

COMMUNITY BLUE SM
GROUP BENEFITS CERTIFICATE

Dear Subscriber:

We are pleased you have selected Blue Cross Blue Shield of Michigan for your health care coverage. Your coverage provides many benefits for you and your eligible dependents. These benefits are described in this book, which is your **certificate**.

Your certificate, your signed application and your BCBSM identification card are your **contract** with us.

You may also have **riders**. Riders make changes to your certificate and are an important part of your coverage. When you receive riders, keep them with this book.

This certificate will help you understand your benefits and each of our responsibilities **before** you require services. Please read it carefully. If you have any questions about your coverage, call us at one of the BCBSM Customer Service telephone numbers listed in the "How to Reach Us" section of this book.

Thank you for choosing Blue Cross Blue Shield of Michigan. We are dedicated to giving you the finest service and look forward to serving you for many years.

Sincerely,

A handwritten signature in black ink, appearing to read "Dan Loepp". The signature is fluid and cursive, with the first name "Dan" and last name "Loepp" clearly distinguishable.

Daniel J. Loepp
President and Chief Executive Officer
Blue Cross Blue Shield of Michigan

About Your Certificate

This certificate is arranged to help you locate information easily. You will find:

- A **Table of Contents** — for quick reference
- **Information About Your Contract**
- **What You Must Pay**
- **Coverage for Hospital, Facility and Alternatives to Hospital Care**
- **Coverage for Physician and Other Professional Provider Services**
- **Coverage for Other Health Care Services**
- **General Conditions of Your Contract**
- **The Language of Health Care** — explanations of the terms used in your certificate
- **How to Reach Us**

This certificate provides you with the information you need to get the most from your BCBSM health care coverage. Please call us if you have any questions.

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Section 1: Information About Your Contract

This section provides answers to general questions you may have about your contract. Topics include:

- **ELIGIBILITY**
 - Who is Eligible to Receive Benefits
 - End Stage Renal Disease (ESRD)
- **CANCELLATION**
 - How to Cancel Coverage
 - Automatic Cancellation
 - Rescission
- **CONTINUATION OF BENEFITS**
 - When You are Totally Disabled
 - Consolidated Omnibus Budget Reconciliation Act
 - Group Conversion Coverage

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 1.8, 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.

ELIGIBILITY

Who is Eligible to Receive Benefits
(continued)

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, the 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.

End Stage Renal Disease (ESRD)

We will coordinate our payment with Medicare for all covered services used by members with ESRD, including hemodialysis and peritoneal dialysis. Therefore, it is important that members with ESRD file a valid application for Medicare with the Social Security Administration. Dialysis services must be provided in a hospital, a panel or participating freestanding ESRD facility or in the home.

ELIGIBILITY

End Stage Renal Disease (ESRD) (continued)

When Medicare Coverage Begins

For members with ESRD, Medicare coverage begins the first day of the fourth month of dialysis, provided you file a valid application for Medicare with the Social Security Administration.

Example: Dialysis begins February 12. Medicare coverage begins May 1.

The period before Medicare coverage begins (up to three months) is the Medicare waiting period.

If you begin a self-dialysis training program in the first three months of your regular course of dialysis, the Medicare waiting period is waived. In this case, Medicare coverage begins on the first day of the month in which you begin your regular course of dialysis.

If you are admitted to a Medicare-approved hospital for a kidney transplant or for related health care services you need prior to a transplant, Medicare coverage begins on the first day of the month in which you are admitted to the hospital. Your transplant must take place that month or within the following two months.

If your transplant is delayed more than two months after you are admitted to the hospital for the transplant or for related health care services you need prior to the transplant, Medicare coverage begins two months before the month of your transplant.

When BCBSM Coverage is the Primary or Secondary Plan

If your BCBSM group coverage is provided through an employer and you are entitled to Medicare because you have ESRD, your BCBSM coverage is your primary plan for all covered services for up to 33 months, which includes the three-month (maximum) waiting period and the 30-

ELIGIBILITY

End Stage Renal Disease (ESRD) (continued)

month coordination period. (A medical evidence report may be used to establish the coordination period.) After the 30-month coordination period ends, BCBSM is your secondary plan and Medicare is your primary plan.

Dual Entitlement

If you have dual entitlement to Medicare **and** have employer group health plan benefits, the following conditions apply:

- If entitlement based on ESRD occurs at the same time as or prior to entitlement based on age or disability, the plan provided by the employer group is the primary plan through the end of the 30-month coordination period.

Example: You retired at age 62 and continued your coverage through your employer as a retiree. You start a regular course of dialysis on June 12, 2008, and on Sept. 1, 2008, you become entitled to Medicare because you have ESRD. In February 2009 you become entitled to Medicare because you turn 65. In this situation, even though you turn 65 during the 30-month coordination period, your employer's plan will be your primary plan for the entire 30-month coordination period from Sept. 1, 2008, through February 2011. Your employer's plan will be your secondary plan starting March 1, 2011.

- If entitlement based on ESRD occurs after entitlement based on age or disability, primary plan status is determined as follows:

ELIGIBILITY

End Stage Renal Disease (ESRD)

(continued)

- If you are a working aged or working disabled individual in your first month of dual entitlement, the plan provided by your employer group is your primary plan and remains your primary plan through the end of the 30-month coordination period.

Example: You became entitled to Medicare in June 2008, when you were 65 years old. You have coverage through your employer's plan and, because you are still working, your employer's plan is your primary plan. On May 27, 2010, you are diagnosed with ESRD and begin a regular course of dialysis. On Aug. 1, 2010, you become entitled to Medicare because you have ESRD. Your employer's plan remains your primary plan for the 30-month coordination period, from Aug. 1, 2010, through Jan. 31, 2013. Medicare becomes your primary plan on Feb. 1, 2013.

- If you are not a working aged or working disabled individual in the first month of dual entitlement, Medicare is your primary plan.

Example: You retired at age 62 and continued your coverage through your employer as a retiree. In August 2008, when you turn 65, you become entitled to Medicare. In January 2009, you begin a regular course of dialysis. On April 1, 2009, you become entitled to Medicare because you have ESRD. Because Medicare was already your primary plan when you became dually entitled, Medicare will remain your primary plan both during and after the coordination period.

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 requested date and all benefits under this certificate will end. However, if you are an inpatient at a hospital or facility on the date your coverage ends, please see the General Condition “Services Before Coverage Begins or After Coverage Ends.”

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

NOTE: If you are responsible for paying all or a portion of the bill then you must pay it on time or your coverage will be automatically cancelled. For example, if you are a retiree or enrolled under COBRA and you pay all or part of your bill directly to BCBSM, we must receive your payment 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

CANCELLATION

Automatic Cancellation (continued)

- 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. However, if you are an inpatient at a hospital or facility on the date your coverage ends, please see the General Condition "Services Before Coverage Begins or After Coverage Ends" in Section 6.

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

When You are Totally Disabled

If your coverage ends because you are no longer employed, we will continue to pay for covered services if the following apply:

- You are totally disabled before this coverage ends.
- The services treat the condition that caused your total disability and the condition is continuous.

If you meet the above conditions we will pay benefits through Dec. 31 of the year following the year when your coverage under this certificate ended.

Example: If coverage ended Oct. 15, 2008, we would continue to pay benefits through Dec. 31, 2009.

CONTINUATION OF BENEFITS

When You are Totally Disabled (continued) We will pay for covered services up to the approved amounts after you pay your deductible and copayments (see Section 2).

NOTE: This section does not apply to a disability that is the result of a work-related accident or injury.

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
- 29 months of coverage 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 becomes entitled to Medicare coverage

CONTINUATION OF BENEFITS

**Consolidated
Omnibus
Budget
Reconciliation
Act**

(continued)

- 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.

**Group
Conversion
Coverage**

If you choose not to enroll in COBRA, or if your COBRA coverage period ends, **individual** coverage may be available through a BCBSM group conversion plan. You or your eligible dependents must submit a written request for group conversion coverage to us:

- Within 30 days of the date your group coverage was canceled **or**
- Within six months before the group continuation option (COBRA) ends

Section 2: What You Must Pay

This section explains the deductible and copayments you must pay each calendar year.

Deductible Requirements

Panel Providers

You pay no deductible for covered services provided by panel providers.

Nonpanel Providers

You are required to pay the following deductible each calendar year for covered services provided by nonpanel providers:

- \$250 for one member
- \$500 for the family (when two or more members are covered under your contract)
 - Two or more members must meet the family deductible.
 - If the one member deductible has been met, but not the family deductible, we will pay covered services only for that member who has met the deductible.
 - Covered services for the remaining family members will be paid when the full family deductible has been met.

You will not be required to pay a deductible for covered nonpanel services when:

- A panel provider refers you to a nonpanel provider

NOTE: You must obtain the referral **before** receiving the referred service or the service will be subject to the nonpanel deductible requirements.

Deductible Requirements
(continued)

Nonpanel Providers (continued)

- You receive services for the exam and treatment of a medical emergency or accidental injury in the outpatient department of a hospital, urgent care center or physician's office
- You receive services from a provider for which there is no PPO panel
- You receive services from a nonpanel provider in a geographic area of Michigan deemed a "low-access area" by BCBSM for that particular provider specialty.

In limited instances, nonpanel deductible requirements may not be imposed for:

- Select professional services performed by nonpanel providers in a panel hospital, participating freestanding ambulatory surgery facility or any other location identified by BCBSM, or
- The reading and interpretation of a screening mammography in instances where a panel provider performs the test, but a nonpanel provider does the analysis and interprets the results.

NOTE: While the nonpanel deductible requirements may not be imposed, covered services will be subject to applicable panel deductible requirements (if any).

You may contact BCBSM for information regarding these professional services.

We will not apply charges toward your deductible if one of the following applies:

- The charges exceed our approved amount.
- The charges are for noncovered services.

Copayment Requirements

Panel Providers

You are required to pay the following flat-dollar copayment or percentage amount for covered services provided by panel providers:

- \$50 per visit for facility services in a hospital emergency room (waived in certain instances, see Page 3.23)
- \$10 copayment per office visit (specific services are listed on Page 4.17)
- 50 percent of the approved amount for:
 - Mental health services
 - Substance abuse treatment
 - Private duty nursing care

NOTE: There is no annual maximum for member copayments when services are rendered by panel providers.

Nonpanel Providers

You are required to pay the following copayments for covered services provided by nonpanel providers:

- \$50 per visit for facility services in a hospital emergency room (waived in certain instances, see Page 3.23). For your requirements on services in a Michigan nonparticipating hospital, see Page 3.51.
- 50 percent of the approved amount for:
 - Mental health services
 - Substance abuse treatment
 - Private duty nursing care

Copayment Requirements
(continued)

Nonpanel Providers (continued)

- 20 percent of the approved amount for most other services

NOTE: Your annual copayment maximum for services that require a 20 percent copayment is:

- \$2,000 for one member
- \$4,000 for two or more members

Once the annual copayment maximum is met, no more copayments will be required for the remainder of the year, except that copayments continue to be required for mental health services, substance abuse treatment and private duty nursing.

NOTE: Copayments for mental health services, substance abuse treatment and private duty nursing are not applied toward your annual copayment maximum.

You will not be required to pay the 20 percent copayment for covered nonpanel services when:

- A panel provider refers you to a nonpanel provider

NOTE: You must obtain the referral **before** receiving the referred service or the service will be subject to the nonpanel copayment requirements.

- You receive services for the exam and treatment of a medical emergency or accidental injury in the outpatient department of a hospital, urgent care center or physician's office
- You receive services from a provider for which there is no PPO panel
- You receive services from a nonpanel provider in a geographic area of Michigan deemed a "low-access area" by BCBSM for that particular provider specialty.

Copayment Requirements
(continued)

Nonpanel Providers (continued)

In limited instances, nonpanel copayment requirements may not be imposed for:

- Select professional services performed by nonpanel providers in a panel hospital, participating freestanding ambulatory surgery facility or any other location identified by BCBSM, or
- The reading and interpretation of a screening mammography in instances where a panel provider performs the test, but a nonpanel provider does the analysis and interprets the results.

NOTE: While the nonpanel copayment requirements may not be imposed, covered services will be subject to applicable panel copayment requirements (if any).

You may contact BCBSM for information regarding these professional services.

We will not apply charges toward your copayments that:

- Exceed our approved amount or
- Are for noncovered services

Annual Maximums

If annual maximums (days or visits) or lifetime maximums (days or visits) apply for specific services, they are described elsewhere in your certificate.

- For preventive care services (described on Pages 4.19 – 4.21) we pay up to a combined maximum of \$250 per member, per calendar year.

Section 3: Coverage for Hospital, Facility and Alternatives to Hospital Care

We pay our approved amount for the hospital, facility and alternatives to hospital care covered under this certificate (copayment and deductible information is in Section 2). It includes:

- **HOSPITAL AND FACILITY CARE**
 - Inpatient Hospital Services That Are Payable
 - Inpatient Hospital Services That Are Not Payable
 - Hospital Admissions That Are Not Payable
 - Outpatient Hospital Services That Are Payable
 - Outpatient Hospital Services That Are Not Payable
 - Outpatient Mental Health Facility Services
 - Outpatient and Residential Substance Abuse Treatment
 - Freestanding Ambulatory Surgery Facility Services
 - Freestanding Outpatient Physical Therapy Facility Services
 - Freestanding ESRD Facility Services
 - Long-Term Acute Care Hospital Services

- **ALTERNATIVES TO HOSPITAL CARE**
 - Home Health Care Services
 - Home Infusion Therapy
 - Hospice Care Services
 - Skilled Nursing Facility Services
 - BlueHealthConnection® Program
 - Integrated Case and Disease Management
 - Alternative Facility Services That Are Not Payable

- **HOW HOSPITALS, FACILITIES AND ALTERNATIVE TO HOSPITAL CARE PROVIDERS ARE PAID**
 - Panel Providers
 - Nonpanel Providers
 - Emergency Services at a Nonparticipating Hospital

- Services That You Must Pay
- Out-of-Area Services
- BlueCard PPO® Program
- Negotiated (non-BlueCard Program) National Account Arrangements
- BlueCard Worldwide® Program

HOSPITAL AND FACILITY CARE

- The services described in this section must be:
 - Prescribed by the attending physician, and
 - Provided during an inpatient hospital stay or
 - Provided in the outpatient department of a hospital or in a facility
- This section has information about benefits provided in or by a participating hospital or facility. It includes:
 - Inpatient Hospital Services
 - Outpatient Hospital and Facility Services
 - Outpatient Mental Health Facility Services
 - Outpatient and Residential Substance Abuse Treatment
 - Freestanding Ambulatory Surgery Services
 - Freestanding Outpatient Physical Therapy Facility Services
 - Freestanding ESRD Facility Services
 - Long-Term Acute Care Hospital Services
 - Home Health Care Services
 - Home Infusion Therapy
 - Hospice Care Services
 - Skilled Nursing Facility Services
- This section includes information about these programs:
 - BlueHealthConnection® Program
 - Integrated Case and Disease Management
- For information about benefits provided in a nonparticipating hospital and facility, see “Nonpanel Providers” on Page 3.51.

HOSPITAL AND FACILITY CARE

- For covered services to be payable, they must be medically necessary (see Section 7).

NOTE: Medically necessary services that can be provided safely in an outpatient or office location are not payable when provided in an inpatient setting.

**Inpatient
Hospital
Services That
Are Payable**

- Semiprivate room
- Nursing services
- Meals, including special diets
- Operating room services, including delivery and surgical treatment rooms
- Services provided in a special care unit, such as intensive care
- Anesthetics given by a qualified employee of the hospital
- Diagnostic laboratory and pathology tests and services that are provided under the direction of a pathologist employed by the hospital
- Oxygen and other therapeutic gases and their administration
- Covered services and devices for pain management when medically necessary as documented by a physician
- Inpatient mental health services and inpatient and residential substance abuse

NOTE: Inpatient mental health services and substance abuse treatment are subject to a 50 percent member copayment (described on Page 2.5).

HOSPITAL AND FACILITY CARE

**Inpatient
Hospital
Services That
Are Payable**
(continued)

- Psychological tests directly related to the condition for which the patient is admitted or when such tests have a full role in rehabilitative or psychiatric treatment programs
- Cardiac rehabilitation services begun during an admission for an invasive cardiovascular procedure (e.g., heart surgery) or an acute cardiovascular event (e.g., heart attack)
- Medical supplies such as gauze, cotton, fabrics, plaster and other materials used in dressings and casts
- Physical therapy treatment, speech and language pathology services, and occupational therapy used to treat the condition for which the member is hospitalized

Physical therapy must be:

- Prescribed by a physician licensed to prescribe it, and
- Given for a neuromuscular condition that can be significantly improved in a reasonable and generally predictable period of time (usually about six months), and
- Given by:
 - An M.D., D.O. or D.P.M.
 - A licensed physical therapist under the direction of a physician or
 - Other individuals under the direct supervision of a licensed physical therapist, M.D. or D.O.

HOSPITAL AND FACILITY CARE

**Inpatient
Hospital
Services That
Are Payable**
(continued)

Services do not include:

- Therapy to treat long-standing, chronic conditions that have not responded to or are unlikely to respond to therapy
- Tests to measure physical capacities such as strength, dexterity, coordination or stamina, unless part of a complete physical therapy treatment program
- Treatment **solely** to improve cognition (e.g., memory or perception), concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought

NOTE: We may pay for treatment to improve cognition when part of a comprehensive rehabilitation plan of care.

- Patient education and home programs (such as home exercise programs)
- Sports medicine for purposes such as prevention of injuries or for conditioning
- Recreational therapy

Speech and language pathology services must be:

- Prescribed by a physician licensed to prescribe them, and
- Given for a condition that can be significantly improved in a reasonable and generally predictable period of time (usually about six months), and

HOSPITAL AND FACILITY CARE

Inpatient Hospital Services That Are Payable (continued)

Speech and language pathology services must be: (continued)

- Given by a speech-language pathologist certified by the American Speech-Language-Hearing Association or by one fulfilling the clinical fellowship year under the supervision of a certified speech-language pathologist

NOTE: The clinical fellowship year occurs after a speech-language pathologist completes all graduate requirements for the master's degree. This year of practice is under the supervision of a certified speech-language pathologist.

Services do not include:

- Treatment **solely** to improve cognition (e.g., memory or perception), concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought

NOTE: We may pay for treatment to improve cognition when part of a comprehensive rehabilitation plan of care.

- Recreational therapy
- Treatment of chronic, developmental or congenital conditions, learning disabilities or inherited speech abnormalities

NOTE: For certain pediatric patients with severe retardation of speech development, a BCBSM medical consultant may determine that speech and language pathology services can be used to treat chronic, developmental or congenital conditions.

HOSPITAL AND FACILITY CARE

**Inpatient
Hospital
Services That
Are Payable**
(continued)

Occupational therapy must be:

- Prescribed by a physician licensed to prescribe it, and
- Given for a condition that can be significantly improved in a reasonable and generally predictable period of time (usually about six months), and
- Given only by a registered occupational therapist or occupational therapy assistant (both must be certified by the National Board of Occupational Therapy Certification and the state of Michigan)

NOTE: The occupational therapy assistant must be under the direct supervision of a registered occupational therapist, who cosigns all assessments and patients' progress notes.

Services do not include:

- Occupational therapy examinations or evaluations without an occupational therapy treatment plan and where there is no progress
- Treatment **solely** to improve cognition (e.g., memory or perception), concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought

NOTE: We may pay for treatment to improve cognition when part of a comprehensive rehabilitation plan of care.

- Recreational therapy
- Sterilization (whether or not medically necessary)
- Prescription drugs, biologicals and solutions (such as irrigation and I.V. solutions) that are:

HOSPITAL AND FACILITY CARE

**Inpatient
Hospital
Services That
Are Payable**
(continued)

- Labeled FDA-approved as defined under the amended Federal Food, Drug and Cosmetic Act, and
- Used during your stay in the hospital
- Special medical foods and formulas for metabolic diseases (see Section 4)
- Maternity care and routine newborn nursery care during a mother's eligible hospital stay

Under federal law, we generally may not 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
- 96 hours following a delivery by cesarean section

However, we may pay for a shorter stay if the attending provider (e.g., your physician or certified nurse midwife), after consultation with the mother, discharges the mother or newborn earlier.

Also, we may not set the level of benefits or out-of-pocket costs so that any portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, we may not require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

However, to use certain providers or facilities or to reduce your out-of-pocket costs, you may be required to obtain preapproval. For information on preapproval, contact your BCBSM customer service representative (see Section 8).

- Whole blood, blood derivatives, blood plasma or packed red blood cells, supplies and their administration

HOSPITAL AND FACILITY CARE

**Inpatient
Hospital
Services That
Are Payable**
(continued)

- Drugs that are FDA-approved for use in chemotherapy treatment
- NOTE:** If the FDA has not approved the drug for the specific disease being treated, BCBSM's Medical Policy staff determines the appropriateness of the drug for that disease by using the following criteria:
 - Current medical literature must confirm that the drug is effective for the disease being treated.
 - Recognized oncology organizations must generally accept the drug as treatment for the specific disease.
 - The physician must obtain informed consent from the patient for the treatment.
- Inhalation therapy
- X-rays
- Electroshock therapy
- Pulmonary function evaluation
- Radioactive isotope studies and use of radium owned or rented by the hospital
- Prosthetic devices permanently implanted in the body or those used externally as part of regular hospital equipment while you are in the hospital (for additional prosthetic and orthotic benefits, see Pages 5.6 – 5.8)
- External prosthetic and orthotic devices prescribed by a physician for use outside of the hospital
- Cost of obtaining, preserving and storing human skin, bone, blood, and bone marrow to be used for medically necessary covered services

HOSPITAL AND FACILITY CARE

**Inpatient
Hospital
Services That
Are Payable**
(continued)

- Hyperbaric oxygenation (therapy given in a pressure chamber)
 - Computerized axial tomography, magnetic resonance imaging and positron emission tomography scans provided in participating facilities
 - Durable medical equipment:
 - Used in the hospital
 - Rented or purchased from the hospital at the time of discharge
 - Cosmetic surgery for:
 - Correction of deformities present at birth. Congenital deformities of the teeth are not covered.
 - Correction of deformities resulting from cancer surgery. (This can include reconstructive surgery after a mastectomy.)
 - Conditions caused by accidental injuries, and
 - Traumatic scars
- NOTE:** Cosmetic surgery and related services are not payable when the services are primarily performed to improve appearance.
- Dialysis services, supplies and equipment to treat:
 - Acute renal (kidney) failure
 - Chronic, irreversible kidney failure (End Stage Renal Disease (ESRD))

HOSPITAL AND FACILITY CARE

**Inpatient
Hospital
Services That
Are Payable**
(continued)

ESRD treatment may also be provided in a panel or participating freestanding facility or in the home (when provided by a program participating with BCBSM to provide such services).

NOTE: Dialysis services used primarily to treat ESRD are also covered by Medicare (individuals with ESRD should apply to Medicare). (See Pages 1.4 – 1.6 for details about ESRD.)

- Psychiatric day treatment or psychiatric night treatment in a participating hospital. We pay for:
 - Services provided by facility staff
 - Ancillary services to patients who are admitted and discharged on the same day of treatment
 - Prescribed drugs given by the hospital in connection with the treatment plan
 - Electroshock therapy when administered by, or under the supervision of, a physician
 - Anesthetics for electroshock therapy when administered by, or under the supervision of, a physician other than the physician giving the electroshock therapy
 - Psychological testing
 - Family counseling

For patients admitted to a **psychiatric night treatment** facility, we also pay for:

- A semiprivate room
- Nursing services and

HOSPITAL AND FACILITY CARE

**Inpatient
Hospital
Services That
Are Payable**
(continued)

- Meals, including special diets

NOTE: You are required to pay 50 percent of the approved amount for psychiatric day or night treatment services.

- Services performed to obtain, test, store and transplant only the following human tissues and organs:
 - Kidney
 - Cornea
 - Skin
 - Bone marrow (described below)

Immunization against certain common infectious diseases during the first 24 months post-transplant are covered. We pay for immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP).

NOTE: The immunization benefit does **not** apply to cornea and skin transplants.

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

- Bone Marrow Transplants

Services must be rendered in a facility participating with BCBSM.

When directly related to two tandem transplants, two single transplants or a single and a tandem transplant per member, per condition, we pay for the following services:

HOSPITAL AND FACILITY CARE

**Inpatient
Hospital
Services That
Are Payable**
(continued)

Bone Marrow Transplants (continued)

Allogeneic Transplants

- Blood tests on first degree relatives to evaluate them as donors (if the tests are not covered by their insurance)
- Search of the National Bone Marrow Donor Program Registry for a donor. A search will begin only when the need for a donor is established and the transplant is preapproved.
- Infusion of colony stimulating growth factors
- Harvesting (including peripheral blood stem cell pheresis) and storage of the donor's bone marrow, peripheral blood stem cell and/or umbilical cord blood, if the donor is:
 - A first degree relative and matches at least four of the six important HLA genetic markers with the patient or
 - Not a first degree relative and matches five of the six important HLA genetic markers with the patient. (This provision does not apply to transplants for Sickle Cell Anemia (ss or sc) or Beta Thalassemia.)

NOTE: Harvesting and storage will be covered if it is not covered by the donor's insurance but only when the recipient of harvested material is a BCBSM member. In a case of Sickle Cell Anemia (ss or sc) or Beta Thalassemia, the donor must be an HLA-identical sibling.

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

HOSPITAL AND FACILITY CARE

**Inpatient
Hospital
Services That
Are Payable**
(continued)

Allogeneic Transplants (continued)

- Donor lymphocyte infusion
- Hospitalization

Autologous Transplants

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

NOTE: A tandem autologous transplant is covered only when it treats germ cell tumors of the testes or multiple myeloma. We pay for up to two tandem transplants or a single and a tandem transplant per patient for this condition. Refer to the definition of “Tandem Transplant” in Section 7.

Allogeneic transplants are covered to treat the following conditions:

- Acute lymphocytic leukemia (high-risk, refractory or relapsed patients)
- Acute non-lymphocytic leukemia (high-risk, refractory or relapsed patients)
- Acute myelogenous leukemia
- Aplastic anemia (acquired or congenital, e.g., Fanconi’s anemia or Diamond-Black fan syndrome)

HOSPITAL AND FACILITY CARE

**Inpatient
Hospital
Services That
Are Payable**
(continued)

Allogeneic transplants are covered to treat the following conditions: (continued)

- Beta Thalassemia
- Chronic myeloid leukemia
- Hodgkin's disease (high-risk, refractory or relapsed patients)
- Myelodysplastic syndromes
- Neuroblastoma (stage III or IV)
- Non-Hodgkin's lymphoma (high-risk, refractory or relapsed patients)
- Osteopetrosis
- Severe combined immune deficiency disease
- Wiskott-Aldrich syndrome
- Sickle Cell Anemia (ss or sc)
- Myelofibrosis
- Multiple myeloma
- Primary amyloidosis (AL)
- Glanzmann thrombasthenia
- Paroxysmal nocturnal hemoglobinuria
- Kostmann's syndrome
- Leukocyte adhesion deficiencies
- X-linked lymphoproliferative syndrome
- Primary, secondary and unspecified thrombocytopenia (e.g., megakaryocytic thrombocytopenia)
- Mantle cell lymphoma
- Congenital leukocyte dysfunction syndromes
- Congenital pure red cell aplasia
- Chronic lymphocytic leukemia
- Mucopolysaccharidoses (e.g., Hunter's, Hurler's, Sanfilippo, Maroteaux-Lamy variants) in patients who are neurologically intact
- Mucopolysaccharidoses (e.g., Gaucher's disease, metachromatic leukodystrophy, globoid cell leukodystrophy, adrenoleukodystrophy) for patients who have failed conventional therapy (e.g., diet, enzyme replacement) and who are neurologically intact

HOSPITAL AND FACILITY CARE

**Inpatient
Hospital
Services That
Are Payable**
(continued)

Allogeneic transplants are covered to treat the following conditions: (continued)

- Renal cell CA
- Plasmacytomas

Autologous transplants are covered to treat the following conditions:

- Acute lymphocytic leukemia (high-risk, refractory or relapsed patients)
- Acute non-lymphocytic leukemia (high-risk, refractory or relapsed patients)
- Germ cell tumors of ovary, testis, mediastinum, retroperitoneum
- Hodgkin's disease (high-risk, refractory or relapsed patients)
- Neuroblastoma (stage III or IV)
- Non-Hodgkin's lymphoma (high-risk, refractory or relapsed patients)
- Multiple myeloma
- Primitive neuroectodermal tumors
- Ewing's sarcoma
- Medulloblastoma
- Wilms' tumor
- Primary amyloidosis
- Rhabdomyosarcoma
- Mantle cell lymphoma

NOTE: In addition to the conditions listed above, we will pay for services related to, or for high-dose chemotherapy, total body irradiation, and allogeneic or autologous transplants to treat conditions that are not experimental. This does not limit or preclude coverage of antineoplastic drugs when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.

HOSPITAL AND FACILITY CARE

**Inpatient
Hospital
Services That
Are Payable**
(continued)

We do not pay the following for bone marrow transplants:

- Services that are not medically necessary (see Section 7 for the definition of medically necessary)
- Services rendered in a facility that does not participate with BCBSM
- Services provided by persons or entities that are not legally qualified or licensed to provide such services
- Services rendered to a transplant recipient who is not a BCBSM member
- Services rendered to a donor when the donor's health care coverage will pay for such services
- Services rendered to a donor when the transplant recipient is not a BCBSM member
- Any services related to, or for, allogeneic transplants when the donor does not meet the HLA genetic marker matching requirements
- Expenses related to travel, meals and lodging for donor or recipient
- An autologous tandem transplant for any condition other than germ cell tumors of the testes
- Search of an international donor registry
- An allogeneic tandem transplant
- The routine harvesting and storage costs of bone marrow, peripheral blood stem cells or a newborn's umbilical cord blood if not intended for transplant within one year
- Experimental treatment
- Any other services or admissions related to any of the above named exclusions

HOSPITAL AND FACILITY CARE

**Inpatient
Hospital
Services That
Are Payable**
(continued)

- Specified Human Organ Transplants

When performed in a designated facility, we pay for transplantation of the following organs:

- Combined small intestine-liver
- Heart
- Heart-lung(s)
- Liver
- Lobar lung
- Lung(s)
- Pancreas
- Partial liver
- Kidney-liver
- Simultaneous pancreas-kidney
- Small intestine (small bowel)
- Multivisceral transplants (as determined by BCBSM)

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

When directly related to the transplant, we pay for:

- Facility and professional services
- Anti-rejection drugs and other transplant-related prescription drugs, during and after the benefit period, as needed. Payment will be based on BCBSM's approved amount.
- Immunization against certain common infectious diseases during the first 24 months post-transplant are covered. We pay for immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP).
- Medically necessary services needed to treat a condition arising out of the organ transplant surgery **if** the condition:

HOSPITAL AND FACILITY CARE

**Inpatient
Hospital
Services That
Are Payable**
(continued)

Specified Human Organ Transplants (continued)

- Occurs during the benefit period and
- Is a direct result of the organ transplant surgery

NOTE: We will pay for any service needed to treat a condition as a direct result of the organ transplant surgery if it is a benefit under any of our certificates.

We also pay for the following:

- Up to \$10,000 for eligible travel and lodging during the initial transplant surgery. This includes:
 - Cost of transportation to and from the designated transplant facility for the patient and another person eligible to accompany the patient (two persons if the patient is a child under the age of 18 or if the transplant involves a living-related donor)

NOTE: In certain limited cases, we may consider return travel needed for an acute rejection episode to the original transplant facility. The condition must be emergent and must fall within the benefit period. The cost of the travel must still fall under the \$10,000 maximum for travel and lodging.

- Reasonable and necessary costs of lodging for the person(s) eligible to accompany the patient (“lodging” refers to a hotel or motel)
- Cost of acquiring the organ (the organ recipient must be a BCBSM member.) This includes, but is not limited to:
 - Surgery to obtain the organ
 - Storage of the organ
 - Transportation of the organ

HOSPITAL AND FACILITY CARE

**Inpatient
Hospital
Services That
Are Payable**
(continued)

Specified Human Organ Transplants (continued)

- Living donor transplants such as partial liver, lobar lung, small bowel, and kidney transplants that are part of a simultaneous kidney transplant
- Payment for covered services for a donor if the donor does not have transplant services under any health care plan

NOTE: We will pay the BCBSM approved amount for the cost of acquiring the organ.

Limitations and Exclusions

During the benefit period, the deductible and copayments do not apply to the specified human organ transplants and related procedures.

We do not pay for the following for specified human organ transplants:

- Services that are not BCBSM benefits
- Services rendered to a recipient who is not a BCBSM member
- Living donor transplants not listed in this certificate
- Anti-rejection drugs that do not have Food and Drug Administration approval
- Transplant surgery and related services performed in a nondesignated facility. You must pay for the transplant surgery and related services you receive in a nondesignated facility unless medically necessary and approved by the BCBSM medical director
- Transportation and lodging costs for circumstances other than those related to the initial transplant surgery and hospitalization

HOSPITAL AND FACILITY CARE

**Inpatient
Hospital
Services That
Are Payable**
(continued)

Specified Human Organ Transplants (continued)

Limitations and Exclusions (continued)

- Items that are not considered directly related to travel and lodging (examples include, but are not limited to the following: mortgage, rent payments, furniture rental, dry cleaning, clothing, laundry services, kennel fees, car maintenance, toiletries, security deposits, cash advances, lost wages, tips, toys, household products, alcoholic beverages, flowers, greetings cards, stationery, stamps, gifts, household utilities (including cellular telephones), maids, babysitters or daycare services, services provided by family members, reimbursement of food stamps, mail/UPS services, Internet service, and entertainment (such as cable television, books, magazines and movie rentals))
- Routine storage cost of donor organs for the future purpose of transplantation
- Services prior to your organ transplant surgery, such as expenses for evaluation and testing, unless covered elsewhere under this certificate
- Experimental transplant procedures. See the “General Conditions of Your Contract” section for guidelines related to experimental treatment.

