Your Benefit Guide

New State Health Plan PPO

For employees hired or rehired on or after April 1, 2010

Blue Cross Blue Shield of Michigan

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

New State Health Plan PPO
Welcome

Welcome to the New State Health Plan PPO (NSHP 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 the NSHP PPO benefits and any future benefit changes. BCBSM will provide 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 how your health coverage works. With this in mind, we have designed this booklet as an easy-to-read guide to your health program. Please read it and make sure you understand what health care services are covered and when you are responsible for out-of-pocket costs.

If you have any questions about your NSHP PPO coverage after reading this booklet, please call the BCBSM State of Michigan Customer Service Center. The toll-free number is 800-843-4876 (TTY 800-240-3050). Our customer service representatives are available Monday through Friday from 8 a.m. to 6 p.m., excluding holidays.

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

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Blue Cross Blue Shield of Michigan contact information

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

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

- Have your BCBSM ID card handy so you can provide your enrollee and group numbers. If you are writing, include this information in your letter.
- To ask if a particular service is covered, have your physician provide you with the five-digit procedure code. If your planned procedure does not have a code, please obtain a complete description of the service. Please also include the diagnosis.
- To inquire 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, please send **copies** of your bills, other relevant documents and any correspondence you may have received from us. 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.

In and outside Michigan 800-843-4876

Special servicing numbers

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)**
SUPPORT Program **800-321-8074**

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

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

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

Visiting

The BCBSM State of Michigan Customer Service Center is open Monday through Friday from 8 a.m. to 6 p.m, excluding holidays. We are located at:

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

You may also receive service at our other locations:

Additional BCBSM walk-in centers

Detroit 600 East Lafayette
Flint 4520 Linden Creek Parkway, Suite A
Grand Rapids 86 Monroe Center NW
Holland151 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

Internet access

Home page	**bcbsm.com**
BCBSM website for State of Michigan employees	**bcbsm.com/som**
Anti-fraud	**bcbsm.com/antifraud**
Healthy Blue Xtras℠*	**healthybluextras.com/**
Care Advisor™*	**bcbsm.com/member/coverage_options/coverage_advisor.shtml**
Network provider locator	**bcbsm.com**

*Access to this website requires registration at the **bcbsm.com** Member Secured Services portal.

State of Michigan contact information

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

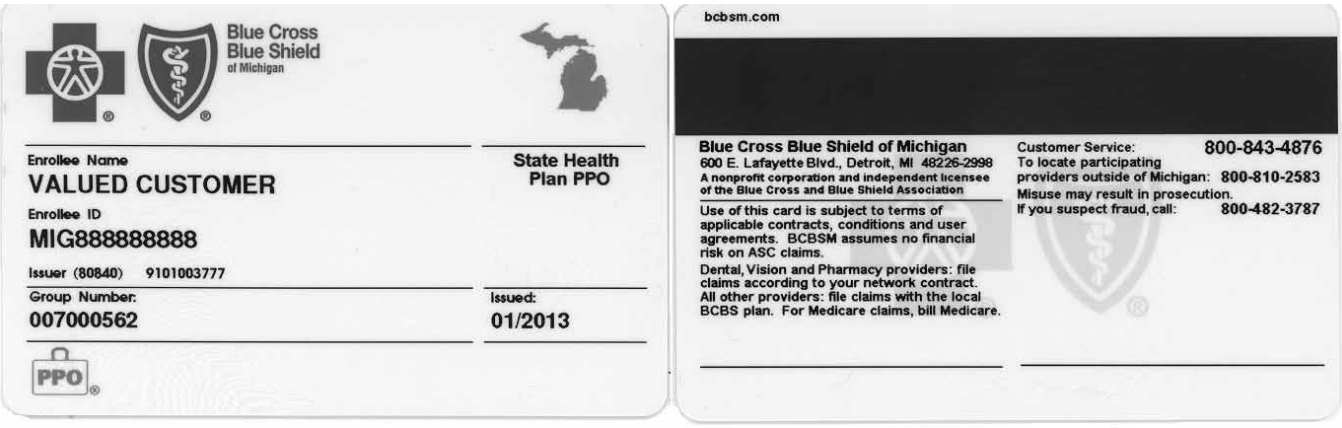
For specific eligibility information and assistance for employees:

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

Your Blue Cross Blue Shield of Michigan ID card

Your BCBSM ID card is your key to receiving quality care. It is issued once you enroll for coverage in the NSHP PPO. Present this ID card every time you seek services.

