are paid based on location and diagnosis.

Your coverage for chiropractic services includes the following:

- One new patient office call every 36 months and one established patient office call each calendar year. A new patient is one who has not been seen by the same provider in 36 months.
- Chiropractic manipulation is limited to one per day, 24 visits per calendar year. When chiropractic office visits and spinal manipulations are performed on the same day by the same provider, and both services are payable, only one \$15 copay is applicable.
- X-rays for accidental injuries
- Limited physical therapy (i.e., traction) Subject to physical, occupational and speech therapy payment guidelines

Second surgical consultations

What you pay for covered services		
In-network	Out-of-network	Nonparticipating
Annual in-network deductible	10% after annual out-of-network deductible	Annual out-of-network deductible plus the difference between the BCBSM approved amount and the provider's charge

Second surgical consultations are covered. They are voluntary and not required for any specific surgeries.

Sleep studies

What you pay for covered services		
In-network	Out-of-network	Nonparticipating
Annual deductible	10% after annual deductible	Annual out-of-network deductible plus the difference between the BCBSM approved amount and the provider's charge

Sleep studies are covered when a patient is referred by a physician to a sleep disorder clinic that is affiliated with a hospital and that is under the direction of physicians. Patient must show signs or symptoms of:

- Narcolepsy characterized by abnormal sleep tendencies, amnesia episodes or continuous agonizing drowsiness
- Severe upper airway apnea, supported by documentation proving severity of condition

Sleep studies are not covered for the following:

- Bruxism
- Drug dependency
- Enuresis
- Hypersomnia
- Impotence
- Night terrors or dream anxiety attacks
- Restless leg syndrome
- Nocturnal myoclonus
- Shift work and schedule disturbances

Hearing care

What you pay for covered services	
Participating	Nonparticipating *
\$0	\$0

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

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

Providers may balance bill above the approved amount for non-basic hearing aids (i.e., digital).

Choosing your hearing provider

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

The types of eligible hearing providers include:

- Audiologists
- Otologists
- Otolaryngologists
- Otorhinolaryngologists
- Hearing aid dealers

To locate a Blues participating hearing care provider in Michigan, call the BCBSM State of Michigan Customer Service Center.

What is covered under your hearing care benefits

Hearing care benefits are available only after you receive a medical clearance examination by a physician (MD or DO) to rule out the presence of a medical condition. There is a \$15 copayment for the medical clearance exam.

You must receive the following services from a **participating provider**:

- **Audiometric examination** — Measures hearing ability, including tests for air and bone conduction, speech reception and speech discrimination
- **Hearing aid evaluation** — Determines what type of hearing aid should be prescribed to compensate for loss of hearing
- **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
- **Conformity test** — Evaluates the performance of a hearing aid and its conformity to the original prescription after it has been fitted

Time limitation

Hearing care benefits are payable once every 36 months unless significant hearing loss occurs earlier and is certified by your physician.

What is not covered under your hearing care benefit

Your hearing care coverage does not cover:

- Your medical clearance examination to determine possible loss of hearing (covered under medical benefit)
- A hearing aid ordered while the patient is a member, but delivered more than 60 days after the patient's coverage terminates
- Replacement of hearing aids that are lost or broken, unless this occurs after 36 months, when benefits are renewed
- Repairs and replacement of parts including batteries and ear molds
- 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 digital-controlled programmable hearing devices (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
- All hearing care services and supplies provided by a nonparticipating provider in Michigan
- Hearing aids that do not meet Food and Drug Administration and Federal Trade Commission requirements

Alternatives to hospital care

Home hemodialysis program

What you pay for covered services		
In-network	Out-of-network	Nonparticipating
Annual deductible	10% after annual deductible	100%

Hemodialysis services are covered in the home. Your physician must arrange for home hemodialysis and all services must be billed by a participating hospital that has an approved hemodialysis program.