**Inpatient
Hospital
Services That
Are Not Payable**

In addition to the services described as nonpayable throughout the previous subsection, we also do not pay for the following:

- Services that may be medically necessary but can be provided safely in an outpatient or office location
- Services of physicians and surgeons not employed by the hospital (see Section 4 for payable physician services)
- Custodial care or rest therapy

HOSPITAL AND FACILITY CARE

**Inpatient
Hospital
Services That
Are Not Payable**
(continued)

- Psychological tests if used as part of, or in connection with, vocational guidance training or counseling
- Dental services. However, facility and anesthesia services may be payable if a hospitalized patient has a medical condition that makes it unsafe for dental treatment to be performed in the office setting. Examples of such medical conditions are:
 - Bleeding or clotting abnormalities
 - Unstable angina
 - Severe respiratory disease
 - Known reaction to analgesics, anesthetics, etc.

Those procedures include:

- Alveoplasty
- Diagnostic X-rays
- Multiple extractions or removal of unerupted teeth
- Gingivectomy

Medical records must verify the patient's concurrent hazardous medical condition.

- Services covered under any other Blue Cross Blue Shield contract or under any health care benefits plan
- Screening services
- Dental transplants and related services, including repair and maintenance of implants and surrounding tissue

**Hospital
Admissions
That Are Not
Payable**

Hospital admissions that are not covered by your certificate include:

- Those for care that is not considered acute, such as:
 - Observation
 - Dental treatment, including extraction of teeth, except as otherwise noted in this certificate
 - Diagnostic evaluations
 - Lab exams

HOSPITAL AND FACILITY CARE

Hospital Admissions That Are Not Payable
(continued)

- Electrocardiography
- Weight reduction
- X-ray, exams or therapy
- Cobalt or ultrasound studies
- Basal metabolism tests
- Convalescence or rest care
- Convenience items

- Those mainly for physical therapy, speech and language pathology services or occupational therapy

Outpatient Hospital Services That Are Payable

The services listed under “Inpatient Hospital Services That Are Payable” are also payable when provided as outpatient care (except for those related to inpatient room, board, and inhalation therapy).

However, the following requirements must also be met when the service is provided on an outpatient basis:

- Facility services are payable for the exam and treatment of a medical emergency or accidental injury in the outpatient department of a hospital.

NOTE: A \$50 copayment per visit is applied to the hospital charges each time services are provided by a panel or nonpanel provider. (See Page 3.51 for charges in a Michigan nonparticipating hospital.)

The \$50 copayment is not applied if:

- The patient is admitted or
 - Services were required to treat an accidental injury
- Emergency services performed by a nonpanel provider are not subject to any deductible or copayment requirements other than the \$50 copayment.

HOSPITAL AND FACILITY CARE

**Outpatient
Hospital
Services That
Are Payable**
(continued)

- Services to treat chronic conditions are payable when they require repeated visits to the hospital.
- Covered services and devices for pain management when medically necessary as documented by a physician
- Drugs and solutions administered in a hospital are payable when they are part of the treatment for the disease, condition or injury.
- Dialysis services (hemodialysis and peritoneal dialysis), supplies and equipment are payable when provided in the home to treat chronic, irreversible kidney failure. Services must be billed by a hospital or freestanding ESRD facility participating with BCBSM and must meet the following conditions:
 - The treatment must be arranged by the patient's attending physician and the physician director, or a committee of staff physicians of a self-dialysis training program.
 - The owner of the patient's home must give the hospital prior written permission to install the equipment.

We pay for:

- Placement and maintenance of a dialysis machine in the patient's home
- Expenses to train the patient and one other person who will assist the patient in the home in operating the equipment
- Laboratory tests related to the dialysis
- Supplies required during the dialysis, such as dialysis membrane, solution, tubing and drugs
- Removal of the equipment after it is no longer needed

The following dialysis services are not payable:

- Electricity or water used to operate the dialyzer

HOSPITAL AND FACILITY CARE

**Outpatient
Hospital
Services That
Are Payable**
(continued)

- Installation of electric power, a water supply or a sanitary waste disposal system
- Services provided by persons under contract with the hospital, agencies or organizations assisting in the dialysis or acting as "back ups," including hospital personnel sent to the patient's home
- Transfer of the dialyzer to another location in the patient's home
- Physician services not paid by the hospital
- Cardiac rehabilitation services are payable when intensive monitoring (i.e., through the use of EKGs) and/or supervision during exercise is required
- Preventive care services (see Pages 4.19 – 4.21)
- Medically necessary mammograms
- Physical therapy, speech and language pathology services, and occupational therapy, are payable when provided for rehabilitation. These services have a combined benefit maximum of 60 visits per member, per calendar year, whether obtained from a panel or nonpanel provider. Visits for mechanical traction performed by a chiropractor in conjunction with spinal manipulation are applied toward this maximum. All services provided in any outpatient location (hospital, facility, office or home) are combined to meet the 60-visit maximum. This benefit maximum renews each calendar year

NOTE: Each **treatment date** counts as one visit even when two or more therapies are provided and when two or more conditions are treated. For example, if a facility provides you with physical therapy and occupational therapy on the same day, the services are counted as one visit.

An initial evaluation is not counted as a visit. If approved, it will be paid separately from the visit and will not be applied towards the maximum benefit limit.

HOSPITAL AND FACILITY CARE

Outpatient Hospital Services That Are Payable (continued)

Physical, occupational and speech therapies are not payable when provided in a nonparticipating freestanding outpatient physical therapy facility, or any other facility independent of a hospital or an independent sports medicine clinic.

Physical therapy must be:

- Prescribed by a doctor of medicine, osteopathy or podiatry, or a dentist
- Given for a neuromuscular condition that can be significantly improved in a reasonable and generally predictable period of time (usually about six months)
- Given by:
 - A doctor of medicine, osteopathy or podiatry
 - A physical therapist
 - A physical therapy assistant under the direct supervision of a physical therapist
 - An athletic trainer under the direct supervision of a physical therapist

Services do not include:

- Therapy to treat long-standing, chronic conditions that have not responded to or are unlikely to respond to therapy
- Tests to measure physical capacities such as strength, dexterity, coordination or stamina, unless part of a complete physical therapy treatment program
- Treatment **solely** to improve cognition (e.g., memory or perception), concentration and/or attentiveness, organizational or problem solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought

HOSPITAL AND FACILITY CARE

Outpatient Hospital Services That Are Payable (continued)

Physical Therapy (continued)

NOTE: We may pay for treatment to improve cognition when part of a comprehensive rehabilitation plan of care.

- Patient education and home programs (such as home exercise programs)
- Sports medicine for purposes such as prevention of injuries or for conditioning
- Recreational therapy

Speech and language pathology services must be:

- Prescribed by a doctor of medicine, osteopathy or a dentist
- Given for a condition that can be significantly improved in a reasonable and generally predictable period of time (usually about six months)
- Given by:
 - A doctor of medicine or osteopathy
 - A speech-language pathologist certified by the American Speech-Language-Hearing Association or by one fulfilling the clinical fellowship year under the supervision of a certified speech-language pathologist

NOTE: We do not pay for services provided by speech-language pathology assistants or therapy aides.

Services do not include:

- Treatment **solely** to improve cognition (e.g., memory or perception), concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought

HOSPITAL AND FACILITY CARE

**Outpatient
Hospital
Services That
Are Payable**
(continued)

NOTE: We may pay for treatment to improve cognition when part of a comprehensive rehabilitation plan of care.

- Recreational therapy
- Treatment of chronic, developmental or congenital conditions, learning disabilities or inherited speech abnormalities

NOTE: For certain pediatric patients with severe retardation of speech development, a BCBSM medical consultant may determine that speech and language pathology services can be used to treat chronic, developmental or congenital conditions.

Occupational therapy must be:

- Prescribed by a doctor of medicine, osteopathy or podiatry, or a dentist
- Given for a condition that can be significantly improved in a reasonable and generally predictable period of time (usually about six months)
- Given by:
 - A doctor of medicine or osteopathy
 - An occupational therapist
 - An occupational therapy assistant under the direct supervision of an occupational therapist
 - An athletic trainer under the direct supervision of an occupational therapist

NOTE: Both the occupational therapist and the occupational therapy assistant must be certified by the National Board of Occupational Therapy Certification and registered or licensed in the state where the care is provided.

HOSPITAL AND FACILITY CARE

**Outpatient
Hospital
Services That
Are Payable**
(continued)

Services do not include:

- Treatment **solely** to improve cognition (e.g., memory or perception), concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought

NOTE: We may pay for treatment to improve cognition when part of a comprehensive rehabilitation plan of care.

- Recreational therapy

**Outpatient
Hospital
Services That
Are Not Payable**

The services listed under “Inpatient Hospital Services That Are Not Payable” are also not payable when provided as outpatient care. In addition, we do not pay for:

- Outpatient inhalation therapy
- Cardiac rehabilitation services that require less than intensive monitoring (EKGs) or supervision because the patient’s endurance while exercising and management of risk factors are stable
- Sports medicine, patient education or home exercise programs

**Outpatient
Mental Health
Facility
Services**

Services in an outpatient mental health facility are payable only when the facility that provides and bills for them is a **participating** facility.

Services That Are Payable

- Mental health services provided by a physician, fully licensed psychologist, clinical licensed master’s social worker or other professional provider as determined by BCBSM (see “Section 4: Coverage for Physician and Other Professional Provider Services”)
- Services provided by the facility's staff
- Family counseling for members of the patient's family
- Ancillary services for patients who are admitted and discharged on the same day of treatment

HOSPITAL AND FACILITY CARE

Outpatient Mental Health Facility Services (continued)

Services That Are Payable (continued)

- Prescribed drugs given by the facility in connection with treatment
- Psychological testing by a physician, a fully licensed psychologist, or a limited licensed psychologist when prescribed and billed by a physician or fully licensed psychologist

NOTE: Outpatient mental health facility services are subject to a 50 percent member copayment (described on Page 2.3).

Services That Are Not Payable

- Services beyond the period required to evaluate or diagnose mental deficiency or retardation, or when the treatment is not likely to improve the patient's condition according to generally accepted professional standards
- Services provided in a skilled nursing facility or through a residential substance abuse treatment program
- Marital counseling

Outpatient and Residential Substance Abuse Treatment

We pay for treatment of substance abuse in **participating** residential and outpatient substance abuse treatment programs. The following criteria for the program must be met:

- You must have program benefits available
- Your attending physician must assign a diagnosis of substance abuse and must certify whether the treatment required is residential or outpatient
- Your attending physician must:
 - Provide an initial physical exam
 - Provide and supervise your care during detoxification and

HOSPITAL AND FACILITY CARE

Outpatient and Residential Substance Abuse Treatment
(continued)

- Provide follow-up care during rehabilitation
- The services must be medically necessary for treatment of your condition
- The services must be approved by BCBSM and provided by a participating substance abuse treatment program

Services That Are Payable

We pay for the following services provided and billed by an approved program:

- Lab exams
- Diagnostic exams
- Supplies and equipment used for detoxification or rehabilitation
- Professional and trained staff services and program services necessary for care and treatment
- Individual and group therapy or counseling
- Counseling for family members
- Psychological testing

We also pay for the following in a **residential** substance abuse treatment program:

- Bed and board
- General nursing services
- Drugs, biologicals and solutions used in the facility

We also pay for the following in an **outpatient** substance abuse treatment program:

- Drugs, biologicals and solutions used in the program, including drugs taken home

NOTE: Outpatient and residential substance abuse treatment is subject to a 50 percent member copayment described in Section 2.

HOSPITAL AND FACILITY CARE

Outpatient and Residential Substance Abuse Treatment
(continued)

Services That Are Not Payable

- Services provided primarily for the treatment of tobacco dependence or a diagnosis other than substance abuse
- Dispensing methadone or testing of urine specimens unless you are receiving therapy, counseling or psychological testing while in the program
- Diversional therapy
- Services provided beyond the period necessary for care and treatment

Freestanding Ambulatory Surgery Facility Services

We pay for medically necessary facility services provided by a BCBSM **participating** ambulatory surgery facility. A patient must be under the care of a licensed doctor of medicine, osteopathy, podiatry or oral surgery to be admitted to an ambulatory surgery facility. The services must be directly related to performing surgical procedures identified by BCBSM as covered ambulatory surgery.

Services That Are Payable

- Use of ambulatory surgery facility
- Anesthesia services and materials
- Recovery room
- Nursing care by, or under the supervision of, a registered nurse
- Drugs, biologicals, surgical dressings, supplies, splints and casts directly related to providing surgery
- Oxygen and other therapeutic gases
- Skin bank, bone bank and other tissue storage costs for supplies and services for the removal of skin, bone or other tissue, as well as the cost of processing and storage
- Administration of blood

HOSPITAL AND FACILITY CARE

Freestanding Ambulatory Surgery Facility Services (continued)

- Routine laboratory services related to the surgery or a concurrent medical condition
- Radiology services performed on equipment owned by, and performed on the premises of, the facility that are necessary to enhance the surgical service
- Housekeeping items and services
- EKGs

Services That Are Not Payable

We do not pay for:

- Services by a **nonparticipating** ambulatory surgery facility
- Professional services by a physician. These services, such as surgery, may be covered under Section 4.

Freestanding Outpatient Physical Therapy Facility Services

We pay for services in a freestanding outpatient physical therapy facility only when the facility that provides and bills for them is a **participating** facility.

NOTE: We will pay the facility directly for the service and not the individual provider who rendered the service.

Services That are Payable

- Physical therapy, speech and language pathology services and occupational therapy as, described on Pages 3.25 - 3.29, are payable when provided for rehabilitation. These services have a **combined** benefit maximum of 60 visits per member, per calendar year. All services provided in any outpatient location (hospital, facility, office or home) are combined to meet the 60-visit maximum. This benefit maximum renews each calendar year.

NOTE: Each treatment date counts as one visit even when two or more therapies are provided and

HOSPITAL AND FACILITY CARE

Freestanding Outpatient Physical Therapy Facility Services (continued)

when two or more conditions are treated. For example, if a facility provides you with physical therapy and occupational therapy on the same day, the services are counted as one visit.

An initial evaluation is not counted as a visit. If approved, it will be paid separately from the visit and will not be applied towards the maximum benefit limit.

Services That Are Not Payable

Pages 3.25 - 3.29 lists services that are not included as payable. In addition, these services are not payable:

- Services of a freestanding facility provided to you while you are an inpatient in a hospital, skilled nursing facility or residential substance abuse treatment program
- Services provided to you in the home
- Services provided by a **nonparticipating** freestanding outpatient physical therapy facility

Freestanding ESRD Facility Services

We pay for medically necessary facility services provided by a BCBSM **panel or participating** end stage renal (kidney) disease facility. ESRD facility services are provided to treat patients with chronic, irreversible kidney disease.

NOTE: When you receive covered services from a **panel** freestanding ESRD facility provider, we pay our approved amount directly to the provider. If your coverage includes an annual deductible and a copayment for panel services, then these amounts will be subtracted from our approved amount. You are responsible for any deductible and copayment amounts. Your panel deductible and copayment requirements (if any) are described in Section 2 of this certificate and in any related riders.

When you receive covered services from a **nonpanel** freestanding ESRD facility provider, you will be required to pay a nonpanel deductible and

HOSPITAL AND FACILITY CARE

**Freestanding
ESRD Facility
Services**
(continued)

copayments. Your nonpanel deductible and copayment requirements (if any) are described in Section 2 of this certificate and in any related riders.

Services That Are Payable

- Use of the freestanding end stage renal disease facility
- Ultrafiltration
- Equipment
- Solutions
- Routine laboratory tests
- Drugs
- Supplies
- Other medically necessary services related to dialysis treatment
- Home hemodialysis (for conditions, benefits and exclusions that also apply to ESRD facility services, see dialysis services described in “Outpatient Hospital Services That Are Payable” on Page 3.24)
 - Continuous ambulatory peritoneal dialysis and self-dialysis training with the number of training sessions limited according to Medicare guidelines
 - Continuous cycling peritoneal dialysis (limited to 14 dialysis treatments per month) and self-dialysis training with the number of training sessions limited according to Medicare guidelines

Services That Are Not Payable

- Services provided by a **nonparticipating** end stage renal disease facility.
- Services not provided by the employees of the ESRD facility.
- Services not related to the dialysis process.

HOSPITAL AND FACILITY CARE

Long-Term Acute Care Hospital Services

The services listed under “Inpatient Hospital Services That Are payable” and “Outpatient Hospital Services That Are payable” may also be payable when provided in a long-term acute care hospital or LTACH.

The services are payable only if the following conditions are met:

- The long-term acute care hospital must be located in Michigan and participate with BCBSM, except under extenuating circumstances as determined by BCBSM.
- The provider must request and receive preapproval for inpatient services

Long-term acute care hospital services count toward any benefit maximums that apply to inpatient hospital services.

We do not pay for:

- Services in a nonparticipating long-term acute care hospital including emergency services, unless there are extenuating circumstances as determined by BCBSM.
- Inpatient admissions that BCBSM has not preapproved
- Services if the patient’s primary diagnosis is a mental health or substance abuse condition

ALTERNATIVES TO HOSPITAL CARE

Home Health Care Services

This program provides an alternative to long-term hospital care by offering coverage for care and services in the patient's home.

The services described below must be:

- Prescribed by the attending physician
- Provided and billed by a **participating** home health care agency
- Medically necessary (as defined in Section 7)

ALTERNATIVES TO HOSPITAL CARE

**Home Health
Care Services**

(continued)

The following criteria for the program must be met:

- The attending physician certifies that the patient is confined to the home because of illness.
 - This means that transporting the patient to a health care facility, physician's office or hospital for care and services would be difficult due to the nature or degree of the illness.
- The attending physician prescribes home health care services and submits a detailed treatment plan to the home health care agency.
- The agency accepts the patient into its program.

Services That Are Payable

The following services must be provided by health care professionals employed by the home health care agency or by providers who participate with the agency in this program. The agency must bill BCBSM for the services. They are:

- Skilled nursing care provided or supervised by a registered nurse employed by the home health care agency
- Social services by a licensed social worker, if requested by the patient's attending physician
- Physical therapy, speech and language pathology services and occupational therapy, as described on Pages 3.4 – 3.7, are payable when provided for rehabilitation.
- If equipment for therapy and speech evaluation cannot be taken to the patient's home, therapy and speech evaluation in an outpatient department of a hospital or a freestanding outpatient physical therapy facility are covered under outpatient benefits and are subject to the 60-visit maximum as described on Page 3.33.

ALTERNATIVES TO HOSPITAL CARE

**Home Health
Care Services**
(continued)

Services That Are Payable (continued)

- Part-time health aide services, including preparing meals, laundering, bathing and feeding **if**:
 - The patient is receiving skilled nursing care or physical or speech therapy
 - The patient's family cannot provide the services **and** the home health care agency has identified a need for these services for the patient to participate in the program
 - The services are provided by a home health aide and supervised by a registered nurse employed by the agency

We pay the following covered services when the home health care is provided by a **participating** hospital:

- Lab services, prescription drugs, biologicals and solutions related to the condition for which the patient is participating in the program
- Medical and surgical supplies such as catheters, colostomy supplies, hypodermic needles and oxygen needed to effectively administer the medical treatment plan ordered by the physician

Services That Are Not Payable

- General housekeeping services
- Transportation to and from a hospital or other facility
- Private duty nursing
- Elastic stockings, sheepskin or comfort items (lotion, mouthwash, body powder, etc.)
- Durable medical equipment
- Physician services
- Custodial or nonskilled care
- Services performed by a nonparticipating home health care provider

ALTERNATIVES TO HOSPITAL CARE

Home Infusion Therapy **This program provides coverage for home infusion therapy services whether or not you are confined to the home.**

To be eligible for home infusion therapy services, your condition must be such that home infusion therapy is:

- Prescribed by the attending physician to manage an incurable or chronic condition or treat a condition that requires acute care if it can be safely managed in the home
- Medically necessary (as defined in Section 7)
- Given by **participating** home infusion therapy providers

Services include:

- Drugs required for home infusion therapy
- Nursing services needed to administer home infusion therapy and treat home infusion therapy-related wound care

NOTE: Nursing services must meet BCBSM's medical necessity guidelines to be payable.

- Durable medical equipment, medical supplies and solutions needed for home infusion therapy

NOTE: Except for chemotherapeutic drugs, services provided for home infusion therapy under the home health care benefit are not covered separately elsewhere in this certificate.

We do not pay for services rendered by **nonparticipating** home infusion therapy providers.

Home infusion therapy services given by a participating BCBSM-approved home infusion therapy provider are considered panel services and will be subject to applicable deductible and copayment requirements for such services.

ALTERNATIVES TO HOSPITAL CARE

Hospice Care Services

We pay for services for the terminally ill provided through a participating hospice program. Hospice care services are payable for four 90-day periods. To be payable, the following criteria must be met:

- The patient or his or her representative elects hospice care services in writing. This written statement must be filed with a participating hospice program.
- The following certifications are submitted to BCBSM:

For the first 90 days of hospice care coverage:

A written certification stating that the patient is terminally ill, signed by the:

- Medical director of the hospice program **or**
- Physician of the hospice interdisciplinary group **and**
- Attending physician, if the patient has one

For the second 90-day period (submitted no later than two days after this 90-day period begins):

The hospice must submit a **second** written certification of terminal illness signed by the:

- Medical director of the hospice **or**
- Physician of the hospice interdisciplinary group

For the third 90-day period (submitted no later than two days after this 90-day period begins):

The hospice must submit a **third** written certification of terminal illness signed by the:

- Medical director of the hospice **or**
- Physician of the hospice interdisciplinary group

For the fourth 90-day period (submitted no later than two days after this 90-day period begins):

The hospice must submit a **fourth** written certification of terminal illness signed by the:

ALTERNATIVES TO HOSPITAL CARE

Hospice Care Services

(continued)

- Medical director of the hospice **or**
- Physician of the hospice interdisciplinary group

- The patient or his or her representative must sign a "Waiver of Benefits" form acknowledging that the patient has been given a full explanation of hospice care. This waiver confirms the patient's (or family's) understanding that regular Blue Cross Blue Shield benefits for conditions related to the terminal illness are not in force while hospice benefits are being used.

NOTE: BCBSM benefits for conditions not related to the terminal illness remain in effect.

Services That Are Payable

Before electing to use hospice care services, the patient and his or her family are eligible to receive counseling, evaluation, education and support services from the hospice staff. These services are limited to a 28-visit maximum.

When a patient elects to use hospice care services regular BCBSM coverage for services in connection with the terminal illness and related conditions are replaced by the following:

Home Care Services

- Up to eight hours of routine home care per day

- Continuous home care for up to 24 hours per day during periods of crisis

- Home health aide services provided by qualified aides. These services must be rendered under the general supervision of a registered nurse.

ALTERNATIVES TO HOSPITAL CARE

Hospice Care Services

(continued)

Facility Services

- Inpatient care provided by:
 - A participating hospice inpatient unit
 - A participating hospital contracting with the hospice program or
 - A skilled nursing facility contracting with the hospice program
- Short-term general inpatient care when the patient is admitted for pain control or to manage symptoms. (These services are payable if they meet the plan of care established for the patient.)
- Five days of occasional respite care during a 30-day period

Hospice Services

- Physician services by a member of the hospice interdisciplinary team
- Nursing care provided by, or under the supervision of, a registered nurse
- Medical social services by a licensed social worker, provided under the direction of a physician
- Counseling services to the patient and to caregivers, when care is provided at home
- BCBSM-approved medical appliances and supplies (these include drugs and biologicals to provide comfort to the patient)
- BCBSM-approved durable medical equipment furnished by the hospice program for use in the patient's home

ALTERNATIVES TO HOSPITAL CARE

Hospice Care Services (continued)

- Physical therapy, speech and language pathology services and occupational therapy when provided to control symptoms and maintain the patient's daily activities and basic functional skills
- Bereavement counseling for the family after the patient's death

The above services are limited to a maximum amount that is reviewed and adjusted periodically. Once you reach the maximum, hospice benefits will continue to be covered under integrated case and disease management (see Page 3.46). Please call us for information about the current maximum amount.

Professional Services

- Provided by the attending physician to make the patient comfortable and to manage the terminal illness and related conditions

NOTE: Payable services do not include physician services provided by a member of the hospice interdisciplinary team.

Payment for professional services is limited to a maximum amount, determined by BCBSM, which is reviewed and adjusted periodically. Once you reach the maximum, hospice benefits will continue to be covered under integrated case and disease management (see Page 3.46). Please call us for information about the current maximum amount. This amount is separate from, and not included in, the limit for the hospice program services described above.

NOTE: Hospice services are not subject to any deductible or copayments.

How to Cancel or Reinstate Hospice Care Services

Hospice care services may be canceled at any time by the patient or his or her representative. Simply submit a written statement to the hospice. When the services are canceled, regular Blue Cross Blue Shield coverage will be reinstated.

ALTERNATIVES TO HOSPITAL CARE

Hospice Care Services
(continued)

Hospice care services may be reinstated at any time. The patient is reinstated for any remaining period for which he or she is eligible.

Services That Are Not Payable

We will not pay for services:

- Other than those furnished by the hospice program. (Remember, the services covered are those provided primarily in connection with the condition causing the patient's terminal illness.)
- Of a hospice program other than the one designated by the patient. (If the designated program arranges for the patient to receive the services of another hospice program, the services are covered.)
- That are not part of the plan of care established by the hospice program for the patient

Skilled Nursing Facility Services

Benefits are provided for skilled care and related physician services in a skilled nursing facility.

We pay for an admission to a skilled nursing facility when:

- The skilled nursing facility **participates** with BCBSM
- The admission is ordered by the patient's attending physician

We require written confirmation of the need for **skilled care** from the patient's attending physician.

Services That Are Payable

We pay for:

- A semiprivate room, including general nursing service, meals and special diets

ALTERNATIVES TO HOSPITAL CARE

**Skilled Nursing
Facility**

Services

(continued)

- Special treatment rooms
- Laboratory examinations
- Oxygen and other gas therapy
- Drugs, biologicals and solutions
- Gauze, cotton, fabrics, solutions, plaster, and other materials used in dressings and casts
- Durable medical equipment used in the facility or outside the facility when rented or purchased from the SNF
- Physician services (up to two visits per week)
- Physical therapy, speech and language pathology services or occupational therapy, as described on Pages 3.4 – 3.7, when medically necessary

NOTE: The physical therapy services performed in a SNF are considered inpatient benefits. Only when these services are provided in any outpatient location does the 60-visit benefit maximum apply.

Length of Stay

We pay only for the period that is necessary for the proper care and treatment of the patient up to a maximum of 120 days per member, per calendar year.

Services That Are Not Payable

- We do not pay for:
- Custodial care
- Care for senility or mental retardation
- Care for substance abuse

ALTERNATIVES TO HOSPITAL CARE

Skilled Nursing Facility Services (continued)

Services That Are Not Payable (continued)

- Care for mental illness (other than for short-term nervous and mental conditions to which the 120-day maximum applies)
- Care provided by a nonparticipating SNF

BlueHealth- Connection® Program

The BlueHealthConnection Program is a benefit under this certificate. It is an integrated health care management program that assists members in navigating the health care system and provides them with tools and information that they may use to make informed decisions about their health care and treatment options. It gives them access to:

- A nurse call center that is accessible by a toll-free telephone number 24 hours per day, seven days a week
- Guided self-management tools such as Web-based information and, under certain circumstances, videos and a health directive handbook that allow members to make decisions about their own health care
- Outreach programs for members whose claims history indicates that telephone or mail contact with them may assist the members' understanding and use of services available through BlueHealthConnection
- Integrated case and disease management, described below, for members with a chronic illness like diabetes or heart disease or acute illness

Integrated Case and Disease Management

Integrated case and disease management is a component of the BlueHealthConnection Program. It is a voluntary program designed to help manage the health care of members with acute or chronic medical conditions, regardless of the setting. Under integrated case and disease management, we will pay for noncontractual services only when such services are specifically described in a signed treatment plan.

ALTERNATIVES TO HOSPITAL CARE

Integrated Case and Disease Management

(continued)

- Services described in the treatment plan will be provided only so long as the plan is in effect.
- Coverage for noncontractual services under integrated case and disease management will only be provided for the specific conditions identified in the treatment plan. Treatment of other conditions remains subject to the terms of this certificate.

Eligibility for Integrated Case and Disease Management

BCBSM decides who is eligible for integrated case and disease management. Eligibility will be determined with reference to factors such as:

- Candidate’s diagnosis
- Admission status
- Clinical status
- Scope of contractual benefits available to the candidate
- Availability of community services to the candidate and his or her family
- Personal and family support available to the candidate
- Substantial probability of lasting improvement in the candidate’s clinical status within 12 months
- Candidates for integrated case and disease management may be identified based on BCBSM claims data. In addition, we will consider referrals of candidates from such sources as:
 - Attending physicians
 - Hospitals
 - Candidate or candidate’s family
 - Employer group

ALTERNATIVES TO HOSPITAL CARE

Integrated Case and Disease Management

(continued)

Termination of Integrated Case and Disease Management

BCBSM may terminate the treatment plan and the member's participation in integrated case and disease management if:

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

Services That Are Not Payable

We do not pay for any services provided by a relative of the member.

ALTERNATIVES TO HOSPITAL CARE

Alternative Facility Services That Are Not Payable

We do not pay for any services you receive in a convalescent and long-term illness care facility, nursing home, rest home or similar nonhospital institution.

NOTE: If a nursing home is your primary residence, then we will treat that location as your home. Under those circumstances, services that are payable in your home will also be covered when provided in a nursing home when performed by health care providers other than the nursing home staff.

HOW HOSPITALS, FACILITIES AND ALTERNATIVE TO HOSPITAL CARE PROVIDERS ARE PAID

Panel Providers

When you receive covered services from a panel provider, we will pay our approved amount directly to the provider. You are responsible only for the copayments described in this certificate.

Nonpanel Providers

When you receive covered services from a nonpanel provider, you will be required to pay a nonpanel deductible and copayments for most covered services (see Section 2).

NOTE: You will not be required to pay a deductible or the additional 20 percent nonpanel copayment if:

- A panel provider refers you to a nonpanel provider

NOTE: You must obtain the referral **before** receiving the referred service or the service will be subject to the nonpanel copayment requirements.

- You receive services for the exam and treatment of a medical emergency or accidental injury in the outpatient department of a hospital, urgent care center or physician's office
- You receive services from a provider for which there is no PPO panel

HOW HOSPITALS, FACILITIES AND ALTERNATIVE TO HOSPITAL CARE PROVIDERS ARE PAID

Nonpanel Providers (continued)

- You receive services from a nonpanel provider in a geographic area of Michigan deemed a “low-access area” by BCBSM for that particular provider specialty.

In limited instances, nonpanel deductible and copayment requirements may not be imposed for select professional services performed by nonpanel providers in a panel hospital, participating freestanding ambulatory surgery facility or any other location identified by BCBSM. You may contact BCBSM for information regarding these professional services.

NOTE: While the nonpanel deductible and copayment requirements may not be imposed, covered services will be subject to applicable panel deductible (if any) and copayment requirements.

- If the provider is **participating**, we will pay our approved amount directly to the provider. Almost all Michigan hospitals and many alternative to hospital providers participate with BCBSM. The provider accepts our payment as payment in full, less any copayments or deductible you are required to pay.
 - You do not need to pay any amounts beyond copayments and deductibles that apply for services covered by your certificate as long as they are medically necessary (except in limited cases described on Page 3.52).
 - Even if the provider’s charge for a covered service is more than our payment, you will not need to pay the difference.

If you need to know if a provider participates, ask your doctor, the provider’s admitting staff, or call us. (Use the numbers listed in Section 8.)

HOW HOSPITALS, FACILITIES AND ALTERNATIVE TO HOSPITAL CARE PROVIDERS ARE PAID

Nonpanel Providers (continued)

- If the provider is **nonparticipating**, you will need to pay most of the charges yourself. Your bill could be substantial because BCBSM coverage at nonparticipating hospitals is limited to services needed to treat an accidental injury or medical emergency.
 - To receive payment for covered services provided by a nonparticipating hospital, you will need to send us a claim. Call your customer service representative (see Section 8) for information on filing claims.
 - You will also be responsible for the difference between our approved amount and the amount charged by the nonparticipating provider.

NOTE: This difference is in addition to the deductible and copayments required for services rendered by nonpanel providers and cannot be applied toward the deductible or copayment maximums described in Section 2.

BCBSM does not pay for services at nonparticipating outpatient physical therapy facilities, mental health or substance abuse treatment facilities, freestanding ambulatory surgery facilities, freestanding ESRD facilities, home health care agencies, hospice programs, skilled nursing facilities or for services provided by nonparticipating home infusion therapy providers.

