Your Benefit Guide

State Health Plan PPO
Medicare-eligible Retirees

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

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Welcome

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

MCSC is responsible for implementing these benefits and any future benefit changes. BCBSM provides certain services on behalf of MCSC through an administrative-service-only contract. Your benefits are not insured with BCBSM, but will be paid from funds administered by MCSC.

BCBSM is committed to providing you with excellent value and quality service and we want you to understand your health coverage. With this in mind, we have designed this booklet as an easy-to-read guide to your benefits. Please read through it to get an understanding of which health care services are covered and when you are responsible for out-of-pocket costs.

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

Contact information

You can call, write or visit the BCBSM Customer Service Center when you have questions about your benefits and claims.

Blue Cross Blue Shield of Michigan

To help us serve you better, here are a few things to remember.

- Have your BCBSM ID card handy so you can provide your enrollee and group numbers.
- To ask about a medical or hearing claim, provide the following:
  - Enrollee's name
  - Enrollee's ID number
  - Member's name
  - Provider's name
  - Date the patient was treated
  - Charge for the service
- When writing to us, include copies (not originals) of your bills, any correspondence you may have received from us and other relevant documents. Keep your original bills and documents for your files.
- Include your daytime telephone number on all of your letters.

Calling

Our customer service hours are Monday through Friday from 8 a.m. to 6 p.m. We are closed on holidays.

Customer Service **800-843-4876**
Anti-fraud hotline **800-482-3787**
Hearing-impaired customers ..... **TTY 800-231-6921**
Human organ transplant program..... **800-242-3504**
BlueCard® ..... **800-810-BLUE-(2583)**
BlueHealthConnection℠..... **800-775-BLUE-(2583)**

Writing

Please send all correspondence to:

State of Michigan Customer Service Center
Blue Cross Blue Shield of Michigan
232 S. Capitol Avenue, L04A
Lansing, MI 48933-1504

Visit

BCBSM Customer Service Center
232 S. Capitol Ave.
Lansing, MI 48933

The BCBSM Customer Service Center is open Monday through Friday from 8 a.m. to 6 p.m., excluding holidays.

Additional BCBSM walk-in centers

Detroit 600 East Lafayette
Flint 4520 Linden Creek Parkway, Suite A
Grand Rapids 86 Monroe Center NW
Holland 151 Central, Suite 160
Marquette 415 S. McClellan Ave.
Portage 8175 Creekside Drive, Suite 100
Southfield 20500 Civic Center Dr.
Traverse City 1769 S. Garfield Ave.
Utica 6100 Auburn Road

Walk-in centers are open from 9 a.m. to 5 p.m., Monday through Friday, excluding holidays.

Online

BCBSM's site for State of Michigan retirees	**bcbsm.com/som**
Provider search	**bcbsm.com/find-a-doctor**

State of Michigan

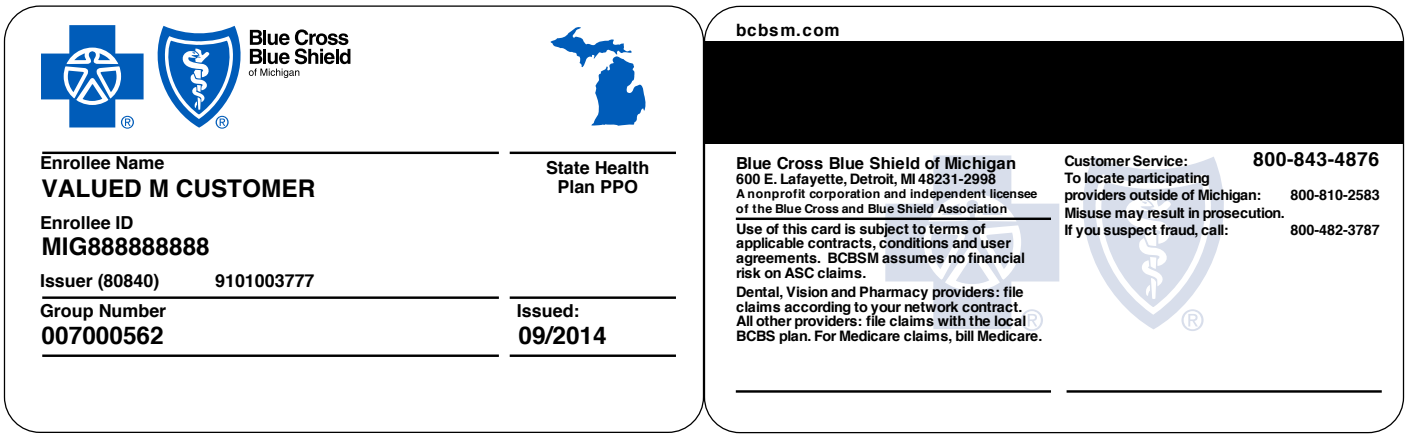
For eligibility information:
Office of Retirement Services
PO Box 30171
Lansing, MI 48909-7671
Local: 517-322-5103
Toll free: 800-381-5111

For benefit information:
Michigan Civil Service Commission
Employee Benefits Division
P.O. Box 30002
Lansing, MI 48909
Local: 517-373-7977
Toll free: 800-505-5011

Your ID card

Your BCBSM ID card is issued once you enroll for coverage in the SHP PPO. Always present both your Medicare and Blue Cross Blue Shield of Michigan ID cards to health care providers before receiving services to make sure they have all the necessary information to submit your claims.

Your card will look similar to the one below.



1st line: **Enrollee Name** is the name of the person who holds the contract. All communications are addressed to this name. Only the enrollee's name appears on the ID card. However, the cards are for use by all covered members.

2nd line: **Enrollee ID** identifies your records in our files.

The **alpha prefix** preceding the enrollee ID number identifies that you have coverage through the SHP PPO.

3rd line: **Issuer** identifies you as a BCBSM member. The number 80840 identifies our industry as a health insurance carrier.

4th line: **Group Number** tells us you are a BCBSM group member through the State of Michigan.

On the back of your ID card, you will find:

- A magnetic strip which will help providers process your claims. It includes information from the front of the card and the enrollee's date of birth. It does not include any benefit or health information.
- BCBSM's toll-free customer service telephone numbers to call us when you have a claim or benefit question.

If you or anyone in your family needs an ID card, log in to your account at **bcbsm.com** or call our Customer Service Center for assistance.

- If your card is lost or stolen, call us. You can still receive services by giving the provider your Enrollee ID number to verify your coverage while your new set of cards is on its way.
- You can also log in to your account at bcbsm.com to access your virtual ID card. This is a great way to show your coverage to a provider using your mobile phone.

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

Eligibility

For more information about the State of Michigan's eligibility requirements for retiree health insurance coverage, visit **www.mi.gov/ors**.

Coordinating Medicare and your supplemental coverage

When you enroll in Medicare, it becomes your primary coverage and will determine if the service rendered is a benefit, and if so, the approved amount for that service. The State Health Plan PPO is your secondary coverage, and provides benefits that may not be covered under Medicare Part A or Part B. In these instances, the State Health Plan PPO becomes your primary coverage, and therefore, it's important to seek services from a Blue Cross Blue Shield participating provider to avoid unnecessary out-of-pocket costs.

For the following services, you need to be sure to see a BCBSM participating provider:

- Needles with syringes for diabetics
- Surgical stockings (up to eight stockings per year)
- Hearing examination and hearing aid devices
- Private duty nursing
- Annual routine Pap smears (Medicare only pays for one every three years)
- X-rays furnished by a chiropractor
- Preventive exams
- Immunizations
- Hepatitis C screening
- Acupuncture
- Temporomandibular Joint Syndrome
- Rabies treatment
- Wigs
- Weight loss benefit

In the event you lose your coverage

You can purchase an individual plan from Blue Cross Blue Shield of Michigan, or coverage from the Health Insurance Marketplace. If you'd like information about which individual plan is best for you, contact a Blue Cross Blue Shield Health Plan Advisor at 1-855-237-3500 or visit **bcbsm.com/stayblue**.