Benefits include:

- Cost of the equipment
- Installation
- Training
- Necessary hemodialysis supplies

Home hemophilia program

What you pay for covered services		
In-network	Out-of-network	Nonparticipating
Annual deductible	10% after annual deductible	100%

This benefit allows you to receive in-home treatment for hemophilia. Your physician must prescribe all services and supplies and they must be billed by a participating hospital. Benefits include:

- All medications, including the antihemophilic factor
- Necessary hemophilia supplies, including syringes and needles
- Training of 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 program

What you pay for covered services	
Participating	Nonparticipating
Annual in-network deductible	100%

The physician must certify that the patient is confined to the home due to illness and that home health care services are being used instead of inpatient hospital care. The physician must also prescribe and submit a detailed treatment plan to the agency. 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
- These services may include assistance with activities of daily living such as bathing, dressing, meal preparation and feeding.
- Social services and nutritional guidance when requested by the patient's physician
- Physical, speech and occupational therapy
- Nursing care by a licensed practical nurse or a licensed vocational nurse when the services of a registered nurse are unavailable

The State Health Plan PPO does not pay for:

- General housekeeping services
- Cost of meals
- Transportation to or from a hospital or other facility
- Elastic stockings, including nonprescription compression socks
- Sheepskin
- Comfort items such as lotion, mouthwash or body powder
- Physician services
- Custodial or nonskilled care

Home infusion therapy

What you pay for covered services	
Participating	Nonparticipating
Annual in-network deductible	Annual in-network deductible plus the difference between the BCBSM approved amount and the provider's charge

Continuous, slow administration of a controlled drug, nutrient, antibiotic, or other fluid into a vein or other tissue. Depending on condition being treated and type of therapy, it can be on a daily, weekly, or monthly basis. Covered services include:

- Nursing and professional administration
- Injectable therapy
- Nutritional therapy
- Line insertion and maintenance
- Medical IV therapy
- Catheter supplies (restoration or repair)

Skilled nursing care

What you pay for covered services	
Participating	Nonparticipating
Annual in-network deductible	100%

Members have 120 skilled nursing days per admission. Care must be received in a BCBSM-approved skilled nursing facility and the following conditions must be met:

- The patient is suffering from or gradually recovering from an illness or injury.
- The patient is expected to improve.
- The admission has been preauthorized by BCBSM.

Your benefit includes coverage for:

- Semi-private room
- Meals and special diets
- Nursing services
- Use of special treatment rooms
- X-ray and laboratory examinations
- Physical, speech and occupational therapy
- Oxygen and other gas therapy
- Drugs, biologicals and solutions
- Materials used in dressings and casts

The benefit renews 90 days after discharge.

Written confirmation of the need for skilled care is required from the patient's physician. All services must be provided at a participating skilled nursing facility.

The State Health Plan PPO does not pay for:

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

Care management programs

What you pay for covered services
\$0

Care management programs provide you with personal support and education about your health care options. Part of your State Health Plan PPO, care management programs are voluntary programs provided to you at no cost.

A continuum of care, care management programs offer you support and information whether you are feeling great or need intensive care. Providing a continuum of care ensures that you do not “fall through the cracks” just because you do not fit into any one category.

The following care management programs are designed to assist BCBSM State Health Plan PPO members:

- BlueHealthConnection
- Chronic Condition Management
- Case Management

BlueHealthConnection

BlueHealthConnection assists you with your health care concerns. It provides you with health information and support to help you understand your health care issues, address their concerns, and work more closely with your providers. You have access to a wealth of health information and support including:

- Online health information at bcbsm.com. You can access BlueHealthConnection to read articles, use online tools and take quizzes that provide a wide variety of health information on thousands of topics.
- Access to registered nurse health coaches 24 hours a day, seven days a week, to help you access health information and answer their health questions.

Chronic Condition Management

If you have been diagnosed with a chronic illness, BlueHealthConnection’s Chronic Condition Management program can help you through it. The program provides coaching, surgical decision support, urgent care needs and general health and wellness assistance. The program’s health coaches can help you gather information you need so you can more effectively talk with your doctors, make health care decisions that fit your lifestyle, and more confidently navigate the health care system.

