



**Blue Cross  
Blue Shield**  
of Michigan



# Your Benefit Guide

## State Catastrophic Health Plan

October 2015

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# Welcome

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Welcome to the State Catastrophic Health Plan, 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.

# Contact information

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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 7 a.m. to 7 p.m. We are closed on holidays.

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

### 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 7 a.m. to 7 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 employees  
Provider search

[bcbsm.com/som](http://bcbsm.com/som)  
[bcbsm.com/find-a-doctor](http://bcbsm.com/find-a-doctor)

## State of Michigan

### Michigan Civil Service Commission

MI HR Service Center  
P.O. Box 30002  
Lansing, Michigan 48909  
Local: 517-335-0529  
Toll free: 877-766-6447

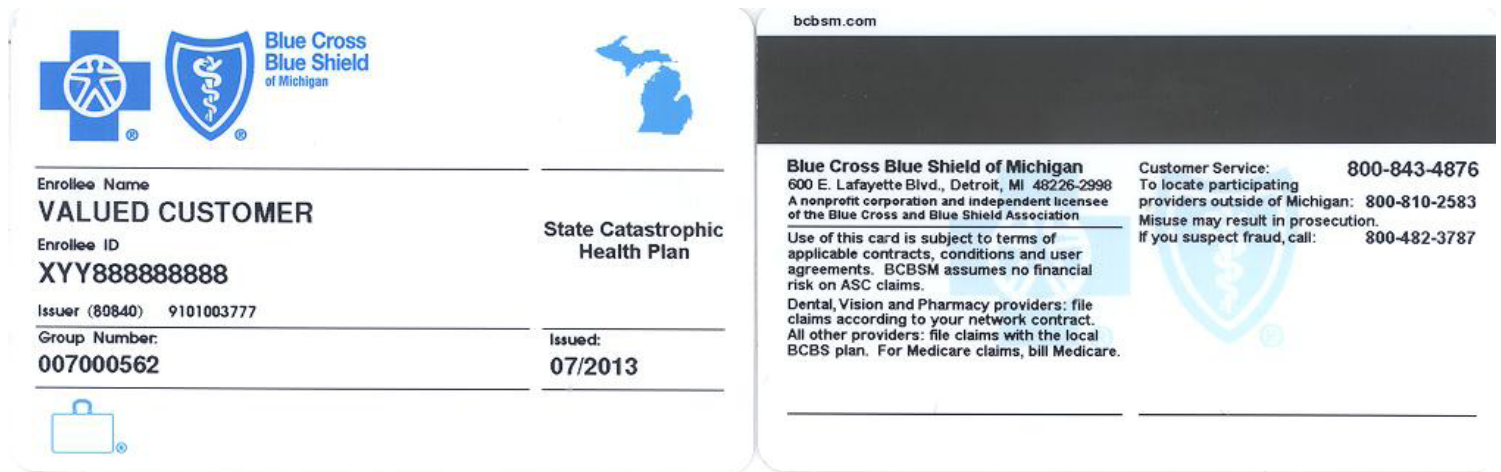
### Michigan Civil Service Commission

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 State Catastrophic Health Plan. Present this ID card every time you need services.

Your card will look similar to the one below.



**1<sup>st</sup> 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.

**2<sup>nd</sup> line:** **Enrollee ID** identifies your records in our files. The **alpha prefix** preceding the enrollee ID number identifies that you have coverage through the State Catastrophic Health Plan.

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

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

**The suitcase** tells providers about your travel benefits. For additional information, go to page 21.

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

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For more information about the State of Michigan's eligibility requirements for employee health insurance coverage, visit [www.michigan.gov/employeebenefits](http://www.michigan.gov/employeebenefits).

## Catastrophic benefits

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

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

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

### General features

The State Catastrophic Health Plan is a hospitalization only plan.

Coverage is provided only for those excess hospital services and supplies furnished to an individual while covered, and only after the member has satisfied their individual policy deductible.

The maximum deductible for a family (two or more members) is one and a half month's base pay.

### Facilities

Coverage is provided for services rendered by an accredited hospital.

### Professional providers

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

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



## Precertification of hospital admissions (PRECERT)

This program helps you and your doctor use your benefits effectively by determining whether a hospital is the proper setting before you're admitted.

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

When your doctor's request is received, BCBSM will:

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

Your doctor can appeal decisions by submitting an appeal request and including additional information about the need for admission. A panel of doctors — excluding the doctor who made the initial decision — will review and decide on the appeal.

If a longer stay is needed once you've been admitted, the hospital and your doctor can request additional days. The extension should be requested at least 48 hours before the end of the initial length-of-stay.