For more information on plans on the Health Insurance Marketplace, visit **healthcare.gov**.

Medicare supplemental benefit details

When you or your covered dependents become eligible for Medicare, your health insurance continues through your Medicare Supplemental benefits with the State Health Plan PPO. These benefits work hand-in-hand with Medicare so that you enjoy the same covered services as non-Medicare members.

Although you have PPO benefits through the State Health Plan PPO, Medicare (your primary insurance) requires that you obtain care from Medicare-affiliated providers.

Acupuncture	**Covered – 80% after deductible**

Covered up to a maximum of 20 visits in a calendar year when performed by a licensed physician (MD or DO), or supervised and billed by a licensed physician (MD or DO).

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

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

Allergy tests and treatments	**Covered – 90% after deductible**

Allergy testing, including survey and therapeutic injections, are covered when performed by or under the supervision of a physician. Coverage also includes:

- Allergy extract and extract injections
- Intradermal, scratch and puncture tests
- Patch and photo tests
- Bronchial challenge tests

Benefits are not payable for:

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

Ambulance services	Covered – 90% after deductible

You are covered for ambulance services to transport a patient to the nearest medical facility capable of treating the patient's condition.

To be covered, the services must be:

- Medically necessary because transport by any other means would endanger the patient's health
- Prescribed by a physician (when used for transferring a patient)
- Provided in a vehicle qualified as an ambulance and part of a licensed ambulance operation
- Used to transport only the patient to a hospital or to transfer the patient from a hospital to another treatment location such as another hospital, skilled nursing facility or the patient's home.

Air or water ambulance is also covered if it meets the criteria above and the patient's emergent condition requires air or water transport rather than ground ambulance. Air or water ambulance providers must be licensed to provide air or water ambulance services and **not** as a commercial air carrier.

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

Ambulatory surgery facility	Participating – 90% after deductible

Coverage is provided 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.

Blood	Covered – 90% after deductible

Coverage includes whole blood, blood derivatives, blood plasma or packed red blood cells and supplies used for administering the services, as well as the cost of drawing and storing self-donated blood intended for scheduled surgery.

Breast reconstruction surgery	Covered – 90% after deductible

Surgery is covered for:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas

Cardiac rehabilitation	Covered – 90% after deductible

Coverage provides intensive monitoring (using EKGs) and/or supervision during exercise in the outpatient department of hospital or physician-directed facility.

Cataract surgery	Covered – 90% after deductible

Cataract surgery and first lens implants are covered.

Certified nurse midwife	Cost share depends on rendered service. See the individual health care benefit detail or the health care summary chart for cost-share.

Covered services provided by a certified nurse midwife include:

- Gynecological exam
- Health maintenance exam
- Injections

Certified nurse practitioner	Cost share depends on rendered service. See the individual health care benefit detail or the benefit summary chart for cost-share.

Services are covered when performed by a certified nurse practitioner, as long as the services are within their scope of licensure.

Chelation therapy	Covered – 90% after deductible

Chelation therapy is used as a treatment for acute mercury, iron, arsenic, lead, uranium, plutonium and other forms of toxic metal poisoning. If you have any questions concerning this benefit, please contact the BCBSM Customer Service Center.

Chemotherapy	Covered – 90% after deductible

Your benefits for chemotherapy are payable in a hospital, outpatient department of a hospital, or in a physician's office. Benefits include the administration and cost of chemotherapy drugs when they are:

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

You are also covered 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.

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

Chiropractic services	Covered up to $20 copay

Coverage includes office visits for:

- New patient: 1 visit every 36 months
- Established patient: 1 visit per calendar year

Coverage includes spinal manipulation for:

- 1 per day; 24 visits per calendar year

Chiropractic mechanical traction and X-rays	Covered – 90% after deductible

Chiropractic mechanical traction and X-rays for accidental injuries are covered. Chiropractic mechanical traction is subject to physical, occupational and speech therapy combined maximum of 90 visits.

Consultations – inpatient or outpatient – hospital	Covered – 90% after deductible

Medical consultations are payable when a physician requires assistance in diagnosing or treating a medical condition.

Consultations and/or pre-anesthesia evaluations are not payable when billed with one of the following diagnostic conditions:

- Experimental
- Obesity
- Research
- Routine
- Routine foot care
- Screening
- Psychological
- Staff consultations required by a facility's or program's rules

Consultations – office	Covered up to $20 copay

In a physicians' office setting, services are covered when they are performed by a physician whose advice or opinion is requested by another physician or other appropriate source for further evaluation of the patient and generally includes exam of patient, patient's record and written report.

Consultations – pre-surgical	Covered – 90% after deductible

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

You may obtain pre-surgical consultations if the surgery will take place in an inpatient or outpatient hospital setting or ambulatory surgery facility and is covered under the SHP PPO.

You are limited to three pre-surgical 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

Cosmetic surgery	Covered – 90% after deductible

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.

Dental surgery	Covered – 90% after deductible

Dental surgery performed on an inpatient basis is covered if a patient has a medical condition that makes it unsafe for dental treatment to be performed in the office setting. Surgery must be performed by an MD or DO. Dental procedures performed by a DDS must be billed to the dental program.

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
- Surgery directly to the temporomandibular joint (jaw joint)
- Arthrocentesis performed for the treatment of temporomandibular joint (jaw joint) dysfunction

Covered medical conditions include:

- Bleeding or clotting abnormalities
- Unstable angina
- Severe respiratory disease
- Known reaction to analgesics, anesthetics, etc.

Dental treatment (accidental dental – emergency only)	Covered – 90% after deductible

Accidental dental services are covered to provide relief of pain and discomfort following an injury, as well as repair of those injuries. These services must be completed within six months of the initial injury to be payable under the SHP PPO. An accidental injury is defined as an external force to the lower half of the face or jaw that damages or breaks sound natural teeth, periodontal structures (gums) or bone. Injury as a result of chewing or biting is not considered an accidental injury.

Emergency dental treatments must be completed within 24 hours following the trauma to relieve the patient of pain and discomfort.

Diabetic supplies	Participating provider – 100%

The SHP PPO covers blood sugar testing monitors, blood sugar and urine test strips, lancet devices and lancets, blood sugar control solutions, and diabetic therapeutic shoes.

Diabetic training	Covered – 90% after deductible

Self-management diabetic training is considered medically necessary depending on diagnosis by an MD or DO who is managing your diabetic condition. Medical necessity may be a significant change with long-term implications in the symptoms or conditions that necessitate changes in self-management. Medical necessity can also be a significant change in medical protocol or treatment.

Diabetes self-management training may be conducted in a group setting, if practicable. 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.

Diagnostic laboratory and pathology	Covered – 90% after deductible

Coverage includes laboratory and pathology exams needed to diagnose a disease, illness or injury.

Dialysis services	Covered – 90% after deductible

Home dialysis

Dialysis services (hemodialysis and peritoneal dialysis), supplies and equipment are payable when provided in the home to treat chronic, irreversible kidney failure.