Case Management

A serious diagnosis can be devastating. And supposed you are diagnosed with more than one illness. Where do you start to get the help you need? The case management program offers comprehensive medical and psychosocial care management services for high-risk, medically complex cases.

Case management professionals realize your health condition can sometimes overwhelm and confuse you. The diagnosis of an illness can have a tremendous emotional impact on you and your loved ones. Not surprisingly, getting the most from your health care coverage may be the last thing on your mind at such a time. That is why Case Management is here to help.

Case management’s medical professionals work with member, provider and family or caregiver to ensure a clear understanding of condition, prognosis and treatment options, coordinating the provider services that the member requires.

For more information on our Care Management programs call 800-775-BLUE (2583) toll free any day, 24 hours a day. Or visit bcbsm.com

Hospice care

What you pay for covered services	
Participating	Nonparticipating
\$0 up to lifetime maximum	100%

A hospice is an agency or facility that is primarily involved in providing care to terminally ill individuals. Hospice care can be an alternative to hospitalization. To be eligible for hospice care:

- The attending physician must certify in writing that life expectancy is six months or less.
- The patient must choose hospice care instead of inpatient services.
- The care must be provided by a Medicare or BCBSM-certified hospice program that is approved for both Medicare and non-Medicare enrollees.

You may apply for hospice care benefits only after discussion with and referral by your attending physician, and your request must be in writing to the hospice agency.

Electing hospice benefits

When the patient elects to enter the program, the hospice benefits will replace the patient's State Health Plan PPO benefits for conditions relating 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, services for medical conditions 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.

The lifetime maximum of your hospice benefit is adjusted annually by the state. Please call the BCBSM State of Michigan Customer Service Center for the current amount.

The following benefits are payable under the hospice program:

- Nursing care when provided by or under the supervision of a registered nurse
- Home health aide and homemaker services
- Medical social services including needs assessment and psychological and dietary counseling when provided by a qualified social worker under the supervision of a physician
- Counseling services for the patient and caregivers, when care is provided in the home. This includes bereavement counseling for the family up to 30 days after the patient's death
- Medical appliances and supplies furnished to lessen the effects of the terminal illness
- Durable medical equipment for use in the patient's home when furnished by the hospice program
- Physical, speech and occupational therapy when provided to control symptoms and maintain the patient's daily activities and basic functional skills

The following services are not covered:

- Costs of transportation
- Funeral arrangements
- Financial or legal counseling
- Pastoral counseling
- Estate planning

Physical, occupational and speech therapy

What you pay for covered services		
In-network	Out-of-network	Nonparticipating
Annual in-network deductible	10% after annual out-of-network deductible	10% after the annual out-of-network deductible plus the difference between the BCBSM approved amount and the provider's charge

Your benefit covers physical, occupational and speech therapy for 90 days per calendar year.

Physical therapy is the use of specific activities or methods to treat a disability when there is a loss of neuromusculoskeletal function due to an illness, injury or following surgery.

Physical therapy is payable when provided in:

- The outpatient department of a participating hospital
- Participating outpatient physical therapy facilities
- Physicians' offices
- Independent licensed physical therapists' offices
- In the home if part of a home health care treatment plan

Physical therapy must require the assistance and supervision of the appropriate licensed therapist and it must be:

- Prescribed by the patient's attending physician
- Designed to improve or restore the patient's functioning level after a loss in musculoskeletal functioning due to an illness or injury
- Provided for a condition that is capable of significant improvement in a reasonable and generally predictable period of time

Examples of covered services are:

- Therapy prescribed to restore musculoskeletal functioning
- Therapy used in conjunction with a treatment program to accelerate the healing of an acute injury or illness involving the muscles or joints

Occupational therapy is a rehabilitative service that uses specific activities or methods to:

- Develop, improve or restore the performance of necessary neuromusculoskeletal functions affected by an illness, injury or following surgery
- Help the patient learn to apply the newly restored or improved function to meet the demands of daily living

It is payable when provided in the outpatient department of a participating hospital.