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

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

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

## Catastrophic hospital benefits

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

### Inpatient hospital benefits

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

- Anesthesia when administered by an employee of the hospital
- Birthing center service
- Bone marrow transplants
- Cardiac rehabilitation
- Cardiology
- CT scans
- Chemotherapy for the treatment of malignant and non-malignant disease
- Dental and related anesthesia expenses in a hospital when a concurrent hazardous health condition exists



- Accidental dental is covered for initial emergency treatment only. Routine restorative dental services are non-payable.
- Diagnostic and therapeutic x-rays, EKGs, cobalt isotopes, radiation therapy, CAT, PET and MRI scans
- Drugs, biologicals and solutions
- Foot care, including orthotics
- General nursing services
- Hemophilia
- Hospital-billed ambulance service charges up to the approved amount for a trip to or from the hospital
- Hyperalimentation
- Injections like tetanus shots, rabies, chemotherapy, etc. covered for trauma or payable diagnosis
- IV therapy
- Laboratory and pathology examinations
- Lithotripsy
- Meals and special diets
- MRA
- Newborn admission
- Non-experimental transplant of a human organ or body tissue

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

- Obstetrical services including delivery

Inpatient examinations of the newborn are a benefit when performed by a physician other than the anesthesiologist or the delivering provider.

- Oxygen and other gas therapy
- Photo therapy for the treatment of psoriasis
- Private room — covered if it meets the guidelines for medical necessity
- Prosthetics and orthotics, durable medical equipment, and medical supplies
- Respiratory and inhalation therapy
- Semi-private room
- Temporal Mandibular Jaw Joint surgery — the follow-up is not covered
- Use of operating, delivery and other treatment rooms
- Veterans Affairs providers — covered as the primary carrier if the condition is not payable as primary under the VA benefit

## Outpatient hospital benefits

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

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

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

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

- Foot care, including orthotics
- Hemophilia
- Hemodialysis
- Hyperbaric O2 treatments
- Hyperalimentation
- Injections, like tetanus shots, rabies, chemotherapy, etc. — covered for trauma or payable diagnosis
- IV therapy
- Lithotripsy
- Maternity services on an outpatient basis if an emergency
- MRAs, MRIs and Pet scans
- Observation beds
- Photo therapy for the treatment of psoriasis
- Preadmission testing must be performed within seven days before a scheduled hospital admission or surgery
- These tests must be medically appropriate, valid at the time of admission and must not be duplicated during the hospital stay.
- Prosthetics and orthotics, durable medical equipment and medical supplies
- Surgery
- Termination of pregnancy

## Inpatient substance abuse treatment benefits

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

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

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

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

## Medical and surgical care benefits

The following services are covered if performed in a hospital:

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

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

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

# General exclusions

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

1. Acupuncture
2. Air and water ambulance services
3. Allergy injections
4. Charges for ambulatory surgical facilities
5. Charges for anti-rejection drugs in a non-hospital setting
6. Blood storage and transportation charges
7. Charges that are determined to be beyond the BCBSM approved amount
8. Professional fee for certified nurse midwife home delivery
9. Charges for services rendered to improve cognition (memory, perception), concentration and or attentiveness, organizational and problem-solving skills, academic skills and impulse control or other behaviors for which behavior modification is being sought
10. Charges for services rendered by a Christian Science Practitioner and charges for services rendered at a Christian Science Sanitarium
11. Birth control
12. Coordinated care management
13. Charges for hospital and physician services for cosmetic surgery and related services except when necessary to improve and restore bodily function or to correct a deformity from disease, trauma, birth or growth defects, or prior therapeutic processes
14. Charges for counseling for sexual dysfunctions that are other than medical
15. Charges for services or supplies not specifically mentioned as covered in your plan coverage documents
16. CT scan or MRI if performed in a mobile unit
17. Charges for custodial care, rest therapy and care in nursing or rest home facilities
18. Services for which a charge is not customarily made
19. 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
20. Outpatient diabetes management program
21. Charges for diagnostic testing for infertility
22. Dialysis services after 30 months of ESRD treatment
23. Prosthetics and orthotics, durable medical equipment and medical supplies unless provided in an inpatient or outpatient setting

24. Charges for a hospital admission that begins before the effective of coverage by the State Catastrophic Health Plan
25. Hospital admissions that begin after the coverage termination date
26. Medical services or supplies provided or furnished before the effective date of coverage or after the coverage termination date
27. Charges for services and supplies provided while a family member is not enrolled, except as may be specifically mentioned in this booklet
28. Charges for services or supplies that have not exceeded the required policy year deductible amount per person
29. Charges for services, care, devices or supplies that are considered experimental or still under clinical investigation by health professionals
30. Charges for or related to any eye surgery done mainly for cosmetic or recreational purposes or to correct refractive errors, except as specifically mentioned in this document
31. Fourth quarter carryover charges
32. Charges for gender reassignment or any treatment leading to (or in connection with) gender reassignment surgery
33. All home based services
34. Home health care
35. Hospice
36. Hospitalization principally for:
  - Observation
  - Diagnostic evaluation
  - Physical therapy
  - X-ray or lab tests
  - Reduction of weight by diet control (with or without medication)
  - Basal metabolism test
  - Electrocardiography
37. Charges for immunizations or any other preventive services and supplies, except as may be specifically mentioned in this booklet
38. Charges from an independent lab
39. Services from institutions that do not meet the definition of a hospital
40. Charges for in vitro fertilization, artificial insemination or embryo transfer procedures
41. Medically necessary services received on an inpatient basis that can be provided safely in an outpatient or office location