Diagnostic tests and radiation services	Covered – 90% after deductible

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

- Diagnostic radiology that includes X-rays, ultrasound, radioactive isotopes, and MRI and CAT scans of the head and body when performed for an eligible diagnosis
- Laboratory and pathology tests
- Diagnostic tests which include EKGs, EEGs, EMGs, thyroid function tests, nerve conduction and pulmonary function studies
- Radiation therapy, which includes radiological treatment by X-ray, isotopes or cobalt for a malignancy
- Medically necessary mammography
- Position emission tomography (PET) scans

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

Durable medical equipment; prosthetic and orthotic, and medical supplies	Participating provider – 100%

Your plan covers items like oxygen, CPAP and related respiratory equipment and supplies, ostomy supplies, and parenteral and enteral nutrition therapy, wheelchairs, walkers, canes, crutches and hospital beds ordered by a doctor or other health care provider for use in the home. Some items must be rented.

Emergency care	$50 copay for emergency room (waived if admitted as inpatient)

Your benefit plan covers the sudden and unexpected condition that threatens life or could result in serious bodily harm if prompt medical attention is not received. The patient's condition must be such that failure to obtain care or treatment could reasonably result in significant impairment to bodily functions, permanent health condition is placed in jeopardy, or condition could result in death.

Your coverage provides payment for the initial examination and treatment of accidental injuries and conditions determined to be medical emergencies. Hospital services associated with the initial examination will be subject to your copayment.

Copayment is waived only if the patient is admitted as inpatient.

Emergency care coverage does not cover:

- Follow-up care
- Chronic conditions unless an acute, life-threatening attack occurs
- Care and treatment once you are stabilized
- Continuation of care beyond that needed to evaluate or stabilize your condition in an emergency department

End Stage Renal Disease (ESRD)	See “Dialysis services” for additional benefit information.

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.

When BCBSM coverage is the primary or secondary plan

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-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.

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.

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. The period before Medicare coverage begins (up to three months) is the Medicare waiting period. In this case, Medicare coverage begins on the first day of the month in which you begin your regular course of dialysis.

Dual entitlement

If you have dual entitlement to Medicare **and** have the SHP PPO 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.
- If entitlement based on ESRD occurs after entitlement based on age or disability, primary plan status is determined as follows:
  - 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.
  - If you are not a working aged or working disabled individual in the first month of dual entitlement, Medicare is your primary plan.

Foot care	Covered – 90% after deductible

Certain services to the foot and ankle are covered. This includes cutting or removal of corns, calluses or trimming of nails or application of skin areas, and other hygienic and preventive maintenance care when related to diabetes or peripheral heart disease.

Hearing care

Your hearing care coverage is designed to identify hearing problems and provide benefits for corrective hearing problems. Hearing benefits are covered only when services are received from a participating provider and are payable once every 36-months, unless significant hearing loss occurs earlier and is certified by your physician. An example of severe hearing loss would be when a person wearing the hearing aid cannot distinguish normal speech 25 percent of the time.

Provider participation does not apply to medical hearing clearance exam

In Michigan, all services, except the medical hearing clearance exam, must be rendered by a participating provider.

All out-of-state providers are paid the amount that is approved by the local Blue Cross Blue Shield Plan. However, if you receive services from a provider who does not participate with the local BCBSM Plan, the Plan will send their approved amount to you. You will be liable for the difference between the approved amount and the provider's charge.

Hearing care: Audiometric examination	Participating provider – 100%

Audiometric examinations must be performed by a participating physician-specialist, audiologist, or hearing aid dealer. Covered services include tests for measuring hearing perception relating to air conduction, bone conduction, speech reception threshold and speech discrimination and providing a summary of findings.

Hearing care: Hearing aid evaluation and conformity test	Participating provider – 100%

Evaluation and test must be prescribed by a physician and performed by a participating physician-specialist, audiologist, or hearing aid dealer.

Hearing care: Hearing aids	Participating provider 100% for standard and binaural aids

Coverage includes payment for standard or binaural hearing aids. Deluxe hearing aids are covered up to the amount paid for standard hearing aids. You are liable for the balance of the cost.

Covered hearing aid services include:

- Medical clearance exam
- Audiometric examination
- Hearing aid evaluation and conformity test
- Ordering and fitting of the hearing aid

Hearing care: Medical hearing clearance exam	Covered up to $20 copay

You are covered for exams to evaluate sensory neural and conductive hearing losses. Exams may include:

- A basic hearing screening, which is a brief evaluation done during a routine office visit.
- Audiometric studies ordered after initial screening indicates there may be an illness or injury including, but not limited to, the following:
  - Established hearing loss
  - Otitis media
  - Ménière's disease
  - Labyrinthitis
  - Vertigo (dizziness)
  - Tinnitus
  - Cochlear otosclerosis
  - Neoplasms of the auditory or central nervous system
  - Congenital anomalies
  - Surgery involving the auditory and/or central nervous system, e.g. skull-based tumors such as acoustic neuroma and meningioma
  - Facial nerve paralysis (Bell's Palsy)
  - Bacterial meningitis
  - Exposure to intense noise
  - Ototoxic drugs
  - Fractures of the temporal bone or trauma affecting the central auditory pathways

Services must be provided prior to receiving hearing aids. For members 17 years or younger, the exam is required for each hearing aid purchase. For members over age 17, the exam is only required on the initial hearing aid purchase.

Hearing care: Ordering and fitting of the hearing aid	Participating provider – 100%

Includes basic hearing aids in-the-ear, behind-the-ear, and worn on the body with ear molds, if necessary, as well as dispensing fees for the normal services required for fitting the hearing aid.

Your hearing care coverage does not cover:

- A hearing aid ordered while the patient is a member, but delivered more than 60 days after the patient's coverage terminates
- Additional charges for eye-glass type hearing aids (sometimes called "deluxe" hearing aids) that exceed the amount BCBSM pays for a basic hearing aid
- Additional charges for digital-controlled programmable hearing devices (sometimes called "deluxe" hearing aids) that exceed the amount BCBSM pays for a basic hearing aid
- Additional charges for unusual or cosmetic equipment such as canal, one half shell or low profile hearing aids (sometimes called "deluxe" hearing aids) that exceed the amount BCBSM pays for a basic hearing aid
- All hearing care services and supplies provided by a nonparticipating provider in Michigan
- Hearing aids that do not meet Food and Drug Administration and Federal Trade Commission requirements
- Medical clearance examination to determine possible loss of hearing (covered under medical benefit)
- Repairs and replacement of parts including batteries and ear molds
- Replacement of hearing aids that is lost or broken, unless this occurs after 36 months, when benefits are renewed
- Services performed by nonparticipating providers in Michigan and outside of Michigan where the Blue Cross and Blue Shield plan contracts with providers for hearing care services
- Medical or surgical treatment (may be covered under your medical/health coverage)
- Drugs or other medications
- The trial and testing of different makes and models of hearing aids when the tests are not supported by the results of the most recent audiometric examination
- Charges for audiometric examinations, hearing aid evaluation tests, conformity tests and hearing aids which are not necessary, according to professionally accepted standards of practice, or which are not prescribed by the physician-specialist
- Charges for spare hearing aids
- Any charges that exceed our approved amount for covered hearing aids if you obtain digitally-controlled programmable hearing devices
- Examinations related to medical-surgical procedures such as tonsillectomies or myringotomies
- Two hearing aids ordered on different dates. These are not considered binaural hearing aids.

Home health care	Participating provider – 90% after deductible

Your home health care benefit covers services when the service is prescribed by an attending physician and provided and billed by a participating home health care agency. The physician must certify that the home health care services are being used instead of inpatient hospital care, and that the patient is confined to the home due to 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.

Covered services include:

- 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 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, and are subject to the physical, speech and occupational therapy 90-visit maximum.