The following explains your coverage when provided by a nonparticipating hospital:

Emergency Services at a Nonparticipating Hospital

We will pay our approved amount, less any member cost-sharing amounts, for emergency services provided by **an accredited nonparticipating hospital:**

- Located outside of Michigan in an area not served by another Blue Cross and/or Blue Shield Plan

HOW HOSPITALS, FACILITIES AND ALTERNATIVE TO HOSPITAL CARE PROVIDERS ARE PAID

Emergency Services at a Nonparticipating Hospital
(continued)

- Located in Michigan but not participating with another Blue Cross and/or Blue Shield Plan
- Participating with another Blue Cross and/or Blue Shield Plan, regardless of the facility's location

Services That You Must Pay

You are required to pay for the following services:

- Services that are not included in this certificate
- Services that are not covered because they are medically unnecessary or experimental **if** you agree to receive them after being advised by hospital staff that they will not be covered **and** you agree in advance and in writing to pay for them

In some cases, you **are required** to pay for services that **are medically necessary**. These limited cases are:

- When you do not inform the hospital that you are a BCBSM member either at the time of admission or within 30 days after you are discharged
- When you fail to provide the hospital with information to identify your coverage

Out-of-Area Services

BCBSM has a variety of relationships with other Blue Cross and/or Blue Shield plans referred to generally as “Inter-Plan Programs.” When you obtain services outside of our service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated national account arrangements available between BCBSM and other Blue Cross and Blue Shield plans.

Typically, when receiving care outside our service area, you will obtain care from providers that have a contract (i.e., are “participating providers”) with the local Blue Cross and/or Blue Shield plan (“Host Plan”). In some instances, you may obtain care from nonparticipating providers. Our payment practices in both instances are described below.

HOW HOSPITALS, FACILITIES AND ALTERNATIVE TO HOSPITAL CARE PROVIDERS ARE PAID

BlueCard PPO® Program

We participate with other Blue Cross and/or Blue Shield plans in the BlueCard PPO Program. This Program offers members of Blue Cross and/or Blue Shield plans medical benefits when they receive health care from BlueCard PPO providers outside the area their local plan services. When you receive covered services in the area served by a Host Plan, we will pay for covered services. However, the Host Plan is responsible for contracting with and generally handling all interactions with its participating providers.

BlueCard PPO Panel Providers

If you receive covered services from an out-of-area PPO panel provider:

- The provider will file your claim with the Host Plan
- The Host Plan will pay the provider and **not** reduce its payment by the amount specified under this certificate for services provided by a nonpanel provider.

Panel status is not based on provider participation with BCBSM but with the plan where the services are rendered.

When you receive covered services outside our service area and the claim is processed through the BlueCard Program, your copayment and deductible will be based on the lower of:

- The billed charges for your covered services; or
- The negotiated price that the Host Plan makes available to us.

Often this “negotiated price” will be a simple discount that reflects an actual price that the Host Plan pays to your provider. Sometimes it is an estimated price that takes into account special arrangements with your provider or provider group that may include settlements, incentive payments, and/or other credits or charges. Occasionally it may be an average price based on a discount that results in

HOW HOSPITALS, FACILITIES AND ALTERNATIVE TO HOSPITAL CARE PROVIDERS ARE PAID

**BlueCard PPO®
Program**
(continued)

expected average savings for similar types of providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

Laws in other states may require the Host Plan to add a surcharge to your claim. If any state laws mandate other liability calculation methods, including a surcharge, we will calculate your liability for any covered services according to applicable law.

BlueCard Nonpanel PPO Providers

If the provider is not a PPO panel provider, we will notify the Host Plan to reduce its payment to the amount specified under this certificate for services provided by a nonpanel provider, unless:

- You were referred to that provider by a PPO panel provider (You must obtain the referral before receiving the referred service or the service will be subject to the nonpanel deductible requirements) or
- You needed care for an accidental injury or a medical emergency (see Emergency Services, Page 3.51)

BlueCard PPO providers may not be available in some areas. In areas where they are not available, you can still receive BlueCard PPO benefits if you receive services from a BlueCard participating provider. The Host Plan must notify BCBSM of the provider's status.

HOW HOSPITALS, FACILITIES AND ALTERNATIVE TO HOSPITAL CARE PROVIDERS ARE PAID

BlueCard PPO® Nonparticipating Providers Outside Our Service Area Program

(continued)

An out-of-area provider that does not participate with BCBSM or the local Host Plan may require you to pay for services at the time they are provided. If so:

- Submit an itemized statement to us for the services. Call your customer service representative (see Section 8) for information on filing claims.
- We will pay you the amount specified under this certificate for covered services provided by a nonparticipating provider. (We do not pay for services of nonparticipating facility providers listed on Page 3.51 and provide very limited coverage for services of nonparticipating hospitals.)

In all cases, you are also responsible for the nonpanel deductible and/or copayment required under this certificate.

To find out if an out of area provider is a BlueCard or BCBSM PPO provider please call 1-800-810-BLUE (2583).

You may also visit the BlueCard Doctor and Hospital Finder Web site at www.bcbs.com for a listing of participating providers.

Subscriber Liability Calculation

When covered services are provided outside of our service area by nonparticipating providers, the amount you pay for such services will generally be based on either the Host Plan's nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment we make for the covered services as set forth in this paragraph.

HOW HOSPITALS, FACILITIES AND ALTERNATIVE TO HOSPITAL CARE PROVIDERS ARE PAID

BlueCard PPO® Exceptions Program

(continued)

In certain situations, we may use other payment bases, such as billed covered charges, the payment we would make if the services had been obtained within our service area, or a special negotiated payment, as permitted under inter-plan programs policies, to determine the amount we will pay for services rendered by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment we will make for the covered services as set forth in this paragraph.

Specialty Providers in the BlueCard Program

The Host Plan can pay provider specialties recognized within the Host Plan's area (even if BCBSM does not contract with the particular provider specialty). If the Host Plan contracts with a provider specialty and the services being performed by this provider are covered under the terms of the BCBSM policy, then this provider's services can be paid.

BlueCard PPO Program Exceptions

The BlueCard PPO Program will not apply if:

- The services are not a benefit under this certificate
- This certificate excludes coverage for services performed outside of Michigan
- The Blue Cross and/or Blue Shield plan does not participate in the BlueCard PPO Program
- You require the services of a provider whose specialty is not part of the BlueCard PPO Program or
- The services are performed by a vendor or provider who has a contract with BCBSM for those services

HOW HOSPITALS, FACILITIES AND ALTERNATIVE TO HOSPITAL CARE PROVIDERS ARE PAID

**Negotiated
(non-BlueCard
Program)
National
Account
Arrangements**

As an alternative to the BlueCard Program, your claims for covered services may be processed through a negotiated national account arrangement with a Host Plan.

The amount you pay for covered services under this arrangement will be calculated based on the negotiated price or lower of either the billed charges or negotiated price made available to us by the Host Plan.

**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.

NOTE: A PPO network is not available outside the United States.

In this BlueCard Worldwide Program Section, when we refer to participating or nonparticipating hospitals or physicians, we mean participating or nonparticipating in the BlueCard Worldwide Program.

Medical Assistance Services

If subscribers need medical services while traveling or living outside of the United States, they are responsible for contacting the BlueCard Worldwide Service Center at 1-800-810-BLUE (or call collect at 804-673-1177 if they are calling from outside the United States) to assist them with information on participating hospitals and physicians and by providing medical assistance services. Failure to contact the BlueCard Worldwide Service Center could result in payment reductions or non-payment of services.

HOW HOSPITALS, FACILITIES AND ALTERNATIVE TO HOSPITAL CARE PROVIDERS ARE PAID

**BlueCard
Worldwide
Program**
(continued)

Coverage for BlueCard Worldwide Participating Hospitals

Inpatient Hospital Services

- Subscribers are responsible for calling the BlueCard Worldwide Service Center to arrange cashless access with a participating hospital if an inpatient admission is necessary. Cashless access means that the subscriber is only required to pay applicable panel deductible(s) and copayment(s) at the time of the admission for all covered services. The hospital will file the claim for the subscriber.
- Subscribers are responsible for panel deductible(s) and copayment(s).
- Subscribers are responsible for the payment of non-covered services.
- Subscribers are responsible for contacting BCBSM for preauthorization. Call the customer service number listed on the back of your BCBSM ID card.

Outpatient Hospital Services

- Subscribers are responsible for payment of all outpatient services at the time the services are rendered.
- Subscribers are responsible for submitting the international claim form(s). Forms are available from BCBSM, the BlueCard Worldwide Service Center or on-line at bcbs.com/bluecardworldwide.
- Subscribers must provide copies of the medical record, itemized bill, and proof of payment with the claim form. BCBSM will only pay for covered services.

HOW HOSPITALS, FACILITIES AND ALTERNATIVE TO HOSPITAL CARE PROVIDERS ARE PAID

**BlueCard
Worldwide
Program**
(continued)

Coverage for Nonparticipating Hospitals

Inpatient Hospital Services

- If subscribers are admitted to a nonparticipating hospital, they are responsible for calling the BlueCard Worldwide Service Center to try to arrange a referral for cashless access and approval from BCBSM. Cashless access means that the subscriber is only required to pay applicable panel deductible(s) and copayment(s) at the time of the admission for all covered services. If approved, the claim will be considered a participating provider payable claim. The hospital will file the claim for the subscriber.
- If cashless access is arranged, the subscriber will be responsible for the panel deductible(s) and copayment(s) and non-covered services.
- A subscriber who does not contact the Service Center to arrange cashless access and approval from BCBSM may be responsible for paying the entire admission.

Outpatient Hospital Services

- Subscribers are responsible for payment of all outpatient services at the time the services are rendered.
- Subscribers are responsible for submitting the international claim form(s). Forms are available from BCBSM, the BlueCard Worldwide Service Center or online at bcbs.com/bluecardworldwide.
- Subscribers must provide copies of the medical record, itemized bill, and proof of payment with the claim form. BCBSM will only pay for covered services.

HOW HOSPITALS, FACILITIES AND ALTERNATIVE TO HOSPITAL CARE PROVIDERS ARE PAID

**BlueCard
Worldwide
Program**
(continued)

Emergency Services at Participating or Nonparticipating Hospitals

- In the case of an emergency, subscribers are advised to go to the nearest hospital.
- If hospitalized, subscribers are advised to follow the process for inpatient hospital services.
- If subscribers are not hospitalized, they are responsible for payment of all professional and outpatient services at the time the services are rendered.
- Subscribers are responsible for submitting the international claim form(s). Forms are available from BCBSM, the BlueCard Worldwide Service Center or online at bcbs.com/bluecardworldwide.
- Subscribers must provide copies of the medical record, itemized bill, and proof of payment with the claim form. BCBSM will only pay for covered services.

BlueCard Worldwide Professional Services

- Subscribers are responsible for payment of all professional services at the time the services are rendered.
- Subscribers are responsible for submitting the international claim form(s). Forms are available from BCBSM, the BlueCard Worldwide Service Center or online at bcbs.com/bluecardworldwide.
- Subscribers must provide copies of the medical record, itemized bill, and proof of payment with the claim form. BCBSM will only pay for covered services.

Section 4: Coverage for Physician and Other Professional Provider Services

This section describes physician and other professional provider services covered by your certificate. It tells you:

- **PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE**
- **PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE NOT PAYABLE**
- **HOW PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES ARE PAID**
 - Panel Providers
 - Nonpanel Providers
 - Out-of-Area Services
 - BlueCard PPO® Program
 - Negotiated (non-BlueCard Program) National Account Arrangements
 - BlueCard Worldwide® Program

Please note that some of the services listed as not payable under your hospital, facility and alternative to hospital care coverage **may** be payable under your physician and other professional provider coverage.

PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE

Other than voluntary sterilization, screening mammography and preventive care services, covered services must be medically necessary as defined in Section 7, and provided by persons who are legally qualified or licensed to provide them.

We pay our approved amount for the services described in this section (deductible and copayment information is in Section 2). These pages explain the extent to which the service is covered.

- Surgery
- Presurgical Consultations
- Anesthetics
- Technical Surgical Assistance
- Obstetrics
- Newborn Examination
- Inpatient Medical Care
- Inpatient Mental Health Care
- Outpatient Mental Health Care
- Inpatient and Outpatient Consultations
- Emergency Treatment
- Chemotherapy
- End Stage Renal Disease (ESRD)
- Therapeutic Radiology
- Diagnostic Radiology
- Diagnostic Services
- Diagnostic Laboratory and Pathology Services
- Allergy Testing and Therapy
- Chiropractic Services
- Physical, Speech and Language Pathology and Occupational Therapy Services
- Office, Outpatient and Home Medical Care Visits
- Cardiac Rehabilitation
- Voluntary Sterilization
- Screening Mammography
- Optometrist Services
- Audiologist Services
- Preventive Care Services

PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE

- Certified Nurse Midwife Services
- Certified Nurse Practitioner Services
- Injectable Drugs
- Specialty Pharmaceuticals
- Special Foods for Metabolic Diseases
- Pain Management

Surgery

Payment includes:

- Physician's surgical fee
- Medical care provided by the surgeon before and after surgery while the patient is in the hospital
- Visits to the attending physician for the usual care before and after surgery

Multiple Surgeries

Multiple surgeries performed on the same day by the same physician are paid according to national standards recognized by BCBSM.

Restrictions

- Dental surgery is payable **only** for:
 - Multiple extractions or removal of unerupted teeth, alveoplasty or gingivectomy when a hospitalized patient has a dental condition that is adversely affecting a medical condition and treatment of the dental condition is expected to improve the medical condition (see Page 3.22 for examples)
 - Surgery directly to the temporomandibular joint (jaw joint) and related anesthesia services
 - Arthrocentesis performed for the treatment of temporomandibular joint (jaw joint) dysfunction

PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE

Surgery
(continued)

NOTE: Temporomandibular joint (jaw joint) dysfunction diagnosis and/or treatment is payable only for the previous two items, surgery and arthrocentesis and:

- Diagnostic X-rays
 - Physical therapy (see Page 4.14 for physical therapy services)
 - Reversible appliance therapy (mandibular orthotic repositioning)
- Surgery for gender reassignment is payable **only** for reconstructive procedures of the genitalia. Surgical procedures involving face, vocal cords, breasts, abdomen, hips or other nongenital areas are not payable.
 - Cosmetic surgery is payable **only** for:
 - Correction of deformities present at birth. Congenital deformities of the teeth are not covered.
 - Correction of deformities resulting from cancer surgery, including reconstructive surgery after a mastectomy
 - Conditions caused by accidental injuries
 - Traumatic scars

NOTE: Physician services for cosmetic surgery are **not payable** when services are primarily performed to improve appearance.

Presurgical Consultations

When your physician recommends surgery, you have the option of having a presurgical consultation with another physician who is a **doctor of medicine, osteopathy, podiatry or an oral surgeon.**

PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE

Presurgical Consultations
(continued)

You may obtain presurgical consultations if the surgery will take place in an inpatient or outpatient hospital setting or ambulatory surgery facility and is covered under this certificate.

You are limited to three presurgical consultations for each surgical diagnosis. The three consultations consist of a:

- Second opinion — a consultation to confirm the need for surgery
- Third opinion — allowed if the second opinion differs from the initial proposal for surgery
- Nonsurgical opinion — given to determine your medical tolerance for the proposed surgery

Deductibles and copayments required under this certificate do not apply to presurgical consultations obtained from panel physicians.

Anesthetics

For surgery

Services for giving anesthetics to patients undergoing covered surgery are payable to either:

- A physician other than the operating physician
- A physician who orders and supervises anesthesiology services
- A certified registered nurse anesthetist in an
 - Inpatient hospital setting
 - Outpatient hospital setting
 - Participating ambulatory surgery facility

CRNA services must be performed under the medical direction of a licensed physician or under the general supervision of a licensed physician responsible for anesthesiology services.

PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE

Anesthetics
(continued)

If the operating physician gives the anesthetics, the service is included in our payment for the surgery.

NOTE: Anesthesiology services performed by a qualified employee of a hospital or facility are not covered in this section of the certificate. (See “Inpatient Hospital Services That Are Payable.”)

For infusion therapy

We pay for local anesthetics only when needed as part of infusion therapy done in a physician’s office.

**Technical
Surgical
Assistance**

In some cases, an additional physician provides technical assistance to the surgeon. We pay the approved amount for TSA, provided according to BCBSM guidelines, in a hospital inpatient or outpatient setting or in an ambulatory surgery facility.

A list of covered TSA surgeries is available from your local customer service center.

We do not pay for TSA:

- When services of interns, residents or other physicians employed by the hospital are available at the time of surgery or
- When services are provided in a location other than a hospital or ambulatory surgery facility

Obstetrics

Prenatal and postnatal services are payable, as are services provided by the physician attending the delivery.

**Newborn
Examination**

A newborn’s routine care is payable when provided during the mother’s inpatient hospital stay. The exam must be provided by a doctor other than the anesthesiologist or the mother’s attending physician.

NOTE: The baby must be eligible for coverage and must be added to your contract within 30 days of the birth. Ask your employer or call BCBSM.

PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE

**Inpatient
Medical Care**

We pay for medical care by your attending physician while you are receiving inpatient services.

**Inpatient
Mental Health
Care**

We pay for the following inpatient mental health services when provided by a physician:

- Individual psychotherapeutic treatment
- Family counseling for members of a patient's family
- Group psychotherapeutic treatment
- Psychological testing when prescribed or performed by a physician
- Electroshock therapy and its related anesthetics
- Inpatient consultations when your physician requires assistance in diagnosing or treating your mental health condition

NOTE: The assistance is required because of the special skill or knowledge of the consulting physician or professional provider.

We do not pay for:

- Staff consultations required by a facility's or program's rules
- Marital counseling
- Services beyond the period required to evaluate or diagnose mental deficiency or retardation or when the treatment is not likely to improve the patient's condition according to generally accepted professional standards

**Outpatient
Mental Health
Care**

Unless otherwise specified, we pay for the following outpatient mental health services when provided by a physician, fully licensed psychologist, clinical licensed master's social worker or other professional provider as determined by BCBSM in an office setting or in a participating outpatient mental health facility (See "Outpatient Mental Health Facility Services" in Section 3 for a description of when these services are payable.)

PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE

**Outpatient
Mental Health
Care**
(continued)

- Individual psychotherapeutic treatment of less than 20 minutes when provided only in a participating outpatient mental health facility
- Individual psychotherapeutic treatment of more than 20 minutes
- Family counseling for members of a patient's family
- Group psychotherapeutic treatment
- Psychological testing by:
 - A physician or a fully licensed psychologist or
 - A limited licensed psychologist when prescribed and performed under, and billed by, a physician or fully licensed psychologist

NOTE: Outpatient mental health care is subject to a 50 percent member copayment (described on Page 2.3).

We do not pay for:

- Staff consultations required by a facility or program's rule
- Marital counseling
- Services beyond the period required to evaluate or diagnose mental deficiency or retardation or when the treatment is not likely to improve the patient's condition according to generally accepted professional standards
- Services provided to an inpatient in a hospital, skilled nursing facility or residential substance abuse treatment program. (Please see Page 3.11 for payable psychiatric day and night treatment.)

PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE

Inpatient and Outpatient Consultations

We pay for inpatient and outpatient consultations when your physician requires assistance in diagnosing or treating your condition. The assistance is required because of the special skill and knowledge of the consulting physician or professional provider.

We do not pay for staff consultations required by a facility's or program's rules.

NOTE: Consultations in a panel physician's office are subject to copayment requirements.

Emergency Treatment

We pay for services of one or more physicians for the exam and treatment of a medical emergency or an accidental injury in the outpatient department of a hospital, urgent care center or physician's office.

NOTE: Deductible and copayments are not required for these emergency panel or nonpanel physician services.

Chemotherapy

We pay our approved amount for chemotherapeutic drugs. To be payable, the drugs must be:

- Ordered by a physician for the treatment of a specific type of malignant disease
- Provided as part of a chemotherapy program
- Approved by the Food and Drug Administration (FDA) for use in chemotherapy treatment

NOTE: If the FDA has not approved the drug for the specific disease being treated, BCBSM's Medical Policy staff determines the appropriateness of the drug for that disease by using the following criteria:

- Current medical literature must confirm that the drug is effective for the disease being treated.

PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE

Chemotherapy
(continued)

- Recognized oncology organizations must generally accept the drug as treatment for the specific disease.
- The physician must obtain informed consent from the patient for the treatment.

We also pay for:

- Physician services to administer the chemotherapy drug, **except** those taken orally
- The chemotherapy drug administered in a medically approved manner
- Other FDA-approved drugs classified as:
 - Anti-emetic drugs used to combat the toxic effects of chemotherapeutic drugs
 - Drugs used to enhance chemotherapeutic drugs
 - Drugs to prevent or treat the side effects of chemotherapy treatment
- Infusion pumps used for the administration of chemotherapy, administration sets, refills and maintenance of implantable or portable pumps and ports

NOTE: Infusion pumps used for the administration of chemotherapy are considered durable medical equipment and are subject to the durable medical equipment guidelines described on Pages 5.2 to 5.4

End Stage Renal Disease

Physician services are payable for the treatment of ESRD. Services may be provided in the hospital, a panel or freestanding ESRD facility or in the home.

NOTE: Physician services for the treatment of ESRD are covered in coordination with Medicare. It is important that individuals with ESRD apply for Medicare coverage through the Social Security Administration. (Please see Page 1.4 – 1.6 for a detailed explanation of ESRD).

PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE

Therapeutic Radiology

We pay for physician services to treat medical conditions by X-ray, radon, radium, external radiation or radioactive isotopes. The services must be provided by your physician or by another physician if prescribed by your physician.

Diagnostic Radiology

We pay for physician services to diagnose disease, illness, pregnancy or injury through:

- X-rays
- Ultrasound
- Radioactive isotopes
- Computerized axial tomography (CAT) scans
- Magnetic resonance imaging (MRI)
- Positron emission tomography (PET) scans
- Medically necessary mammography

NOTE: You may call us for information about any restrictions.

The services must be provided by your physician or by another physician if prescribed by your physician.

NOTE: Complex radiology such as CAT, MRI and PET scans must be performed in participating facilities. You or your physician may call us for a list of participating facilities.

We do not pay for procedures not directly related and necessary to diagnose the disease, illness, pregnancy or injury (such as an ultrasound solely to determine the sex of the fetus).

Diagnostic Services

We pay for diagnostic services used by a physician to diagnose disease, illness, pregnancy or injury.

- Physician services are payable for tests such as:
 - Thyroid function
 - Electrocardiogram (EKG)
 - Electroencephalogram (EEG)
 - Pulmonary function studies

PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE

Diagnostic Services
(continued)

- Physician and independent physical therapist services are payable for the following tests:
 - Electromyogram (EMG)
 - Nerve conduction

We pay for EMG and nerve conduction tests performed by an independent physical therapist if ordered by a physician. The independent physical therapist must be certified by the American Board of Physical Therapy Specialties to perform these tests.

Diagnostic Laboratory and Pathology Services

We pay for laboratory and pathology exams needed to diagnose a disease, illness, pregnancy or injury. The services must be provided by your panel physician or by another physician or a panel laboratory if your panel physician refers you to one.

- Standard office laboratory tests approved by BCBSM performed in a panel physician's office are payable. Other laboratory tests must be sent to a panel laboratory.
- You will be required to pay the nonpanel copayment if services are provided by a nonpanel laboratory or in a nonpanel hospital.

Allergy Testing and Therapy

We pay for the following allergy testing and therapy services, performed by or under the supervision of, a physician.

- Allergy Testing
 - Survey, including history, physical exam, and diagnostic laboratory studies
 - Intradermal, scratch and puncture tests
 - Patch and photo tests
 - Double-blind food challenge test and bronchial challenge test

PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE

Allergy Testing and Therapy

(continued)

- Allergy Therapy
 - Allergy immunotherapy by injection (allergy shots)
 - Injections of antiallergen, antihistamine, bronchodilator or antispasmodic agents

We do not pay for:

- Fungal or bacterial skin tests (such as those given for tuberculosis or diphtheria)
- Self-administered, over-the-counter drugs
- Psychological testing, evaluation or therapy for allergies
- Environmental studies, evaluation or control

Chiropractic Services

We pay for the following chiropractic spinal manipulative treatment:

- Spinal manipulation to treat misaligned or displaced vertebrae of the spine, with a maximum of 24 visits (panel and nonpanel providers combined) per member per calendar year.
- Office visits:
 - For new patients, we pay for one office visit every 36 months. A new patient is one who has not received services within 36 months.
 - For established patients, we pay for one office visit per year. An established patient is one who has received services within 36 months.
- Mechanical traction once per day when it is performed with chiropractic spinal manipulation. Visits for mechanical traction are applied toward your benefit limit for physical, speech and language pathology, and occupational therapy services.
- Radiological services when X-rays are medically necessary to treat the spinal misalignment.

Copayments are not required when services are provided in a panel physician's office.

PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE

**Physical,
Speech and
Language
Pathology and
Occupational
Therapy
Services**

We pay physician services for physical therapy, speech and language pathology services, and occupational therapy when provided for rehabilitation.

These services have a **combined** benefit maximum of 60 visits per member, per calendar year, whether obtained from a panel or nonpanel provider. All services provided in any outpatient location (hospital, facility, office or home) are combined to meet the 60-visit maximum. The benefit maximum renews each calendar year. Visits for mechanical traction performed by a chiropractor in conjunction with spinal manipulation are applied toward this maximum.

NOTE: Each treatment date counts as one visit even when two or more therapies are provided and when two or more conditions are treated. For example, if a facility provides you with physical therapy and occupational therapy on the same day, the services are counted as one visit.

An initial evaluation is not counted as a visit. If approved, it will be paid separately from the visit and will not be applied towards the maximum benefit limit.

Physical therapy must be:

- Prescribed by a doctor of medicine, osteopathy or podiatry, or a dentist
- Given for a neuromuscular condition that can be significantly improved in a reasonable and generally predictable period of time (usually about six months)

We pay for physical therapy performed by:

- A doctor of medicine, osteopathy or podiatry
- A dentist for the oral-facial complex
- An optometrist for services for which he or she is licensed

PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE

**Physical,
Speech and
Language
Pathology and
Occupational
Therapy
Services**
(continued)

- A chiropractor doing mechanical traction (see Chiropractic Services on Page 4.13)
- A physical therapist in a physician's or independent physical therapist's office
- An independent physical therapist in his or her office
- A physician assistant or certified nurse practitioner employed by a physician
- A certified nurse practitioner in an independent practice
- A physical therapy assistant or athletic trainer under the direct supervision of a physical therapist
- A physical therapy assistant or athletic trainer under the direct supervision of an independent physical therapist in the therapist's office

Services do not include:

- Therapy to treat long-standing, chronic conditions that have not responded to or are unlikely to respond to therapy
- Tests to measure physical capacities such as strength, dexterity, coordination or stamina, unless part of a complete physical therapy treatment program
- Treatment **solely** to improve cognition (e.g., memory or perception), concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought

NOTE: We may pay for treatment to improve cognition when part of a comprehensive rehabilitation plan of care.

- Patient education and home programs (such as home exercise programs)
- Sports medicine for purposes such as prevention of injuries or for conditioning
- Recreational therapy

PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE

Physical, Speech and Language Pathology and Occupational Therapy Services
(continued)

Speech and language pathology services must be:

- Prescribed by a doctor of medicine, osteopathy or a dentist
- Given for a condition that can be significantly improved in a reasonable and generally predictable period of time (usually about six months), and
- Given by a speech-language pathologist (or an independent speech-language pathologist, in his or her office, who must be) certified by the American Speech-Language-Hearing Association or by one fulfilling the clinical fellowship year under the supervision of a certified speech-language pathologist

NOTE: We do not pay for services provided by speech-language pathology assistants or therapy aides.

Services do not include:

- Treatment **solely** to improve cognition (e.g., memory or perception), concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought

NOTE: We may pay for treatment to improve cognition when part of a comprehensive rehabilitation plan of care.

- Recreational therapy
- Treatment of chronic, developmental or congenital conditions, learning disabilities or inherited speech abnormalities

NOTE: For certain pediatric patients with severe retardation of speech development, a BCBSM medical consultant may determine that speech and language pathology services can be used to treat chronic, developmental or congenital conditions.

PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE

Physical, Speech and Language Pathology and Occupational Therapy Services
(continued)

Occupational therapy must be:

- Prescribed by a doctor of medicine, osteopathy or podiatry, or a dentist
- Given for a condition that can be significantly improved in a reasonable and generally predictable period of time (usually about six months)
- Given by:
 - An occupational therapist or an independent occupational therapist in his or her office
 - An occupational therapy assistant under the direct supervision of an occupational therapist
 - An athletic trainer under the direct supervision of an occupational therapist

NOTE: Both the occupational therapist and the occupational therapy assistant must be certified by the National Board of Occupational Therapy Certification and registered or licensed in the state where the care is provided.

Services do not include:

- Treatment **solely** to improve cognition (e.g., memory or perception), concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought

NOTE: We may pay for treatment to improve cognition when part of a comprehensive rehabilitation plan of care.

- Recreational therapy

Office, Outpatient and Home Medical Care Visits

We pay for office, outpatient and home medical care visits and therapeutic injections by a physician. Office visits include:

- Urgent care visits
- Office consultations

PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE

**Office,
Outpatient and
Home Medical
Care Visits**
(continued)

NOTE: Only medically necessary services are payable, less applicable deductible and copayments.

The following services will not require any copayments when provided in a panel **or** nonpanel physician's office:

- First aid and medical emergency treatment

The following are examples of services that will not require any copayments when provided in a panel physician's office:

- Prenatal and postnatal care
- Allergy testing and therapy
- Therapeutic injections
- Presurgical consultations

We do not pay for routine eye refractions and audiometric tests, **except** in connection with a medical diagnosis, pregnancy, or injury

**Cardiac
Rehabilitation**

We pay for intensive monitoring (EKGs) and/or supervision during exercise in a physician-directed clinic (one in which a physician is on-site).

**Voluntary
Sterilization**

We pay for voluntary sterilization.

**Screening
Mammography**

We pay for one routine mammogram per member, per calendar year performed to screen for breast cancer.

**Optometrist
Services**

We pay our approved amount for covered services performed by a licensed optometrist within the scope of his or her license.

- The medical and surgical services performed by the optometrist must be provided within the state of Michigan.

PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE

Optometrist Services
(continued)

- The optometrist must be licensed in the state of Michigan and certified by the Michigan Board of Optometry to administer and prescribe therapeutic pharmaceutical agents.
- Services performed by the optometrist will be considered services obtained from a nonparticipating provider if the optometrist does not participate under BCBSM's vision program.

Audiologist Services

- We pay our approved amount for covered services performed by an audiologist who is licensed or legally qualified to perform the services.

NOTE: To be payable, services performed by an audiologist must be referred by a provider who is legally authorized to prescribe the services.

Preventive Care Services

We pay for the preventive care services listed below, along with the related reading and interpretation of your test results, only when rendered by panel providers. However, if a panel provider performs a covered preventive test, but a nonpanel provider reads and interprets the results, we will pay the nonpanel claim as if the service was performed by a panel provider. This means your nonpanel deductible and nonpanel copayment will not be imposed.

Covered services are subject to a combined maximum of \$250 per member, per calendar year. Copayments are not required for these services.

- **Health Maintenance Examination**

One examination per member, per calendar year. This comprehensive history and physical examination includes blood pressure measurement, skin exam for malignancy, breast exam, testicular exam, rectal exam and health counseling regarding potential risk factors.

PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE

Preventive Care Services

(continued)

- **Flexible Sigmoidoscopy Examination**

One routine flexible sigmoidoscopy examination per member, per calendar year.

- **Gynecological Examination**

One routine gynecological examination per member, per calendar year.

- **Routine Pap Smear**

Laboratory and pathology services for one routine Pap smear per member, per calendar year, when prescribed by a physician.

- **Fecal Occult Blood Screening**

One fecal occult blood screening per member, per calendar year to detect blood in the feces or stool.

- **Well-Baby and Child Care Visits**

We pay for well-baby and child care visits as follows:

- Six visits for children from birth through 12 months
- Six visits for children 13 months through 23 months
- Six visits for children 24 months through 35 months
- Two visits for children 36 months through 47 months
- Visits beyond 47 months are limited to one per member, per calendar year under the health maintenance examination benefit

- **Immunizations**

We pay for childhood immunizations as recommended by the Advisory Committee on Immunization Practices or other sources as recognized by BCBSM

PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE

Preventive Care Services

(continued)

- **Prostate Specific Antigen Screening**

We pay for one routine prostate specific antigen screening per member, per calendar year.

- **Routine Laboratory and Radiology Services**

We pay for the following services once per member, per calendar year, when performed as routine screening:

- Chemical profile
- Complete blood count or any of its components
- Urinalysis
- Chest X-ray
- EKG
- Cholesterol testing

Certified Nurse Midwife Services

We pay for covered services provided by a certified nurse midwife. These covered certified nurse midwife services include but are not limited to:

- Normal vaginal delivery when provided in:
 - An inpatient hospital setting
 - A hospital-affiliated birthing center that is owned and operated by a participating state-licensed and accredited hospital, as defined by BCBSM
- Pre-natal care
- Post-natal care, including a Papanicolaou (PAP) smear during the six-week visit

Certified Nurse Practitioner Services

We pay for covered services provided by a certified nurse practitioner.

PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE

Injectable Drugs We pay for covered injectable drugs or biologicals and their administration. The injectable drugs and biologicals must be FDA approved in order to be covered. The injectable drug or biological must be ordered or furnished by a physician and administered by the physician or under the physician's supervision.

Specialty Pharmaceuticals We pay for BCBSM approved specialty pharmaceuticals administered by a panel or participating professional provider (see definition in "The Language of Healthcare").

- We pay for the drug and its administration when ordered and billed by the physician, **or**
- We pay for the drug when billed by the specialty pharmacy provider and we pay the physician for administration of the drug.

NOTE: Self-injected drugs are not covered.

Hemophilia Medication

- We pay for hemophilia factor product obtained from a panel, nonpanel, participating or nonparticipating professional provider (see definitions in "The Language of Healthcare").
- The cost of the hemophilia factor product includes the supplies necessary for infusion. We will reimburse a participating provider directly; if the provider is nonparticipating, we will reimburse the member.