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 NSHP 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.

The suitcase tells providers about your travel benefits.

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.

Here are some tips about your ID card:

- Carry your card with you at all times.
- If you or anyone in your family needs an ID card, please go to the secured site at **bcbsm.com** and request one, or call the BCBSM State of Michigan Customer Service Center for assistance.
- Call the BCBSM State of Michigan Customer Service Center if your card is lost or stolen. You can still receive services by giving the provider your Enrollee ID number to verify your coverage.

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

Explanation of benefits 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 State of Michigan Customer Service Center.

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

Eligibility guidelines

You are eligible to enroll in the NSHP PPO on the first day of the bi-weekly payroll period following your first day of employment. You must contact the MI HR Service Center to enroll in the NSHP PPO. You are eligible to enroll in the NSHP PPO if:

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

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

Enrolling for coverage

You may enroll for health coverage when you meet the NSHP PPO requirements for eligibility. You may enroll yourself and your eligible dependents within the first 31 days of your hire date. You must enroll by contacting the MI HR Service Center.

Note: Employees who work for an agency that does not participate with the MI HR Service Center must contact their respective agency's human resource office.

Dual eligibility

If you and your spouse are both covered by State Health plans (retiree or active), you may:

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

If you choose to maintain separate coverage, your child or children can only be covered by one of the parent's plans, not both. This applies even if you are divorced.

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

- Continues to meet eligibility requirements;
- Was covered as a dependent of the departing employee or was enrolled separately as an employee; and
- Notifies the MI HR Service Center of his or her intent to transfer enrollment prior to the departure of the spouse from State service.

Once you return to work, you must wait until the State's next open enrollment period before you may transfer your coverage back into your own name.

Dependent coverage

Eligible dependents include your spouse and any of your children until they turn the age of 26.

Continuing coverage for incapacitated children

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

If your enrolled dependent is deemed an incapacitated child, your coverage for this child will continue beyond age 19 as long as:

- He or she became incapacitated before age 19,
- Documentation verifying the child's condition was provided to the insurance carrier prior to the child becoming 19,
- The child continues to be incapacitated, and
- Your coverage does not terminate for any other reason.

To ensure uninterrupted coverage for your incapacitated child, you must apply for continuation before the end of the month in which the child turns 19. To apply for continuation coverage, contact the MI HR Service Center or the State of Michigan Customer Service Center for a *BCBSM State Health Plan Disabled Dependent Application* form.

The Disabled Dependent Application form is also available on the State of Michigan's website at **www.michigan.gov/documents/mdcs/BCBSM_Disabled_Dependent_Application.pdf_270240_7.pdf**. Print a copy of this form. Make a copy of the completed form for your files.

Mail the completed form to:

Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Mail Code 517J
Detroit, MI 48226
Attn: Senior Medical Analyst

For more information on dependent eligibility, refer to:

http://www.michigan.gov/documents/mdcs/Dependent_Eligibility_Guidelines_325895_7.pdf

Coverage for spouses legally recognized under Michigan law

Your legal spouse may be covered as a dependent under your coverage, as long as he or she is not also separately enrolled (at the same time) as a State employee or retiree.

Ex-spouses are not eligible to be covered as dependents. Contact the MI HR Service Center immediately to cancel an ex-spouse's enrollment. You must provide the MI HR Service Center with a copy of the divorce decree within 31 days of the divorce. Your ex-spouse will be provided an application to continue State-sponsored coverage in his or her own name for up to 36 months by making a direct premium payment pursuant to federal COBRA regulations. The COBRA option is explained in this benefit booklet.

Coverage for Other Eligible Adult Individuals

Other Eligible Adult Individuals (OEAIs) coverage is currently offered to employees represented by UAW Local 6000, SEIU Local 517 M, and NEREs who do not have a spouse eligible to enroll in the State-Sponsored Group Insurance Health Plans. These employees may enroll one OEAI if the individual meets ALL of the following eligibility criteria:

- Is at least 18 years of age,
- Is not the employee's spouse, child, parent, grandparent, foster parent, grandchild, parent-in-law, sibling, aunt, uncle, or cousin; and
- Has jointly shared the same regular and permanent residence for at least 12 continuous months, and continues to share a common residence with the employee other than as a tenant, boarder, renter, or employee.