The following covered services are payable when the home health care is provided by a **participating** hospital:

- Lab services, 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

Your home health care coverage does not cover:

- Services by a non-participating agency or provider
- Custodial care, rest therapy and care in nursing or rest home facilities
- Health care services provided by persons who are not legally qualified or licensed to provide such services
- Comfort items such as lotion, mouthwash or body powder
- Cost of meals
- Custodial or non-skilled care
- Elastic stockings, including nonprescription compression socks
- General housekeeping services
- Physician services
- Sheepskin
- Transportation to or from a hospital or other facility

Home Hemophilia	Covered - 90% after deductible

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

Benefits include:

- All medications, including the antihemophilic factor
- Necessary hemophilia supplies, including syringes and needles
- Training of the patient or a family member on how to inject the antihemophilic factor when the training is provided through an approved facility

Home infusion therapy (HIT)	Participating provider – 90% after deductible

Home infusion therapy services are covered 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
- Given by participating HIT providers

Services include:

- Drugs required for HIT
- Nursing services needed to administer HIT 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, HIT is only covered under the home health care benefit.

We do not cover services rendered by a nonparticipating provider.

Home visits	Covered – 90% after deductible

Home visits by a physician are covered.

Hospice care	BCBSM or Medicare-certified hospice program – 100%

Hospice services consist of health care services provided to a terminally ill person. Services must be provided by a participating hospice program. Services are payable for four 90-day periods. Written statements and certifications are required. Regular benefits for conditions related to the terminal illness are not in force while hospice benefits are being used. Benefits for conditions **not** related to the terminal illness remain in effect.

Hospice services include meetings with the hospice staff for a maximum of 28 visits for preadmission counseling, evaluation, education and support services.

They also include the following services:

Home 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.

Hospital services

- Inpatient care provided by a:
  - Participating hospice inpatient unit
  - Participating hospital contracting with the hospice program or
  - 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
- 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
- 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

Physician services

Services provided by the attending physician (not part of the hospice team) to make the patient comfortable and to manage the terminal illness and related conditions.

Hospice care is limited to a maximum amount that is reviewed and adjusted periodically. Please call the BCBSM Customer Service Center for information about the current maximum amount.

Your hospice services coverage does not cover:

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

Hospital care – inpatient	**In-network – 90% after deductible**

Your coverage includes the following inpatient hospital services when medically necessary:

- Semi-private room and board, general nursing services and special diets
- Services provided in a special care unit, such as intensive care
- Unlimited general medical care days
- Anesthesia, laboratory, oxygen, radiology and pathology services, drugs, durable medical equipment, medical and surgical supplies, prosthetic and orthotic appliances
- Chemotherapy, inhalation therapy and hemodialysis
- Diagnostic and radiology services
- Maternity care, and routine nursery care for a newborn during an eligible mother's hospital stay
- Operating and other surgical treatment rooms, delivery room and special care units
- Physical, speech and occupational therapy
- Pain management
- Cardiac rehabilitation services
- Whole blood, blood derivatives, blood plasma or packed red blood cells, supplies and their administration

- Hyperbaric oxygenation (therapy given in a pressure chamber)
- Organ transplants
- Other inpatient services and supplies necessary for treatment

Your hospital care coverage does not cover:

- Hospital admissions that begin **before** the effective date of coverage
- Hospital admissions that begin **after** the coverage termination date
- Hospitalization principally for:
  - Basal metabolism tests
  - Diagnostic evaluation
  - Electrocardiography
  - Observation
  - Physical therapy
  - Reduction of weight by diet control (with or without medication)
  - X-ray or lab tests

Hospital care – outpatient	**In-network – 90% after deductible**

The services listed under "Hospital care – inpatient" are also payable when provided as outpatient care when performed in the outpatient department of a hospital or, where noted, in a freestanding facility approved by BCBSM. See the individual benefit listing for details.

Your hospital care coverage does not cover routine hospital outpatient care requiring repeated visits for the treatment of chronic conditions.

Human organ transplants Call HOTP at 1-800-242-3504 for more information

Human organ transplants: Specified	**100% in designated facilities when pre-approved**

Specified human organ transplants are covered when performed in a designated facility. All services must be pre-certified. We cover 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 which begins five days before, and ends one year after, the organ transplant.

When directly related to the transplant, we cover:

- 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 (as recommended by the Advisory Committee on Immunization Practices (ACIP)
- Medically necessary services to treat a condition arising out of the organ transplant surgery if the condition:
  - Occurs **during** the benefit period and
  - Is a **direct** result of the organ transplant surgery

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

We also cover the following:

- Up to $10,000 for eligible travel and lodging during the initial transplant surgery. This includes the 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).Transportation, meals and lodging costs for circumstances other than those related to the initial transplant surgery and hospitalization are not covered.

  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, meals 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. Storage of donor organs for the purpose of future transplants is not covered.
  - Transportation of the organ
- 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

Human organ transplants: Bone marrow, kidney, cornea and skin

The SHP PPO covers human organ and tissue transplants such as bone marrow, kidney, cornea and skin when they are received at a participating hospital or designated cancer center. Bone marrow and organ transplants are only covered when the transplant is pre-approved.

All payable human organ transplant services, except anti-rejection drugs and other transplant-related prescription drugs, are payable during the first 24 months post-transplant. Post-transplant immunizations for cornea and skin transplants are not covered.

Human organ transplants: Bone marrow transplants	100% in designated facilities when pre-approved

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

- Allogeneic transplants are covered for the following services:
  - 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 pre-approved.
  - 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 or beta thalassemia.)
    - Harvesting and storage are 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 or beta thalassemia, the donor must be an HLA-identical sibling.
  - High-dose chemotherapy and/or total body irradiation
  - Infusion of bone marrow, peripheral blood stem cells, and/or umbilical cord blood
  - T-cell depleted infusion
  - Donor lymphocyte infusion
  - Hospitalization
- Autologous transplants are covered for the following services:
  - 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 cover up to two tandem transplants or a single and a tandem transplant per patient for this condition.
- 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)
- Allogeneic transplants are covered to treat the following conditions:
  - 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 lymph proliferative 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
- Mucolipidoses (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
- Plasmacytomas
- Renal cell carcinoma

• 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 (AL)
  - 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.

Human organ transplants: Skin, cornea and kidney transplant	Covered – 90% after deductible

Benefits are payable for services and expenses for transplanting organs and tissues to an eligible recipient. Coverage includes services to obtain, test, store and transplant and surgical removal of the donated part (including skin, cornea and kidney) from a living or non-living donor.

Injections	Covered – 90% after deductible

Fluids that are forced into a vein or body organ or under the skin to fight disease are payable.

Laboratory and pathology tests	Covered – 90% after deductible

Coverage includes laboratory tests and procedures required to diagnose a condition or injury.

Medical eye exams	Covered up to $20 copay

Benefit includes the diagnosis and treatment of an illness, injury or disease.

Office visits and office consultations	Covered up to $20 copay

We cover office visits and consultations.

Optical services	Covered – 90% after deductible

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

Osteopathic manipulation	Covered up to $20 copay

Coverage is provided for osteopathic manipulation.

Physical, occupational and speech therapy (combined maximum of 90 visits)	Covered – 90% after deductible

Physical therapy, speech and language pathology services, and occupational therapy, are payable when provided for rehabilitation. This includes services rendered in a physician's office and an outpatient facility. Developmental speech therapy for children through 6 years is also covered. (The benefit maximum does not apply for developmental speech therapy.)

NOTE: 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 facility.

Benefit maximum

These services have a combined benefit maximum of 90 visits per member, per calendar year, whether services are rendered in an outpatient location (hospital, facility, office or home), or obtained from an in-network or out-of-network provider.

Mechanical traction performed by a chiropractor **is** applied toward this maximum.

The physical therapy, speech and language pathology services and occupational therapy benefit maximum renews each calendar year.