Speech and language pathology services are rehabilitative services that use a specific activity or method to treat speech, language, swallowing or voice impairment due to an illness, injury or following surgery.

Your benefit covers therapy for:

- Nondevelopmental speech disorders, which are characterized by a communicative loss caused by trauma or organic conditions such as aphasia following a stroke or dysphonia resulting from vocal cord surgery
- Severe congenital and developmental speech disorders, which are characterized by severe communicative deficits as a result of congenital (present at or existing from birth) and developmental conditions, for children age 6 and under

Speech and language pathology services are payable when provided in the outpatient department of a participating hospital.

Physical therapy, occupational therapy and speech and language pathology services are paid based on location and diagnosis. To avoid incurring expenses for services that are not payable, we recommend you call or write the BCBSM State of Michigan Customer Service Center before receiving the service.

Your coverage for physical, occupational and speech therapy does not pay for:

- Long-standing, chronic conditions such as arthritis
- Health club membership or spa membership
- Massage therapy
- Developmental conditions or learning disabilities
- Inpatient hospital admissions principally for speech or language therapy

Physical therapy, occupational therapy and speech and language pathology services are paid based on location and diagnosis. To avoid incurring expenses for services that are not payable, we recommend you call or write the BCBSM State of Michigan Customer Service Center before receiving the service.

Durable medical equipment, prosthetic and orthotic and supplies through the SUPPORT program

What you pay for covered services		
In-network (Michigan)	Out-of-network (Michigan)	Nonparticipating (Michigan)
\$0	20%	Not covered

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.

Medical equipment and supplies obtained outside of 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 BCBS Plan. If you obtain items from a supplier that does not participate with the local BCBS Plan, you may be required to pay for the difference between the approved amount and provider's charge.

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

Your benefit covers durable medical equipment when the equipment is appropriate for home use and prescribed by a physician. The prescription must include a description of the equipment and a diagnosis. When these criteria are met, your benefit allows for:

- **Renting equipment** — For rental equipment, a new prescription must be written when the current prescription expires.
If the rental fee exceeds the purchase price based on your physician's estimated duration of need, you will be advised to purchase rather than rent the equipment.
- **Purchasing equipment** — Your benefit includes purchasing equipment only when it is less expensive than continued rental. The purchase of new and used equipment is covered provided the equipment is purchased only from a professional supplier.
- **Repairing equipment** — Repair costs are covered on purchased equipment when the condition is due to normal wear and tear.
- **Replacing equipment** — The replacement of purchased equipment is covered when there is loss or irreparable damage of your equipment or a change in your condition or size.
- **Contraceptive devices** — Covers one per year physician-prescribed contraceptive devices such as diaphragms or IUDs and their insertion.
- **Wigs** — You 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. There is no deductible or copayment up to the \$300 lifetime maximum. Additional replacements for children due to growth are available.

Prosthetic and orthotic appliances

What you pay for covered services		
In-network (Michigan)	Out-of-network (Michigan)	Nonparticipating (Michigan)
\$0	20%	Not covered

You have coverage under the SUPPORT program for prosthetic and orthotic appliances. Your benefit covers prosthetic and orthotic appliances when they are prescribed by a physician and supplied by a licensed orthotist or prosthetist. Benefits include:

- Prosthetic and orthotic appliances that are prefabricated, custom-fitted and made
- Temporary appliances
- Delivery, services and fitting charges
- Repair of covered appliances
- Adjustment or replacement of appliances when they are damaged beyond repair because of wear, growth or change in the patient's condition or size

Braces do not have to be attached to a shoe.

- Optical services following cataract surgery — Your benefits include the examination and fitting of one pair of contact lenses when prescribed by a physician following cataract surgery and obtained within one year of the surgery. Cataract sunglasses are not covered.

Using the SUPPORT network

The SUPPORT network is composed of independent suppliers. For help finding a SUPPORT provider, call the SUPPORT program. 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.

SUPPORT program exclusions and limitations

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

Durable medical equipment 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.