Special Foods for Metabolic Diseases We pay for special medical foods, including special infant formulas and low-protein modified food products, for the dietary treatment of inherited metabolic diseases of childhood, after a complete medical evaluation by the physician of the patient's condition. These foods will not be covered unless they are prescribed by a physician after he or she has performed a complete medical evaluation.

PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE

Special Foods for Metabolic Diseases
(continued)

The following criteria apply:

- The cost of special medical foods must be higher than the cost of foods that are not special medical foods.
- Medical documentation must support the diagnosis of a covered condition that requires special medical foods, as identified by BCBSM.
- A medical formula will be provided for infants from birth through 24 months maximum when the formula represents at least 50 percent of the child’s caloric intake.
- Special medical foods and low-protein modified foods will be covered for pediatric patients up to and including age 18.

You must submit a prescription from the treating physician along with receipts for all special dietary purchases to BCBSM for handling. Mail your receipts along with a “Member Application for Payment Consideration” to:

Blue Cross Blue Shield of Michigan
Special Claims Processing, Mail Code B532
27000 W. Eleven Mile Road
Southfield, MI 48034-2200

You can obtain the above-mentioned form by visiting our Web site at **bcbsm.com** and clicking on “Member Forms” under the “Member Secured Services” tab. If you can’t access the Web site or you have trouble finding what you need, please contact Customer Service at one of the telephone numbers listed in Section 8.

All member cost-sharing requirements apply.

We do not pay for the following:

- Nutritional products, supplements, medical foods, infant formulas or low-protein modified foods for medical conditions not identified by BCBSM as being related to inherited metabolic diseases of childhood

PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE PAYABLE

Special Foods for Metabolic Diseases
(continued)

We do not pay for the following: (continued)

- Foods used by patients with inherited diseases of childhood that are not special medical foods, special infant formulas or low-protein modified foods
- Nutritional products, supplements or foods used for the patient's convenience or for weight reduction programs
- Diabetes mellitus is excluded as a payable diagnosis for this benefit.

Pain Management

Covered services and devices for pain management when medically necessary as documented by a physician

PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE NOT PAYABLE

The following services are not payable:

- Services covered under any other Blue Cross or Blue Shield contract or under any other health care benefits plan
- Self-treatment by a professional provider and services given by the provider to parents, siblings, spouse or children
- Services for cosmetic surgery when performed primarily to improve appearance, except for those conditions listed on Page 4.4
- Health care services provided by persons who are not eligible for payment or appropriately credentialed or privileged (as determined by BCBSM) or providers who are not legally authorized or licensed to order or provide such services

NOTE: If BCBSM has not credentialed or privileged a participating/PPO panel provider to perform a service, the provider will be financially responsible for the entire cost of the service and cannot bill you for it. This includes the charge

PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE NOT PAYABLE

for the service and any copayments, deductibles or other cost-sharing amounts. If you receive services from a nonparticipating/nonpanel provider who is not credentialed or privileged to perform service, you will have to pay for the entire cost of the service.

- Dental care except to treat accidental injuries or multiple extractions or removal of unerupted teeth, alveoplasty or gingivectomy when a hospitalized patient has a dental condition that is adversely affecting a medical condition and treatment of the dental condition is expected to improve the medical condition (see Page 3.22 for examples).
- Dental implants and related services, including repair and maintenance of implants and surrounding tissue
- Weight loss programs
- Contraceptive devices and medications used for the express purpose of preventing pregnancy
- Rest therapy or services provided to you while you are in a convalescent home, long-term care facility, nursing home, rest home or similar nonhospital institution

NOTE: If a nursing home is your primary residence, then we will treat that location as your home. Under those circumstances, services that are payable in your home will also be covered when provided in a nursing home when performed by health care providers other than the nursing home staff.

- Services, care, supplies or devices not prescribed by a physician
- Services provided during nonemergency medical transport
- Experimental treatment

PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE NOT PAYABLE

- Hearing aids or services to examine, prepare, fit or obtain hearing aids
- Services to examine, prepare, fit or obtain eyeglasses or other corrective eye appliances, unless you lack a natural lens
- Hospital services, including services provided by hospital employees (see Section 3)
- Drugs, medical appliances, materials or supplies (see Pages 3.4 and 3.7 for an explanation of when these services are covered)
- Any irreversible medical and/or dental services performed for diagnosis and/or treatment of temporomandibular joint (jaw joint) dysfunction, **except** for:
 - Surgery directly to the temporomandibular joint (jaw joint) and related anesthesia services
 - Diagnostic X-rays
 - Arthrocentesis
 - Physical therapy (see Page 4.14 for physical therapy services)

NOTE: The above restriction applies to any condition causing temporomandibular joint (jaw joint) dysfunction.

- Alternative medicines or therapies (such as acupuncture, herbal medicines and massage therapy)

PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES THAT ARE NOT PAYABLE

- Cardiac rehabilitation services that do not require intensive monitoring (EKGs) or supervision because the patient's endurance while exercising and management of risk factors are stable
- Infertility services that do not treat a medical condition other than infertility. This can include services such as:
 - Sperm washing
 - Post-coital test
 - Monitoring of ovarian response to ovulatory stimulants
 - In vitro fertilization
 - Ovarian wedge resection or ovarian drilling
 - Reconstructive surgery of one or both fallopian tubes to open the blockage that causes infertility
 - Diagnostic studies done for the sole purpose of infertility assessment
 - Any procedure done to enhance reproductive capacity or fertility

NOTE: You or your physician can call us to determine if other proposed services are a covered benefit under your certificate.

- Sports medicine, patient education (except as otherwise specified) or home exercise programs
- Screening services (except as otherwise stated)

HOW PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES ARE PAID

Panel Providers When you receive covered services from a panel provider, we will pay our approved amount directly to the provider. You are responsible only for the copayments described in this certificate.

NOTE: If you need to know what providers are paid directly, call us at one of the numbers listed in the “How to Reach Us” section.

Panel M.D.s, D.O.s, podiatrists, chiropractors, fully licensed psychologists, oral surgeons and other providers as identified by BCBSM may bill you for services not covered by your certificate. However, if the service is not covered because BCBSM determined that it was medically unnecessary or experimental, the provider may bill you only if:

- You acknowledge in writing before you receive the service that we will not cover it because it is medically unnecessary or experimental and you agree to receive the service and pay for it, and
- The provider gives you an estimate of what the services will cost you.

Panel providers may also bill you for a claim submitted to BCBSM after the time allowed because you failed to furnish the provider with required identifying information. In this situation, the provider may bill you only if a claim was submitted within three months after the provider obtained the necessary information.

Participating providers may **not** bill you for:

- Services that are not covered because BCBSM determined that the provider lacked the appropriate credentials or privileges needed to perform the service, or the provider failed to comply with BCBSM policies when rendering the services.
- An overpayment made to the provider which BCBSM later requires the provider to repay to BCBSM.

HOW PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES ARE PAID

Nonpanel Providers

When you receive covered services from a nonpanel provider, you will be required to pay a nonpanel deductible and a copayment for most covered services (see Section 2).

NOTE: You will not be required to pay the additional 20 percent nonpanel copayment if:

- A panel provider refers you to a nonpanel provider

NOTE: You must obtain the referral **before** receiving the referred service or the service will be subject to the nonpanel copayment requirement.

- You receive services for the exam and treatment of a medical emergency or accidental injury in the outpatient department of a hospital, urgent care center or physician's office
- You receive services from a provider for which there is no PPO panel
- You receive services from a nonpanel provider in a geographic area of Michigan deemed a “low-access area” by BCBSM for that particular provider specialty.

In limited instances, nonpanel deductible and copayment requirements may not be imposed for:

- Select professional services performed by nonpanel providers in a panel hospital, participating free-standing ambulatory surgery facility or any other location identified by BCBSM, or
- The reading and interpretation of a screening mammography in instances where a panel provider performs the test, but a nonpanel provider does the analysis and interprets the results

HOW PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES ARE PAID

Nonpanel Providers
(continued)

NOTE: While the nonpanel deductible and copayment requirements may not be imposed, covered services will be subject to applicable panel deductible and copayment requirements (if any).

- If the nonpanel provider is **participating**, we will pay our approved amount directly to the provider.

NOTE: If you need to know what providers are paid directly, call us at one of the numbers listed in the “How to Reach Us” section.

A participating provider, other than an M.D., D.O., podiatrist, chiropractor or fully licensed psychologist **may bill you** when:

- You receive a service not covered by your contract
- You acknowledge that we will not pay for medically unnecessary services and you agree, in writing, before receiving the services, that you will pay
- We deny a claim from a participating provider that was submitted more than two years after the service because you did not furnish needed information

Participating M.D.s, D.O.s, podiatrists, chiropractors and fully licensed psychologists may bill you for services not covered by your certificate. However, if the service is not covered because BCBSM determined that it was medically unnecessary or experimental, the provider may bill you only if:

- You acknowledge in writing before you receive the service that we will not cover it because it is medically unnecessary or experimental and you agree to receive the service and pay for it, and
- The provider gives you an estimate of what the services will cost you.

HOW PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES ARE PAID

Nonpanel Providers
(continued)

Participating providers may also bill you for a claim submitted to BCBSM after the time allowed because you failed to furnish the provider with required identifying information. In this situation, the provider may bill you only if a claim was submitted within three months after the provider obtained the necessary information.

Participating providers may **not** bill you for:

- Services that are not covered because BCBSM determined that the provider was ineligible or lacked the appropriate credentials or privileges needed to perform the service, or the provider failed to comply with BCBSM policies when rendering the services.
- An overpayment made to the provider which BCBSM later requires the provider to repay to BCBSM.

If the nonpanel provider is **nonparticipating**, you will need to pay most of the charges yourself. Your bill could be substantial. After paying the provider, you should submit a claim to us. If we approve the claim, we will send payment to the subscriber.

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

Nonparticipating providers, except independent physical therapists, certified nurse practitioners, independent occupational therapists, independent speech-language pathologists and audiologists, **may** agree to participate on a per claim basis. This means that they will accept the approved amount (less applicable copayments and deductible) as payment in full for a specific service. If so:

- The provider will submit a claim to us
- We will send payment to the nonparticipating provider

HOW PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES ARE PAID

Out-of-Area Services

BCBSM has a variety of relationships with other Blue Cross and/or Blue Shield plans referred to generally as “Inter-Plan Programs.” When you obtain services outside of our service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated national account arrangements available between BCBSM and other Blue Cross and Blue Shield plans.

Typically, when receiving care outside our service area, you will obtain care from providers that have a contract (i.e., are “participating providers”) with the local Blue Cross and/or Blue Shield plan (“Host Plan”). In some instances, you may obtain care from nonparticipating providers. Our payment practices in both instances are described below.

BlueCard® PPO Program

We participate with other Blue Cross and/or Blue Shield plans in the BlueCard PPO Program. This Program offers members of Blue Cross and/or Blue Shield plans medical benefits when they receive health care from BlueCard PPO providers outside the area their local plan services. When you receive covered services in the area served by a Host Plan, we will pay for covered services. However, the Host Plan is responsible for contracting with and generally handling all interactions with its participating providers.

BlueCard PPO Panel Providers

If you receive covered services from an out-of-area PPO panel provider:

- The provider will file your claim with the Host Plan
- The Host Plan will pay the provider and not reduce its payment by the amount specified under this certificate for services provided by a nonpanel provider.

Panel status is not based on provider participation with BCBSM but with the plan where the services are rendered.

HOW PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES ARE PAID

BlueCard® PPO Program

(continued)

When you receive covered services outside our service area and the claim is processed through the BlueCard Program, your copayment and deductible will be based on the lower of:

- The billed charges for your covered services; or
- The negotiated price that the Host Plan makes available to us.

Often this “negotiated price” will be a simple discount that reflects an actual price that the Host Plan pays to your provider. Sometimes it is an estimated price that takes into account special arrangements with your provider or provider group that may include settlements, incentive payments, and/or other credits or charges. Occasionally it may be an average price based on a discount that results in expected average savings for similar types of providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

Laws in other states may require the Host Plan to add a surcharge to your claim. If any state laws mandate other liability calculation methods, including a surcharge, we will calculate your liability for any covered services according to applicable law.

BlueCard Nonpanel PPO Providers

If the provider is not a PPO panel provider, we will notify the Host Plan to reduce its payment to the amount specified under this certificate for services provided by a nonpanel provider, unless:

HOW PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES ARE PAID

BlueCard® PPO Program

(continued)

- You were referred to that provider by a PPO panel provider (You must obtain the referral before receiving the referred service or the service will be subject to the nonpanel deductible requirements) or
- You needed care for an accidental injury or a medical emergency (see Emergency Services, Page 3.51)

BlueCard PPO providers may not be available in some areas. In areas where they are not available, you can still receive BlueCard PPO benefits if you receive services from a BlueCard participating provider. The Host Plan must notify BCBSM of the provider's status.

Nonparticipating Providers Outside Our Service Area

An out-of-area provider that does not participate with BCBSM or the local Host Plan may require you to pay for services at the time they are provided. If so:

- Submit an itemized statement to us for the services. Call your customer service representative (see Section 8) for information on filing claims.
- We will pay you the amount specified under this certificate for covered services provided by a nonparticipating provider.

In all cases, you are also responsible for the nonpanel deductible and/or copayment required under this certificate.

To find out if an out of area provider is a BlueCard or BCBSM PPO provider please call 1-800-810-BLUE (2583).

You may also visit the BlueCard Doctor and Hospital Finder Web site at www.bcbs.com for a listing of participating providers.

HOW PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES ARE PAID

BlueCard® PPO Program

(continued)

Subscriber Liability Calculation

When covered services are provided outside of our service area by nonparticipating providers, the amount you pay for such services will generally be based on either the Host Plan's nonparticipating provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment we make for the covered services as set forth in this paragraph.

Exceptions

In certain situations, we may use other payment bases, such as billed covered charges, the payment we would make if the services had been obtained within our service area, or a special negotiated payment, as permitted under inter-plan programs policies, to determine the amount we will pay for services rendered by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment we will make for the covered services as set forth in this paragraph.

Specialty Providers in the BlueCard Program

The Host Plan can pay provider specialties recognized within the Host Plan's area (even if BCBSM does not contract with the particular provider specialty). If the Host Plan contracts with a provider specialty and the services being performed by this provider are covered under the terms of the BCBSM policy, then this provider's services can be paid.

HOW PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES ARE PAID

BlueCard® PPO Program

(continued)

BlueCard PPO Program Exceptions

The BlueCard PPO Program will not apply if:

- The services are not a benefit under this certificate
- This certificate excludes coverage for services performed outside of Michigan
- The Blue Cross and/or Blue Shield plan does not participate in the BlueCard PPO Program
- You require the services of a provider whose specialty is not part of the BlueCard PPO Program or
- The services are performed by a vendor or provider who has a contract with BCBSM for those services

Negotiated (non-BlueCard Program) National Account Arrangements

As an alternative to the BlueCard Program, your claims for covered services may be processed through a negotiated national account arrangement with a Host Plan.

The amount you pay for covered services under this arrangement will be calculated based on the negotiated price or lower of either the billed charges or negotiated price made available to us by the Host Plan.

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.

NOTE: A PPO network is not available outside the United States.

In this BlueCard Worldwide Program Section, when we refer to participating or nonparticipating hospitals or physicians, we mean participating or nonparticipating in the BlueCard Worldwide Program.

HOW PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES ARE PAID

**BlueCard
Worldwide®
Program**
(continued)

Medical Assistance Services

If subscribers need medical services while traveling or living outside of the United States, they are responsible for contacting the BlueCard Worldwide Service Center at 1-800-810-BLUE (or call collect at 804-673-1177 if they are calling from outside the United States) to assist them with information on participating hospitals and physicians and by providing medical assistance services. Failure to contact the BlueCard Worldwide Service Center could result in payment reductions or non-payment of services.

Coverage for BlueCard Worldwide Participating Hospitals

Inpatient Hospital Services

- Subscribers are responsible for calling the BlueCard Worldwide Service Center to arrange cashless access with a participating hospital if an inpatient admission is necessary. Cashless access means that the subscriber is only required to pay applicable panel deductible(s) and copayment(s) at the time of the admission for all covered services. The hospital will file the claim for the subscriber.
- Subscribers are responsible for panel deductible(s) and copayment(s).
- Subscribers are responsible for the payment of non-covered services.
- Subscribers are responsible for contacting BCBSM for preauthorization. Call the customer service number listed on the back of your BCBSM ID card.

HOW PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES ARE PAID

**BlueCard
Worldwide
Program**
(continued)

Outpatient Hospital Services

- Subscribers are responsible for payment of all outpatient services at the time the services are rendered.
- Subscribers are responsible for submitting the international claim form(s). Forms are available from BCBSM, the BlueCard Worldwide Service Center or on-line at bcbs.com/bluecardworldwide.
- Subscribers must provide copies of the medical record, itemized bill, and proof of payment with the claim form. BCBSM will only pay for covered services.

Coverage for Nonparticipating Hospitals

Inpatient Hospital Services

- If subscribers are admitted to a nonparticipating hospital, they are responsible for calling the BlueCard Worldwide Service Center to try to arrange a referral for cashless access and approval from BCBSM. Cashless access means that the subscriber is only required to pay applicable panel deductible(s) and copayment(s) at the time of the admission for all covered services. If approved, the claim will be considered a participating provider payable claim. The hospital will file the claim for the subscriber.
- If cashless access is arranged, the subscriber will be responsible for the panel deductible(s) and copayment(s) and non-covered services.
- A subscriber who does not contact the Service Center to arrange cashless access and approval from BCBSM may be responsible for paying the entire admission.

HOW PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES ARE PAID

**BlueCard
Worldwide
Program**
(continued)

Outpatient Hospital Services

- Subscribers are responsible for payment of all outpatient services at the time the services are rendered.
- Subscribers are responsible for submitting the international claim form(s). Forms are available from BCBSM, the BlueCard Worldwide Service Center or on-line at bcbs.com/bluecardworldwide.
- Subscribers must provide copies of the medical record, itemized bill, and proof of payment with the claim form. BCBSM will only pay for covered services.

Emergency Services at Participating or Nonparticipating Hospitals

- In the case of an emergency, subscribers are advised to go to the nearest hospital.
- If hospitalized, subscribers are advised to follow the process for inpatient hospital services.
- If subscribers are not hospitalized, they are responsible for payment of all professional and outpatient services at the time the services are rendered.
- Subscribers are responsible for submitting the international claim form(s). Forms are available from BCBSM, the BlueCard Worldwide Service Center or on-line at bcbs.com/bluecardworldwide.
- Subscribers must provide copies of the medical record, itemized bill, and proof of payment with the claim form. BCBSM will only pay for covered services.

HOW PHYSICIAN AND OTHER PROFESSIONAL PROVIDER SERVICES ARE PAID

**BlueCard
Worldwide
Program**
(continued)

BlueCard Worldwide Professional Services

- Subscribers are responsible to pay for payment of all professional services at the time the services are rendered.
- Subscribers are responsible for submitting the international claim form(s). Forms are available from BCBSM, the BlueCard Worldwide Service Center or on-line at bcbs.com/bluecardworldwide.
- Subscribers must provide copies of the medical record, itemized bill, and proof of payment with the claim form. BCBSM will only pay for covered services.

Section 5: Coverage for Other Health Care Services

This section describes coverage for other health care services in addition to your hospital, facility and professional provider services. Unless otherwise noted, the facility and professional services listed below are paid as described in Section 3 and Section 4.

Dental Care and Dental Appliances Emergency Dental Treatment

We pay our approved amount for treatment of accidental injuries. An accidental injury is defined as occurring when an external force to the lower half of the face or jaw damages or breaks sound natural teeth, periodontal structures (gums) or bone.

We pay for emergency treatment within 24 hours of the accidental injury to relieve pain and discomfort.

You must complete follow-up treatment within six months of the accidental injury.

We do not pay for:

- Treatment that was previously paid as a result of an accident
- Dental conditions existing before the accident
- Dental implants and related services including repair and maintenance of implants and surrounding tissue
- Services to treat temporomandibular joint dysfunction (as described below)

Temporomandibular Joint (Jaw Joint) Dysfunction

We do not pay for medical and/or dental services performed for irreversible treatment of temporomandibular joint (jaw joint) dysfunction, except for:

- Surgery directly to the temporomandibular joint (jaw joint) and related anesthesia services
- Diagnostic X-rays

**Dental Care and
Dental
Appliances**
(continued)

- Arthrocentesis
- Physical therapy (see Page 4.14 for physical therapy services)
- Reversible appliance therapy (mandibular orthotic repositioning)

NOTE: The above restriction applies to any condition causing temporomandibular joint (jaw joint) dysfunction.

**Durable Medical
Equipment**

We pay our approved amount for rental or purchase of durable medical equipment when prescribed by a physician or certified nurse practitioner and obtained from a DME supplier who meets BCBSM qualification standards. In many instances we cover the same items covered by Medicare Part B as of the date of purchase or rental. In some instances however, BCBSM guidelines may differ. Please call your local customer service center for specific coverage information.

DME items must meet the following guidelines:

- The prescription includes a description of the equipment and the reason for the need or the diagnosis.
- The physician writes a new prescription when the current prescription expires; otherwise, we will stop payment on the current expiration date, or 30 days after the date of the patient's death, whichever is earlier.

NOTE: If the equipment is:

- Rented, we will not pay for the charges that exceed the BCBSM purchase price. Participating providers cannot bill the member when the total of the rental payments exceeds the BCBSM purchase price.
- Purchased, we will pay to have the equipment repaired and restored to use, but not for routine periodic maintenance

Durable Medical Equipment

(continued)

Continuous Positive Airway Pressure (CPAP)

When prescribed by a physician, the CPAP device, humidifier (if needed) and related supplies and accessories are covered as follows:

- We will cover the rental fee only for the CPAP device and humidifier. Our total rental payments will not exceed our approved amount to purchase the device and humidifier. Once our rental payments equal the approved purchase price, you will own this equipment and no additional payments will be made by BCBSM for the device or humidifier.

We will pay for the purchase of any related supplies and accessories.

- After the first 90 days of rental, you are required to show that you have complied with treatment requirements for BCBSM to continue to cover the equipment and the purchasing of supplies and accessories. The CPAP device supplier must document your compliance.
- If you fail to comply with treatment requirements, you must return the rented device to the supplier or you may be held liable by the supplier for the cost of continuing to rent the equipment.

If you fail to comply with treatment requirements, we will also no longer cover the purchase of supplies and accessories.

We do not pay for:

- Exercise and hygienic equipment, such as exercycles, Moore Wheel, bidet toilet seats and bathtub seats
- Deluxe equipment, such as motorized wheelchairs and beds, unless medically necessary and required so that patients can operate the equipment themselves
- Comfort and convenience items, such as bed boards, bathtub lifts, overbed tables, adjust-a-beds, telephone arms or air conditioners
- Physician's equipment, such as stethoscopes

Durable Medical Equipment
(continued)

- Self-help devices not primarily medical in nature, such as sauna baths and elevators
- Experimental equipment

Medical Supplies

We pay up to the approved amount for medically necessary quantities of medical supplies and dressings used in your home for the treatment of a specific medical condition. Refer to Section 7 for the definition of “medically necessary.”

Private Duty Nursing Services

We pay our approved amount for skilled care given by a private duty nurse in your home or in a hospital if:

- The patient's medical condition requires 24-hour care
- The patient requires medically necessary skilled care for a portion of the 24-hour period
- The skilled care (for example, ventilator care) is given by a professional registered nurse or licensed practical nurse
- The skilled care is given in a hospital because the hospital lacks intensive or cardiac care units or has no space in such units
- The skilled care is provided by a nurse who is not related to, or living with, the patient

We do not pay for custodial care.

Private duty nurses may require you to pay for services at the time they are provided. Submit an itemized statement to us for services. **All progress notes must be submitted with the claim form.** We will pay the approved amount to you.

NOTE: These services are subject to a 50 percent member copayment (see Section 2).

**Professional
Ambulance
Services**

We pay our approved amount for ambulance services to transport a patient up to 25 miles. We will pay for a greater distance if the destination is the nearest medical facility capable of treating the patient's condition. In either case the following conditions must be met:

- The service must be medically necessary because transport by any other means would endanger the patient's health.
- The service must be to transport the patient to a hospital or to transfer the patient from a hospital to another treatment location such as another hospital, skilled nursing facility, medical clinic or the patient's home.

NOTE: When ambulance service is used only to **transfer** the patient, the attending physician must prescribe the transfer.

- The service must be provided in a vehicle qualified as an ambulance and part of a licensed ambulance operation. (Services by fire departments, rescue squads or other emergency transport providers whose fees are in the form of a voluntary donation are not payable.)
- The fee must be only for the transportation of the patient, and not include additional services that may be provided by physicians or other professionals and billed as ambulance service.

NOTE: When air ambulance service is required, it is payable if:

- The use of an air ambulance is medically necessary and ordered by the attending physician
- No other means of transport is available, or the patient's condition requires transport by air rather than ground ambulance
- The patient is transported to the nearest facility capable of treating the patient's condition and

Professional Ambulance Services

(continued)

- The provider is licensed as an air ambulance service and is not a commercial airline

We pay the approved amount for ambulance service when the ambulance has responded and the patient is stabilized and transport is not necessary or is refused, and in instances where the ambulance company arrives but the person that needed treatment has expired.

Prosthetic and Orthotic Devices

We pay our approved amount for prosthetic and orthotic devices prescribed by a physician or certified nurse practitioner. This includes the cost of purchasing, replacing, obtaining, developing and fitting the basic device and any medically necessary special features.

Repairs, limited to the cost of a new device, are also covered. The prescription must include a description of the equipment and the reason for the need or the diagnosis.

NOTE: For purposes of ocular prostheses only, the definition of physician includes an optometrist who is also a prosthetist.

The replacement of a prosthetic device is payable if necessary due to:

- A change in the patient's condition
- Damage to the device so that it cannot be restored
- Loss of the device

Coverage Guidelines

BCBSM covers external prosthetic and orthotic devices that are generally considered payable by Medicare Part B as of the date of purchase or rental. In some instances however BCBSM guidelines may differ. Please call your local customer service center for specific coverage information.

To be covered, custom-made devices must be furnished by a provider that is fully accredited, or with BCBSM approval, conditionally accredited by the American Board for Certification in Orthotics and Prosthetics, Inc (ABC). You may call us to confirm a provider's status.

Prosthetic and Orthotic Devices

(continued)

Prosthetic and orthotic suppliers may include M.D.s, D.O.s, D.P.M.s, prosthetists and orthotists who meet BCBSM qualification standards.

NOTE: If a provider is participating with BCBSM but is not accredited by ABC, only the following devices are covered:

- External breast prostheses following a mastectomy. These include:
 - Two post-surgical brassieres and
 - Two brassieres in any 12-month period thereafter

Additional brassieres are covered if they are required because of significant change in body weight or for hygienic reasons

- Prefabricated custom-fitted orthotic devices
- Artificial eyes, ears, noses and larynxes
- Ostomy sets and accessories, catheterization equipment and urinary sets
- Prescription lenses (eyeglasses or contacts) following cataract surgery for any disease of the eye or to replace a missing organic lens. Optometrists may provide these devices.
- External cardiac pacemakers
- Therapeutic shoes, shoe modifications and inserts for persons with diabetes
- Maxillofacial prostheses (as defined in Section 7) when approved. Dentists may provide these devices.
- Some prefabricated items, such as wrist braces, ankle braces, or shoulder immobilizers, are payable when provided by an M.D., D.O., or D.P.M. because the patient has an urgent need for the devices. Please call your local customer service center for information on which devices are covered.

**Prosthetic and
Orthotic
Devices**
(continued)

Devices and Services That Are Not Payable

Some prosthetic and orthotic devices and services are not covered under your certificate. These include:

- Nonrigid devices and supplies such as elastic stockings, garter belts, arch supports, and corsets.
- Hearing aids
- Spare prosthetic devices
- Routine maintenance of the prosthetic device
- Prosthetic devices that are experimental
- Hair prostheses such as wigs, hair pieces, hair implants, etc.

**Outpatient
Diabetes
Management
Program**

We pay up to the approved amount for selected services and medical supplies to treat and control diabetes when determined to be medically necessary and prescribed by an M.D. or D.O. Refer to Section 7 for the definition of “medically necessary”.

Diabetes services and medical supplies include:

- Blood glucose monitors
- Blood glucose monitors for the legally blind
- Insulin pumps
- Test strips for glucose monitors
- Visual reading and urine test strips
- Lancets
- Spring-powered lancet devices
- Syringes
- Insulin
- Medical supplies required for the use of an insulin pump
- Nonexperimental drugs to control blood sugar
- Medication prescribed by a doctor of podiatric medicine, M.D. or D.O. that is used to treat foot ailments, infections and other medical conditions of the foot, ankle or nails associated with diabetes

**Outpatient
Diabetes
Management
Program**

(continued)

- Diabetes self-management training conducted in a group setting, whenever practicable, if:
 - Self-management training is considered medically necessary upon diagnosis by an M.D. or D.O. who is managing your diabetic condition and when needed under a comprehensive plan of care to ensure therapy compliance or to provide necessary skills and knowledge
 - Your M.D. or D.O. diagnoses a significant change with long-term implications in your symptoms or conditions that necessitate changes in your self-management or a significant change in medical protocol or treatment
 - The provider of self-management training must be certified to receive Medicare or Medicaid reimbursement or be certified by the Michigan Department of Community Health.

NOTE: Syringes, insulin and prescription drug benefits are provided if you do not have coverage under a prescription drug certificate.

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 available in a hospital maintained by the state or federal government, unless payment is required by law
- 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 for Drugs and Devices

We do not pay for any drug or device prescribed for uses or in dosages other than those specifically approved by the Food and Drug Administration. (This is often referred to as the off-label use of a drug or device.) However, we will pay for such drugs and the reasonable cost of supplies needed to administer them, if the prescribing M.D. or D.O. can substantiate that the drug is recognized for treatment of the condition for which it is prescribed by one of the following:

- The American Hospital Formulary Service Drug Information
- The United States Pharmacopoeia Dispensing Information, Volume 1, “Drug Information for the Health Care Professional”
- Two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.

NOTE: Chemotherapeutic drugs are not subject to this general condition.

Deductibles and Copayments Paid Under Other Certificates

We do not pay deductibles or copayments that you were required to pay under any other certificate.

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

Experimental Treatment
(continued)

- 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.

Experimental Treatment
(continued)

- 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 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
- Refuse to cover your health 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 health 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.

Payment of Covered Services The covered services described in this certificate, such as multiple surgeries or a series of services such as laboratory tests, are combined and paid according to payment policies adopted by BCBSM.

- Personal Costs** We will not pay for:
- Transportation and travel, even if prescribed by a physician, except as provided in this certificate

Section 6: General Conditions of Your Contract

Personal Costs (continued)

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

Physician of Choice

You may continue to receive services from the physician of your choice. However, you should receive services from a panel physician in order to avoid out-of-panel costs to you.

Refunds of Premium

If we determine that we must refund a premium, we will refund 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, and 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.

Semiprivate Room Availability

If a semiprivate room is not available when you are admitted to a participating hospital, you may be placed in a room with more than two beds. When a semiprivate room is available, you will be placed in it. You may select a private room; however, you will be responsible for any additional cost. BCBSM will not pay the difference between the cost of hospital rooms covered by your certificate and more expensive rooms.

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

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

Our payment will cover only the services, treatment, care or supplies you receive while your coverage is in effect if your coverage begins or ends while you are:

- An inpatient in a facility such as: hospice, long-term acute care facility, rehabilitation hospital, psychiatric hospital, skilled nursing facility or other facility identified by BCBSM, **or**
- Under a course of treatment for an episode of illness from a home health agency, ESRD facility or outpatient hospital physical/occupational/speech therapy unit or other facility identified by BCBSM.

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

**Subscriber
Liability**

At the discretion of your provider, certain technical enhancements may be employed to complement a medical procedure. These enhancements may involve additional costs above and beyond the approved maximum payment level for the basic procedure. The costs of these enhancements are not covered by this certificate. Your provider must inform you of these costs. You then have the option of choosing any enhancements and assuming the liability for these additional charges.

Section 6: General Conditions of Your Contract

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 and Unauthorized Providers

Benefits are not payable for health care services provided by persons who are not appropriately credentialed or privileged (as determined by BCBSM), or legally authorized or licensed to order or 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 Health Care

This section explains the terms used in your certificate.

Accidental Injury

Any physical damage caused by an action, object or substance outside the body. This may include:

- Strains, sprains, cuts and bruises
- Allergic reactions caused by an outside force such as bee stings or another insect bite
- Extreme frostbite, sunburn, sunstroke
- Poisoning
- Drug overdosing
- Inhaling smoke, carbon monoxide or fumes
- Attempted suicide

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.

Acute Care Facility

A facility that provides acute care. This facility primarily treats patients with conditions that require a hospital stay of less than 30 days. The facility is not used primarily for:

- Custodial, convalescent, tuberculosis or rest care
- Care of the aged or substance abusers
- Skilled nursing or other nursing care

Administrative Costs

Costs incurred by the organization sponsoring an approved oncology clinical trial. They may include, but are not limited to, the costs of gathering data, conducting statistical studies, meeting regulatory or contractual requirements, attending meetings or travel.