Visit count

Each treatment date counts as one visit even if two or more therapies are provided and 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)
- Given by a(n):
  - Doctor of medicine, osteopathy or podiatry
  - Dentist for the oral-facial complex
  - Chiropractor rendering mechanical traction
  - Optometrist for services which he or she is licensed
  - Certified nurse practitioner in an independent practice
  - Physical therapist
  - Physical therapist in a physician's or independent physical therapist's office
  - Independent physical therapist in his or her office
  - Physical therapy assistant and athletic trainer under the direct supervision of a physical therapist
  - Physician assistant or certified nurse practitioner employed by a physician
  - Physical therapy assistant or athletic trainer under the direct supervision of an independent physical therapist in the therapist's office

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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 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

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(n):
  - Occupational therapist
  - Occupational therapy assistant under the direct supervision of an occupational therapist
  - 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.

Exclusions

Specific exclusions

Your physical therapy benefits do not pay for:

- Health club membership or spa membership
- Massage therapy

Your speech and language pathology services benefits do not pay for:

- Services provided by speech-language pathology assistants or therapy aides
- Congenital or inherited speech abnormalities for members over the age of 6
- Developmental conditions or learning disabilities for members over the age of 6
- Inpatient hospital admissions principally for speech or language therapy

General exclusions

We do not pay for:

- 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 for member above the age of 6 years

  NOTE: For certain pediatric patients (above the age of six years) 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
- Therapy to treat long-standing, chronic conditions such as arthritis 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
- Patient education and home programs (such as home exercise programs)
- Sports medicine for purposes such as prevention of injuries or for conditioning
- Recreational therapy

Pre-admission testing	In-network – 90% after deductible

Testing must be performed within seven days before a scheduled hospital admission or surgery. These tests must be medically appropriate, valid at the time of admission and must not be duplicated during the hospital stay.

Preventive services — $1,500 maximum Certain services are not included in this maximum.

Preventive services may include tests or services recommended by your doctor when they are used to first detect or screen for a disease or condition. Examples of preventive services are those included in annual exams, such as health maintenance exams (physicals) or OB-GYN visits.

For a complete list of preventive services covered under the SHP PPO, visit: **www.bcbsm.com/som**.

Private duty nursing	Covered – 80% after deductible Contact the BCBSM Customer Service Center before receiving services

Covered when the patient's medical condition requires in-home private duty nursing services. Services must be prescribed by a physician and provided by a registered or licensed practical nurse. It does not cover services provided by, or within the scope of practice, or medical assistants, nurse's aides, home health aides, or other non-nurse level caregivers.

Contact the BCBSM Customer Service Center before receiving services.

Skilled nursing care	Covered – 90% after deductible (in a BCBSM-approved skilled nursing facility)

Your benefits provide for skilled care and related physician services in a skilled nursing facility (SNF). Admission is covered when:

- Care is received in a BCBSM-approved SNF
- The admission is ordered by the patient's attending physician
- The patient is suffering from or gradually recovering from an illness or injury and is expected to improve

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

Benefit period

Maximum of 120 days, for each benefit period, in a SNF for general conditions is payable. Period renews after 90 days.

NOTE: For each inpatient hospital care day used, the available benefit period for treatment in a SNF is reduced by two days.

The following services are covered:

- Semiprivate room, general nursing services, meals and special diets
- Special treatment rooms
- Laboratory examinations
- Oxygen and other gas therapy
- Drugs, biologicals and solutions used while in the SNF
- Gauze, cotton, fabrics, solutions, plaster, and other materials used in dressings and casts
- Durable medical equipment used in the SNF or for use outside of the facility when rented or purchased from the facility upon discharge
- Physical therapy, speech and language pathology services or occupational therapy when medically necessary and provided for rehabilitation. We cover up to 90 therapy treatments per condition provided within 180 days of the first treatment. To determine the benefit maximum, services are counted from the first day of treatment and renewed:
  - Immediately after surgery for the condition that was treated, or
  - Following a distinct aggravation of the condition that was treated, or
  - Each calendar year

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

NOTE: Physical therapy services given to treat the same condition count towards meeting the maximum regardless of who provides the service or where it is provided.

Your skilled nursing care coverage does not cover:

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

Sleep studies	Covered – 90% after deductible

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

- Narcolepsy characterized by abnormal sleep tendencies, amnesia episodes or continuous agonizing drowsiness
- Severe upper airway apnea

Sleep studies are not covered for the following:

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

Specified oncology clinical trials	Covered – 90% after deductible in designated facilities when pre-approved

Coverage is provided for a study conducted on a group of patients to determine the effect of a treatment. This includes Phase I, Phase II, Phase III and Phase IV.

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

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

- The inpatient admission and length of stay must be medically necessary and pre-approved. No retroactive approvals will be granted.
- The services must be performed at a National Cancer Institute (NCI)-designated cancer center or an affiliate of an NCI-designated center.
- The treatment plan, also called “protocol,” must meet the guidelines of the American Society of Clinical Oncology statement for clinical trials.

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

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

Surgery	Covered – 90% after deductible

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

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

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

Coverage also includes the administration of anesthesia, performed in connection with a covered service by a physician, other professional provider or certified registered nurse anesthetist who is not the surgeon or the assistant at surgery or by the surgeon in connection with covered oral surgical procedures.

Your surgical benefit does not cover:

- Cosmetic surgery and related services solely for improving appearance, except as specified in this booklet
- Dental surgery other than for the removal of impacted teeth or multiple extractions when the patient must be hospitalized for the surgery because a concurrent medical condition exists
- Reverse sterilization

A technical surgical assistant is covered for certain major surgeries that require surgical assistance by another physician.

Temporomandibular Joint Syndrome (TMJ)	Covered – 90% after deductible

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

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

The following is not covered:

- Irreversible TMJ services with the exception of surgery directly related to the jaw joint
- Treatment of TMJ and related jaw-joint problems by any method other than as specified in this benefit booklet

Urgent care visits	Covered up to $20 copay

Non-emergency treatments are covered at independent urgent care facilities.

Weight loss	Covered – 100% up to $300 lifetime maximum

When preauthorized by BCBSM, benefits are available for non-medical weight reduction up to a lifetime maximum of $300.

Wigs

You have a lifetime maximum of $300 for wigs, wig stands and supplies, such as adhesives. This benefit is for those who need wigs because of cancer or alopecia. Additional replacements for children due to growth are not limited to the lifetime maximum.

Medicare supplemental benefit summary

	In-network
Cost share	
Out-of-pocket dollar maximums	$2,000 per member $4,000 per family
Deductible	$400 per member $800 per family
Coinsurance	10% for most services 20% for acupuncture and private duty nursing
Fixed dollar copays	$50 for emergency room visit, $20 for office and urgent care visits, medical eye exam, medical hearing exam, osteopathic, chiropractic manipulation
Preventive services – Limited to $1500 per calendar year per person (for most services)	
Annual gynecological exam	100%
Annual physical	100%
Adult vaccinations	100%
Colonoscopy	100%
Mammography	100%
Prostate screening	100%
Emergency medical care	
Ambulance services	90% after deductible
Emergency room	$50 copay (waived if admitted as inpatient)
Diagnostic tests and radiation services	
Diagnostic mammography	90% after deductible
Diagnostic tests	
Lab and pathology tests	
Position Emission Tomography (PET) scans	
Radiation therapy	
X-rays, ultrasound, MRI and CAT scans	
Hospital care	
Chemotherapy	90% after deductible
Consultations – inpatient and outpatient	
Inpatient care – unlimited days	
Alternatives to hospital care	
Home health care (unlimited visits)	90% after deductible (participating provider only)
Hospice care	100% (participating provider only)
Private duty nursing – Contact the BCBSM Customer Service Center before receiving services	80% after deductible
Skilled nursing care (120 skilled days per admission period)	90% after deductible (in a BCBSM-approved facility)
Urgent care visit	Up to $20 copay