42. Charges for mental health care
43. Benefits for any expenses incurred during an inpatient or outpatient hospital confinement due to a mental or nervous condition (including the treatment of alcoholism or substance abuse) after it has been determined that such a condition is not subject to a favorable modification
44. Charges for services and supplies that are furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any member in the armed forces of a government
45. 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
46. Treatment of a condition caused by military action or war, declared or undeclared
47. Care and services payable by government-sponsored health care programs, such as Medicare or TRICARE, formerly CHAMPUS, for which a member is eligible
48. Services and supplies that are not medically necessary according to accepted standards of medical practice
49. Services for which the patient is not obligated to pay or services without cost
50. Treatment of occupational injury or disease that the State of Michigan is obligated to furnish or otherwise fund
51. Office visits, office consultations and home office visits
52. Outpatient substance abuse services
53. Outpatient audiology testing
54. Outpatient clinic fees
55. Charges for services and supplies received by members or their dependents outside of the United States, except in the case of temporary absence due to travel
56. Charges for patient education, whether or not such services are provided in a physician's office or facility that also provides medical, psychiatric or rehabilitation services
57. Charges for services or supplies for personal comfort or convenience or personal hygiene, including charges for telephone, radio, television, barber or beauty service
58. Charges for physical therapy in a freestanding facility or office setting
59. Private duty nursing
60. Charges for private hospital rooms in excess of a semi-private rate for room and board, except as specifically mentioned in this document.
61. Separate charges for the professional services of a resident physician, intern or other employee of a hospital whether made by the individual or by the hospital (Such charges are already a part of the hospital's billed facility charge.)

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

This list of exclusions is not meant to be all-inclusive.



# Coordination of benefits

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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 State Catastrophic Health Plan 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 State Catastrophic Health Plan is primary, then full benefits under the plan will be paid. If the State Catastrophic Health Plan 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 State Catastrophic Health Plan 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 State Catastrophic Health Plan is not primary, so your provider can bill the other group health plan. We will also send you an Explanation of Benefit Payments 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 EOB form you received from your primary plan. Please make copies of all forms and receipts for your files.

## Keeping your COB information updated

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

## Subrogation

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

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

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

## Filing claims

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When you use your benefits, a claim must be filed before payment can be made. Blues participating providers should automatically file all claims for you. All you need to do is show your BCBSM ID card.

However, if you receive services from nonparticipating providers, they may or may not file a claim for you.

To file your own claim, follow these steps:

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

**Please file claims promptly because most services have a filing limitation.**

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

# Your right to file an internal grievance

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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 must decide within 24 hours whether or not to accept the recommendation. 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 2 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

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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](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



# BlueCard program

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BlueCard is a national program that enables members of one Blue company to obtain health care services while traveling or living in another Blue company's service area. The program links participating health care providers with the independent Blue companies across the country and in more than 200 countries and territories worldwide, through a single electronic network for claims processing and reimbursement.

As you do when you are at home, always carry your BCBSM ID card. And in an emergency, go directly to the nearest hospital. But when you need medical assistance, contact BlueCard.

## Within the United States

To receive services from a provider outside of Michigan, but within the U.S.:

1. Go to **bcbs.com/bluecardworldwide** and search through the *BlueCard Doctor and Hospital Finder* to find the nearest doctors and hospitals.

You may also call toll-free **1-800-810-BLUE (2583)** any day of the week to speak with an assistance coordinator. The coordinator, in conjunction with a medical professional, will arrange a physician appointment or hospitalization, if necessary.

2. Show your BCBSM ID card to the provider. Remind your provider to include the alphabetical prefix on all of your claims.
3. Pay the applicable in-network deductibles, coinsurance and copayments required. After you receive care, you should:
  - Not have to complete any claim forms
  - Not have to pay upfront for medical services, except for the usual out-of-pocket expenses (noncovered services, deductible, coinsurance and copayment)
  - Receive an explanation of benefits from BCBSM.

If you are in one of the few areas without BCBSM or participating providers, while you will not be expected to pay the out-of-network deductibles, coinsurance or copayments, you may need to submit itemized receipts directly to BCBSM if you receive services from a non-network provider. BlueCard does not include hearing services.