Allogeneic (Allogenic) Transplant	A procedure using another person's bone marrow, peripheral blood stem cells or umbilical cord to transplant into the patient. This includes syngeneic transplants.
Ambulatory Surgery	Elective surgery that does not require the use of extensive hospital facilities and support systems, but is not usually performed in a doctor's office. Only surgical procedures identified by BCBSM as ambulatory surgery are covered.
Ambulatory Surgery Facility	A freestanding outpatient surgical facility offering surgery and related care that can be safely performed without the need for overnight inpatient hospital care. It is not an office of a physician or other private practice office.
Ancillary Services	Services such as drugs, dressings, laboratory services, physical therapy or other care that supplements the primary care the patient receives. They do not include room, board and nursing care.
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.
Arthrocentesis	Surgical puncture of a joint to inject and/or withdraw fluid. When performed for temporomandibular joint (jaw joint) dysfunction, this surgery may be performed for reversible, irreversible or diagnostic purposes.
Attending Physician	<p>The physician in charge of a case who exercises overall responsibility for the patient's care:</p> <ul style="list-style-type: none">• Within a facility (such as a hospital and other inpatient facility)• As part of a treatment program• In a clinic or private office setting <p>The attending physician may be responsible for coordination of care delivery by other physicians and/or ancillary staff.</p>

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.
Autologous Transplant	A procedure using the patient's own bone marrow or peripheral blood stem cells to transplant back into the patient.
BCBSM	Blue Cross Blue Shield of Michigan.
Benefit Period	The period of time that begins five days before, and ends one year after, the organ transplant. All payable human organ transplant services, except anti-rejection drugs and other transplant related prescription drugs, must be provided during this period of time.
Biological	A virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, allergenic product, or similar product, used for the prevention, treatment, or cure of a disease or condition of human beings. FDA regulations and policies have established that biological products include blood-derived products, vaccines in vivo diagnostic allergenic products, immunoglobulin products, products containing cells or microorganisms, and most protein products.
Birth Year	A 12-month period of time beginning with a child's month and day of birth.
BlueCard PPO® Program	A program that allows Blue Cross Blue Shield PPO 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.

- Blue Cross Plan** Any hospital service plan approved by the Blue Cross and Blue Shield Association at the time the hospital service is furnished.
- Blue Shield Plan** Any medical service plan approved by the Blue Cross and Blue Shield Association at the time the medical service is furnished.
- Calendar Year** A period of time beginning January 1 and ending December 31 of the same year.
- Carrier** An insurance company providing a health care plan for its members.
- Certificate** This book, which describes your benefit plan, **and** any riders that amend this certificate.
- Certified Nurse Midwife** A nurse who provides some maternity services and who:
- Is licensed as a registered nurse by the state of Michigan
 - Has a specialty certification as a nurse midwife by the Michigan Board of Nursing
 - Has current national certification as a midwife by an organization recognized by the Michigan Board of Nursing
- Certified Nurse Practitioner** A nurse who provides some medical services and who:
- Is licensed as a registered nurse by the state of Michigan
 - Has a specialty certification as a certified nurse practitioner by the Michigan Board of Nursing
 - Meets BCBSM qualification standards
 - When outside the state of Michigan, is legally qualified to perform services in the state where services are performed

Certified Registered Nurse Anesthetist

- A nurse who provides anesthesiology services and who:
- Is licensed as a registered nurse by the state of Michigan
 - Has a specialty certification as a certified registered nurse anesthetist by the Michigan Board of Nursing
 - Meets BCBSM qualification standards
 - When outside of the state of Michigan, is legally qualified to perform anesthesiology services in the state where the services are performed

Chronic Condition

A condition that recurs frequently or one that may or may not have been present at birth but will last a long time, perhaps throughout the patient's life. Therapy may not help and the chronic condition may eventually result in significant disability and/or death. Arthritis and heart disease are examples of chronic diseases.

Claim for Damages

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

Clinical Licensed Master's Social Worker

- A clinical licensed master's social worker who provides some mental health services and who:
- Is licensed as a clinical social worker by the state of Michigan.
 - Meets BCBSM qualification standards.
 - When outside of the state of Michigan, is legally qualified to perform services in the state where services are performed.

Clinical Trial

- A study conducted on a group of patients to determine the effect of a treatment. For purposes of this certificate clinical trials include:
- Phase II - a study conducted on a 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.

Clinical Trial (continued)	<ul style="list-style-type: none">Phase III - a study conducted on a much larger group of patients to compare the results of a new treatment of a condition to the results of conventional treatment. Phase III gives an indication as to whether the new treatment leads to better, worse or no change in outcome.
Colony Stimulating Growth Factors	Factors that stimulate the multiplication of very young blood cells.
Congenital Condition	A condition that exists at birth.
Contraceptive Medication	Any drug used for the express purpose of preventing pregnancy at the time of its administration.
Contract	This certificate and any related riders, your signed application for coverage and your BCBSM ID card.
Conventional Treatment	Treatment that has been scientifically proven to be safe and effective for treatment of the patient's condition.
Coordination Period	A period of time, defined by Medicare, that begins in the first month of Medicare entitlement due to ESRD and lasts for 30 months.
Copayment	The portion of the approved amount that you must pay for a covered service after your deductible, if required, has been met.
Covered Services	A health care service that is identified as payable in this certificate. Such services must be medically necessary, as defined in this certificate, and ordered or performed by a provider that is legally authorized or licensed to order or perform the service. The provider must also be appropriately credentialed or privileged, as determined by BCBSM, to order or perform the service.
Custodial Care	Care primarily used in helping the patient with activities of daily living or meeting personal needs. Such care includes help in walking, getting in and out of bed, and bathing, dressing and taking medicine. Custodial care can be

Custodial Care (continued)	provided safely and reasonably by people without professional skills or training.
Deductible	The amount that you must pay for covered services, under any certificate, before benefits are payable.
Dental Care	Care given to diagnose, treat, restore, fill, remove or replace teeth or the structures supporting the teeth, including changing the bite or position of the teeth.
Designated Facility	To be a covered benefit, human organ transplants must take place in a “BCBSM-designated” facility. A designated facility is one that BCBSM determines to be qualified to perform a specific organ transplant. We have a list of designated facilities and will make it available to you and your physician upon request.
Detoxification	The medical process of removing an intoxicating or addictive substance from the body of a person who is dependent on that substance.
Developmental Condition	A condition that can delay or completely stop the normal progression of speech development. Speech therapy may not help these conditions.
Dialysis	The process of cleaning wastes from the blood artificially. This job is normally done by the kidneys. If the kidneys fail, the blood must be cleaned artificially with special equipment. The two major forms of dialysis are hemodialysis and peritoneal dialysis.
Direct Supervision	The type of supervision that requires the supervising personnel to be in the same physical structure where the service is being performed.
Diversional Therapy	Planned recreational activities, such as hobbies, arts and crafts, etc., not directly related to functional therapy for a medical condition.
Dual Entitlement	When an individual is entitled to Medicare on the basis of both ESRD and age or disability.

Durable Medical Equipment Equipment that can withstand repeated use and that is used for a medical purpose by a patient who is ill or injured. It may be used in the home.

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

Eligibility As used in Section 1 of this certificate under **End Stage Renal Disease**, eligibility means the member's right to Medicare coverage under Title XVIII of the Social Security Act, as amended. Otherwise, eligibility means the member's right to coverage under this certificate.

Emergency Medical Condition Emergency Medical Condition is a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) which could cause a prudent layperson with average knowledge of health and medicine to reasonably expect that the absence of immediate medical attention would result in:

- The health of the patient (or with respect to a pregnant woman, the health of the woman or her unborn child) to be in serious jeopardy, or
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part (or with respect to a pregnant woman who is having contractions, there is inadequate time for a safe transfer to another hospital before delivery or the transfer may pose a threat to the health and safety of the woman or unborn child)

Emergency Services Emergency Services include medical screening exams (as required under Section 1167 of the Social Security Act) that are within the capability of an emergency room department of a hospital, and include ancillary services routinely available in a hospital's emergency room to evaluate an emergency medical condition. They also include, within the capabilities of the staff and facilities available at the hospital, additional medical exams and treatment (as required under Section 1867 of the Social Security Act) to stabilize the patient.

End Stage Renal Disease (ESRD)	Chronic, irreversible kidney failure that requires a regular course of dialysis or a kidney transplant as verified by a medical evidence report (defined in this section) or a provider bill that contains a diagnosis of chronic renal (kidney) failure.
Enrollment Date	The first date of coverage or, if there is a new hire waiting period, the first day of the waiting period.
Entitlement (or Entitled)	The member's right to receive Medicare benefits once the member has met the eligibility requirements to qualify for Medicare coverage, has filed a valid application for benefits, and has met any applicable waiting period requirements.
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."
Facility	A hospital or clinic that offers acute care or specialized treatment, such as substance abuse treatment, rehabilitation treatment, skilled nursing care or physical therapy.
Fecal Occult Blood Screening	A laboratory test to detect blood in feces or stool.
First Degree Relative	An immediate family member who is directly related to the patient: either a parent, sibling or child.
First Priority Security Interest	The right to be paid before any other person from any money or other valuable consideration recovered by: <ul style="list-style-type: none">• Judgment or settlement of a legal action• Settlement not due to legal action• Undisputed payment

**First Priority
Security
Interest**
(continued)

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

**Flexible
Sigmoidoscopy**

A visual examination of the lower portion of the colon through the rectum, using a flexible instrument called a sigmoidoscope.

**Food and Drug
Administration
(FDA)**

An agency with the U.S. Department of Health and Human Services that is responsible for protecting the public health by assuring the safety, efficacy and security of human drugs.

**Freestanding
Outpatient
Physical
Therapy
Facility**

An independently owned and operated facility, separate from a hospital, which provides outpatient physical therapy services and occupational therapy or speech and language pathology services.

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

**Gynecological
Examination**

A history and physical examination of the female genital tract.

**Hazardous
Medical
Condition**

The dangerous state of health of a patient who is at risk for loss, harm, injury or death.

**Health
Maintenance
Examination**

A comprehensive history and physical examination including blood pressure measurement, skin examination for malignancy, breast examination, testicular examination, rectal examination and health counseling regarding potential risk factors.

Hematopoietic Transplant	A transplant of bone marrow, peripheral blood stem cells or umbilical cord blood.
Hemodialysis	The use of a machine to clean wastes from the blood after the kidneys have failed.
High-Dose Chemotherapy	A procedure in which patients are given cell destroying drugs in doses higher than those used in conventional therapy. Stem cell replacement is required after high-dose chemotherapy is given.
High-Risk Patient	An individual who has an increased risk of mortality or morbidity according to standard criteria recognized by the oncology community.
HLA Genetic Markers	Specific chemical groupings that are part of many body cells, including white blood cells. Called human leukocyte antigens, these chemical groupings are inherited from each parent and are used to detect the constitutional similarity of one person to another. Close (or the degree of) identity is determined by tests using serologic (test tube) methods and/or molecular (DNA fingerprinting) techniques. An HLA identical match occurs when the six clinically important markers of the donor are identical to those of the patient.
Home Health Care Agency	An organization that is primarily engaged in providing skilled nursing services and other therapeutic services in the patient's home.
Hospice	A public agency, private organization or subdivision of either, which primarily provides care for terminally ill persons.
Hospital	A facility that: <ul style="list-style-type: none">• Provides inpatient diagnostic, therapeutic and surgical services for injured or acutely ill persons on a 24-hour per day basis and• Is fully licensed and certified as a hospital, as required by all applicable laws and• Complies with all applicable national certification and accreditation standards

Hospital
(continued)

Hospital services must be provided by or under the supervision of a professional staff of licensed physicians, surgeons and registered nurses.

NOTE: A facility that provides specialized services that does not meet all of the above requirements does not qualify as a hospital under this certificate, regardless of its affiliation with any hospital that does meet the above requirements. Such facilities include but are not limited to the following:

- Facilities that provide custodial, convalescent, pulmonary tuberculosis, rest or domiciliary care
- Facilities that serve as institutions for exceptional children or for the treatment of the aged or of substance abusers
- Skilled nursing facilities or other nursing care facilities

Host Plan

A Blue Cross and/or Blue Shield plan outside of Michigan that participates in the BlueCard PPO Program and processes claims for services that you receive in that state.

Independent Occupational Therapist

An occupational therapist who provides some occupational therapy services and who:

- Is licensed as an occupational therapist by the state of Michigan
- Meets BCBSM qualification standards
- When outside the state of Michigan, is legally qualified to perform services in the state where services are performed.

Independent Physical Therapist

A physical therapist who provides some physical therapy services and who:

- Is licensed as a physical therapist by the state of Michigan
- Meets BCBSM qualification standards

Independent Physical Therapist
(continued)

- When outside the state of Michigan, is legally qualified to perform services in the state where services are performed.

Independent Speech-Language Pathologist

A speech-language pathologist who provides some speech-language therapy services and who:

- Is licensed as a speech-language pathologist by the state of Michigan. If the state of Michigan has not released license applications or has not issued licenses, then a Certificate of Clinical Competence from the American Speech and Hearing Association is an acceptable alternative until the state issues licenses.
- Meets BCBSM qualification standards
- When outside the state of Michigan, is legally qualified to perform services in the state where services are performed.

Infusion Therapy

The continuous, slow administration of a controlled drug, nutrient, antibiotic or other fluid into a vein or other tissue on a daily, weekly or monthly basis, depending on the condition being treated and type of therapy.

Injectable Drugs

Payable drugs that are ordered or furnished by a physician and administered by the physician or under the physician's supervision.

Irreversible Treatment

Refers to medical and/or dental treatment of temporomandibular joint (jaw joint) dysfunction.

- The treatment is to the mouth, teeth, jaw, jaw joint, skull, and the complex of muscles and nerves, including blood vessels and tissues related to the jaw joint.
- The treatment is intended to cause permanent change to a person's bite or position of the jaws.
- The treatment includes, but is not limited to:
 - Crowns, inlays, caps, restorations and grinding

Irreversible Treatment
(continued)

- Orthodontics, such as braces, orthopedic repositioning and traction
- Installation of removable or fixed appliances such as dentures, partial dentures or bridges
- Surgery directly to the jaw joint and related anesthesia services
- Arthrocentesis

Jaw Joint Disorders

These include, but are not limited to:

- Skeletal defects of the jaws or problems with the bite that cause pain and inability to move the jaw properly
- Muscle tension, muscle spasms, or problems with the nerves, blood vessels or tissues related to the jaw joint that cause pain and inability to move the jaw properly
- Defects within the temporomandibular joint (jaw joint) that cause pain and an inability to move the jaw properly

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.

Lobar Lung

A portion of a lung from a cadaver or living donor.

Long-Term Acute Care Hospital

A specialty hospital that focuses on treating patients requiring extended intensive care; meets BCBSM qualification standards and is certified by Medicare as an LTACH.

Mammogram

A low dose X-ray of the breast, two views per breast. The radiation machine must be state-authorized and specifically designed and used to perform mammography.

Mandibular Orthotic Reposition Device

An appliance used in the treatment of temporomandibular joint dysfunction.

Maternity Care Hospital and professional services for any condition due to pregnancy except ectopic (tubal) pregnancy.

Maxillofacial Prosthesis A custom-made replacement of a missing part of the face or mouth such as an artificial eye, ear, nose or an obturator to close a cleft. Excludes replacement of teeth or appliances to support teeth.

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

Medical Evidence Report A form required by the Centers for Medicare and Medicaid Services that a physician must complete and submit for each ESRD patient beginning dialysis.

Medically Necessary A service must be medically necessary to be covered. There are three definitions: one applies to professional providers (M.D.s, D.O.s, podiatrists, chiropractors, fully licensed psychologists and oral surgeons); another applies to hospitals and LTACHs; and a third applies to other providers.

- **Medical necessity for payment of professional provider services:**

Health care services that a professional provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the member's illness, injury or disease and
- Not primarily for the convenience of the member, professional provider, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce

**Medically
Necessary**
(continued)

equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that member's illness, injury or disease.

NOTE: "Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician or provider society recommendations and the views of physicians or providers practicing in relevant clinical areas and any other relevant factors.

- **Medical necessity for payment of services of other providers:**

Determination by physicians acting for BCBSM, based on criteria and guidelines developed by physicians for BCBSM who are acting for their respective provider type 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 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.

- **Medical necessity for payment of hospital and LTACH services:**

Determination by BCBSM that allows for the payment of covered hospital services when all of the following conditions are met:

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

**Medically
Necessary**
(continued)

- The service, treatment, or supply is **appropriate** for the symptoms and is consistent with the diagnosis.
 - **Appropriate** means that the type, level and length of care, treatment or supply and setting are needed to provide safe and adequate care and treatment.
 - For inpatient hospital stays, acute care as an inpatient must be necessitated by the patient's condition because safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.
- The service is not mainly for the convenience of the member or health care provider.
- The treatment is not generally regarded as experimental by BCBSM.
- The treatment is not determined to be medically inappropriate by the Utilization Quality and Health Management Programs (applies only to hospitals, not to LTACHs).

Member

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

**Nonpanel
Providers**

Hospitals, physicians and other licensed facilities or health care professionals who have not signed an agreement to provide services under this PPO program.

**Nonparticipating
Providers**

Physicians and other health care professionals, or hospitals and other facilities or programs that have not signed a participation agreement with BCBSM to accept the approved amount as payment in full. Some nonparticipating providers, however, may agree to accept the approved amount on a per claim basis.

Occupational Therapy

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

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

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.

Orthopedic Shoes

Orthopedic shoes are prescribed by a physician or certified nurse practitioner to support or correct the bones, joints, muscles, tendons and ligaments of a weak or deformed foot.

Orthotic Device

An appliance worn outside the body to correct a body defect of form or function.

Out-of-Area Services

Services available to members living or traveling outside a health plan's service area.

Outpatient Mental Health Facility

A facility that provides outpatient mental health services. It must have a participating agreement with BCBSM. Sometimes referred to as an outpatient psychiatric care facility (OPC), it may include centers for mental health care such as clinics and community mental health centers, as defined in the Federal Community Mental Health Centers Act of 1963, as amended. The facility may or may not be affiliated with a hospital.

Outpatient Substance Abuse Treatment Program	A program that provides medical and other services on an outpatient basis specifically for substance abusers.
Panel Providers	Hospitals, physicians and other licensed facilities or health care professionals who provide services through this PPO program. Panel providers have agreed to accept our approved amount as payment in full for covered services provided under this PPO program.
Pap Smear	A method used to detect abnormal conditions, including cancer of the female genital tract.
Partial Liver	A portion of the liver taken from a cadaver or living donor.
Participating PPO Provider	A provider who participates with the Host Plan's PPO.
Participating Providers	Physicians and other health care professionals, or hospitals and other facilities or programs that have signed a participation agreement with BCBSM to accept the approved amount as payment in full. Copayments and/or deductibles, which may be required of you, are subtracted from the approved amount before we make our payment.
Patient	The subscriber or eligible dependent that is awaiting or receiving medical care and treatment.
Per Claim Participation	Available to some nonparticipating providers when they elect to accept the approved amount for specific covered services as payment in full.
Peripheral Blood Stem Cell Transplant	A procedure in which blood stem cells are obtained by pheresis and infused into the patient's circulation.
Peritoneal Dialysis	Removal of wastes from the body by perfusion of a chemical solution through the abdomen.

Pheresis	Removal of blood from the donor or patient in order to separate and retain specific components of the blood (red cells, white cells, platelets and stem cells).
Physical Therapy	<p>The use of specific activities or methods to treat disability when there is a loss of neuromusculoskeletal functions due to an illness or injury, or following surgery. Treatments include exercise and therapy of the patient’s specific muscles or joints to restore or improve:</p> <ul style="list-style-type: none">• Muscle strength• Joint motion• Coordination• General mobility
Physician	A doctor of medicine, osteopathy, podiatry, chiropractic or an oral surgeon. 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, osteopathy, podiatry, or chiropractic) or a professional provider (a doctor of medicine, osteopathy, podiatrist, chiropractor, fully licensed psychologist, clinical licensed master’s social worker or oral surgeon) 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.
Pre-existing Condition	A condition for which medical advice, diagnosis, care or treatment was recommended or received within the six month period ending on the enrollment date.
Preferred Provider Organization	A limited group of health care providers who have agreed to provide services to BCBSM members enrolled in the PPO program. These providers accept the approved amount as payment in full for covered services.

Presurgical Consultation	A consultation that allows a member to get an additional opinion from a physician who is a doctor of medicine, osteopathy, podiatry or an oral surgeon when surgery is recommended.
Primary Payer	The health care coverage plan that pays first when you are provided benefits by more than one carrier. (For example, you may have BCBSM group coverage and Medicare.)
Primary Plan	The health care plan obligated to pay for services before any other health care plan that covers the member or patient.
Professional Provider	<p>One of the following:</p> <ul style="list-style-type: none">• Doctor of Medicine (M.D.)• Doctor of Osteopathy (D.O.)• Podiatrist• Chiropractor• Fully licensed psychologist• Clinical licensed master’s social worker• Oral surgeon• Other providers as identified by BCBSM <p>Professional providers may also be referred to as “practitioners.”</p>
Prosthetic Device	<p>An artificial appliance that:</p> <ul style="list-style-type: none">• Replaces all or part of a body part or• Replaces all or part of the functions of a permanently disabled or poorly functioning body organ
Provider	A person (such as a physician) or a facility (such as a hospital) that provides services or supplies related to medical care.
Psychiatric Day Treatment	Treatment for mental or emotional disorders given to a patient who lives at home and goes to a facility for each day of treatment.

Psychiatric Night Treatment

Treatment for mental or emotional disorders given to a patient who lives at home, but goes to a facility at night for treatment and is given meals and a bed.

Psychologist

A practitioner of clinical psychology, counseling or guidance, who is fully licensed and certified by the state of Michigan or by the state where you receive services. Where there are no certification or licensure requirements, the psychologist must be recognized by the appropriate professional society.

Purging

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

Qualified Beneficiary

Persons eligible for continued group coverage under COBRA. This includes the employee, spouse and children (including those born to, or placed for adoption with, the employee during the period of COBRA coverage).

Qualifying Event

One of the following events that allows a qualified beneficiary to receive COBRA coverage:

- Termination of employment, other than for gross misconduct, or reduction of hours
- Death of the employee
- Divorce
- Loss of dependent status due to age, marriage, change in student status, etc.
- The employee becomes entitled to coverage under Medicare

Radiology Services

These include X-ray exams, radium, radon, cobalt therapy, ultra-sound testing, radioisotopes, computerized axial tomography scans, magnetic resonance imaging scans and positron emission tomography scans.

Refractory Patient

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

Relapse	When a disease recurs after a period of time following therapy. This period of time is defined by evidence-based literature pertaining to the patient's condition.
Remitting Agent	Any individual or organization that has agreed, on behalf of the subscriber, to: <ul style="list-style-type: none">• Collect or deduct premiums from wages or other sums owed to the subscriber and• Pay the subscriber's BCBSM bill
Research Management	Services, such as diagnostic tests, which are performed solely to support the sponsoring organization's research. They are not necessary for treating the patient's condition.
Residential Substance Abuse Treatment Program	A program that provides medical and other services specifically for substance abusers in a facility that operates 24 hours a day, seven days a week. Treatment in a residential program is sometimes called "intermediate care."
Respite Care	Relief to family members or other persons caring for terminally ill persons at home.
Reversible Treatment	Refers to medical and/or dental treatment of temporomandibular joint (jaw joint) dysfunction. <ul style="list-style-type: none">• The treatment is to the mouth, teeth, jaw, jaw joint, skull, and the complex of muscles and nerves, including blood vessels and tissues related to the jaw joint.• This treatment is not intended to cause permanent change to a person's bite or position of the jaws.• This treatment is designed to manage the patient's symptoms. It can include, but is not limited to, the following services:<ul style="list-style-type: none">- Arthrocentesis- Physical therapy (see Page 4.14 for physical therapy services)- Reversible appliance therapy (mandibular orthotic repositioning)

Rider	A document that changes 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.
Screening Services	Procedures or tests ordered for a patient (or for almost all patients of a particular class or group) that are not directly related to the diagnosis or treatment of a specific disease or injury. For example, tests routinely performed as part of a physical are considered screening services.
Secondary Plan	The health care plan obligated to pay for services after the primary plan has paid for services.
Self-Dialysis Training	Teaching a member to conduct dialysis on himself or herself.
Semiprivate Room	A hospital room with two beds.
Service Area	<p>The geographic area in which BCBSM is authorized to use the Blue Cross and Blue Shield name and service marks.</p> <p>NOTE: BCBSM may contract with providers in areas contiguous with the state of Michigan. These providers' claims will not be subject to BlueCard rules.</p>
Services	Surgery, care, treatment, supplies, devices, drugs or equipment given by a health care provider to diagnose or treat a disease, injury, condition or pregnancy.
Skilled Care	<p>A level of care that can be given only by a licensed nurse to ensure the medical safety of the patient and the desired medical result. Such care must be:</p> <ul style="list-style-type: none">• Ordered by the attending physician• Medically necessary according to generally accepted standards of medical practice• Provided by a registered nurse or a licensed practical nurse supervised by a registered nurse or physician

Skilled Nursing Facility	A facility that provides continuous skilled nursing and other health care services by or under the supervision of a physician and a registered nurse.
Small Bowel Transplant	A procedure in which the patient's small intestine is removed and replaced with the small intestine of a cadaver.
Special Foods for Metabolic Disease	<p>Special medical foods that are formulated for the dietary treatment of an inherited metabolic disease. The nutritional requirements of the patient are established by medical evaluation and the diet is administered under the supervision of a physician. These formulations are exempt from the general requirements for nutritional labeling under the statutory and regulatory guidelines of the federal Food and Drug Administration.</p> <p>Special infant formulas are liquid feedings used for the treatment of inherited metabolic diseases. These formulas can provide up to 85 percent of the protein, vitamin and mineral needs of an infant.</p> <p>A low-protein modified food product is one specially formulated to provide less than one gram of protein per serving. It is intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease, but does not include a food that is naturally low in protein.</p>
Specialty Hospitals	Hospitals that treat specific diseases, such as mental illness.
Specialty Pharmaceuticals	Biotech drugs including high cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include vaccines and chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin.
Specialty Pharmacy	Companies that specialize in specialty pharmaceuticals and the associated clinical management support.

Speech and Language Pathology Services

Rehabilitative services that use specific activities or methods to treat speech, language or voice impairment due to an illness, injury or following surgery.

Stabilize

Stabilize, with respect to an emergency medical condition, means that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the patient from a facility (or with respect to a woman who is having contractions, to deliver the child (including the placenta)).

Stem Cells

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

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.

Substance Abuse

Taking alcohol or other drugs in amounts that can:

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

Substance abuse is alcohol or drug abuse or dependence as classified in Categories 303.3 – 305.0 and 305.2 – 305.9 of the most current edition of the “International Classification of Diseases.”

Substance Abuse Treatment Program Services

Subacute services to restore a person’s mental and physical well-being when the person is a substance abuser. Services must be provided and billed by an approved residential or outpatient substance abuse treatment program.

Syngeneic Transplant	A procedure using bone marrow, peripheral blood stem cells or umbilical cord blood from a patient's identical twin to transplant into the patient.
Tandem Transplant	A procedure in which the patient is given chemotherapy followed by a blood stem cell (peripheral or umbilical cord blood) transplant or bone marrow transplant, and if the patient's cancer has not progressed, a second round of chemotherapy followed by a blood stem cell or bone marrow transplant. The second round of chemotherapy and transplant is usually performed within six months of the first transplant and if not, it must be approved by BCBSM. Tandem transplants are also referred to as dual transplants or sequential transplants. A tandem transplant is considered to be one transplant.
T-Cell Depleted Infusion	A procedure in which T-Cells (immunocompetent lymphocytes) are eliminated from peripheral blood stem cells, bone marrow or umbilical cord blood.
Technical Surgical Assistance	Professional active assistance given to the operating physician during surgery by another physician not in charge of the case. NOTE: Professional active assistance requires direct physical contact with the patient.
Terminally Ill	A state of illness causing a person's life expectancy to be 12 months or less according to a medically justified opinion.
Therapeutic Shoes	Therapeutic or diabetic shoes are prescribed by a physician or certified nurse practitioner and are either "off-the-shelf" or custom-molded shoes which assist in protecting the diabetic foot.
Total Body Irradiation	A procedure that exposes most of the body to ionizing radiation to produce an anti-tumor effect that helps prevent rejection of a bone marrow, peripheral blood stem cell or umbilical cord blood transplant.
Treatment Plan	A written plan that describes the goals, expected outcomes, type and limited duration of services to be provided to the

Treatment Plan (continued)	member under integrated case and disease management. The treatment plan may include medically necessary services that BCBSM determines should be provided because of the member's condition as specified in the plan, even if those services are not covered under the patient's hospital and professional certificates. (Such services are referred to as non-contractual services.) All services described in the treatment plan must be ordered by the member's physician. Because plans that include non-contractual services are a binding contract between the member and BCBSM, they must be signed by the member (or representative) and the BCBSM case manager.
Urgent Care	Walk-in care needed for an unexpected illness or injury that requires immediate treatment to prevent long-term harm. Urgent care centers are not the same as emergency rooms or doctors' offices.
Valid Application	An application for Medicare benefits filed by a member with ESRD according to the rules established by Medicare.
Waiting Period	Defined by Medicare as the period of time (up to three months) before a member with ESRD, who has begun a regular course of dialysis, becomes entitled to Medicare. Entitlement begins on the first day of the fourth month of dialysis, provided the member files a valid application for Medicare.
Ward	A hospital room with three or more beds.
We, Us, Our	Used when referring to Blue Cross Blue Shield of Michigan.
Well-Baby Care	Services provided in physician's office to monitor the health and growth of a healthy child.
Working Aged	Employed individuals age 65 or over, and individuals age 65 or over with employed spouses of any age, who have group health plan coverage by reason of their own or their spouse's current employment.

**Working
Disabled**

Disabled individuals under age 65 who have successfully returned to work but continue to have a disabling impairment.

You and Your

Used when referring to any person covered under the 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 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 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-free800-972-9797

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 bcbsm.com to find the center nearest you. The centers are open Monday through Friday, 9 a.m. to 5 p.m.

Detroit

600 E. Lafayette Blvd., Detroit 48226
Downtown, three blocks north of Jefferson at St. Antoine

Flint

4520 Linden Creek Parkway, Suite A, Flint 48507

Grand Rapids

86 Monroe Center N.W., Grand Rapids 49503

Holland

151 Central Ave., Holland, 49423

To Visit
(continued)

Lansing

1403 Creyts Road, Lansing 48917
One-quarter mile south of I-496, Creyts Road exit

Marquette

415 S. McClellan Ave., Marquette 49855
Up on the hill

Portage

8175 Creekside Dr., Suite 100 Portage 49024

Southfield

27000 W. 11 Mile Road, Southfield 48034
East of Inkster Road on the first floor of Tower 300

Traverse City

1769 S. Garfield, Traverse City 49686
Across from Cherryland Center

Utica

6100 Auburn Road, Utica 48317
Diagonally across from the AAA building

Form No. 6225



Bureau Approved 09/11

**BLUE SHIELD 65
G-I
BENEFIT CERTIFICATE**

Dear Subscriber:

We are pleased you have selected Blue Cross Blue Shield of Michigan for your health care coverage. Your coverage provides many benefits for you and your eligible dependents. These benefits are described in this book, which is your **certificate**.

Your certificate, your signed application and your BCBSM identification card are your **contract** with us.

You may also have **riders**. Riders make changes to your certificate and are an important part of your coverage. When you receive riders, keep them with this book.

This certificate will help you understand your benefits and each of our responsibilities **before** you require services. Please read it carefully. If you have any questions about your coverage, call us at one of the BCBSM Customer Service telephone numbers listed in the "How to Reach Us" section of this book.

Thank you for choosing Blue Cross Blue Shield of Michigan. We are dedicated to giving you the finest service and look forward to serving you for many years.

Sincerely,

A handwritten signature in black ink, appearing to read "Dan Loepf". The signature is written in a cursive, flowing style.

Daniel J. Loepf
President and Chief Executive Officer
Blue Cross Blue Shield of Michigan

About Your Certificate

This certificate is arranged to help you locate information easily. You will find:

- A **Table of Contents** for quick reference
- **Information About Your Contract**
- **How Services are Paid**
- **Blue Shield Complementary Coverage**
- **What is Not Covered**
- **General Conditions of Your Contract**
- **The Language of Health Care** - explanations of the terms used in your certificate
- **How to Reach Us** - a list of Customer Service Center telephone numbers and addresses

This certificate refers to you as the **subscriber** because the contract is in your name.

The term **patient** refers to either you or one of your dependents who are enrolled in Medicare Part A and Medicare Part B when services are received. Your eligible dependents are those listed on your application.

Medicare pays the costs for most of your hospital and medical services, but it will not pay for all of them. This Blue Shield Complementary Group Benefit Plan helps pay some of the costs Medicare does not pay. This plan will also extend benefits beyond those Medicare offers to you and your eligible dependents.

This certificate provides you with the information you need to get the most from your Blue Shield Complementary Coverage. Please call us if you have any questions.

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Section 1: Information About Your Contract

This section provides answers to general questions you may have about your contract. Topics include:

ELIGIBILITY

- Who is Eligible for Blue Shield 65 Complementary Coverage?

CANCELLATION

- How to Cancel Coverage
- Automatic Cancellation

GROUP CONVERSION COVERAGE

ELIGIBILITY

Who is Eligible for Blue Shield 65 Complementary Coverage?

You, your spouse (this does not include the person who marries a member who has coverage as a surviving spouse) and your eligible dependents listed on your application and who are enrolled in Medicare Part A and Part B are eligible for Complementary coverage.

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.

If you are no longer eligible for Medicare coverage, you must change to the group contract for non-Medicare employees.

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 requested date. All benefits under this certificate will end.