	In-network
Human organ transplants – Contact HOTP at 800-242-3504 for additional criteria and information	
Bone marrow	100% in designated facilities when pre-approved
Kidney, cornea and skin	90% after deductible
Liver, heart, lung, pancreas and other specified organs	100% in designated facilities when pre-approved
Surgical services	
Surgery	90% after deductible
Vasectomy	
Voluntary female sterilization	
Hearing care	
Audiometric exam	**Participating** 100%
Hearing aid evaluation and conformity test	
Hearing aid (ordering and fitting)	
Hearing aids (standard only)	
Medical hearing clearance exam	Up to $20 copay
Other services	
Acupuncture	80% after deductible
Allergy testing and therapy	90% after deductible
Anesthesia	90% after deductible
Cardiac rehabilitation	90% after deductible
Chiropractic / spinal manipulation 24 visits per calendar year	Up to $20 copay
Durable medical equipment; prosthetic and orthotic appliances and medical supplies	100%
Injections	90% after deductible
Observation care	90% after deductible
Office consultations	Up to $20 copay
Office visit	
Osteopathic manipulation therapy	
Outpatient hospital and home visits	90% after deductible
Outpatient physical, speech and occupational combined 90 visit maximum per calendar year	90% after deductible
Wig, wig stand, adhesives	$300 lifetime maximum Additional wigs covered for children due to growth

This benefit chart is intended as an easy-to-read summary. It is not a contract. Additional limitations and exclusions may apply to covered services. Every effort has been made to ensure the accuracy of this information. However, if statements in this description differ from the applicable coverage documents, then the terms and conditions of those documents will prevail. Payment amounts are based on the BCBSM-approved amount, less any applicable deductible and/or copay amount required by the SHP PPO. This coverage is provided pursuant to a contract entered into with the State of Michigan and shall be construed under the jurisdiction and according to the laws of the state of Michigan.

Selecting providers when using your State Health Plan PPO

When you select hospitals, doctors or other medical providers, always ask if they accept assignment of Medicare claims. This means they will not bill you for the difference between their charge and the Medicare-approved amount. These providers will also file your Medicare claims for you. To find out if a particular provider accepts Medicare assignment, check directly with the provider or call 800-MEDICARE. To find a Medicare provider in a particular area, call the local Medicare administrator, or visit **medicare.gov**. You can obtain the number of the local Medicare administrator by calling 800-MEDICARE.

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

Explanation of cost-share

You pay the deductible, coinsurance and copayments required by the State Health Plan PPO as well as services not covered by the State Health Plan PPO.

Deductibles

Your deductible is the specified amount you pay during each calendar year for services before your plan begins to pay. Your supplemental plan also pays the Medicare annual deductible for services covered under the State Health Plan PPO.

Certain benefits can be rendered before your deductible is fulfilled. For example, there is no deductible for office visits, office consultations, urgent care visits, osteopathic and chiropractic spinal manipulations, medical eye exams and medical hearing exams.

For details on the services that do or do not require fulfillment, please refer to the benefit summary chart or benefit explanation in this booklet.

4th quarter carryover of in-network deductible

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

Coinsurance

After you have met your deductible, you are responsible for the coinsurance, a percentage of the BCBSM allowed amount. Coinsurance is not the same as your deductible, but your supplemental plan pays the Medicare coinsurance for services covered under the State Health Plan PPO.

Copayments

A copayment is a fixed dollar amount that you pay at the time of service, such as an office visit copay.

Out-of-pocket maximum

The out-of-pocket maximum is the dollar amount you pay in deductible, copayment, and coinsurance during the calendar year. Once you satisfy your out-of-pocket maximum the SHP PPO will cover 100% of the allowed amount for covered services including coinsurances for mental health and substance abuse. Effective October 2015, prescription drug copays under the State Prescription Drug plan will apply to the annual out-of-pocket maximum. Certain coinsurance, deductible and other charges cannot be used to meet your out-of-pocket maximum. These coinsurance, deductible and other charges are:

- Charges for noncovered services
- Charges in excess of our approved amount
- Deductibles or copayments required under other BCBSM coverage

Dollar maximums

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

What is not covered

In addition to the exclusions listed with the benefit, the following services are not covered under the SHP PPO:

- Care and services available at no cost to you in a veteran, marine or other federal hospital or any hospital maintained by any state or governmental agency
- Care and services received under another certificate offered by BCBSM or another Blue Cross Blue Shield Plan
- Care and services payable by government-sponsored health care programs, such as Medicare or TRICARE for which a member is eligible. These services are not payable even if you have not signed up to receive the benefits provided by such programs.
- Infertility treatment
- Items for the personal comfort or convenience of the patient
- Medical services or supplies provided or furnished before the effective date of coverage or after
- the coverage termination date
- Medically necessary services that can be provided safely in an outpatient or office location are not payable when provided in an inpatient setting.
- Premarital or pre-employment exams
- Services and supplies that are not medically necessary according to accepted standards of medical practice
- Services, care, devices or supplies considered experimental or investigative
- Services for which a charge is not customarily made
- Services for which the patient is not obligated to pay or services without cost
- Services that are not included in your plan coverage documents
- Services are not covered for incarcerated members
- Transportation and travel except as specified in this benefit booklet
- Treatment of occupational injury or disease that the State of Michigan is obligated to furnish or otherwise fund

Value-added programs at no cost to you

As a retiree enrolled in the SHP PPO, you and your eligible dependents can participate in several wellness and discount programs. While these programs are designed to improve health and complement traditional health care, some also could save you money. For more information on these value-added programs, visit **bcbsm.com**.

Care management is available to you once you have exhausted all of your Medicare benefits. It offers comprehensive care management services for high-risk, medically complex cases. Case management works with the member, provider and caregivers to ensure a clear understanding of the member's condition, prognosis and treatment options. They also help coordinate provider services for the member. For more information on our case management program, visit **http://www.bcbsm.com/index/healthy-living/bluehealthconnection/our-case-management-programs.html**.

Digital health coaching

BlueHealthConnection's digital health coaching programs provide the support you need to make sustainable lifestyle and behavior changes to improve your health.

The programs give you access to:

- Techniques to help relieve stress
- Tips for weight management and healthy eating
- Methods to help you enjoy life despite painful chronic conditions
- Confidential help for any level of depression and much more

You can learn more about digital health coaching programs can by logging in as a member at **bcbsm.com**.

Healthy Blue Xtras℠ and Blue365℠

With Healthy Blue Xtras, you can get score big savings and special offers on health products and services from both Michigan and national companies just by showing your BCBSM ID card. This discount savings program is offered through an easy-to-use online tool updated daily for your convenience. Check out **bcbsm.com/xtras** to get started.

Quit the Nic

The Quit the Nic program can help you quit tobacco for good. As part of the program, a nurse health coach will discuss your readiness to quit, and will guide you through a series of topics to help you through the quitting process. Together, you'll establish an action plan to gradually stop using tobacco and determine a final quit date.

To learn more about Quit the Nic, call 1-800-775-BLUE.

The Nurse Line

With this free, new and confidential service, our team of nurses can discuss treatment options and provide advice on how to handle situations that in the past would have prompted everything from unnecessary anxiety to a needless trip to the emergency room. You can contact them with any health-related questions you may have — whether you have a cold or a chronic condition, our nurses are here to support you every minute of the day. To learn more, call 1-800-775-BLUE.

The Engagement Center

The Engagement Center is a central hub that can help members get questions answered, learn more about how to manage their health and make the most of BCBSM's service and tools. To contact the Engagement Center, call 1-800-775-2583 from 8 a.m. to 8 p.m. EST Monday through Saturday.