The following are not covered:

- Nonmedical equipment
- Exercise and hygienic equipment
- Comfort and convenience items
- Self-help devices such as elevators
- Deluxe equipment, such as motorized wheelchairs, unless medically necessary and required so the patient can operate the equipment themselves
- Routine maintenance expenses, such as the cost of batteries

Human organ transplants

The State Health Plan PPO covers certain human organ and tissue transplants when they are received at a participating hospital or, where noted, in a BCBSM-approved transplant facility, designated transplant facility or designated cancer center.

In some cases, BCBSM must approve the transplant.

Organ and tissue transplants

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

- Cornea
- Kidney
- Skin

The State Health Plan PPO will pay for covered services for donors if the donor does not have transplant benefits under any other health care plan.

Bone marrow transplants

What you pay for covered services		
In-network	Out-of-network	Nonparticipating
\$0	10% after annual out-of-network deductible	100%

Bone marrow transplants involve replacing the bone marrow of a patient with bone marrow or peripheral blood stem cells. The replacement bone marrow may be from a donor (an **allogeneic** transplant) or removed from you before treatment and then returned (an **autologous** transplant).

Bone marrow transplants are only covered when the transplant is pre-approved, or what we call "preauthorized," by BCBSM and must be received at a BCBSM-designated transplant facility. Preauthorization is a process that allows physicians and other professional providers to determine, before treating a patient, if BCBSM will cover the cost of a proposed service.

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Benefits for **allogeneic** transplants are payable only to treat the following conditions when the transplant is not considered experimental or investigational for the condition being treated:

- Acute lymphocytic leukemia
- Acute non-lymphocytic leukemia
- Aplastic anemia
- Beta Thalassemia, major
- Chronic myeloid leukemia
- Hodgkin's disease (relapsed and stage III or IV)
- Hurler's syndrome
- Myelodysplastic syndromes
- Myelofibrosis
- Neuroblastoma (stage III or IV)
- Non-Hodgkin's lymphoma (intermediate or high grade)
- Osteopetrosis
- Severe combined immune deficiency disease (SCID)
- Sickle cell disease (when complicated by stroke)
- Wiskott-Aldrich syndrome

Benefits for autologous transplants are payable only to treat the following conditions when the transplant is not considered experimental or investigational for the condition being treated:

- Acute lymphocytic leukemia
- Acute non-lymphocytic leukemia
- Ewing’s sarcoma
- Germ cell tumors of ovary, testis, mediastinum and retroperitoneum
- Hodgkin’s disease (stage III or IV)
- Medulloblastoma
- Metastatic breast cancer (stage IV)
- Multiple myeloma
- Neuroblastoma (stage III or IV)
- Non-Hodgkin’s lymphoma (intermediate or high grade)
- Primitive neuroectodermal tumors
- Wilms’ Tumor

Solid organ transplants

What you pay for covered services	
Designated facility	Non-designated
Annual in-network deductible	100%

Solid human organ transplants are only covered when the transplant is pre-approved, or “preauthorized,” by BCBSM and must be received at a BCBSM-designated transplant facility. Preauthorization is a process that allows physicians and other professional providers to determine, before treating a patient, if BCBSM will cover the cost of a proposed service.

The transplant facility or your physician must request preauthorization from BCBSM before surgery.

Specified transplants include transplants of the:

- Liver
- Partial liver (a portion of the liver taken from a brain-dead or living donor)
- Heart
- Lungs
- Lobar lung (transplantation of a portion of a lung from a brain dead or living donor)
- Heart-lungs
- Pancreas
- Simultaneous pancreas-kidney
- Small intestine (small bowel)
- Combined small bowel-liver

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

Please call the BCBSM Human Organ Transplant Program for additional information on human organ transplants.