CANCELLATION

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.
- You become ineligible for Medicare.

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

GROUP CONVERSION COVERAGE

If you become ineligible for coverage under this contract, you may be eligible for an approved individual Medicare Supplemental Plan.

You or your eligible dependents must submit a written request for your choice of coverage:

- Within 30 days of the date your group coverage was canceled.

Section 2: How Services Are Paid

Payment for Medicare Deductible and Coinsurance

We pay the deductible and coinsurance required by Medicare. Our payments are based on Medicare's approved amount for eligible expenses.

When your provider sends us a claim, it must show the following:

- Your contract number;
- Type and date of service, and
- The diagnosis.

The provider may be required to verify services were provided.

If your provider does not send us a claim, you may send us a copy of the "Explanation of Medicare Benefits" form you receive from Medicare.

Medicare participating providers are paid directly by Medicare. Other providers are paid directly by Medicare when they accept assignment. We also pay these providers.

If a provider does not participate and does not accept assignment, you must pay the provider. Medicare pays you. We also pay you.

Payment for Emergency Services Outside the United States

You will usually be asked to pay the bill for emergency care outside the United States. You should get an itemized receipt. When you return to the United States, send the receipt to us. We will pay you for covered services.

Section 3: Blue Shield Complementary Coverage

Annual Deductible

Medicare requires you to pay a deductible each year for covered services. The amount of the deductible may be increased from time to time by the federal government. We will pay this deductible for you.

Coinsurance

We pay the Medicare coinsurance for Part B Services.

Drugs Used in Chemotherapy

We will pay for drugs used in chemotherapy if Medicare does not pay for them. We will pay our approved amount for drugs:

- Ordered by a physician for the treatment of a specific type of malignant disease
- Provided as part of a chemotherapy program
- Approved by the Food and Drug Administration (FDA) for use in chemotherapy

NOTE: If the FDA has not approved the drug for the specific disease being treated, BCBSM's Medical Policy Staff determines the appropriateness of the drug for that disease by using the following criteria:

- Current medical literature must confirm that the drug is effective for the disease being treated.
- Recognized oncology organizations must generally accept the drug as treatment for the specific disease.
- The physician must obtain informed consent from the patient for the treatment.

We pay for:

- Physician services for the administration of the chemotherapy drug, **except** those taken orally

Drugs Used in Chemotherapy
(continued)

- The chemotherapy drug administered in a medically approved manner
- Other FDA-approved drugs classified as:
 - Anti-emetic drugs used to combat the toxic effects of chemotherapeutic drugs
 - Drugs used to enhance chemotherapeutic drugs
 - Drugs to prevent or treat the side effects of chemotherapy treatment
- Administration sets, refills and maintenance of implantable or portable pumps and ports

We will also pay for disposable syringes and needles for self-administered chemotherapy.

Chiropractic Services

Medicare only pays for manual manipulation of the spine by a chiropractor. We will pay our approved amount for other services of a chiropractor if:

- Medicare would have paid for them if performed by a physician, **and**
- The chiropractor is legally qualified to perform the services.

Emergency Services Outside the United States

Medicare generally does not pay for care outside the United States. Medicare only pays for physician services in a foreign hospital if:

- An emergency occurs in the U.S. and the hospital in Canada or Mexico is closer than one in the U.S., or
- You are traveling through Canada to, or from, Alaska when an emergency occurs.

We pay the deductible and coinsurance when Medicare pays for this care.

Section 3: Blue Shield Complementary Coverage

**Emergency
Services
Outside the
United States**
(continued)

We will pay approved amounts for other emergency care. We will pay only if:

- Medicare does not pay, and
- Medicare would pay if the services were provided in the United States.

Section 4: What Is Not Covered

We do not pay for:

- Home and office medical visits.
- Osteopathic or chiropractic manipulation therapy.
- Whole blood and packed red blood cells.
- Hospital services, including services provided by hospital employees.
- Dental services such as care, treatment, or replacement of teeth.
- Services that you could get free if you did not have health care coverage.
- Services covered under any other Blue Cross or Blue Shield contract or under any other health care benefits plan.
- A provider's charge in excess of Medicare's approved amount.
- A provider's charge in excess of our approved amount for emergency care received outside the United States.
- Care that is not reasonable and necessary under Medicare program standards. Medicare does not pay for services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury.
- Drugs or devices not approved by the Food and Drug Administration (FDA).
- Experimental chemotherapy drugs.
 - Please see “Experimental Treatment” in the General Conditions section of this certificate for information regarding how BCBSM determines if a treatment is experimental.

Section 4: What Is Not Covered

- Services performed by immediate relatives or members of your household.
- Self-treatment by a professional provider and services given by the provider to parents, siblings, spouse or children.
- Services provided by employer facilities.
- Private duty nursing.

Section 5: General Conditions of Your Contract

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

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 available in a hospital maintained by the state or federal government, unless payment is required by law
- Those payable by government-sponsored health care programs 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 (COB) 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 for Drugs and Devices We do not pay for any drug or device prescribed for uses or in dosages other than those specifically approved by the federal Food and Drug Administration. (This is often referred to as the off-label use of a drug or device.) However, we will pay for such drugs and the reasonable cost of supplies needed to administer them, if the prescribing M.D. or D.O. can substantiate that the drug is recognized for treatment of the condition for which it is prescribed by one of the following:

- The American Medical Association Drug Evaluations
- The American Hospital Formulary Service Drug Information
- The United States Pharmacopoeia Dispensing Information, Volume 1, “Drug Information for the Health Care Professional”

**Coverage for
Drugs and
Devices**
(continued)

- Two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.

NOTE: Chemotherapeutic drugs are not subject to this general condition.

**Deductibles and
Copayments
Paid Under
Other
Certificates**

We do not pay deductibles or copayments that you were required to pay under any other certificate.

**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

Experimental Treatment
(continued)

How BCBSM Determines If a Treatment Is Experimental
(continued)

- 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

Experimental Treatment
(continued)

How BCBSM Determines If a Treatment Is Experimental
(continued)

- 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.

Experimental Treatment
(continued)

Limitations and Exclusions (continued)

- 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 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
- Refuse to cover your health 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 health 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

Section 5: General Conditions of Your Contract

Other Coverage (continued)

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.

Payment of Covered Services

The covered services described in this certificate, such as multiple surgeries or a series of services such as laboratory tests, are combined and paid according to payment policies adopted by BCBSM.

Personal Costs

We will not pay for:

- Transportation and travel, even if prescribed by a physician, except as provided in this certificate
- Care, services, supplies or devices that are personal or convenience items
- Charges to complete claim forms
- Domestic help

Physician of Choice

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

Section 5: General Conditions of Your Contract

Refunds of Premium	If we determine that we must refund a premium, we will refund up to a maximum of two years of payments.
Release of Information	<p>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.</p> <p>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.</p>
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.
Time Limit for Legal Action	Legal action against us may not begin later than two years after we have received a completed 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 health 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 6: The Language Of Health Care

This section explains the terms used in your certificate. The terms are listed in alphabetical order.

Accidental Injury

Any physical damage caused by an action, object or substance outside the body. This may include:

- Strains, sprains, cuts and bruises
- Allergic reactions caused by an outside force such as a bee sting or another insect bite
- Burns, frostbite, sunburn, sunstroke
- Poisoning
- Drug overdosing
- Inhaling smoke, carbon monoxide or fumes
- Attempted suicide

Approved Amount

The lower of the billed charge or the BCBSM maximum payment level for a covered service. The approved amount applies to services covered by BCBSM and not Medicare.

BCBSM

Blue Cross Blue Shield of Michigan.

Certificate

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

Claim for Damages

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

Coinsurance

A part of the Medicare approved amount Medicare requires you to pay after you have met your deductible. (We pay this amount for you.)

Contract

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

Covered Services

The services, treatments or supplies identified as payable in this certificate.

Deductible	The amount Medicare requires of you before benefits are paid. (We pay this amount for you.)
Effective Date	The date your coverage begins under this contract. This date is established by BCBSM.
Emergency Care	Care needed immediately because of an injury or an illness which occurred suddenly and unexpectedly.
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	<p>The right to be paid before any other person from any money or other valuable consideration recovered by:</p> <ul style="list-style-type: none">• Judgment or settlement of a legal action• Settlement not due to legal action• Undisputed payment <p>This right may be invoked without regard for:</p> <ul style="list-style-type: none">• Whether plaintiff's recovery is partial or complete• Who holds the recovery• Where the recovery is held
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.
Hospital	<p>A facility that:</p> <ul style="list-style-type: none">• Provides inpatient diagnostic, therapeutic and surgical services for injured or acutely ill persons on a 24-hour per day basis and• Is fully licensed and certified as a hospital, as required by all applicable laws and

Hospital
(continued)

- Complies with all applicable national certification and accreditation standards

Hospital services must be provided by or under the supervision of a professional staff of licensed physicians, surgeons and registered nurses.

NOTE: A facility that provides specialized services that does not meet all of the above requirements does not qualify as a hospital under this certificate, regardless of its affiliation with any hospital that does meet the above requirements. Such facilities include but are not limited to the following:

- Facilities that provide custodial, convalescent, pulmonary tuberculosis, rest or domiciliary care
- Facilities that serve as institutions for exceptional children or for the treatment of the aged or of substance abusers
- Skilled nursing facilities or other nursing care facilities

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.

Medicare

The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

**Medicare
Approved
Amount**

The portion of the provider's charge approved by Medicare as payable. The charge includes the Medicare Part B payment level and deductible and/or coinsurance amounts.

**Medicare
Eligible
Expenses**

Health care costs which are recognized as reasonable and necessary by Medicare.

**Medicare
Participating
Provider**

A provider who has signed a contract with the federal government to provide care to patients enrolled in the Medicare Program, and to accept Medicare's approved amount as payment in full for covered services.

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.
Off-Label	The use of a drug or device for clinical indications other than those stated in the labeling approved by the Food and Drug Administration.
Participating Providers	Physicians and other health care professionals, hospitals and other facilities or programs that have signed a participation agreement with BCBSM to accept the approved amount as payment in full.
Patient	The subscriber or eligible dependent who is awaiting or receiving medical care and treatment.
Physician	A doctor of medicine, osteopathy, podiatry, chiropractic or dentistry.
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.
Private Duty Nurse	A registered or licensed practical nurse who does not belong to a hospital staff but is prepared to care for an individual patient and is employed directly by the patient or his/her representative for complete personal attention during an eight-hour shift.
Provider	A person (such as a physician) or a facility (such as a hospital) that provides services or supplies related to medical care.
Reasonable and Necessary	Services and items generally accepted by the professional medical community as necessary and suitable for treatment or diagnosis of a patient's illness or injury.
Remitting Agent	Any individual or organization that has agreed, on behalf of the subscriber, to: <ul style="list-style-type: none">• Collect or deduct premiums from wages or other sums owed to the subscriber and• Pay the subscriber's BCBSM bill.

Section 6: The Language Of Health Care

Rider	A document that changes 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.
Services	Surgery, care, treatment, supplies, devices, drugs or equipment given by a health care provider to diagnose or treat a disease, injury, condition or pregnancy.
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 the subscriber's contract.

Section 7: How To Reach Us

Your Local Customer Service Centers

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 bcbsm.com to find the center nearest you. The centers are open Monday through Friday.

Alpena

135 W. Chisholm St., Alpena 49707
On the main street in downtown Alpena
Open from 9 a.m. to 5 p.m.

Detroit

500 E. Lafayette Blvd., Detroit 48226
Downtown, three blocks north of Jefferson at St. Antoine
Open from 8:30 a.m. to 4:30 p.m.

To Visit
(continued)

Flint

4520 Linden Creek Parkway, Suite A, Flint 48507
Open from 8:30 a.m. to 5 p.m.

Grand Rapids

86 Monroe Center N.W., Suite 122, Grand Rapids 49503
Open from 9 a.m. to 5 p.m.

Holland

259 Hoover Blvd., Suite 180, Holland 49423
Near U.S. 31 and 8th Street
Open from 9 a.m. to 12:30 p.m. and 1:35 to 5 p.m.

Jackson

1000 N. Wisner, Suite 5, Jackson 49202
Open from 8:30 a.m. to 5 p.m.

Lansing

1405 Creyts Road, Lansing 48917
One-quarter mile south of I-496, Creyts Road exit
Open from 8:30 a.m. to 4:30 p.m.

Marquette

415 S. McClellan Ave., Marquette 49855
Up on the hill
Open 8:30 a.m. to 5 p.m.

Mt. Pleasant

1620 S. Mission, Mt. Pleasant 48858
In the Campus Court shopping mall
Open from 8:30 a.m. to 12:30 p.m. and from 1:30 to 5 p.m.

Muskegon

1034 E. Sternberg Road, Muskegon 49444
The Pointes Mall
Open from 9 a.m. to 12:30 p.m. and from 1:35 to 5 p.m.

Portage

2255 W. Centre Ave., Portage 49024
One mile east of Centre Avenue, exit off Rt. 131 at Oakland
Drive
Open from 9 a.m. to 5 p.m.

To Visit
(continued)

Port Huron

2887 Krafft Road, Suite 200, Port Huron 48060
Open from 8:30 a.m. to 5 p.m.

Saginaw

4300 Fashion Square Blvd., Saginaw 48603
One-quarter mile south of the Fashion Square Mall
Open from 8:30 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.

Additional Referral Services for Older Adults

The following referral services are also available to you:

The Michigan Medicare/Medicaid Assistance Program (MMAP) and State Long-Term Care Ombudsman Project

MMAP offers assistance in understanding Medicare, Medicaid, supplemental and long-term care insurance. Trained volunteers provide education and counseling sessions. For more information about MMAP, call:

BCBSM's Senior Help Line 1-800-327-9148

from 9:00 am to 4:30 pm, Monday through Friday

To Visit
(continued)

The State Long-Term Care Ombudsman Project offers information about long-term care options and services from a local Long-Term Care Ombudsman Office. Questions about your rights, financing, admittance procedures and more can be answered. Call **BCBSM's Senior Help Line** for the phone number of the office nearest you.

The Legal Hotline for Older Michiganians

This statewide program offers residents, age 60 and older, access to experienced attorneys. Hotline attorneys offer consultation, legal advice and limited legal service at no charge. Referrals are made in cases where additional legal services are needed. Call:

1-800-347-LAWS (5297) throughout Michigan

or 372-5959 Lansing Area

Form No. 0738



Bureau Approved 07/09

IMPORTANT

KEEP THIS RIDER WITH YOUR CERTIFICATE

RIDER TBHD TEMPORARY BENEFITS FOR HOSPITAL SERVICES

AMENDS

**ALL BCBSM GROUP, NONGROUP AND GROUP CONVERSION
CERTIFICATES
(Excluding MESSA, Dental Care, Vision Care, Prescription Drug Program
and Medicare Supplemental Certificates)**

Rider TBHD amends the certificates named above to add temporary benefits for designated services, emergency care, travel and lodging. It also provides an expiration date for these benefits.

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



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

Your certificate is amended as follows:

SECTION 1: Definitions

Accidental Injury

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

- Strains, sprains, cuts and bruises
- Allergic reactions caused by an outside force such as a bee sting or another insect bite
- Burns, frostbite, sunburn, sunstroke
- Swallowing poison
- Drug overdosing
- Inhaling smoke, carbon monoxide or fumes
- Attempted suicide

Contracted Area Hospital

A BCBSM participating or panel hospital located in the same area as a noncontracted area hospital.

Designated Services

Services that BCBSM determines only a noncontracted area hospital is equipped to provide.

Emergency Care

Care to treat an accidental injury or medical emergency.

Medical Emergency

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

Noncontracted Area Hospital

A BCBSM nonparticipating and nonpanel hospital located in an area defined by BCBSM.

Definitions (continued)

Nonpanel Providers

Hospitals, physicians and other licensed facilities or health care professionals who have not signed an agreement to provide services under our PPO program.

Nonparticipating Hospital

A hospital that has not signed a participation agreement with BCBSM to accept our approved amount as payment in full.

Out-of-area Hospital

A BCBSM panel or participating hospital that is more than 75 miles from a noncontracted area hospital. It is not in the same area as a contracted or noncontracted area hospital.

Panel Providers

Hospitals, physicians and other licensed facilities or health care professionals who have signed an agreement to provide services under our PPO program. Panel providers have agreed to accept our approved amount as payment in full for covered services.

Participating Hospital

A hospital that has signed a participation agreement with BCBSM to accept our approved amount as payment in full. Copayments or deductibles, which may be required of you, are subtracted from the approved amount before we make our payment.

Preapproval

A process that allows you or your provider to know if we will cover proposed services before you receive them. If preapproval is not obtained **before** you receive certain services described in this rider, they will not be covered.

SECTION 2: Mandatory Preapproval

Preapproval of the services described in this rider (except emergency care or ambulance services) must be obtained from BCBSM before we will consider them for payment. If the required approval is not obtained, you must pay for these services.

Our customer service representatives can provide you and your physician with the telephone number to call for preapproval (see the "How to Reach Us" section of your certificate). If the request for preapproval relates to a bone marrow or organ transplant, please ask your customer service representative for the telephone number of the Human Organ Transplant Program.

Mandatory Preapproval (continued)

NOTE: Preapproval of services is not a guarantee that a claim for them will be paid. All claims are subject to a review of the reported diagnosis, medical necessity verification, the availability of benefits at the time the claim is processed as well as the requirements, conditions, limitations, exclusions, maximums, deductibles and copayments under your certificate.

Preapproval must be obtained as follows:

- Designated Services

Your physician must obtain preapproval for designated services by calling BCBSM. If preapproval is not obtained, the designated services you receive will not be covered and you will be responsible for the hospital's charges.

- Travel and Lodging

You must obtain preapproval for any travel and lodging expenses before they are incurred. If you do not obtain preapproval, travel and lodging will not be covered and you will be responsible for these costs. Please call BCBSM to obtain preapproval.

SECTION 3: Payable Services

• Designated Services and Emergency Care

Coverage Requirements

We will pay for designated services and emergency care (as defined in Section 1) that you receive from a noncontracted area hospital when all of the following criteria are met:

- The services are medically necessary and would be covered if the noncontracted area hospital was a BCBSM panel or participating hospital
- The designated services are preapproved, as described in Section 2
- The noncontracted area hospital is within 75 miles of your primary residence (this applies only to designated services)

Payable Services (continued)

• **Designated Services and Emergency Care** (continued)

Payment for Designated Services and Emergency Care

When the above criteria are met, we will pay the subscriber as follows:

- Designated Services

We will pay our approved amount, less any deductibles and copayments required under your certificate. Our approved amount may be less than the hospital's bill. You are required to pay the difference.

- Emergency Care

We will pay our approved amount rather than the rate for emergency care specified in your certificate. You are responsible for any deductibles and copayments required under your certificate. Our approved amount may be less than the hospital's bill. You are required to pay the difference.

NOTE: If you have BCBSM PPO coverage, we will waive the deductibles and copayments that apply to nonpanel services. However, you will still be required to pay any deductibles or copayments applicable to panel services.

Transport from a Noncontracted Area Hospital

If you are receiving designated services or emergency care and your physician determines you are medically stable, you may choose to be transferred from the noncontracted area hospital to the nearest participating or panel hospital equipped to treat your condition. We will pay our approved amount for your one-way ambulance transport to that hospital.

If you use a nonparticipating ambulance for your transport, its bill may be more than our approved amount. You are required to pay the difference.

NOTE: If you transfer to a participating, nonpanel hospital and have BCBSM PPO coverage, we will waive the deductibles and copayments that apply to nonpanel services. However, you will still be required to pay any deductibles or copayments applicable to panel services.

Payable Services (continued)

Transport from a Noncontracted Area Hospital (continued)

BCBSM certificates provide only limited coverage for emergency services at nonparticipating hospitals and no coverage for nonemergency admissions. If you choose to remain in the noncontracted area hospital, payment for your continued stay will be limited to the amount we pay nonparticipating hospitals, as described in your certificate.

Limitations and Exclusions

- If you go to a noncontracted area hospital and receive services that we determine are not designated services, our payment will be limited to the amount we pay nonparticipating hospitals, as described in your certificate. The balance you owe may be substantial since we do not pay for nonemergency services in a nonparticipating hospital.
 - We will not pay for designated services that were not preapproved, as described in Section 2.
 - Ambulance transport services are payable under this rider only if related to an admission covered under this rider. However, if your certificate covers nonemergency transports, you will be responsible for any deductibles or copayments required under your certificate.
- **Travel and Lodging**

If you need to obtain services at an out-of-area hospital, we will pay for the cost of travel and lodging if all of the following are met:

- You live within 75 miles of the noncontracted area hospital
- You cannot reasonably obtain covered services from a contracted area hospital or other participating provider within 75 miles of the noncontracted area hospital and your physician directs you to an out-of-area hospital, and
- You obtain services from the out-of-area BCBSM panel or participating hospital that is closest to the noncontracted area hospital.

Payable Services (continued)

• **Travel and Lodging** (continued)

Payment will be subject to the following provisions:

Inpatient Services

If you require inpatient services from an out-of-area hospital, we will pay up to \$250 per day for the reasonable and necessary cost of travel and lodging up to a maximum of \$5,000 per admission. These maximums apply to the combined expenses for you and the person(s) eligible to accompany you. Our payment will be the lesser of your actual expenses or the \$250 or \$5,000 maximums.

Coverage will begin on the day before your admission and end on your date of discharge. We will pay for the following:

- Travel for you and another person (two persons if the patient is a child under the age of 18) to and from the out-of-area hospital
- Lodging for the person(s) eligible to accompany you

Outpatient Services

If you require outpatient services from an out-of-area hospital or from a physician, we will pay up to \$125 for travel and lodging each time you require these services. Physician services must be directly related to an admission to an out-of-area hospital.

Limitations and Exclusions

- We do not pay for travel and lodging that were not preapproved, as described in Section 2.
- Travel and lodging will be paid only after you submit your original receipts to us.
- Travel does not include an ambulance transport to an out-of-area hospital.

Payable Services (continued)

Limitations and Exclusions (continued)

- We do not pay for travel and lodging beyond the maximums stated above.
- We will not pay for items that we do not consider directly related to travel and lodging, such as: dry cleaning, clothing, laundry services, kennel fees, car maintenance, toiletries, security deposits, toys, household products, alcoholic beverages, flowers, greeting cards, stationery, stamps, household utilities (including cellular telephones), maids, babysitters or daycare services and entertainment such as cable television, books, magazines, movie rentals or charges for hospital services that are not covered (telephone, television, private room).
- Deductibles or copayments required under your certificate will not apply to travel and lodging. However, if you are enrolled in a BCBSM HSA benefit plan, the annual deductible requirement will be imposed for travel and lodging.

Section 4: When Benefits End

The benefits covered under this rider are temporary. They will end six months from the date a noncontracted hospital terminated its participating contract with BCBSM.

GENERAL

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

BLUE CROSS BLUE SHIELD OF MICHIGAN

**Daniel J. Loepf
President and Chief Executive Officer**

Form No. 1700



Bureau Approved 04/11

IMPORTANT

KEEP THIS RIDER WITH YOUR CERTIFICATE

RIDER GCP-D GROUP COMPLIMENTARY INPATIENT DAYS

AMENDS

**GROUP MEDICARE PART A COMPLEMENTARY BENEFIT
CERTIFICATE 2017**

Rider GCP-D amends the certificate above to increase the number of inpatient hospital days.

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



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

Your certificate is amended as follows:

The following language is added to the “Additional Days of Inpatient Hospital Care” section of your certificate:

We pay for up to 275 additional days of inpatient care.

NOTE: For groups that are not required to comply with the Mental Health Parity Act, the 275 days of inpatient care includes 30 days of care for nervous/mental conditions.

For groups that are required to comply with the Mental Health Parity Act, the 30-day limit for nervous/mental conditions does not apply.

These days are renewed when you have not received services from a hospital or skilled nursing facility for 60 days in a row.

GENERAL

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

BLUE CROSS BLUE SHIELD OF MICHIGAN

Daniel J. Loepf
President and Chief Executive Officer



**GROUP MEDICARE PART A
COMPLEMENTARY BENEFIT
CERTIFICATE**

Dear Subscriber:

We are pleased you have selected Blue Cross Blue Shield of Michigan for your health care coverage. Your coverage provides many benefits for you and your eligible dependents. These benefits are described in this book, which is your **certificate**.

Your certificate, your signed application and your BCBSM identification card are your **contract** with us.

You may also have **riders**. Riders make changes to your certificate and are an important part of your coverage. When you receive riders, keep them with this book.

This certificate will help you understand your benefits and each of our responsibilities **before** you require services. Please read it carefully. If you have any questions about your coverage, call us at one of the customer service telephone numbers listed in the "How to Reach Us" section of this book.

Thank you for choosing Blue Cross Blue Shield of Michigan. We are dedicated to giving you the finest service and look forward to serving you for many years.

Sincerely,

A handwritten signature in black ink, appearing to read "Dan Loepf". The signature is written in a cursive style with a large initial "D".

Daniel J. Loepf
President and Chief Executive Officer
Blue Cross Blue Shield of Michigan

About Your Certificate

This certificate is arranged to help you locate information easily. You will find:

- A **Table of Contents** for quick reference
- **Information About Your Contract**
- **Medicare Complementary Coverage**
- **How Services Are Paid**
- **General Conditions of Your Contract**
- **The Language of Health Care** - explanations of the terms used in your certificate
- **How to Reach Us** - a list of Customer Service Center telephone numbers and addresses

This certificate refers to you as the **subscriber** because the contract is in your name.

The term **patient** refers to either you or one of your dependents who is enrolled in Medicare Part A or Medicare Part A and Part B when services are received. Your eligible dependents are those listed on your application.

Medicare Part A pays the costs for most of your inpatient hospital services and Medicare Part B pays for hospital outpatient services and medical services, but it will not pay for all of them. Blue Cross Blue Shield of Michigan's (BCBSM) Medicare Complementary Coverage helps pay some of the costs Medicare does not pay. This plan will also extend benefits beyond those Medicare offers to you and your eligible dependents.

We hope this certificate provides you with the information you need to get the most from your BCBSM Medicare Complementary Coverage. Please call us if you have any questions.

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Section 1: Information About Your Contract

This section provides answers to general questions you may have about your contract. Topics include:

ELIGIBILITY

- Who is Eligible for Medicare Complementary Coverage?

CONTRACT DATES

- When Your Coverage is Effective

CANCELLATION

- How to Cancel Coverage
- Automatic Cancellation

GROUP CONVERSION COVERAGE

ELIGIBILITY

Who is Eligible for Medicare Complementary Coverage?

You, your spouse (this does not include the person who marries a member who has coverage as a surviving spouse) and your eligible dependents listed on your application and who are enrolled in Medicare Part A or Medicare Part A and Part B are eligible for Complementary coverage. 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.

CONTRACT DATES

When Your Coverage is Effective

The effective date of your coverage is printed on your identification card. If you add names of eligible persons to your contract after this date, we will tell you when their coverage begins.

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.

If you are no longer eligible for Medicare coverage, you must change to the group contract for non-Medicare employees.

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 requested date. All benefits under this certificate will end.

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 are paying BCBSM back under a voluntary agreement between you and BCBSM.

CANCELLATION

Automatic Cancellation (continued)

- You no longer qualify as a dependent.
- You become ineligible for Medicare.

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.

GROUP CONVERSION COVERAGE

If you become ineligible for coverage under this contract, you may be eligible for an approved individual Medicare Supplemental Plan.

You or your eligible dependents must submit a written request for your choice of coverage within 30 days of the date your group coverage was canceled.

Section 2: Medicare Complementary Coverage

If you have only Medicare Part A, we pay the deductible and coinsurance related to any inpatient hospital services. If you have Medicare Part A and Part B, then we pay the deductible and coinsurance related to any inpatient hospital services and services provided on an inpatient or outpatient basis by a Medicare hospital, Medicare skilled nursing facility or Medicare home health agency.

Medicare Part A Inpatient Hospital Coinsurance and Deductible

Medicare Part A helps pay for 90 inpatient hospital days in a benefit period, plus 60 lifetime reserve days. However, Medicare requires you to pay a deductible and coinsurance related to any inpatient hospital services. We pay the deductible for the:

- 1st to 60th day of care in any Medicare benefit period.

We pay the coinsurance for the:

- 61st to 90th day of care in any Medicare benefit period.
- 91st through 150th Medicare lifetime reserve days.

Additional Days of Inpatient Hospital Care

We pay for up to 30 additional days of reasonable and necessary inpatient care in a benefit period if you have used all of the inpatient hospital or long-term acute care hospital days covered by Medicare. These days are renewed when you have not received services from a hospital or skilled nursing facility for 60 days in a row.

We pay for inpatient hospital care that is covered by Medicare.

Nursery Care

We pay for newborn nursery care during the mother's stay in a participating hospital for covered maternity care.

Emergency Services Outside the United States

Medicare generally does not pay for care received outside the United States. However, under certain conditions, we pay for services even though Medicare does not pay for them.

We pay for emergency services when you are hospitalized in an accredited hospital outside the United States. Our payment is limited to 30 days of inpatient care per benefit period, when the following conditions are met:

Emergency Services Outside the United States
(continued)

- Your condition or the circumstances under which you are admitted qualifies for Medicare coverage. That is, Medicare would have paid for covered services if you had been in a Medicare participating hospital;
- You are admitted under the rules of the hospital;
- You use the services and supplies while you are in the hospital;
- You need continuous acute care under the constant supervision of physician and registered nurses;
- Services are ordered by a physician and furnished and billed by the hospital.

Medicare Part B Coinsurance and Deductible

We pay the Medicare deductible and coinsurance for services provided on an inpatient or outpatient basis by a Medicare hospital, Medicare skilled nursing facility or Medicare home health agency. Such services include:

- Purchase or rental of durable medical equipment
- Outpatient physical therapy and speech therapy services provided in a Medicare-approved facility.

Skilled Nursing Facility Care

Medicare Part A pays for care in a Medicare-approved skilled nursing facility for up to 100 days in a benefit period. Medicare requires you to pay coinsurance for the 21st through the 100th day of care.

We pay the coinsurance if Medicare covers the skilled nursing facility stay.

Hospital Services Which are Not Payable

Some services provided in the hospital are not covered under your hospital care coverage. They are listed below.

Please note, however, that some of the following services may be included in your Medicare Part B and the BCBSM Part B Complementary coverages.

- Services of physicians and surgeons not employed by the hospital
- Services of private duty nurses

Section 2: Medicare Complementary Coverage

Hospital Services Which are Not Payable (continued)

- Whole blood or packed red blood cells
- Ambulance services
- Prosthetic and other appliances
- Services provided by employer facilities
- Services you receive after your contract ends. However, we do continue to pay for inpatient services in a hospital or skilled nursing facility during an admission that begins before the date your coverage ends.
- Services you receive if your admission begins before your coverage under this contract is effective
- Services that you could get free if you did not have health care coverage
- Dental services in connection with the care, treatment, filling, removal or replacement of teeth or structures directly supporting teeth
- Care and services received under another certificate offered by us or another Blue Cross Plan
- Care that is not reasonable and necessary under Medicare program standards
- Drugs or devices not approved by the Food and Drug Administration (FDA)
- Services performed by immediate relatives or members of your household
- Cosmetic surgery primarily to improve appearance. However, we will pay when:
 - It is to improve the functions of a malformed part of the body;
 - It is related to an accidental injury that happens while you are covered under this contract.

**Hospital
Services Which
are Not Payable**
(continued)

- Care which cannot be considered acute, such as:
 - Observation
 - Dental treatment, including extraction of teeth, unless otherwise noted in this certificate
 - Diagnostic evaluation
 - Physical therapy, speech and occupational therapy
 - X-ray exams
 - Lab exams
 - Electrocardiography (EKG)
 - Basal metabolism tests
 - Weight reduction
 - Convalescence or rest
 - Custodial Care
 - Convenience

Section 3: How Services Are Paid

Payment for Medicare Coinsurance and Deductible

We pay the coinsurance and deductible required by Medicare. Our payments are based on Medicare's approved amount for covered services.

When your provider sends us a claim, it must show the following:

- Your contract number,
- Type and date of service, and
- The diagnosis.

The provider may be required to verify services were provided.

If your provider does not send us a claim, you may send us a copy of the "Explanation of Medicare Benefits" form you receive from Medicare.

If Medicare sends its payment to the provider, then we will also send our payment to the provider. However, if Medicare sends its payment to you, we will also send our payment to you.

Payment for Additional Inpatient Hospital or Long-Term Acute Care Hospital Days

Medicare Participating Hospital

When you use additional days of inpatient care in a **Medicare participating hospital**:

- The hospital sends the bill to us.
- The hospital accepts our payment as payment in full for covered services. Even if the hospital's charge for a covered service is more than our payment, you will not have to pay the difference.
- You do not have to pay for services covered by your certificate as long as they are medically necessary, as defined by Medicare.

**Payment for
Additional
Inpatient
Hospital or
Long-Term
Acute Care
Hospital Days
(continued)**

Long-Term Acute Care Hospital

The services listed under “Medicare Participating Hospital” may also be payable when provided in a long-term acute care hospital, or LTACH.

The services are payable only if the following conditions are met:

- The provider must request and receive preapproval for inpatient services.
- The long-term acute care hospital must be located in Michigan and participate with BCBSM, except under extenuating circumstances as determined by BCBSM.

Long-term acute care hospital services count toward any benefit maximums that apply to inpatient hospital services.

We do not pay for:

- Services in a nonparticipating long-term acute care hospital including emergency services, unless there are extenuating circumstances as determined by BCBSM.
- Inpatient admissions that BCBSM has not preapproved
- Services if the patient’s primary diagnosis is a mental health or substance abuse condition

Nonparticipating Hospital

If you go to a **nonparticipating hospital**, we will pay:

- Up to \$70.00 per day for your stay in an accredited general acute-care facility.
- Up to \$15.00 per day for your stay in an accredited specialty hospital, such as a psychiatric hospital.