## Around the world

The plan will only pay for services for emergency and unexpected illnesses for residents of the United States traveling in foreign countries. In addition, coverage applies only if:

- The hospital is accredited
- The physician is licensed

To use the BlueCard Worldwide program, call the BCBSM Customer Service Center before you leave to get details on your benefits out of the U.S. and a list of participating providers at your destination.

If you need medical assistance for inpatient services out of the U.S., call the BlueCard Worldwide Service Center at **1-800-810-BLUE (2583)** or collect at **1-804-673-1177**. In most cases, you should not need to pay upfront for inpatient care at participating BlueCard Worldwide hospitals, except for the out-of-pocket expenses (noncovered services, copayment deductible and/or coinsurance) you normally pay. The hospital should submit your claim on your behalf.

If you receive services from a non-participating provider, you will need to pay up front, then complete a BlueCard Worldwide claim form and send it with the bill(s) to the BlueCard Worldwide Service Center (the address is on the form). The claim form is available from your BCBSM Service Center, the BlueCard Worldwide Service Center, or online at **bcbsm.com/som**.

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

# Medicare coverage

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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

The State Catastrophic Health Plan is primary, which means it pays first, for actively working employees and their enrolled dependents. If you or your dependent is eligible to enroll in Medicare because of End State Renal Disease, the State Catastrophic Health Plan will pay first for 30 months, whether or not you are enrolled in Medicare. During this time, Medicare is the secondary payer. At the end of the 30 months, Medicare becomes the primary payer.

## 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:

- 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.
- 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 State Catastrophic Health Plan 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](http://www.medicare.gov).

## Applying for Medicare

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

If you do not enroll in Part B during your initial enrollment period, you will have to wait until the next general enrollment period to enroll.

General enrollment periods are held January 1 through March 31 of each year, and Part B coverage starts on July 1 of that year. Your Part B premium will go up 10 percent for each 12-month period that you have been eligible for Part B but did not take it.

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

You can get more information on Medicare by logging on to the Medicare Web site at **[www.medicare.gov](http://www.medicare.gov)**.

# Glossary

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

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

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

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

**Adequate access** is defined by how far you live from PPO providers and hospitals. The State Catastrophic Health Plan 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

**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.

**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.

**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 State Catastrophic Health Plan. Covered services must be medically necessary to be payable, unless otherwise specified.

**Custodial care** is care mainly for helping a person with activities of daily living, such as walking, getting in and out of bed, bathing, dressing, eating or taking medicine. 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 State Catastrophic Health Plan.

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

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

**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.

**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.

**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 State Catastrophic Health Plan 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.

**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.

**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.

**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.

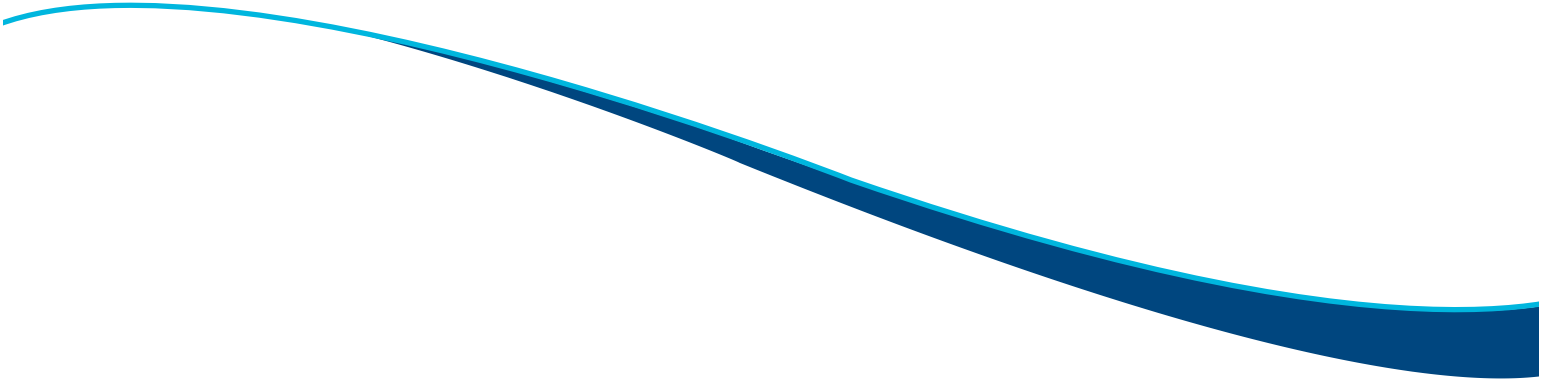
**Subscriber** is the person who signed and submitted the application for State Catastrophic Health Plan coverage.

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

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







**Blue Cross  
Blue Shield**  
of Michigan

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