Dependent children of an OEAI may enroll in health insurance only under the same conditions that apply to dependent children of employees, if eligibility criteria are met.

Enrolling an OEAI or an OEAI's dependent children

Submit the following documentation to the MI HR Service Center:

1. Enrollment application and affidavit
2. Proof of age in the form of a copy of a birth certificate, passport, driver's license, or other governmental document indicating date of birth
3. Documents establishing joint residence for the past 12 months (e.g., bank statement, utility bills, etc.)

Proper required documentation must be submitted prior to enrollment of an OEAI's dependent, including ***Verification of Eligibility*** (CS-1830).

In accordance with IRS regulations, State of Michigan employees are responsible for paying taxes associated with the fair-market value of enrolling an OEAI and the OEAI's dependents. Additional information on OEAI tax implications is available on the Employee Benefits Division website.

When the criteria for enrollment are no longer met, you must notify the MI HR Service Center within 14 calendar days. Coverage will end effective the date that OEAI eligibility criteria were no longer met.

Dependent exclusions

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

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

Canceling dependent coverage

Your dependent's coverage will automatically terminate when:

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

If we are notified more than 31 days after the date of the event, the change to your contract will be delayed, which may cause errors when your claims are processed. Please remember to report any membership changes to the MI HR Service Center promptly so these changes can be reflected on your records.

If you fail to give timely notice, you may be liable for any payments made by BCBSM on behalf of your dependent for medical services that have been provided subsequent to the date of the event.

Making coverage changes

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

- You get married or divorced.
  - You may enroll a new spouse within 31 days of your marriage; the effective date of the insurance will be the first day of the next pay period after notification to MI HR.
  - You may enroll in the NSHP PPO if you recently lost insurance coverage because of a divorce.

  Note: A former spouse's eligibility for State-sponsored insurance coverage will end on the date of your divorce.
- An eligible child is born, adopted, or you obtain guardianship. The effective date will be the date of birth, adoption, or legal guardianship.
- Your dependent 19- to 26-year-old child has returned to school, or stopped attending school.
- Your spouse begins or ends employment.
- You or your spouse change from part-time to full-time (or vice versa) or take an unpaid leave of absence resulting in a significant change in your coverage.
- There is a significant change in your or your spouse's coverage through your spouse's non-State of Michigan employer plan.

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

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

Open enrollment period

During open enrollment, you can:

- Enroll in the NSHP PPO if you are not already enrolled.
- Add eligible dependents.

Address changes

If you change your address, or if your address is incorrect in our records, please notify MI HR. This will ensure you will continue to receive any notices BCBSM sends to you.

Terminating coverage

Employees

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

Dependent coverage

Your dependent's coverage will automatically terminate when:

- Your dependent no longer meets the definition of an eligible dependent (You must immediately notify the MI HR Service Center if you divorce or if a child become ineligible. **Ex-spouses are not eligible for coverage**.)
- Your dependent becomes eligible for coverage as a State of Michigan employee.
- The entire group or the group dependent contract is discontinued.
- Your coverage terminates.

If we are notified more than 31 days after the date of the event, the change to your contract will be delayed, which may cause errors when your claims are processed. If you fail to give timely notice, you may be held responsible for any payments made by State of Michigan and BCBSM on behalf of your ineligible dependent after the date of the event. Please remember to report any membership changes to the MI HR Service Center promptly so these changes can be reflected on your records.

Continuing health care coverage

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

Continuing coverage under COBRA

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

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

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

- Spouses who lose coverage because of divorce or legal separation
- Children who no longer meet dependent eligibility requirements under the NSHP PPO
- Surviving dependents that will lose group coverage in the case of your death. NSHP PPO coverage will automatically continue for dependents that are to receive an immediate monthly pension benefit from the State of Michigan upon your death. If your dependents are not going to receive a monthly pension benefit following your death, their coverage will end 30 days following your death.