If the hospital is located in an area where there is no Blue Cross and Blue Shield plan, we will pay the hospital's regular charges.

**Payment for
Emergency
Services
Outside the
United States**

We will pay the charges for emergency services you receive in an accredited hospital located outside the United States. You will usually be asked to pay the bill at the time care is provided. You should get an itemized receipt. When you return to the United States, send the receipt to us. We will pay you for covered services.

**Out-of-Area
Services**

BCBSM has a variety of relationships with other Blue Cross and/or Blue Shield plans referred to generally as “Inter-Plan Programs.” When you obtain services outside of our service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated national account arrangements available between BCBSM and other Blue Cross and Blue Shield plans.

**BlueCard
Program**

Under Medicare Supplemental plans, when you receive treatment from a provider that participates with the Host Plan and accepts Medicare assignment, the amount you pay for services otherwise covered by the federal Medicare Program will be calculated based on the Medicare allowable amount. If the provider does not accept Medicare assignment, you may be liable for the difference between the amount that the provider bills and the Medicare limiting charge, which will include the payment we will make for the covered services as set forth in your contract.

If you have additional benefits for services which Medicare would not otherwise cover, the amount you pay for such services when received from a participating provider will be calculated based on the negotiated price/lower of either billed charges or negotiated price made available to us by the Host Plan.

Nonparticipating Providers Outside Our Service Area

Under Medicare Supplemental plans, when you receive treatment from a provider that does not participate with the Host Plan, but does accept Medicare assignment, the amount you pay for services otherwise covered by the federal Medicare Program will be calculated based on the Medicare allowable amount. If the provider does not accept Medicare assignment, you may be liable for the difference between the amount that the provider bills and the Medicare limiting charge, which will include the payment we will make for the covered services as set forth in this paragraph.

**BlueCard
Program**
(continued)

If you have additional benefits for services which Medicare would not otherwise cover, the amount you pay for such services provided by a provider not participating with the Host Plan will be calculated based on either the Host Plan's nonparticipating provider local payment, or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment we will make for the covered services as set forth in this paragraph.

**Negotiated
(non-BlueCard
Program)
National
Account
Arrangements**

As an alternative to the BlueCard Program, your claims for covered services may be processed through a negotiated national account arrangement with a Host Plan.

The amount you pay for covered services under this arrangement will be calculated based on the negotiated price or lower of either the billed charges or negotiated price made available to us by the Host Plan.

Section 4: General Conditions Of Your Contract

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

Additional Costs for Hospital Room

BCBSM will not pay the difference between the cost of hospital rooms covered by your certificate and more expensive rooms.

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 available in a hospital maintained by the state or federal government, unless payment is required by law
- 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.

Section 4: General Conditions of Your Contract

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 Services.**
- We may add, limit, delete or clarify benefits by issuing a rider. Keep any riders you receive with this certificate.

Changing Your Coverage You may sign up for other coverage if you become ineligible for coverage under this contract. The effective date will be determined by us.

Coordination of Benefits (COB) 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 for Drugs and Devices We do not pay for any drug or device prescribed for uses or in dosages other than those specifically approved by the federal Food and Drug Administration. (This is often referred to as the off-label use of a drug or device.) However, we will pay for such drugs and the reasonable cost of supplies needed to administer them, if the prescribing MD or DO can substantiate that the drug is recognized for treatment of the condition for which it is prescribed by one of the following:

- The American Hospital Formulary Service Drug Information
- The United States Pharmacopoeia Dispensing Information, Volume 1, “Drug Information for the Health Care Professional”

Section 4: General Conditions of Your Contract

Coverage for Drugs and Devices (continued)

- Two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.

NOTE: Chemotherapeutic drugs are not subject to this general condition.

Coverage Under Previous Contracts

This certificate replaces any previous contracts you had with us.

Deductibles and Copayments Paid Under Other Certificates

We do not pay deductibles or copayments that you were required to pay under any other certificate.

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

Section 4: General Conditions of Your Contract

Experimental Treatment (continued)

- 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

Section 4: General Conditions of Your Contract

Experimental Treatment (continued)

- 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.

Section 4: General Conditions of Your Contract

Experimental Treatment (continued)

- 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 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
- Refuse to cover your health 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 health 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.

Section 4: General Conditions of Your Contract

Other Coverage (continued)

- 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.

Payment of Covered Services

The covered services described in this certificate, such as multiple surgeries or a series of services such as laboratory tests, are combined and paid according to payment policies adopted by BCBSM.

Personal Costs

We will not pay for:

- Transportation and travel, even if prescribed by a physician.
- Care, services, supplies or devices that are personal or convenience items.
- Charges to complete claim forms.
- Domestic help

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 refund up to a maximum of two years of payments.

Section 4: General Conditions of Your Contract

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.

Time Limit for Legal Action

Legal action against us may not begin later than two years after we have received a completed 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 health 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 5: The Language of Health Care

This section explains the terms used in your certificate. The terms are listed in alphabetical order.

Accidental Injury

Any physical damage caused by an action, object or substance outside the body. This may include:

- Strains, sprains, cuts and bruises
- Allergic reactions caused by an outside force such as a bee sting or another insect bite
- Burns, frostbite, sunburn, sunstroke
- Poisoning
- Drug overdosing
- Inhaling smoke, carbon monoxide or fumes
- Attempted suicide

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.

Approved Amount

The lower of the billed charge or our maximum payment level for the covered service. The approved amount applies to services covered by BCBSM and not Medicare.

BCBSM

Blue Cross Blue Shield of Michigan.

Benefit Period

A period of consecutive days that begins with the first day on which a patient receives covered inpatient hospital or skilled care services. A benefit period ends when the patient has not received such services for 60 days in a row.

BlueCard® Participating Provider

A provider who participates with the Host Plan.

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.

Certificate	This book, which describes your benefit plan, and any riders that amend this certificate.
Claim for Damages	A lawsuit against, or demand to, another person or organization for compensation for an injury to a person.
Coinsurance	A part of the Medicare approved amount Medicare requires you to pay after you have met your deductible. (We pay this amount for you.)
Contract	This certificate and any related riders, your signed application for coverage and your BCBSM ID card.
Covered Services	The services, treatments or supplies identified as payable in this certificate.
Custodial Care	Care primarily used in helping the patient with activities of daily living or meeting personal needs. Such care includes help in walking, getting in and out of bed, bathing, dressing and taking medicine. Custodial care can be provided safely and reasonably by people without professional skills or training.
Deductible	The amount Medicare requires of you before benefits are paid.
Durable Medical Equipment	Equipment which can withstand repeated use and which is used mainly for a medical purpose by a patient who is ill or injured. It may be used in the home.
Effective Date	The date your coverage begins under this contract. This date is established by BCBSM.
Emergency Care	Care needed immediately because of an injury or an illness which occurred suddenly and unexpectedly.
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 "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

**Food and Drug
Administration
(FDA)**

An agency within the U.S. Department of Health and Human Services that is responsible for protecting the public health by assuring the safety, efficacy and security of human drugs.

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.

Hospital

A facility that:

- Provides inpatient diagnostic, therapeutic and surgical services for injured or acutely ill persons on a 24-hour per day basis **and**
 - Facilities that provide custodial, convalescent, pulmonary tuberculosis, rest or domiciliary care
 - Facilities that serve as institutions for exceptional children or for the treatment of the aged or of substance abusers
 - Skilled nursing facilities or other nursing care facilities

Host Plan	A Blue Cross and/or Blue Shield Plan outside of Michigan that participates in the BlueCard Program and processes claims for services that you receive in that state.
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.
Lifetime Reserve Days	An extra 60 inpatient hospital days covered by Medicare, which cannot be renewed.
Long-Term Acute Care Hospital (LTACH)	A specialty hospital that focuses on treating patients requiring extended intensive care; meets BCBSM qualification standards and is certified by Medicare as an LTACH.
Medicare	The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.
Medicare Approved Amount	The portion of the provider's charge approved by Medicare as payable. The charge includes the Medicare Part A or Medicare Part B payment level and deductible and/or coinsurance amounts.
Medicare Home Health Agency	A home health care agency which has a contract with the federal government to provide care to patients enrolled in the Medicare Program, and to accept Medicare's approved amount as payment in full for covered services.
Medicare Participating Hospital	A hospital which has a contract with the federal government to provide care to patients enrolled in the Medicare Program, and to accept Medicare's approved amount as payment in full for covered services.
Medicare Skilled Nursing Facility	A skilled nursing facility which has a contract with the federal government to provide care to patients enrolled in the Medicare Program. The facility agrees to accept Medicare's approved amount as payment in full.
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 Hospital	Any hospital, which <u>has not</u> signed a participation agreement with BCBSM agreeing to accept the approved amount as payment in full.
Out-of-Area Services	Services available to members living or traveling outside a health plan's service area.
Participating Hospital	A hospital which <u>has</u> signed an agreement with BCBSM to accept the approved amount for covered services as payment in full.
Patient	The subscriber or eligible dependent who is awaiting or receiving medical care and treatment.
Physical Therapy	<p>The use of specific activities or methods to treat disability when there is a loss of neuromusculoskeletal functions due to an illness or injury, or following surgery. Treatments include exercise and therapy of the patient's specific muscles or joints to restore or improve:</p> <ul style="list-style-type: none">• Muscle strength• Joint motion• Coordination• General mobility
Physician	A doctor of medicine, osteopathy, podiatry, chiropractic or an oral surgeon. 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, osteopathy, podiatry, chiropractic) or a professional provider (a doctor of medicine, osteopathy, podiatrist, chiropractor, fully licensed psychologist or oral surgeon) 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.

Private Duty Nurse A registered or licensed practical nurse who does not belong to a hospital staff but is prepared to care for an individual patient and is employed directly by the patient or his/her representative for complete personal attention during an eight-hour shift.

Professional Provider One of the following:

- Doctor of Medicine
- Doctor of Osteopathy
- Podiatrist
- Chiropractor
- Fully licensed psychologist
- Oral surgeon
- Other providers as identified by BCBSM

Professional providers may also be referred to as “practitioners.”

Prosthetic Appliance An artificial device which:

- Replaces all or part of a body part, or
- Replaces all or part of the functions of a permanently disabled or poorly functioning body organ.

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

Reasonable and Necessary Services and items generally accepted by the professional medical community as necessary and suitable for treatment or diagnosis of a patient's illness or injury.

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 changes 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.
Service Area	The geographic area in which BCBSM is authorized to use the Blue Cross and Blue Shield name and service marks. NOTE: BCBSM may contract with providers in areas contiguous with the state of Michigan. These providers' claims will not be subject to BlueCard rules.
Services	Surgery, care, treatment, supplies, devices, drugs or equipment given by a health care provider to diagnose or treat a disease, injury, condition or pregnancy.
Speech Therapy	Active treatment of speech, language or voice impairment due to illness, injury or as a result of surgery. Speech therapy is part of the general physical therapy benefit.
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 the subscriber's contract.

Section 6: How To Reach Us

Your Local Customer Service Centers

This section lists phone numbers and addresses to help you get information quickly. You may call us or visit our centers, or visit our website at www.bcbsm.com.

To Call

Most of our customer service lines are open for calls between 8:30 a.m. and 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 1-800-637-2227

Area code 231, 269 or 616

West Michigan toll-free 1-800-972-9797

Area code 517 or 989

Central Michigan toll-free..... 1-800-258-8000

Area code 906

Marquette 1-906-228-9112
Upper Peninsula toll-free 1-800-562-7884

To Visit

BCBSM customer service centers are located throughout Michigan. Check the following list to find the center nearest you. Unless stated otherwise, the centers are open from 8:30 a.m. until 5 p.m., Monday through Friday.

Detroit

600 E. Lafayette Blvd., Detroit 48226
Downtown, three blocks north of Jefferson at St. Antoine

Flint

4520 Linden Creek Parkway, Suite A, Flint 48507

Grand Rapids

86 Monroe Center, N.W., Grand Rapids 49503
Open from 9 a.m. – 5 p.m.

To Visit
(continued)

Holland

151 Central Ave., Holland 49423
Open from 9 a.m.- 5 p.m.

Lansing

1403 Creyts Road, Lansing 48917
One-quarter mile south of I-496, Creyts Road exit

Marquette

415 S. McClellan Ave., Marquette 49855
Up on the hill

Portage

8175 Creekside Dr., Suite 100, Portage 49024
Open from 9 a.m. – 5 p.m

Southfield

27000 W. 11 Mile Road, Southfield 48034
East of Inkster Road on the first floor of Tower 300

Traverse City

1769 S. Garfield, Traverse City 49686
Across from Cherryland Center
Open from 9 a.m. – 5 p.m

Utica

6100 Auburn Road, Utica 48317
Diagonally across from the AAA building

Additional Referral Services for Older Adults

The following referral services are also available to you:

The Michigan Medicare/Medicaid Assistance Program (MMAP) and State Long-Term Care Ombudsman Project

MMAP offers assistance in understanding Medicare, Medicaid, supplemental and long-term care insurance. Trained volunteers provide education and counseling sessions. For more information about MMAP, call:

BCBSM's Senior Help Line 1-800-327-9148

from 9:00 a.m. to 4:30 p.m., Monday through Friday

The State Long-Term Care Ombudsman Project offers information about long-term care options and services from a local Long-Term Care Ombudsman Office. Questions about your rights, financing, admittance procedures and more can be answered. Call **BCBSM's Senior Help Line** for the phone number of the office nearest you.

The Legal Hotline for Older Michiganians

This statewide program offers residents, age 60 and older, access to experienced attorneys. Hotline attorneys offer consultation, legal advice and limited legal service at no charge. Referrals are made in cases where additional legal services are needed. Call:

1-800-347-LAWS (5297) throughout Michigan

or 372-5959 Lansing Area

Form No. 2017



Bureau Approved 08/10

IMPORTANT

KEEP THIS RIDER WITH YOUR CERTIFICATE

RIDER GPC-SAT-II SUBSTANCE ABUSE TREATMENT PROGRAM BENEFITS

AMENDS

**GROUP MEDICARE PART A COMPLEMENTARY
BENEFIT CERTIFICATE
2017**

**BLUE SHIELD-65 G-I
CERTIFICATE
0738**

**BLUE SHIELD-65 G-II
CERTIFICATE
0800**

**BLUE SHIELD-65 G-IV
CERTIFICATE
0863**

Rider GPC-SAT-II amends the above-referenced certificates by adding benefits for intermediate and outpatient care of substance abuse in approved residential and outpatient substance abuse treatment programs.

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



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

Your certificate is amended as follows:

SECTION ONE - DEFINITIONS

Substance Abuse Treatment Program Services

Subacute services to restore a person's mental and physical well-being when the person is a substance abuser. Services must be provided and billed by an approved residential or outpatient substance abuse treatment program.

Approved Substance Abuse Treatment Program

A residential or outpatient program that provides medical or other services for substance abusers. It must meet all state licensure and BCBSM approval requirements, and have entered into an agreement with BCBSM to provide those services.

Outpatient Substance Abuse Treatment Program

A program that provides medical and other services on an outpatient basis specifically for drug or alcohol abusers on an outpatient basis.

Residential Substance Abuse Treatment Program

A program that provides medical and other services specifically for substance abusers in a facility which operates 24 hours a day, seven days a week. Treatment in a residential program is sometimes called "intermediate care."

Substance Abuse

Taking alcohol or other drugs in amounts that can:

- Harm a person's physical, mental, social and economic well-being
- Taking enough alcohol or drugs to cause the person to lose self-control
- While being habitually under its influence, endangering the safety or welfare of others

Substance abuse is alcohol or drug abuse or dependence as classified in categories 303.0-305.9 of the most current edition of the "International Classification of Diseases."

YOU and **YOUR** is each person covered under your contract.

SECTION TWO – FACILITY SERVICES BENEFITS

Your Blue Cross Complementary Group Benefit Certificate pays Medicare Part A deductible and coinsurance amounts when Medicare pays for inpatient substance abuse treatment. This rider adds benefits for Approved Substance Abuse Treatment Program Services when Medicare does not pay for this type of treatment. This section describes your Substance Abuse Treatment Program benefits.

Special Requirements for Eligibility

You are eligible to receive benefits for services in an Approved Substance Abuse Treatment Program only if:

- You enter a program on or after the effective date of this rider
- Your physician assigns a diagnosis of substance abuse and certifies the appropriate level of care (residential or outpatient) you require
- Your physician provides the initial physical examination, provides and supervises personal care during detoxification and follow-up care during your rehabilitation
- You have benefits remaining for Substance Abuse Treatment Services
- The services you receive are medically necessary for proper care and treatment

Covered Services

When you enter an Approved Residential Substance Abuse Treatment Program, your benefits will include the following services when provided and billed by the program:

- Bed and board, including general nursing services
- Laboratory examinations related to the treatment received in the program
- Drugs, biologicals and solutions related to the treatment received in the program and used in the facility
- Supplies and use of equipment for detoxification or rehabilitation

Covered Services (continued)

- All professional, other trained staff and facility services necessary for patient care and treatment, including diagnostic examinations
- Individual and group therapy or counseling
- Psychological testing
- Counseling for family members

When you enter an Approved Outpatient Substance Abuse Treatment Program, your benefits will include the following services when provided and billed by the program:

- All professional, other trained staff, and program services necessary for the treatment of ambulatory patients, including diagnostic examinations
- Individual and group therapy or counseling
- Counseling for family members
- Laboratory examinations related to the treatment received in the program
- Drugs, biologicals and solutions related to the treatment received in the program including drugs to be taken home
- Psychological testing
- Supplies and use of equipment needed for detoxification or rehabilitation

Benefit Limits

Benefits for Approved Residential Substance Abuse Treatment Program services are limited to 30-days per benefit period.

- A new benefit period begins when there are at least 60 continuous days between the date of your discharge from a hospital (or another facility to which the benefit period applies) and your next admission. This sixty-day benefit renewal period is required whether or not benefits were provided for your last admission.

Benefit Limits (continued)

There is no annual benefit limit for covered treatment performed in an Approved Outpatient Substance Abuse Treatment Program.

Limitations and Exclusions

- Benefits do not include services provided primarily in connection with diagnoses other than substance abuse.
- Benefits do not include dispensing methadone or testing urine specimens, unless therapy, counseling or psychological testing is provided while in the program.
- Benefits do not include diversional therapy.
- Benefits are provided only for the period necessary for your proper care and treatment.
- Benefits are not provided for residential substance abuse services for admissions which began before the effective date of this rider.
- Benefits are not provided for services after the date your coverage under this rider ends. However, benefits will continue for Residential Substance Abuse Treatment Facility Services for an inpatient admission that began before the date coverage under this rider ends.

SECTION THREE – PHYSICIAN SERVICES BENEFITS

Your certificate (either the Blue Sheild-65 G-I, G-II or G-IV certificate listed at the beginning of this rider) is amended by adding benefits for medical care by a physician for treatment of substance abuse.

Covered Services

- Benefits are provided for medical care by a physician for treatment of substance abuse in an Approved Residential Substance Abuse Treatment Program.

Covered Services (continued)

- While you are an inpatient in an Approved Residential Substance Abuse Treatment Program, and when requested by the physician in charge of the case, benefits are provided for the assistance of a consulting physician in the diagnosis or treatment of a condition which requires special skill or knowledge. This benefit does not include staff consultations required by a facility or program's rules.
- Professional services for outpatient treatment of substance abuse are considered outpatient psychiatric care. Benefits are payable for such care, less the amount paid or payable by Medicare.

Benefits Limits

Benefits for medical care in Residential Substance Abuse Treatment Programs are limited to 30 days.

- A new benefit period begins when there are at least 60 continuous days between the date of your discharge from a residential substance abuse treatment facility and your next admission. This sixty-day benefit renewal period is required whether or not benefits were provided for your last admission.

GENERAL

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

BLUE CROSS BLUE SHIELD OF MICHIGAN

**Daniel J. Loepp
President and Chief Executive Officer**

Form No. 4087



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

Bureau Approved 06/11

IMPORTANT

KEEP THIS RIDER WITH YOUR CERTIFICATE

RIDER BMT HEMATOPOIETIC TRANSPLANT

AMENDS

**ALL BCBSM GROUP, NONGROUP and
GROUP CONVERSION BENEFIT CERTIFICATES
(excluding Dental Care, Vision Care, and
Prescription Drug Program certificates)**

Rider BMT amends the certificates named above to clarify the conditions for which hematopoietic transplants and tandem transplants are payable.

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



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

Your certificate is amended as follows:

SECTION 1: Services That Are Payable

The description of bone marrow transplant benefits in your certificate is replaced with the following:

Bone Marrow Transplants

The services covered in your basic certificate(s) and rider(s) are payable when directly related to two tandem transplants, two single transplants or a single and a tandem transplant per member per condition as covered under this rider.

Services must be rendered in a facility participating with BCBSM.

We pay for the following services:

Allogeneic Transplants

- Blood tests on first degree relatives to evaluate them as donors (if the tests are not covered by their insurance)
 - Search of the National Bone Marrow Donor Program Registry for a donor. A search will begin only when the need for a donor is established and the transplant is preapproved.
 - Infusion of colony stimulating growth factors
 - Harvesting (including peripheral blood stem cell pheresis) and storage of the donor's bone marrow, peripheral blood stem cell and/or umbilical cord blood, if the donor is:
 - A first degree relative and matches at least four of the six important HLA genetic markers with the patient; or
 - Not a first degree relative but matches five of the six important HLA genetic markers with the patient. (In a case of sickle cell anemia (ss or sc) or beta-thalassemia, the donor must be an HLA-identical sibling.)
- NOTE:** Harvesting and storage will be covered if it is not covered by the donor's insurance, but only when the recipient of harvested material is a BCBSM member.
- High-dose chemotherapy and/or total body irradiation

SECTION 1: Services That Are Payable (continued)

Allogeneic Transplants (continued)

- Infusion of bone marrow, peripheral blood stem cells, and/or umbilical cord blood
- T cell depleted infusion
- Donor lymphocyte infusion
- Hospitalization

Autologous Transplants

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

NOTE: A tandem autologous transplant is covered only when it treats germ cell tumors of the testes or multiple myeloma. Refer to the definition of “Tandem Transplant” in the “Language of Health Care” section of this rider.

SECTION 2: Conditions for Which Transplants Are Payable

In addition to the following conditions, we will pay for services related to, or for high-dose chemotherapy, total body irradiation, and allogeneic or autologous transplants to treat conditions that are not experimental. This rider does not limit or preclude coverage of antineoplastic drugs when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.

Allogeneic transplants are covered to treat:

- Acute lymphocytic leukemia (high-risk, refractory or relapsed patients)

SECTION 2: Conditions for Which Transplants Are Payable (continued)

- Acute non-lymphocytic leukemia (high-risk, refractory or relapsed patients)
- Acute myelogenous leukemia (high-risk, refractory or relapsed patients)
- Aplastic anemia (acquired or congenital, e.g., Fanconi's anemia or Diamond-Black fan syndrome)
- Beta-thalassemia
- Chronic myeloid leukemia
- Hodgkin's disease (high-risk, refractory or relapsed patients)
- Myelodysplastic syndromes
- Neuroblastoma (stage III or IV)
- Non-Hodgkin's lymphoma (high-risk, refractory or relapsed patients)
- Osteopetrosis
- Severe combined immune deficiency disease
- Wiskott-Aldrich syndrome
- Sickle cell anemia (ss or sc)
- Myelofibrosis
- Multiple myeloma
- Primary amyloidosis (AL)
- Glanzmann thrombasthenia
- Paroxysmal nocturnal hemoglobinuria
- Kostmann's syndrome
- Leukocyte adhesion deficiencies
- X-linked lymphoproliferative syndrome
- Primary, secondary and unspecified thrombocytopenia (e.g., megakaryocytic thrombocytopenia)
- Mantle cell lymphoma
- Congenital leukocyte dysfunction syndromes
- Congenital pure red cell aplasia
- Chronic lymphocytic leukemia
- Mucopolysaccharidoses (e.g., Hunter's, Hurler's, Sanfilippo, Maroteaux-Lamy variants) in patients who are neurologically intact
- Mucopolysaccharidoses (e.g., Gaucher's disease, metachromatic leukodystrophy, globoid cell leukodystrophy, adrenoleukodystrophy) for patients who have failed conventional therapy (e.g., diet, enzyme replacement) and who are neurologically intact
- Renal cell CA
- Plasmacytomas

Autologous transplants are covered to treat:

- Acute lymphocytic leukemia (high-risk, refractory or relapsed patients)
- Acute non-lymphocytic leukemia (high-risk, refractory or relapsed patients)

SECTION 2: Conditions for Which Transplants Are Payable (continued)

- Germ cell tumors of ovary, testis, mediastinum, retroperitoneum
- Hodgkin's disease (high-risk, refractory or relapsed patients)
- Neuroblastoma (stage III or IV)
- Non-Hodgkin's lymphoma (high-risk, refractory or relapsed patients)
- Multiple myeloma
- Primitive neuroectodermal tumors
- Ewing's sarcoma
- Medulloblastoma
- Wilms' tumor
- Primary amyloidosis
- Rhabdomyosarcoma
- Mantle cell lymphoma

SECTION 3: Limitations and Exclusions

In addition to the limitations and exclusions listed in your certificate(s) and rider(s), we do not pay for:

- Services that are not medically necessary (see your certificate for the definition of medically necessary)
- Services rendered in a facility that does not participate with BCBSM
- Services provided by persons or entities that are not legally qualified or licensed to provide such services
- Services rendered to a transplant recipient who is not a BCBSM member
- Services rendered to a donor when the donor's health care coverage will pay for such services
- Services rendered to a donor when the transplant recipient is not a BCBSM member
- Expenses related to travel, meals or lodging for the donor or recipient
- Any services related to, or for, allogeneic transplants when the donor does not meet the HLA genetic marker matching requirements
- An autologous tandem transplant for any condition other than germ cell tumors of the testes or multiple myeloma

SECTION 3: Limitations and Exclusions (continued)

- An allogeneic tandem transplant
- Search of an international donor registry
- The routine harvesting and storage costs of bone marrow, peripheral blood stem cells or a newborn's umbilical cord blood if not intended for transplant within one year
- Experimental treatment
- Any other services or admissions related to any of the above named exclusions

NOTE: Services not covered under this rider may be covered in your certificates and other riders. Please refer to Rider GLE-1 for additional information.

The lifetime maximum, copayments and deductibles, if any, in your underlying certificate(s) apply to the services in this rider.

SECTION 4: "The Language of Health Care" section of your certificate is amended to add the following:

Allogeneic (Allogenic) Transplant

A procedure using another person's bone marrow, peripheral blood stem cells or umbilical cord blood to transplant into the patient. This includes syngeneic transplants.

Autologous Transplant

A procedure using the patient's own bone marrow or peripheral blood stem cells to transplant back into the patient.

Colony Stimulating Growth Factors

Factors that stimulate the multiplication of very young blood cells.

First Degree Relative

An immediate family member who is directly related to the patient: either a parent, sibling or child.

Hematopoietic Transplant

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

SECTION 4: “The Language of Health Care” section of your certificate is amended to add the following: (continued)

High-Dose Chemotherapy

A procedure in which patients are given cell destroying drugs in doses higher than those used in conventional therapy. Stem cell replacement is required after high dose chemotherapy is given.

High-Risk Patient

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

HLA Genetic Markers

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

Peripheral Blood Stem Cell Transplant

A procedure in which blood stem cells are obtained by pheresis and infused into the patient’s circulation.

Pheresis

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

Purging

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

Refractory Patient

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

Relapse

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

SECTION 4: “The Language of Health Care” section of your certificate is amended to add the following: (continued)

Services

Surgery, care, treatment, supplies, devices, drugs or equipment given by a health care provider to diagnose or treat a disease or condition.

Stem Cells

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

Syngeneic Transplant

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

Tandem Transplant

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

T Cell Depleted Infusion

A procedure in which T cells (immunocompetent lymphocytes) are eliminated from peripheral blood stem cells, bone marrow or umbilical cord blood.

Total Body Irradiation

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

GENERAL

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

BLUE CROSS BLUE SHIELD OF MICHIGAN

**Daniel J. Loepp
President and Chief Executive Officer**

Form No. 4398



Bureau Approved 10/07

IMPORTANT

KEEP THIS RIDER WITH YOUR CERTIFICATE

RIDER ECIP EXTENDED COVERAGE FOR INPATIENT PSYCHOLOGISTS' SERVICES

AMENDS

**ALL BCBSM GROUP, NONGROUP AND
GROUP CONVERSION BENEFIT CERTIFICATES
THAT PROVIDE MEDICAL-SURGICAL
COVERAGE**

Rider ECIP amends the certificates named above to clarify and extend coverage for inpatient mental health care when provided by fully licensed **psychologists who have hospital privileges**.

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



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

Your certificate is amended as follows:

SECTION 1: Definitions

Hospital privileges

Permission granted by a hospital to allow accredited professional providers on the hospital's medical staff to perform certain services at that hospital.

SECTION 2: What We Pay

Your current certificate limits **coverage for inpatient mental health care** services provided by a fully licensed psychologist to psychological testing performed *under the supervision of a physician*. We pay you or the supervising physician according to the guidelines described in your certificate.

This Rider ECIP adds coverage for the following inpatient services performed by fully licensed psychologists with hospital privileges:

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

NOTE: The assistance is required because of the special **skill/knowledge of the consulting psychologist**.

SECTION 3: How We Pay

Rider ECIP allows direct reimbursement to participating, fully licensed psychologists for covered services. When a participating fully licensed psychologist submits a claim for covered services, we pay the provider *directly*.

For services provided by a nonparticipating, fully licensed psychologist, you should expect to pay the provider and then submit a claim to us. If we approve the claim, we will send payment to you minus the difference between our approved amount and the charge of the nonparticipating provider.

NOTE: For members enrolled in PPO, we pay according to the **guidelines for panel and nonpanel providers described in your certificates. You are responsible for any deductible, copayments or out-of-panel sanctions that may be required.**

SECTION 4: Limitations and Exclusions

We do not pay benefits:

- **For staff consultations required by a facility or program's rules, or**
- Beyond the period required to evaluate or diagnose mental deficiency or retardation, or when the treatment is not likely to improve the patient's condition according to generally accepted professional standards.

The limitations and conditions placed on benefits for mental health care and inpatient consultations and, described in your certificate continue to apply to the coverage provided by Rider ECIP.

GENERAL

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

BLUE CROSS BLUE SHIELD OF MICHIGAN

**Daniel J. Loepp
President and Chief Executive Officer**

Form No. 5216



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

Bureau Approved 12/09

IMPORTANT

Keep This Rider With Your Certificate

RIDER SOCT SPECIFIED ONCOLOGY CLINICAL TRIALS

AMENDS

**ALL BCBSM GROUP, NONGROUP AND GROUP CONVERSION CERTIFICATES
(excluding Medicare Supplemental, Dental Care, Vision Care
and Prescription Drug certificates)**

Rider SOCT amends the certificates named above to provide coverage for preapproved, specified bone marrow and/or peripheral blood stem cell transplants and related services to treat stages II, III and IV breast cancer and/or all stages of ovarian cancer during an approved clinical trial.

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



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

Your certificate is amended as follows:

SECTION 1: Definitions

Affiliate Cancer Center

A health care provider that has contracted with an NCI-approved cancer center to provide treatment.

Autologous Transplant

A procedure using the patient's own bone marrow or peripheral blood stem cells to transplant back into the patient.

Clinical Trial

A study conducted on a group of patients to determine the effect of a treatment. For purposes of this rider, clinical trials include:

- 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 conducted on a much larger group of patients to compare the results of a new treatment of a condition to a conventional or standard treatment. Phase III gives an indication as to whether the new treatment leads to better, worse or no change in outcome.

Colony Stimulating Growth Factors

Factors that stimulate the multiplication of very young blood cells.

Designated Cancer Center

A site approved by the National Cancer Institute as a cancer center comprehensive cancer center, clinical cancer center or an affiliate of one of these centers. The names of the approved centers and their affiliates are available to you and your physician upon request.

High-Dose Chemotherapy

A procedure in which patients are given cell destroying drugs in doses higher than those used in conventional therapy. Stem cell replacement is required after high-dose chemotherapy is given.

Peripheral Blood Stem Cell Transplant

A procedure where blood stem cells are obtained by pheresis and infused into the patient's circulation.

SECTION 1: Definitions (continued)

Pheresis

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

Purging

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

Service

Surgery, care, treatment, supplies, devices, drugs or equipment given by a health care provider to diagnose or treat a disease or condition.

Stem Cells

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

Total Body Irradiation

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

SECTION 2: Coverage Under This Rider

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

SECTION 3: Mandatory Preapproval

We will not pay benefits under this rider for services, admissions or lengths of stay that are not preapproved.

The preapproval process allows you and your provider to know if we will cover proposed services, hospital admissions and lengths of stay in a hospital before treatment begins. If preapproval is not obtained **before** you receive services or are admitted to a hospital, the services, admission and length of stay will not be covered under this rider.

SECTION 3: Mandatory Preapproval (continued)

NOTE: Preapproval is good only for one year after it is issued. However, preapproved services, admissions or a length of stay will not be paid if you no longer have coverage under this rider at the time they occur.

A decision to preapprove services, an admission or length of stay will be based on the information your provider submits to us. BCBSM reserves the right to request other information to determine if preapproval is appropriate.