Other covered services

What you pay for covered services unless otherwise noted		
In-network	Out-of-network	Nonparticipating
Annual in-network deductible	10% after annual out-of-network deductible	Annual deductible plus deductible the difference between the BCBSM approved amount and the provider's charge

Your coverage also includes the following services:

- **Blood** — Includes the cost of drawing and storing self-donated blood intended for your scheduled surgery
- **Specified oncology clinical trials** — Covers antineoplastic drugs for the treatment of stages II and III breast cancer and all stages of ovarian cancer when they are provided following an approved phase II or III clinical trial

This benefit does not limit or preclude coverage of antineoplastic drugs when Michigan law requires these drugs, and the reasonable cost of their administration, be covered. Payment is determined by services provided.

For services to be covered, the following requirements must be met:

- The inpatient admission and length of stay must be medically necessary and preapproved. No retroactive approvals will be granted.
- The services must be performed at a National Cancer Institute-designated cancer center or an affiliate of an NCI-designated center.
- The treatment plan, also called "protocol," must meet the guidelines of the February 19, 1993, American Society of Clinical Oncology statement for clinical trials.
- The patient must be an eligible BCBSM member with hospital, medical and surgical coverage.

If these requirements are not met, the services will not be covered and you will be responsible for all charges.

Please call the BCBSM State of Michigan Customer Service Center for additional information on specified oncology clinical trials.

- **Eye and ear examinations** — Covered for the diagnosis and treatment of an illness, injury or disease, including medical clearance examinations. Medical clearance exams have a \$15 fixed dollar copayment.
- **Weight loss benefit** — Benefits are available for nonmedical weight reduction up to a lifetime maximum of \$300.
- **Injections** — Fluids that are forced into a vein or body organ or under the skin to fight disease are payable.
- **Rabies treatment** — Rabies treatment is a benefit after the initial emergency room treatment.
- **Cardiac rehabilitation** — Covered service provides a program that teaches patients how to lower risks associated with heart disease through exercise and lifestyle modifications. May be provided by outpatient department of hospital or physician-directed clinic.
- **Diabetic training** — Services provided under a comprehensive plan of care related to the member's diabetic condition to ensure therapy compliance and development of necessary skills and knowledge in self-management (includes self-administration of injectable drugs). Member must have eligible diabetes diagnosis.
- **Contraception devices** — Benefits include Depo Provera injections, Norplant, intrauterine device and diaphragm. One IUD per year; insertion and removal are covered. One diaphragm per year. Includes initial exam for measurement.

Private duty nursing

What you pay for covered services unless otherwise noted		
In-network	Out-of-network	Nonparticipating
10% after annual in-network deductible	10% after annual out-of-network deductible	Annual out-of-network deductible plus the difference between the BCBSM approved amount and the provider's charge

Covered when the patient's condition requires 24-hour, continuous skilled care by a professional nurse on a one-to-one basis

Nonskilled care or care provided by a nurse who ordinarily resides in the patient's home or is a member of the immediate family is not covered. Services must be prescribed by a physician and provided by a registered or licensed practical nurse. The attending physician must complete a certification statement each month the patient is required to have private duty nursing care.

To avoid incurring expenses for private duty nursing services that are not payable, we recommend you call or write the BCBSM State of Michigan Customer Service Center before receiving private duty nursing services.

What is not covered under the State Health Plan PPO

The following services are not covered under the State Health Plan PPO:

- Care and services available at no cost to you in a veteran, marine or other federal hospital or any hospital maintained by any state or governmental agency
- Medically necessary services received on an inpatient basis that can be provided safely in an outpatient or office location
- 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 and related jaw-joint problems by any method other than as specified in this benefit book
- Hospital admissions that begin before the effective date of coverage
- Hospital admissions that begin after the coverage termination date
- Medical services or supplies provided or furnished 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)
 - Basal metabolism tests
 - Electrocardiography
- Items for the personal comfort or convenience of the patient
- Premarital or pre-employment exams
- Reverse sterilization
- Services and supplies that are not medically necessary according to accepted standards of medical practice
- Treatment of occupational injury or disease that the State of Michigan is obligated to furnish or otherwise fund
- Care and services received under another certificate offered by BCBSM or another Blue Cross Blue Shield Plan