COBRA notification and application

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

To enroll in COBRA, please submit an *Application to Continuation of Insurances* (form CS-1820) to:

Michigan Civil Service Commission
Employee Benefits Division
P.O. Box 30002
Lansing, MI 48909

The form must be submitted within 60 days from the date of your qualifying life event or the date coverage ends, whichever is later and whichever applies.

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

Continuing coverage while on a leave of absence or layoff

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

Your human resource office will send you an *Application to Continuation of Insurances*. You must submit this completed application to MCSC, Employee Benefits Division within 60 days of the qualifying event or the date the coverage ends, whichever is later.

If you are on layoff, you can also continue NSHP PPO Plan coverage for up to 18 months by paying the full monthly premium.

Your human resource office will send you an *Application to Continuation of Insurances*. This completed application must be sent to the Michigan Civil Service Commission, Employee Benefits Division within 60 days of the date your coverage ends.

When you return to work, you may want to contact the MI HR Service Center to verify that your active coverage has been reinstated.

Continuing coverage when you retire

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

Continuing coverage under BCBSM's individual plans

BCBSM's individual coverage is available to you or your dependents when you become ineligible for coverage under the NSHP PPO. Benefits for you and your dependents will change under individual coverage, but there will be no interruption of coverage provided you pay the initial and subsequent bills. To ensure continuous coverage, and for additional information on how to apply for BCBSM individual coverage, please visit **bcbsm.com**/myblue.

Certificate of creditable coverage

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

Value-added programs

As an employee enrolled in the NSHP 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**.

BlueHealthConnection® connects you to a huge set of resources to help you get healthy, stay healthy, or manage illness. You have access to:

- **General health education** on subjects such as how to avoid the flu.
- **Symptom management and health coaching** if you need general advice about medical concerns, and assistance in determining whether and where to obtain care for acute health care problems.
- **Shared decision-making** that includes a discussion of options with a health coach or condition-specific treatment option videos if you are considering surgery for a significant medical condition.
- **My Health Assessment** which evaluates your current health status so you can take the path toward a healthier you.
- **Quit the Nic** is the telephone-based smoking-cessation program that enables you to work one-on-one with a health coach to develop an action plan, set a quit date and stay smoke-free for life.
- **The Nurse Line** gives you access to registered nurse health coaches 24 hours a day, seven days a week, to answer health care questions about symptom management, general health information, and health decision support.
- **My Health Programs** which assess your motivation, confidence and barriers in making changes before developing an action plan just for you.
- **The Library** that contains information about conditions, diseases, recipes, tests, wellness and more.
- **Healthy Living** that contains articles, guides and interactive tools about healthy living.
- **Health Centers** that help you keep current on topics such as asthma, cancer, diabetes, heart disease, obesity and pregnancy.
- **Your Family** that provides research on a variety of topics that are specifically for men, women, children and older adults.
- **Tools and Media** such as calculators, health tracking tools and other interactive tools to monitor your health.

Healthcare Advisor™ enables you to research quality and cost through WebMD services:

- **Hospital Advisor** – Helps you compare and rank hospitals by their experience with a procedure or diagnosis.
- **Provider Selection Advisor** – Helps you find health care providers and facilities that match your location and your preferences.

Healthy Blue Xtras℠ and Blue365℠ are savings programs we offer exclusively to our members to help you save money.

With Healthy Blue Xtras, you can score big savings and special offers on a variety of healthy products and services from companies across Michigan. And you can take advantage of offers from businesses around the United States with Blue365, the Blues' national savings program.

The Blues have teamed up with companies like Weight Watchers®, Nino Salvaggio®, Shanty Creek Resorts® and Costco®. From groceries and fitness gear to yoga and gym packages, even travel, you will find promotions on everything you need to support a healthy, balanced lifestyle.

Selecting providers when using your New State Health Plan PPO

Your benefits are provided through the Community Blue Preferred Provider Organization health care plan.

There are three levels of BCBSM provider participation. The level of a provider's participation impacts the costs for which you will be responsible. The three levels are:

- Network providers
- Non-network but participating providers
- Nonparticipating providers

Network providers

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

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

To find PPO providers, visit **bcbsm.com**. You may also call the BCBSM State of Michigan Customer Service Center for assistance in locating PPO providers in your area.