Explanation of benefits payments

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

- The family member who received services
- Who provided the service, the payments made and any amount saved by using a network or participating provider
- Helpful information about BCBSM programs
- Service dates, charges, payments and any balance you may owe

You may access your EOBP forms online by visiting **bcbsm.com** and signing in at the Members Secured Services site. You may also receive your EOBPs by mail.

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

If you think your provider is intentionally billing us for services you did not receive, or that someone is using your BCBSM ID card illegally, contact our anti-fraud toll-free hotline at 800-482-3787. Your call will be kept strictly confidential.

Coordination of benefits

Coordination of benefits (COB) is the process group health care plans and insurance carriers use to manage benefits when members are covered by more than one plan. Under COB, group health care plans and insurance carriers work together to make sure members receive the maximum benefits available under their plans. Your SHP PPO requires that your benefit payments are coordinated with those from any other group plan for services that may be payable under both plans.

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

How COB works

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

These are the guidelines used to determine which plan pays first:

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

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

Processing your COB claims

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

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

Be sure to include the EOBP form you received from your primary plan. **Please make copies of all forms and receipts for your files.**

Keeping your COB information updated

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

Subrogation

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

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

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

Filing claims

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

To file your own claim, follow these steps:

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

   State of Michigan Customer Service Center
   Blue Cross Blue Shield of Michigan
   232 S. Capitol Avenue, Mail Code L04A
   Lansing, MI 48933-1504

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

Medicare coverage

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

- Age 65 or older
- Under age 65 but have received a Social Security disability benefit for at least 24 months

Medicare is your primary coverage, which means it pays your claims first. To take advantage of your supplemental benefits under the SHP PPO, you must submit a retiree Insurance Enrollment/Change Request form to the ORS when you retire. For additional information, please visit **michigan.gov/ors**.

Enrolling in Medicare

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

Automatic enrollment for those already receiving Social Security benefits

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

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

You might need to enroll in Medicare Part A and Part B

When you are first eligible for Medicare, you have a seven-month Initial Enrollment Period to sign up for Part A and/or Part B. If you do not sign up when you are first eligible, you can sign up during the General Enrollment Period (January 1 through March 31 of each year), but your coverage will start July 1, and you may have to pay a higher premium for late enrollment.

You are covered under a group health plan based on current employment, therefore, you qualify for a Special Enrollment Period during which you may sign up for Part A and/or Part B. The Special Enrollment Period provides two options for enrollment:

1. You may enroll in Part A and/or Part B anytime, as long as you or your spouse (or family member if you are disabled) are working, and covered by a group health plan.
2. You may enroll during the eight-month period that begins the month after the employment ends or the group health plan coverage ends, whichever happens first.

Remember if you do not enroll in Part B of Medicare at the appropriate time, your health care coverage will be adjusted as if Medicare coverage was in place. The SHP PPO will not reimburse that portion of expenses normally covered by Medicare. This will result in limited or no payment.

For more information on Medicare log on to the Medicare website at **www.medicare.gov**.

Your right to file an internal grievance

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

Internal grievances

Standard internal grievance procedure

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

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

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

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

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

  Mail your request to:
  Conference Coordination Unit
  Blue Cross Blue Shield of Michigan
  P.O. Box 2459
  Detroit, MI 48231-2459

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

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

  You may authorize in writing another person including, but not limited to, a physician to act on your behalf at any stage in the standard internal grievance procedure.

  Although we have 35 days within which to give you our final determination, you have the right to allow us additional time if you wish. You may obtain copies of information relating to our denial, reduction or termination of coverage for a health care service for a reasonable copying charge.

Expedited internal grievance procedure

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

The procedure is as follows:

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

  Call the expedited grievance hot line: 313-225-6800.

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

- In addition to the information found above, you should also know:
  - You may authorize in writing another person including, but not limited to, a physician to act on your behalf at any stage in the expedited internal grievance procedure.
  - If our decision is communicated to you orally, we must provide you with written confirmation within two business days.

External review

Standard external review

If you complete our standard internal grievance procedure and disagree with our final determination, or if we fail to provide you with our final determination within 35 days from the date we receive your written grievance, you may request an external review from the commissioner. You must do so within 60 days of the date you received either our final determination or the date our final determination was due. Mail your request for a standard external review, including the required forms that we will supply to you, to:

Department of Insurance and Financial Services
Appeals Section
Health Plans Division
P.O. Box 30220
Lansing, MI 48909-7720

If your request for external review concerns a medical issue and is otherwise found to be appropriate for external review, the commissioner will assign an independent review organization, consisting of independent clinical peer reviewers, to conduct the external review. You will have an opportunity to provide additional information to the commissioner within seven days after you submit your request for external review.

The assigned independent review organization will recommend within 14 days whether the commissioner should uphold or reverse our determination. The commissioner must decide within seven business days whether or not to accept the recommendation. The commissioner's decision is the final administrative remedy.

If your request for external review is related to non-medical contractual issues and is otherwise found to be appropriate for external review, the commissioner's staff will conduct the external review. The commissioner's staff will recommend whether the commissioner should uphold or reverse our determination. The commissioner will notify you of the decision and it will be your final administrative remedy.

Expedited external review

Once you have filed a request for an expedited internal grievance, you may also request an expedited external review from the commissioner before you receive our determination. A physician must substantiate orally or in writing that you have a medical condition for which the time frame for completion of an expedited internal grievance would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function. You may file a request for an expedited external review only when you think that we have wrongfully denied, terminated or reduced coverage for a health care service prior to your having received that health care service. You must make your request within 10 days of your receipt of our adverse determination, and you may do so in writing or by telephone.

If in writing, mail your request to:

Department of Insurance and Financial Services
Appeals Section
Health Plans Division
P.O. Box 30220
Lansing, MI 48909-7720

If by telephone, call toll-free number: **1-877-999-6442**.

Immediately after receiving your request, the commissioner will decide if it is appropriate for external review and assign an independent review organization to conduct the expedited external review. If the independent review organization decides that you do not have to first complete the expedited internal grievance procedure, it will review your request and recommend within 36 hours whether the commissioner should uphold or reverse our determination. The commissioner's decision is your final administrative remedy.

Sections 402 and 403 of Public Act 350

What we may not do

The sections below provide the exact language in the law.

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

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

- Fail to provide promptly a reasonable explanation of the basis for a denial of a claim or for the offer of a compromise settlement
- Fail to promptly settle a claim where liability has become reasonably clear under one portion of the certificate in order to influence a settlement under another portion of the certificate

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

The things we cannot do under this section are:

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

What we must do

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

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

Disclosure required by the Patient Protection Act

Upon enrollment, we must provide subscribers, in plain English, a written description of the terms and conditions of Blue Cross Blue Shield of Michigan's certificate. The form must list all information that is available to the member upon request.

The following information is available to you by calling or writing Blue Cross Blue Shield of Michigan customer service at the number or address listed on page one of this book. You can request:

- A description of the current provider network in your service area
- A description of the professional credentials of participating health professionals
- The licensing verification telephone number for the Michigan Department of Consumer and Industry Services
- A description of any prior authorization requirements and any limitations, restrictions or exclusions
- A description of the financial relationships between the Blue Cross Blue Shield of Michigan managed care areas and any closed provider network

We require that your request for information be submitted to Blue Cross Blue Shield of Michigan in writing.