- Care and services payable by government-sponsored health care programs, such as Medicare or TRICARE for which a 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 appearance, except as specified in this handbook
- Services rendered for gender reassignment
- Treatment of a condition caused by military action or war, declared or undeclared
- Services, care, devices or supplies considered experimental or investigative
- Services for which a charge is not customarily made
- Services for which the patient is not obligated to pay or services without cost
- 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 benefit book

Filing claims

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

To file your own claim, follow these steps:

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

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

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

Filing claims for services received outside the United States

Submit claims as noted above for services received outside the United States, using the guidelines under the *Choosing a network provider— care out of the country* section of this book.

Your right to file an internal 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 an internal 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.

Internal grievances

Standard internal grievance procedure

Under the standard internal 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 internal grievance procedure is as follows:

- 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. Payments 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.

- 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:
 - 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 internal grievance procedure.
 - 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.
 - 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.

Expedited internal grievance procedure

If a physician substantiates orally or in writing that adhering to the time frame 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 internal 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 in a timely manner to a request for benefits or payment.

The procedure is as follows:

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

Call the expedited grievance hot line: 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:
 - 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 internal grievance procedure.
 - If our decision is communicated to you orally, we must provide you with written confirmation within two 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 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 that 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 provide promptly 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 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 there under, 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.

Other general information

Coordination of benefits

Coordination of benefits is how group health care plans and insurance carriers coordinate benefits when members are covered by more than one plan. Under COB, group health care plans and insurance carriers work together to make sure members receive the maximum benefits available under their plans. Your State Health Plan PPO 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 group health care plans. 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

When a patient has double coverage, BCBSM determines who should pay before processing the claim. If the State Health Plan PPO is primary, then full benefits under the plan will be paid. If the State Health Plan PPO is secondary, payment towards the balance of the cost of covered services — up to the total allowable amount determined by both group plans — will be paid.

The guidelines used to determine which plan pays first are as follows:

- If a group health plan does not have a coordination of benefits provision, that plan is primary.
- If husband and wife have their own coverage, the husband's health coverage is primary when he receives services and the wife's coverage is primary when she receives services.
- If a child is covered under both the mother's and the father's plan, the plan of the parent (or legal guardian) whose birthday is earlier in the year is primary. If the child's parents are divorced, benefits will be paid according to any court decree. If no such decree exists, benefits are determined in the following order unless a court order places financial responsibility on one parent:
 1. Custodial parent
 2. Stepparent (if remarried)
 3. Noncustodial parent
 4. Noncustodial stepparent (if remarried)

If the primary plan cannot be determined by using the guidelines above, then the plan covering the child the longest is primary.

Processing your COB claims

When we receive your claim, we determine which plan is primary. Then we process your claim as follows:

- If we are primary, we pay for covered services up to the maximum amount allowed under your benefit plan, less any deductible or copays.
- If the other health plan is primary, we will return the claim to your provider, indicating that we are not primary, so your provider can bill the other group health plan. We will also send you an *Explanation of Benefit Payments* form that tells you we have billed another carrier.
- If we are both primary and secondary, we will process your claim first under the primary plan, and then automatically process the same claim under the secondary plan.
- If we are secondary and the primary plan has already paid, either you or your provider can submit a claim to us for consideration of any balances.

Be sure to include the EOB form you received from your primary plan.

Please make copies of all forms and receipts for your files.

Keeping your COB information updated

After enrollment, we will periodically send you a COB questionnaire to update your coverage information. Please complete and return this questionnaire so we can continue processing your claims without delay.

Subrogation

Occasionally, another person, insurance company or organization may be legally obligated to pay for health care services that we have 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 money through a lawsuit, settlement or other means for services paid under your coverage, you must reimburse BCBSM. However, this does not apply if the funds you receive are from additional health coverage you purchased in your name from another insurance company.