If your PPO physician leaves the network

Your physician is your partner in managing your health care. However, physicians retire, move or otherwise cease to be affiliated with our PPO network. Should this happen, your physician will notify you that he or she is no longer in the PPO network. If you have difficulty choosing another physician, please contact the BCBSM State of Michigan Customer Service Center for assistance. If you wish to continue care with your current physician, a customer service representative will explain the financial costs to you when services are performed by a physician who is no longer in the PPO network.

Non-network participating providers

When you receive care from a provider who is not part of the PPO network, without a referral from a PPO provider, your care is considered out-of-network. For most out-of-network services, you have a 20 percent copayment and a higher deductible. Some services, such as most of your preventive care services, are not covered out-of-network.

Participating providers

If you choose to receive services from a non-network provider, you can still limit your out-of-pocket costs if the provider participates in BCBSM's Traditional plan. When you use BCBSM participating providers:

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

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

Referrals to non-network providers

Your in-network PPO provider should refer you to another in-network PPO provider when available. If another in-network provider is not available, the referring provider should refer you to a Blue participating provider. This is a provider who accepts the Blue Traditional plan.

In the event you are referred to a non-network provider, even if he or she is a participating provider, your in-network provider must provide a *TRUST Preferred Provider Organization (PPO) Program Referral Form*. A referral is only valid when it is obtained before the referred services are provided. The referring physician must complete the form and provide copies to you and the physician to whom you were referred. A verbal referral is not acceptable.

Non-PPO network hospitals and facilities

If you choose to go to a non-PPO network hospital or facility when you have adequate access to a network hospital, the NSHP PPO will pay 80 percent after your out-of-network deductible. You will be responsible for the difference.

Nonparticipating providers

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

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

Additionally, BCBSM will reimburse you based on our medical policy guidelines for payment. For example, multiple surgeries that are through the same incision are considered related and the NSHP PPO pays the approved amount only for the more difficult procedure. You would be responsible for the surgical procedure(s) that was considered related.

Nonparticipating hospitals and facilities

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

Exceptions to the rule

When you are in Michigan, we will waive the out-of-network deductibles and copayments if you do not have adequate access to a PPO provider.

The NSHP PPO access standards are:

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

BlueCard PPO program

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 PPO doctors and hospitals.

   You may also call toll-free **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.

   If you need to be hospitalized, call your BCBSM State of Michigan Service Center for pre-certification or pre-authorization.

   You can find both phone numbers on your Blue ID card.
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 and copayments required by the NSHP PPO.

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, copayment)
- Receive an explanation of benefits from BCBSM.

If you are in one of the few areas without Blues PPO or participating providers, while you will not be expected to pay the out-of-network deductibles 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 vision and hearing services.

Around the world

The NSHP PPO 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 State of Michigan 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 **800-810-BLUE (2583)** or collect at **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, deductible, or copayment) you normally pay. The hospital should submit your claim on your behalf.

In addition to contacting the BlueCard Worldwide Service Center, call your BCBSM State of Michigan Customer Service Center for pre-certification or pre-authorization. You can find both phone numbers on your Blue ID card.

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 **bcbs.com/bluecardworldwide**.

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 deductibles or copayments that may apply.

New State Health Plan PPO
Health care benefit summary*

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

	In-network	Out-of-network
Diagnostic tests and radiation services		
Diagnostic mammography	Covered – 90% after deductible	Covered – 80% after deductible
Diagnostic tests		
Lab and pathology tests		
Position emission tomography (PET) scans		
Radiation therapy		
X-rays, ultrasound, MRI and CAT scans		
Emergency medical care		
Ambulance services	Covered 90% after deductible	
Emergency room	Covered – $200 copay** (waived if admitted as inpatient)	
Hearing care		
Audiometric exam	**Participating** Covered – 100%	**Non-participating** Not covered when provided by a nonparticipating provider in Michigan.
Hearing aid evaluation and conformity test		
Hearing aid ordering and fitting		
Hearing aids (standard only)		
Medical hearing clearance exam	Covered – $20 copay**	80% after deductible
Hospital care		
Chemotherapy	Covered – 90% after deductible	Covered – 80% after deductible
Consultations – inpatient and outpatient		
Inpatient care	Covered – 90% after deductible	Covered – 80% after deductible
	Unlimited days	
Hospital care (alternatives)		
Home health care	Covered – 90% after deductible (participating provider only)	
Hospice care	Covered – 100% (BCBSM or Medicare-certified hospice program)	
Skilled nursing care	Covered – 90% after deductible (120 skilled days per admission period)	
Urgent care visit	Covered – $20 copay**	Covered – 80% after deductible