Appeals to Civil Service Commission

If you have exhausted the internal grievance procedures with BCBSM, you may appeal a denial by BCBSM to the Employee Benefit Division of the Civil Service Commission. The complaint must be received within 14 calendar days after the date that the final internal decision of BCBSM was issued. Additional information on appeals can be found in Civil Service Regulation 5.18, Complaints About Benefits, which is available in the Rules and Regulations section of the Michigan Civil Service Commission Web site (**http://www.michigan.gov/documents/mdcs/SPDOC13-09a_434763_7.pdf**). Appeals are sent to:

Employee Benefits Division
P. O. Box 30002
Lansing, MI 48909

Glossary

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

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

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

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

Adequate access is defined by how far you live from PPO providers and hospitals. The SHP PPO access standards are:

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

Affordable Care Act (ACA), also known as the Patient Protection and Affordable Care Act (PPACA), is the health reform legislation that includes health-related provisions intended to extend coverage to uninsured Americans, to implement measures that will lower health care costs and improve system efficiency.

Allowed amount is the maximum amount on which payment is based for covered health care services. This may be called “eligible expense,” “payment allowance” or “negotiated rate.” If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance billing.)

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

Appeal is a complaint made if a member disagrees with a decision to deny a request for health care services or payment for services already received, or to stop services that are being received.

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

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

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

Balance billing means that a provider will bill you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the BCBSM allowed amount is $70, the provider may bill you for the remaining $30. A BCBSM PPO network provider may not balance bill you.

Benefit is coverage for health care services available according to the terms of your health care plan.

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

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

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

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

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

Coinsurance is a member's out-of-pocket percentage of the BCBSM allowed amount for covered services.

Complications of pregnancy are conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a nonemergency caesarean section are not considered complications of pregnancy.

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

Copayment (or copay) is the designated portion of the approved amount you are required to pay for covered services.

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

Custodial care is care mainly for helping a person with activities of daily living, such as walking, getting in and out of bed, bathing, dressing, eating or taking medicine. Custodial care can be provided safely and reasonably by people without professional skills or training to help patients with daily activities or personal needs, such as walking, getting in and out of bed, bathing, dressing and taking medicine. It also includes medical services, such as respiratory care, that a dedicated lay person can learn to perform. Custodial care is not covered by the SHP PPO.

Deductible is the specified amount you pay each calendar year for services before your plan begins to pay.

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

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

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

Emergency first aid is the initial exam and treatment of conditions resulting from accidental injury. First aid may include the following conditions which may require first aid treatment:

- Allergic reactions to bee stings or insect bites
- Attempted suicide
- Food poisoning
- Ingestion of poisons (accidental or intentional)
- Inhalation of smoke, carbon monoxide or fumes
- Sprains, strains
- Rape, attempted rape, questionable rape
- Cuts, abrasions, bruises
- Contusions
- Epitasis (nose bleed) if no packing or cautery is performed
- Sunburn or frostbite if no dressing is applied
- Application of butterfly suture
- Splinting or strapping billed along with traumatic diagnosis or as initial treatment of fracture
- Gastric lavage

Emergency medical condition is an illness, injury, symptom or condition so serious that you must seek care right away to avoid severe harm.

Emergency medical transportation is an ambulance that is used for an emergency medical condition.

Emergency room care provides emergency services in an emergency room.

Emergency services provide an evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

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

Excluded services are health care services for which your health plan does not pay or cover.

Experimental or investigative is a service, procedure, treatment, device or supply that has not been scientifically demonstrated to be safe and effective for treatment of the patient's condition. BCBSM makes this determination based on a review of established criteria, such as:

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

Facility is a hospital that offers medical care or specialized treatment, such as rehabilitation treatment, skilled nursing care or physical therapy.

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

Freestanding outpatient physical therapy facility is an independently owned and operated facility, separate from a hospital that provides outpatient physical therapy services and occupational or functional occupational therapy or speech and language pathology services.

Grievance is a complaint that does not involve coverage or payment disputes. For example, a complaint regarding one of our network providers or a complaint concerning the quality of care is considered a grievance. This type of complaint does not involve a request for an initial determination or an appeal.

Health insurance is a contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home health care is a range of health care services that can be given in the home. Home health care is usually less expensive, more convenient, but as effective as care in a hospital or skilled nursing facility. The goal of home health care is to treat an illness or injury.

Hospice services provide comfort and support for persons in the last stages (usually six months or less) of a terminal illness and their families.

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

Hospital outpatient care is care in a hospital that usually does not require an overnight stay.

Hospitalization is care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

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

In-network copayment is the fixed amount you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are usually less than out-of-network copayments.

In-network providers are providers who have met PPO standards and signed agreements to participate in the Community Blue network and to accept our approved amount as payment in full for covered services.

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

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

- The covered service is for the treatment, diagnosis of the symptoms of an injury, condition or disease.
- The service, treatment or supply is *appropriate* for the symptoms and is consistent with the diagnosis.
  - *Appropriate* means the type, level and length of care, treatment or supply and setting are needed to provide safe and adequate care and treatment.

For inpatient hospital stays, acute care as an inpatient must be necessitated by the patient's condition because safe and adequate care cannot be received as an outpatient or in a less intense medical setting. This means that:

- The services are not mainly for the convenience of the member or health care provider.
- The treatment is not generally regarded as experimental or investigational by BCBSM.
- The treatment is not determined to be medically inappropriate by the Utilization Management and Quality Assessment programs.

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

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

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

- Generally accepted as necessary and appropriate for the patient's condition, considering the symptoms. The covered service is consistent with the diagnosis.
- Essential or relevant to the evaluation or treatment of the disease, injury, condition or illness. It is not mainly for the convenience of the member or physician.
- Reasonably expected to improve the patient's condition or level of functioning. In the case of diagnostic testing, the results are used in the diagnosis and management of the patient's care.

Medically necessary are health care services or supplies needed to prevent, diagnose or treat an illness, injury, disease or its symptoms and that meet accepted standards of medicine.

Member is any person covered under the SHP PPO plan. This includes the subscriber and any eligible dependents listed in BCBSM membership records.

Network is a group of doctors, hospitals, DME and other health care providers contracted with BCBSM to provide services to members. Members typically pay less for using a network provider.

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

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

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

Out-of-network refers to services not rendered by a BCBSM PPO network provider.

Out-of-network costs are increased copayment and deductible amounts members may incur if they receive services from a provider that does not belong to the BCBSM PPO network without a referral. These costs could also include charges from a nonparticipating provider that are above the approved BCBSM amount.

Out-of-pocket maximum is the dollar amount you pay in deductibles, copayments, and coinsurance during the calendar year. Once you satisfy your out-of-pocket maximum, the plan will cover 100% of the allowed amount for covered services. Certain coinsurance, deductibles and other charges cannot be used to meet your out-of-pocket maximum, such as out-of-network coinsurance, out-of-network deductible and charges for non-covered services.

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

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

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

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

Physician or professional provider is a medical doctor (MD), doctor of osteopathy (DO), doctor of podiatric medicine (DPM), doctor of dental surgery (DDS), doctor of medical dentistry (DMD), or a fully licensed psychologist.

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

Reconstructive surgery is surgery or follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Referral process is the formal process members must follow when referred to a non-BCBSM PPO network provider by a network provider. The referring network provider must provide a completed Preferred Provider Organization Program Referral form to the member and the physician before the referred services are provided. A verbal referral is not acceptable.

Skilled nursing care is furnished or supervised by a licensed nurse under the general direction of a physician to ensure the patient's safety and to achieve a medically desired result. Eligible members are eligible for services when they require care that is at a lower level than provided in a hospital but is at a higher level than is generally available on an outpatient basis, in the home or basic nursing home.

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

Specialty hospital is a hospital, such as a children's hospital or a chronic disease hospital that provides care for a specific disease or population.

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

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

Subscriber is the person who signed and submitted the application for SHP PPO Drug plan coverage.

Urgent care covers an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

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

You and Your are used when referring to any person covered under the SHP PPO.

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