Medicare and Medicare Advantage coverage

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

- Age 65 or older (except for certain pension recipients and spouses covered under the State Police Retirement System)
- Diagnosed with End Stage Renal Disease (Please see the *Hemodialysis* heading in the *Hospital Coverage* section of this book.)
- Under age 65 but have received a Social Security disability benefit for at least 24 months

The State Health Plan PPO is primary, which means it pays first, for actively working employees and their enrolled dependents. However, Medicare will become primary for actively working employees and their enrolled dependents with End Stage Renal Disease after 33 months and the State Health Plan PPO will act as a supplement to Medicare coverage.

Medicare coverage for inpatient and physician services

Medicare has two parts: Part A and Part B. Part A helps pay for inpatient hospital care and certain follow-up care after you leave the hospital. It is provided to you at no cost. Part B helps pay for physician's services and other medical services and items. There is a monthly premium that you must pay for Part B coverage.

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

If you do not sign up for Part B when you are first eligible, your monthly premium for Part B may go up 10 percent for each full 12-month period that you could have had Part B, but did not sign up for it. If you delay taking Part B because you or your spouse (or a family member, if you are disabled) is working and has group health plan coverage based on current employment, you may not have to pay the higher premium.

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 payment or no payment.

Enrolling in Medicare

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

Automatic enrollment

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

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

Remember that if you 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.

Applying for Medicare

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

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

Remember that if you 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 payment or no payment.

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

Glossary

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

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

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

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

Adequate access is defined by how far you live from PPO providers and hospitals. The State Health Plan PPO access standards are as follows:

- 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

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

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

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

Autologous transplant is a procedure using the patient's own bone marrow or peripheral blood stem cells for transplantation back into the patient.

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

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

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

Clinical trial is 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 effects 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.

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

Contraceptive device is a device such as, but not limited to, a diaphragm, intrauterine device or contraceptive implant designed to prevent pregnancy.

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

Coordination of benefits is a program that coordinates your health benefits when you have coverage under more than one group health plan.

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

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

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

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

Designated cancer center is a site approved by the National Cancer Institute as a comprehensive cancer center, clinical cancer center, consortium cancer center or an affiliate of one of these centers.

Designated facility is a facility that BCBSM determines to be qualified to perform a specific organ transplant.

Durable medical equipment is 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 is the initial exam and treatment of conditions resulting from accidental injury.

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

Experimental or investigative is a service, procedure, treatment, device or supply that has not been scientifically demonstrated to be safe and effective for treatment of the patient's condition. BCBSM 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 and Blue Shield Association or other local or national bodies

Freestanding facility is a facility separate from a hospital that provides outpatient services, such as skilled nursing care or physical therapy.

Freestanding outpatient physical therapy facility is 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 services.

High-dose chemotherapy is a procedure that involves giving a patient cell destroying drugs in doses higher than approved by the FDA for therapy.

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

Independent physical therapist is 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 provide adequately physician-prescribed physical therapy.

In-network refers to services received by providers who are part of the Community Blue/Blue Preferred PPO network.

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

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

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

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

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

- When you do not inform the hospital that you are a BCBSM member 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

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

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

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

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

Network providers are providers who have met PPO standards and signed agreements to participate in the Community Blue/Blue Preferred network and to accept our approved amount as payment in full for covered services.

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

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

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

Out-of-network costs are increased copayment and deductible amounts members may be responsible for if they go out-of-network without a referral. These costs could also include charges from a nonparticipating provider that are above the approved BCBSM amount.

Out-of-network refers to services not rendered by a PPO network provider.

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

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

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

Peripheral blood stem cell transplant is a procedure where blood stem cells are obtained by pheresis and infused into the patient's circulation.

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

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

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

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

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

Skilled nursing facility is a facility that provides convalescent and short or long-term illness care with continuous nursing and other health care services by or under the supervision of a physician and a registered nurse.

The facility may be operated independently or as part of an accredited acute care hospital. It must meet all applicable local and state licensing and certification requirements.

Specialty hospital is 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.

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

Stem cells are 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 is the person who signed and submitted the application for State Health Plan PPO coverage.

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

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



Blue Cross
Blue Shield
of Michigan

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