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

The designated cancer center must submit its written request for preapproval to:

Blue Cross Blue Shield of Michigan
Human Organ Transplant Program
Mail Code J607
600 Lafayette East
Detroit, MI 48226

Fax: (313) 225-5827

Preapproval will be granted if:

- The patient is an eligible BCBSM member.
- The patient has BCBSM hospital-medical-surgical coverage.
- The proposed services will be rendered in a designated cancer center or in an affiliate of a designated center.
- The proposed services are medically necessary.
- An inpatient admission to a designated cancer center and the length of stay at the center are medically necessary (in those cases requiring inpatient treatment). A request for an admission and length of stay must be preapproved by BCBSM before the admission occurs.

SECTION 4: Services That Are Payable

The services covered in your basic certificate(s) and rider(s) are payable when directly related to a transplant covered under this rider. The transplant must be performed at a designated cancer center or its affiliate to be a covered benefit under this rider.

Immunization against certain common infectious diseases during the first 24 months post-transplant are covered. We pay for immunizations as recommended by the Advisory Committee on Immunization (ACIP).

We pay for the following only *after* they have been preapproved by BCBSM:

Autologous Transplants

- Infusion of colony stimulating growth factors
- Harvesting (including peripheral blood stem cell phereses) and storage of bone marrow and/or peripheral blood stem cells
- Purging or positive stem cell selection of bone marrow or peripheral blood stem cells
- High-dose chemotherapy and/or total body irradiation
- Infusion of bone marrow and/or peripheral blood stem cells
- Hospitalization

Allogeneic Transplants

- Blood tests to evaluate donors (if not covered by the potential donor's insurance)
- Search of the National Bone Marrow Donor Program Registry for a donor. A search will begin only when the need for a donor is established and the transplant is preapproved.
- Infusion of colony stimulating growth factors

SECTION 4: Services That Are Payable (continued)

Allogeneic Transplants (continued)

- Harvesting (including peripheral blood stem cell pheresis) and storage of the donor's bone marrow, peripheral blood stem cell and/or umbilical cord blood. (We will cover harvesting and storage even if it is not covered by the donor's insurance.)

NOTE: The recipient of harvested material must be a BCBSM member.

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

SECTION 5: Travel and Lodging

We will pay up to a total of \$5,000 for travel and lodging expenses directly related to preapproved services rendered during an approved clinical trial. The expenses must be incurred during the period that begins with the date of preapproval and ends 180 days after the transplant. However, these expenses will not be paid if your coverage under this rider is no longer in effect.

We will pay the expenses of an adult patient and another person, or the expenses of a patient under the age of 18 years and expenses for two additional people. The following per day amounts apply to the combined expenses of the patient and persons eligible to accompany the patient:

- \$60 per day for travel
- \$50 per day for lodging

NOTE: These daily allowances may be adjusted periodically. Please contact BCBSM for the current maximums allowed.

SECTION 6: Limitations and Exclusions

In addition to the limitations and exclusions listed in your certificate(s) and rider(s), we do not pay for:

- An admission to a designated center or a length of stay at a designated center that has not been preapproved
- Services that have not been preapproved
- Services that are not medically necessary (see your certificate for the definition of “medically necessary”)
- Services rendered at a nondesignated cancer center
- Services provided by persons or entities that are not legally qualified or licensed to provide such services
- Donor services for a transplant recipient who is not a BCBSM member
- Services rendered to a donor when the donor’s health care coverage will pay for such services
- The routine harvesting and storage costs of bone marrow, peripheral blood stem cells or a newborn’s umbilical cord blood if not intended for transplant within one year
- More than two single transplants per member for the same condition
- Non-health care related services and/or research management (such as administrative costs)
- Transplants performed at a center that is not a designated cancer center or its affiliate
- Search of an international donor registry
- Experimental treatment not included in this rider
- Items or services that are normally covered by other funding sources (e.g., investigational drugs funded by a drug company)

SECTION 6: Limitations and Exclusions (continued)

- Items that are not considered by BCBSM to be directly related to travel and lodging. Examples include, but are not limited to: mortgage, rent payments, furniture rental, dry cleaning, clothing, laundry services, kennel fees, car maintenance, toiletries, security deposits, cash advances, lost wages, tips, toys, household products, alcoholic beverages, flowers, greeting cards, stationery, stamps, gifts, household utilities (including cellular telephones), maids, babysitters or day care services, services provided by family members, reimbursement of food stamps; mail/UPS services; internet connection, and entertainment (such as cable television, books, magazines and movie rentals).
- Any other services, admissions or length of stay related to any of the above exclusions

NOTE: Services not covered under this rider may be covered in your certificates and other riders. Please refer to Rider GLE-1 for additional information.

The lifetime maximum, copayments and deductibles, if any, in your underlying certificate(s) applies to the services covered under this rider, unless stated otherwise.

GENERAL

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

BLUE CROSS BLUE SHIELD OF MICHIGAN

**Daniel J. Loepp
President and Chief Executive Officer**

Form No. 5401



Bureau Approved 04/11

IMPORTANT

KEEP THIS RIDER WITH YOUR CERTIFICATE

**RIDER CBC-MT
COMMUNITY BLUE COPAYMENT REQUIREMENT
FOR MANIPULATIVE TREATMENT**

AMENDS

**COMMUNITY BLUE GROUP BENEFIT CERTIFICATE
6225**

Rider CBC-MT amends the certificate named above to impose the same flat-dollar copayment requirement for chiropractic and osteopathic manipulative treatment by a panel provider as is required for all panel physician office visits.

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



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

The “What You Must Pay” section of your certificate that addresses copayment requirements for panel providers is amended as follows:

You must pay the same flat dollar copayment for chiropractic and osteopathic manipulative treatment as you pay for office visits in a panel physician’s office.

NOTE: When an office visit and manipulative treatment service is billed on the same day, by the same panel physician, only one copayment will be required for the office visit.

The “Physician Services That are Payable” section of your certificate that addresses chiropractic services is amended as follows:

Chiropractic Services

We pay for chiropractic spinal manipulation to treat misaligned or displaced vertebrae of the spine. Chiropractic benefits are provided for a maximum of 24 visits per member, per calendar year. We also pay for x-rays when the diagnosis is an incomplete or partial dislocation in the spinal area.

NOTE: Services provided by nonpanel providers are combined with services provided by panel providers to meet the 24-visit maximum per year. (See “What You Must Pay” section above for copayment requirement).

GENERAL

Until further notice, all the terms, definitions, limitations, exclusions and conditions of your certificates and related riders remain unchanged and in full force and effect, except as otherwise provided in Rider CBC-MT.

BLUE CROSS BLUE SHIELD OF MICHIGAN

**Richard E. Whitmer
President and Chief Executive Officer**

IMPORTANT

KEEP THIS RIDER WITH YOUR CERTIFICATE

**RIDER CBC 20%-P
COMMUNITY BLUE COPAYMENT REQUIREMENT
20% FOR PANEL SERVICES**

Amends

COMMUNITY BLUE GROUP BENEFITS CERTIFICATE

6225

Rider CBC 20%-P amends the certificate named above to add a member copayment requirement of 20 percent for most covered panel services.

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



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

The “What You Must Pay” section of your certificate is amended as follows:

Copayment Requirements

You must pay 20 percent of the approved amount for most covered services provided by **panel** providers.

NOTE: This rider does not include an annual maximum for member copayments.

Limitations and Exclusions

This copayment does not apply to:

- Covered services performed in a panel physician's office
- Services subject to a flat dollar copayment requirement (refer to Section 2 of your certificate)
- Services for the initial exam to treat a medical emergency or an accidental injury in the outpatient department of a hospital, urgent care center or physician's office
- Chiropractic spinal manipulation
- Prenatal and postnatal care visits
- Allergy testing and therapy
- Therapeutic injections
- Hospice care benefits
- Preventive care services (specific services are listed in Section 4 of your certificate)
- Presurgical consultations

This rider does not change your copayment requirement for:

- Mental health services
- Substance abuse treatment
- Private duty nursing care

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 CBC 20%-P.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN

Daniel J. Loepf
President and Chief Executive Officer

Form No. 5766



Bureau Approved 06/11

IMPORTANT

KEEP THIS RIDER WITH YOUR CERTIFICATE

**RIDER CBC 40% NP
COMMUNITY BLUE COPAYMENT REQUIREMENT
40% FOR NONPANEL SERVICES**

AMENDS

**COMMUNITY BLUE GROUP BENEFITS CERTIFICATE
6225**

Rider CBC 40% NP amends the certificate named above to increase the member copayment requirement to 40 percent for most covered nonpanel services.

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



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

The “What You Must Pay” section of your certificate is amended to increase the member copayment requirement as follows:

You must pay 40 percent of the approved amount for most covered nonpanel services.

This copayment does not apply when:

- A panel provider refers you to a nonpanel provider

NOTE: You must obtain the referral **before** receiving the referred service or the service will be subject to nonpanel cost sharing requirements.

- You receive services for the initial exam to treat a medical emergency or an accidental injury in the outpatient department of a hospital, urgent care center or physician's office
- You receive services from a provider for which there is no PPO panel
- You receive services from a nonpanel provider in a geographic area in Michigan deemed a “low access area” by BCBSM for that particular provider specialty

This rider does not change:

- Your flat dollar copayment requirement for facility services in a hospital emergency room
- Your copayment requirement for mental health services, substance abuse treatment and private duty nursing care
- The annual copayment maximum for nonpanel provider services described in your certificate

The “What You Must Pay” section and the “How Hospitals, Facilities and Alternative to Hospital Care Providers Are Paid” and the “How Physician and Other Professional Provider Services Are Paid” subsections in your certificate are amended to add the following:

In limited instances, nonpanel deductible and copayment requirements may not be imposed for select professional services performed by nonpanel providers in a panel hospital, participating freestanding ambulatory surgery facility or any other location identified by BCBSM. You may contact Blue Cross Blue Shield of Michigan for information regarding these professional services.

NOTE: While the nonpanel deductible and copayment requirements may not be imposed, covered services will be subject to applicable panel deductible and copayment requirements.

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 CBC 40% NP.

BLUE CROSS BLUE SHIELD OF MICHIGAN

**Daniel J. Loepp
President and Chief Executive Officer**

Form No. 5771



Bureau Approved 11/06

IMPORTANT

KEEP THIS RIDER WITH YOUR CERTIFICATE

**RIDER CBD \$500-P
COMMUNITY BLUE DEDUCTIBLE REQUIREMENT
FOR PANEL SERVICES**

AMENDS

**COMMUNITY BLUE GROUP BENEFITS CERTIFICATE
6225**

Rider CBD \$500-P amends the certificate named above to add an annual deductible requirement for most covered panel services.

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



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

The “What You Must Pay” section of your certificate is amended to add the following:

Deductible Requirements

Panel Providers

You are required to pay the following deductible each calendar year for most covered services provided by panel providers:

- \$500 for one member
- \$1,000 for the family (when two or more members are covered under your contract)
 - Two or more members must meet the family deductible.
 - If the one-member deductible has been met, but not the family deductible, we will pay covered services only for that member who has met the deductible.
 - Covered services for the remaining family members will be paid when the full family deductible has been met.

NOTE: Amounts applied toward an annual deductible for nonpanel services also count toward the deductible for panel services. However, deductible amounts for panel services are not applied toward the deductible for nonpanel services.

When a Deductible is Not Required

You are not required to pay a deductible for the following:

- Covered services performed in a panel physician’s office, including presurgical consultations
- Covered mental health services performed in a panel physician’s office
- Services subject to a flat-dollar copayment requirement (see Section 2 of your certificate)
- Services for the initial exam to treat a medical emergency or an accidental injury in the outpatient department of a hospital, urgent care center or physician’s office
- Chiropractic spinal manipulation
- Prenatal and postnatal care visits

When a Deductible is Not Required (continued)

- Allergy testing and therapy
- Therapeutic injections
- Hospice care benefits
- Preventive care services (specific services are listed in Section 4 of your certificate)

Limitations and Exclusions

We will not apply charges toward your panel deductible requirements that:

- Exceed our approved amount
- Are for noncovered services and limited covered services (i.e., accidental injuries and medical emergencies)

GENERAL

Until further notice, all the terms, definitions, limitations, exclusions, and conditions of your certificate and related riders remain unchanged and in full force and effect, except as provided in Rider CBD \$500-P.

BLUE CROSS BLUE SHIELD OF MICHIGAN

**Daniel J. Loepp
President and Chief Executive Officer**

Form No. 5784



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

Bureau Approved 06/11

IMPORTANT

KEEP THIS RIDER WITH YOUR CERTIFICATE

**RIDER CBD \$1000-NP
COMMUNITY BLUE DEDUCTIBLE REQUIREMENT FOR
NONPANEL SERVICES**

AMENDS

**COMMUNITY BLUE GROUP BENEFIT CERTIFICATE
6225**

Rider CBD \$1000-NP amends the certificate named above to increase the annual deductible requirement for most covered nonpanel services.

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



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

The “What You Must Pay” section of your certificate is amended to increase the annual deductible requirement as follows:

You are required to pay the following deductible each calendar year for most covered services provided by nonpanel providers:

- \$1,000 for one member
- \$2,000 for the family (when two or more members are covered under your contract)
 - Two or more members must meet the family deductible
 - If the one member deductible has been met, but not the family deductible, we will pay covered services only for that member.
 - Covered services for the remaining family members will be paid when the full family deductible has been met.

NOTE: Amounts applied toward an annual deductible for nonpanel services also count toward the deductible for panel services. However, deductible amounts for panel services are not applied toward the deductible for nonpanel services.

You are not required to pay a deductible for the following covered nonpanel services when:

- A panel provider refers you to a nonpanel provider

NOTE: You must obtain the referral **before** receiving the referred service or the service will be subject to nonpanel cost sharing requirements.

- You receive services for the initial exam to treat a medical emergency or an accidental injury in the outpatient department of a hospital, urgent care center or physician's office
- You receive services from a provider for which there is no PPO panel
- You receive services from a nonpanel provider in a geographic area in Michigan deemed a “low access area” by BCBSM for that particular provider specialty

This rider does not change:

- Your flat dollar copayment requirement for facility services in a hospital emergency room
- Your copayment requirement for mental health services, substance abuse treatment and private duty nursing care

The “What You Must Pay” section and the “How Hospitals, Facilities and Alternative to Hospital Care Providers Are Paid” and the “How Physician and Other Professional Provider Services Are Paid” subsections in your certificate are amended to add the following:

In limited instances, nonpanel deductible and copayment requirements may not be imposed for select professional services performed by nonpanel providers in a panel hospital, participating freestanding ambulatory surgery facility or any other location identified by BCBSM. You may contact Blue Cross Blue Shield of Michigan for information regarding these professional services.

NOTE: While the nonpanel deductible and copayment requirements may not be imposed, covered services will be subject to applicable panel deductible and copayment requirements.

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 CBD \$1000-NP.

BLUE CROSS BLUE SHIELD OF MICHIGAN

**Daniel J. Loepp
President and Chief Executive Officer**

Form No. 5789



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

Bureau Approved 11/06

IMPORTANT

Keep This Rider With Your Certificate

RIDER CB-CM-P \$1500 COMMUNITY BLUE COPAYMENT MAXIMUM FOR PANEL SERVICES

AMENDS

**COMMUNITY BLUE
GROUP BENEFITS CERTIFICATE**

(Form No. 6225)

Rider CB-CM-P \$1500 amends the certificate named above to add an annual copayment maximum for most covered panel services.

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



An Independent Licensee of the
Blue Cross and Blue Shield Association

Your certificate is amended as follows:

SECTION 1: What You Must Pay

The copayment percentage you pay for most covered services provided by panel providers is limited to the following copayment maximum each calendar year:

- \$1,500 for one member;
- \$3,000 for the family (when two or more members are covered under your contract).
 - Two or more members must meet the family copayment maximum.
 - If the one member copayment maximum has been met, but not the family copayment maximum, we will not require any more copayments for that member the remainder of the calendar year.
 - Copayments for the remaining family members will be required until the full family annual copayment maximum has been met.

Copayments applied toward the annual copayment maximum for nonpanel services also count toward the copayment maximum for panel services. However, copayments for panel services are not applied toward the annual copayment maximum for nonpanel services.

SECTION 2: Limitations and Exclusions

Copayments for the following services are not applied toward the annual copayment maximum:

- services that require flat dollar copayments, and
 - mental health services, substance abuse treatment and private duty nursing care.
-
-
-

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 CB-CM-P \$1,500.

BLUE CROSS BLUE SHIELD OF MICHIGAN

**Richard E. Whitmer
President and Chief Executive Officer**



IMPORTANT

Keep This Rider With Your Certificate

RIDER CB-CM-NP \$3000 COMMUNITY BLUE COPAYMENT MAXIMUM FOR NONPANEL SERVICES

AMENDS

COMMUNITY BLUE
GROUP BENEFITS CERTIFICATE

(Form No, 6225)

Rider CB-CM-NP \$3000 amends the certificate named above to increase the annual copayment maximum for most covered nonpanel 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: What You Must Pay

The copayment percentage you pay for most covered services provided by nonpanel providers is limited to the following copayment maximum each calendar year:

- \$3,000 for one member;
- \$6,000 for the family (when two or more members are covered under your contract).
 - Two or more members must meet the family copayment maximum.
 - If the one member copayment maximum has been met, but not the family copayment maximum, we will not require any more copayments for that member the remainder of the calendar year.
 - Copayments for the remaining family members will be required until the full family annual copayment maximum has been met.

Copayments applied toward the annual copayment maximum for nonpanel services also count toward the copayment maximum for panel services. However, copayments for panel services are not applied toward the annual copayment maximum for nonpanel services.

SECTION 2: Limitations and Exclusions

Copayments for the following services are not applied toward the annual copayment maximum:

- services that require flat dollar copayments, and
 - mental health services, substance abuse treatment and private duty nursing care.
-
-
-

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 CB-CM-NP \$3000.

BLUE CROSS BLUE SHIELD OF MICHIGAN

**Richard E. Whitmer
President and Chief Executive Officer**

Form No, 5859



Bureau Approved 9/96

IMPORTANT

KEEP THIS RIDER WITH YOUR CERTIFICATE

RIDER HCR-PCB-2 HEALTH CARE REFORM - PREVENTIVE CARE BENEFITS

AMENDS

COMMUNITY BLUE GROUP BENEFITS CERTIFICATE 6225
BLUE CHOICE HEALTH CARE BENEFITS CERTIFICATE 3920
HEALTHY BLUE 70 GROUP BENEFITS CERTIFICATE 1949
HEALTHY BLUE 80 GROUP BENEFITS CERTIFICATE 1831
HEALTHY BLUE 90 GROUP BENEFITS CERTIFICATE 1945
HEALTHY BLUE OUTCOMES GROUP BENEFITS CERTIFICATE 717B

Rider HCR-PCB-2 amends the certificates named above to add coverage for additional immunizations and preventive care benefits as required under the Patient Protection and Affordable Care Act (PPACA).

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



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

“Preventive Care Services” under the “Coverage for Physician and Other Professional Provider Services” section of your certificate is amended to add adult immunizations as follows:

Preventive Care Services

This rider removes the annual dollar maximum for preventive care benefits. We pay for the covered preventive care services listed in your certificate (and below) only when rendered by **panel** providers. Deductible and copayment amounts are not required for these services.

NOTE: Members enrolled in the Blue Choice Certificate must utilize panel providers for routine physical examinations, gynecological examinations, well-baby and child care visits and adult and childhood immunizations. All other preventive care benefits may be obtained from a panel or nonpanel provider (Nonpanel services are subject to nonpanel deductible and copayment requirements).

Members enrolled in one of the Healthy Blue (70, 80 or 90) Certificates may utilize panel or nonpanel providers for preventive care services. (Nonpanel services are subject to nonpanel deductible and copayment requirements).

- **Adult Immunizations**

We pay for adult immunizations as recommended by the Advisory Committee on Immunization Practices or other sources as recognized by BCBSM.

We pay for all other immunizations and preventive care benefits mandated by the Patient Protection and Affordable Care Act (PPACA) at the time services are performed.

NOTE: To see a list of the preventive benefits and immunizations that are mandated by PPACA, you may go to the following website: www.bcbsm.com. You may also contact BCBSM customer service.

The “Outpatient Hospital Services That Are Payable” subsection of the “Coverage for Hospital, Facility and Alternatives to Hospital Care” section of your certificate and the “Coverage for Physician and Other Professional Provider Services” section are amended to add the following:

Colonoscopy

Facility and professional benefits for colonoscopy services are payable at 100 percent of the BCBSM approved amount as follows:

- We pay for one routine screening colonoscopy once per member per calendar year, whether performed by a panel or nonpanel provider.
 - Services performed by a **panel** provider are not subject to any deductible or copayment requirements.
 - Services performed by a **nonpanel** provider are subject to the nonpanel deductible and copayment requirements of your certificate.
 - Subsequent medically necessary colonoscopies performed during the same calendar year by a panel or nonpanel provider are subject to your deductible and copayment requirements.

The “Coverage for Physician and Other Professional Provider Services” section of your certificate is amended to replace screening mammography services with the following:

Screening Mammography

Screening mammography services are payable at 100 percent of the BCBSM approved amount as follows:

- We pay for one routine mammogram and the related reading, once per member per calendar year. This service is not subject to any deductible or copayment requirements when provided by **panel** providers. Mammography services performed by a **nonpanel** provider are subject to the nonpanel deductible and copayment requirements of your certificate.

NOTE: Nonpanel readings and interpretations are payable only when the screening mammogram itself is performed by a **panel** provider.

GENERAL

Until further notice, all the terms, definitions, limitations, exclusions, and conditions of your certificate and related riders remain unchanged and in full force and effect, except as provided in Rider HCR-PCB-2.

BLUE CROSS BLUE SHIELD OF MICHIGAN

**Daniel J. Loepp
President and Chief Executive Officer**

Form No. 772C



Bureau Approved 11/10

IMPORTANT

KEEP THIS RIDER WITH YOUR CERTIFICATE

RIDER GLE-1 GENERAL LIMITATIONS AND EXCLUSIONS

AMENDS

**ALL BCBSM GROUP, NONGROUP AND GROUP CONVERSION
BENEFIT
CERTIFICATES**

Rider GLE-1 amends the certificates named above to:

- Exclude benefits for experimental treatments
- Exclude benefits for services related to experimental treatments

These exclusions may be waived when the experimental treatment or related services are provided during a BCBSM-approved oncology clinical trial.

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



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

SECTION 1: Definitions

Administrative Costs

Costs incurred by the organization sponsoring the approved oncology clinical trial. They may include, but are not limited to, the costs of gathering data, conducting statistical studies, meeting regulatory or contractual requirements, attending meetings or travel.

Clinical Trial

A study conducted on a group of patients to determine the effect of a treatment. For purposes of this rider, clinical trials include:

- Phase II - a study conducted on a 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 conducted on a much larger group of patients to compare the results of a new treatment of a condition to the results of conventional treatment. Phase III gives an indication as to whether the new treatment leads to better, worse or no change in outcome.

Conventional Treatment

Treatment that has been scientifically proven to be safe and effective for treatment of the patient's condition.

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 “experimental services.”

Research Management

Services, such as diagnostic tests, which are performed solely to support the sponsoring organization’s research. They are not necessary for treating the patient’s condition.

Services

Surgery, care, treatment, supplies, devices, drugs or equipment given by a health care provider to diagnose or treat disease, injury, condition or pregnancy.

SECTION 2: 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 in Section 4 of this rider. In addition, we do not pay for administrative costs related to experimental treatment or for research management.

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

SECTION 3: 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

SECTION 3: How BCBSM Determines If A Treatment Is Experimental (continued)

- Information from the Blue Cross and Blue Shield Association or other local or national bodies
- Information from independent, non-governmental, 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.

SECTION 4: 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).

SECTION 4: Services That Are Payable (continued)

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

Section 5: Limitations and Exclusions

- This rider 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.

GENERAL

Until further notice, all the terms, definitions, limitations, exclusions, and conditions of your certificate and related riders remain unchanged and in full force and effect, except as provided in Rider GLE-1.

BLUE CROSS BLUE SHIELD OF MICHIGAN

**Richard E. Whitmer
President and Chief Executive Officer**

Form No. 9930



Bureau Approved 12/03

IMPORTANT

KEEP THIS RIDER WITH YOUR CERTIFICATE

**RIDER PD-TTC \$10/\$40/\$80-RXCM
PRESCRIPTION DRUG TRIPLE-TIER COPAYMENT WITH
MINIMUM AND MAXIMUM AMOUNTS AND A COST
MANAGEMENT PROGRAM**

AMENDS

**PREFERRED RX PROGRAM CERTIFICATE
3607**

**FLEXIBLE BLUE RX PROGRAM CERTIFICATE
8223**

**SIMPLY BLUE HSA GROUP BENEFITS CERTIFICATE (WITH RX DRUGS)
685C**

Rider PD-TTC \$10/\$40/\$80-RXCM amends the certificates named above by imposing a triple tier copayment for prescription drugs. Included are provisions for up to a 90-day supply of prescription drugs, a revised MAC program and the mail-order drug program.

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



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

Your certificate is amended as follows:

The “Prescription Drug Coverage” section of your certificate is amended to add the following language:

Please read all the sections in this rider as they may impact what your prescription drug cost-sharing will be.

Mail Order Prescription Drugs

This rider provides coverage for drugs obtained from panel mail-order providers. Your copayment for a 31 – 90 day supply of covered drugs is twice the amount you would pay for a supply of 30 days or less.

Prescription Drug 90-Day At Retail Supply

This rider provides coverage for drugs obtained from the 90-Day Retail Network. Your copayment for an 84 – 90 supply of covered drugs is twice the amount you would pay for a supply of 30 days or less. A supply for a period of 31 – 83 days is **not** covered.

Covered Drugs Obtained from a Panel Pharmacy

Generic Drugs

Your copayment for generic drugs is as follows:

If your physician prescribes a generic drug for the time period of: ↓	And you obtain the drug through:		
	90-Day Retail Network Pharmacy	Panel Mail Order Provider	Panel Pharmacy (not part of the 90-Day Retail Network)
1 – 30 days	You pay \$10	You pay \$10	You pay \$10
31 – 83 days	BCBSM does not cover it	You pay \$20	BCBSM does not cover it
84 – 90 days	You pay \$20	You pay \$20	BCBSM does not cover it

If the approved amount of the drug is less than your copayment, then you pay only the approved amount of the drug.

Formulary Brand-Name Drugs

Your copayment for each formulary brand name drug is as described below, even if:

- your prescription is marked “DAW”;
- there is no generic equivalent drug available.

Your copayment for formulary brand name drugs is as follows:

If your physician prescribes a formulary brand name drug for the time period of: ↓	And you obtain the drug through:		
	90-Day Retail Network Pharmacy	Panel Mail Order Provider	Panel Pharmacy (not part of the 90-Day Retail Network)
1 – 30 days	You pay \$40	You pay \$40	You pay \$40
31 – 83 days	BCBSM does not cover it	You pay \$80	BCBSM does not cover it
84 – 90 days	You pay \$80	You pay \$80	BCBSM does not cover it

If the approved amount of the drug is less than your copayment, then you pay only the approved amount of the drug.

Nonformulary Brand-Name Drugs

Your copayment for each nonformulary brand name drug is as described below, even if:

- your prescription is marked “DAW”;
- there is no generic equivalent drug available.

For a nonformulary brand name drug, the minimum copayment you will be responsible for is \$80.

Your copayment for nonformulary brand name drugs is as follows: (see next page)

Nonformulary Brand-Name Drugs (continued)

If your physician prescribes a nonformulary brand name drug for the time period of: ↓	And you obtain the drug through:		
	90-Day Retail Network Pharmacy	Panel Mail Order Provider	Panel Pharmacy (not part of the 90-Day Retail Network)
1 – 30 days	You pay \$80	You pay \$80	You pay \$80
31 – 83 days	BCBSM does not cover it	You pay \$160	BCBSM does not cover it
84 – 90 days	You pay \$160	You pay \$160	BCBSM does not cover it

Covered drugs obtained from nonpanel retail pharmacies continue to be subject to any additional cost-sharing requirements described in your benefit package.

NOTE: If the approved amount of a generic or brand-name drug is less than your copayment, then you pay only the approved amount of the drug. However, under the Maximum Allowable Cost Program you are also responsible for the difference between the MAC allowance and the approved amount.

For Maximum Allowable Cost (MAC) Drugs

The MAC program described in your certificate is replaced with the following:

If you have a prescription filled by any type of panel pharmacy, and the pharmacist fills it with a generic equivalent drug, you are required to pay only the copayment and/or deductible, if applicable, as described in your benefit package.

If you obtain a brand name drug when a generic equivalent drug is available, you must pay:

- the difference between the maximum allowable cost and the BCBSM approved amount for the brand name drug **PLUS**
- your copayment and/or deductible, if applicable.

For Maximum Allowable Cost (MAC) Drugs (continued)

For example, if you obtain a nonformulary brand name drug when a generic equivalent is available:

	\$150	BCBSM Approved Amount
-	110	Maximum Allowable Cost Amount
	40	The Difference
+	80	Your Copayment (\$80 minimum)
	\$120	What you pay

Exception: If your physician requests and receives authorization for a brand name drug from BCBSM and writes “Dispense as Written” or “DAW” on the prescription order, you pay only your copayment and/or deductible, if applicable, as described in your benefit package.

Mandatory Preauthorization

Certain drugs require preauthorization. We will pay for each drug, each refill of a drug, and select over-the-counter (OTC) drugs prescribed by a physician, as follows:

When preauthorization of a prescription drug is required, authorization must be obtained from BCBSM before we will consider them for payment. If the required preauthorization is not requested or approval is not obtained, we will deny payment and you will be responsible for 100 percent of the pharmacy’s charge.

We will pay our approved amount for select prescription drugs obtained from a pharmacy or panel mail order provider if both of the following are met:

- The prescribing physician requests preauthorization and demonstrates that the drug meets BCBSM’s preauthorization criteria.
- We approve the request.

NOTE: Any deductibles or copayments required under your benefit package will apply to select prescription drugs and over-the-counter drugs.

The “Prescription Drugs Not Covered” section in your certificate is amended by adding the following:

- We will not pay for drugs obtained from nonpanel mail-order providers, including Internet providers.

Prescription Drugs Not Covered (continued)

- The Maintenance Drug provision is removed (i.e., “More than a 30-day supply of a covered drug...”)
- We will not pay for more than 12 doses of an impotence drug in a 30-day period or 36 doses of an impotence drug in a 90-day period.
- We will not pay for prescriptions for quantities of 84 through 90 days that are not provided by a 90-Day Retail Network provider or a panel BCBSM mail order provider.
- We will not pay for injectable drugs purchased directly by the member for administration by a professional provider.
- We will not pay for more than a 30-day supply of a covered prescription drug that BCBSM defines as a “specialty pharmaceutical” whether or not the drug is obtained from a 90-Day Retail Network provider or mail-order provider. We may make exceptions if a member requires more than a 30-day supply.

The “Language of Health Care” section of your certificate is being changed to add the following definitions:

Formulary

A formulary is a preferred list of high-quality, cost-effective medications. It represents the clinical judgment of physicians, pharmacists and other experts in the diagnosis and treatment of disease and promotion of health.

Formulary Brand Name Drug

A brand name drug that is on BCBSM’s Formulary listing .

Nonformulary Brand Name Drug

A brand name drug that is not on BCBSM’s Formulary listing.

Nonpanel Mail-Order Provider

A provider who has not been selected to provide covered drugs through our PPO program. Nonpanel mail-order providers have not agreed to accept the approved amount as payment in full for covered drugs provided to members in our PPO mail-order program.

Panel Mail-Order Provider

A provider selected by BCBSM to provide covered drugs through our PPO program. Panel mail-order providers have agreed to accept the approved amount as payment in full for the covered drugs provided to members enrolled in our PPO mail-order program.

Language of Health Care (continued)

Select Prescription Drugs

Prescription drugs identified by BCBSM as requiring preauthorization. A description of the drugs and the criteria for approval are provided in a list that is updated periodically by BCBSM. Your physician or pharmacist can call us for this list. Select prescription drugs do not include antineoplastic drugs or drugs needed to treat an immediate life-threatening condition.

Select Over-the-Counter Drugs

Over-the-counter drugs identified by BCBSM as select prescription drugs. A prescription for the select OTC drug is required from the member's physician. In some cases, over-the-counter drugs may need to be tried before BCBSM will approve use of other drugs.

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 PD-TTC \$10/\$40/\$80-RXCM.

BLUE CROSS BLUE SHIELD OF MICHIGAN

Daniel J. Loepp
President and Chief Executive Officer



IMPORTANT

KEEP THIS RIDER WITH YOUR CERTIFICATE

**RIDER PD-XED
PRESCRIPTION DRUG – EXCLUDES ELECTIVE
DRUGS**

AMENDS

ALL BCBSM PRESCRIPTION DRUG GROUP BENEFIT CERTIFICATES

Rider PD-XED amends the certificates named above to exclude elective drugs.

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



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The section on **The Language of Health Care** in your certificate is amended by adding the following definition:

Elective Drugs

Lifestyle drugs such as those that treat sexual impotency or infertility, help in weight loss or help to stop smoking. They are not designed to treat acute or chronic illnesses or prescribed for medical conditions that have no demonstrable physical harm if not treated.

The section on **Prescription Drugs Not Covered** in your certificate is amended by adding the following:

We do not pay for:

- Elective drugs

Note: We determine when a drug is an elective drug. Drugs will not be classified as elective if they are approved to treat certain conditions such as cancer, pain, psychosis, depression, cardiovascular disease, diabetes, asthma or infection.

GENERAL

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

BLUE CROSS BLUE SHIELD OF MICHIGAN

**Richard E. Whitmer
President and Chief Executive Officer**