* Limitations apply. Refer to benefit details in this booklet.
** No deductible

New State Health Plan PPO
Health care benefit summary*

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

	In-network	Out-of-network
Human organ transplants – Contact HOTP at 800-242-3504 for additional criteria and information		
Bone marrow	Covered-100% in designated facilities when pre-approved	
Kidney, cornea and skin	Covered – 90% after deductible	Covered – 80% after deductible
Liver, heart, lung, pancreas and other specified organs	Covered – 100% in designated facilities only	
Maternity services provided by a physician or certified nurse midwife		
Delivery and nursery care	Covered – 90% after deductible	Covered – 80% after deductible
Prenatal and postnatal care		
Other services		
Acupuncture	Covered – 80% after deductible	
Allergy testing and therapy	Covered – 90% after deductible	Covered – 80% after deductible
Anesthesia	Covered – 90% after deductible	
Cardiac rehabilitation	Covered – 90% after deductible	Covered – 80% after deductible
Chiropractic/spinal manipulation	Covered – $20 copay** 24 visits per calendar year	Covered – 80% after deductible
Durable medical equipment; prosthetic and orthotic appliances and supplies	Covered – 100% through SUPPORT program	Covered – 80% of approved amount (member responsible for difference)
Injections	Covered – 90% after deductible	Covered – 80% after deductible
Observation care	Covered – 90% after deductible	
Office consultations	Covered – $20 copay**	Covered – 80% after deductible
Office visit		
Osteopathic manipulation therapy		
Outpatient hospital and home visits	Covered – 90% after deductible	
Outpatient physical, speech and occupational therapy	Covered – 90% after deductible	Covered – 80% after deductible
Private duty nursing	Covered – 80% after deductible	
Wig, wig stand, adhesives	$300 lifetime maximum through the SUPPORT program (Additional wigs covered for children due to growth.)	
Surgical services		
Pre-surgical consultations	Covered – 90% after deductible	Covered – 80% after deductible
Surgery		
Vasectomy		

* Limitations apply. Refer to benefit details in this booklet.
** No deductible

New State Health Plan PPO
Health care benefit summary*

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

Preventive services

The NSHP PPO covers certain evidence-based preventive services and immunizations with no cost share when the services are rendered by a PPO network provider. This means that, under the provisions of the Affordable Care Act (ACA), you do not need to meet a deductible or pay a copay first when receiving preventive services from an in-network provider. For questions related to preventive services rendered out-of-network, please contact SOM customer service at 800-843-4876.

You are encouraged to visit your provider regularly for checkups. These preventive services can help keep you healthy by detecting potential health problems while they still can be avoided — or easily treated. This can prevent serious and costly medical conditions down the road.

Types of services considered preventive

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 ACA, visit:
http://www.healthcare.gov//law/resources/regulations/prevention/recommendations.html

Additional preventive services

The NSHP PPO also offers the following preventive services, covered in- and out-of-network:

	In-network	Out-of-network
Colorectal cancer screening, includes: • Colonoscopy • Double-contrast barium enema • Digital rectal exam	Covered – 100%	Covered – 80% after deductible
Immunizations – childhood (through age 18)	Covered – 100%	Covered – 80% after deductible
Vaccinations: • H1N1 • Influenza (flu) • Meningococcal (meningitis) • Pneumococcal (pneumonia) • Yellow Fever • Zoster (shingles)	Covered – 100%	

Annual deductibles	In-network	Out-of-network
	$400 per member $800 per family	$800 per member $1,600 per family
Annual out-of-pocket dollar maximums		
	$1,500 per member $3,000 per family	$3,000 per member $6,000 per family

Explanation of cost-share

Out-of-pocket costs

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

Deductibles

Your deductible is the specified amount you pay during each benefit period for services before your plan begins to pay. Deductible amounts are determined by whether you receive services in-network or out-of-network. The in-network deductible is lower than the out-of-network deductible.

Certain benefits can be rendered before your deductible is fulfilled. For example, there is no deductible for in-network 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 in-network 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.

Copayments

After you have met your deductible, you are responsible for copayment amounts that are determined by whether you receive services in-network or out-of-network.

Annual copayment maximums

You are only required to pay a certain amount in copayments each year. However, certain copayments and other charges cannot be used to meet your copayment maximum. These copayments and other charges are:

- Fixed-dollar copayments
- Private duty nursing copayments
- Deductibles
- Charges for noncovered services
- Charges in excess of our approved amount
- Deductibles or copayments required under other BCBSM coverage

New State Health Plan PPO
Health care benefit details

Unless otherwise specified, a service must be medically necessary to be covered by the NSHP PPO. A service is deemed medically necessary if it is required to diagnose or treat a condition, and which BCBSM determines is:

- Appropriate with regard to the standards of good medical practice and not experimental or investigational
- Not primarily for your convenience or the convenience of a provider; and
- The most appropriate supply or level of service which can be safely provided to you. "Appropriate" means the type, level and length of care, treatment or supply and setting that are needed to provide safe and adequate care and treatment.

Acupuncture	**Covered – 80% after deductible** **(No network required)**

Covered up to a maximum of 20 visits in a calendar year when performed 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	**In-network – 90% after deductible** **Out-of-network – 80% 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 (No network required)

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 Nonparticipating – Not covered

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.

The following services are payable:

- Facility use
- Anesthesia services and materials
- Recovery room
- Nursing care by, or under the supervision of, a registered nurse
- Drugs, biologicals, surgical dressings, supplies, splints and casts directly related to surgery provided
- Oxygen and other therapeutic gases
- Administration of blood
- Skin bank, bone bank and other tissue storage costs for supplies and services for the removal of skin, bone or other tissues, as well as the costs of processing and storage
- Routine laboratory services related to the surgery or a concurrent medical condition
- Radiology services performed on equipment owned by, and performed on the premises of, the facility that are necessary to enhance the surgical service
- EKGs

Blood	In-network – 90% after deductible Out-of-network – 80% 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	In-network – 90% after deductible Out-of-network – 80% 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	In-network – 90% after deductible Out-of-network – 80% after deductible

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

Care management program	No charge

Care management offers comprehensive medical and psychosocial care management services for high-risk, medically complex cases. Case management's medical professionals work with member, provider and family or caregiver to ensure a clear understanding of condition, prognosis and treatment options, coordinating the provider services that the member requires.

For more information on care management programs call 800-775-BLUE (2583) toll-free any day, 24 hours a day, or visit **bcbsm.com**.

Cataract surgery	In-network – 90% after deductible Out-of-network – 80% 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
- Normal vaginal delivery when provided in:
  - An inpatient hospital setting
  - A hospital-affiliated birthing center that is owned and operated by a participating state-licensed and accredited hospital, as defined by BCBSM
- Pre-natal care
- Post-natal care, including a Pap smear during the six-week visit.

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

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

Chelation therapy	In-network – 90% after deductible Out-of-network – 80% 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 State of Michigan Customer Service Center.

Chemotherapy	In-network – 90% after deductible Out-of-network – 80% 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.

  Note: Infusion pumps are covered under the SUPPORT Program.

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

Chiropractic services	In-network – $20 Out-of-network – 80% after deductible

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	In-network – 90% after deductible Out-of-network – 80% 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	In-network – 90% after deductible Out-of-network – 80% 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	In-network – $20 Out-of-network – 80% after deductible

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	In-network – 90% after deductible Out-of-network – 80% 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 NSHP 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

Contraceptive devices	In-network – 100% after deductible Out-of-network – 80% after deductible

Contraceptive devices, their insertion, removal and reinsertion are covered one per year for women only. Benefits include Depo Provera injections, intrauterine devices and diaphragms. Includes initial exam for measurement.

Cosmetic surgery	In-network – 90% after deductible Out-of-network – 80% 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	In-network – 90% after deductible Out-of-network – 80% 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 services for initial injuries sustained in an accident are a covered benefit. Injury as a result of chewing or biting is not considered an accidental injury.

Dental treatment (emergency only)	In-network – 90% after deductible Out-of-network – 80% 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 NSHP 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.

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

Diabetic supplies	

See “Durable Medical Equipment Medical Supplies SUPPORT program.”

Diabetic training	In-network – 100% after deductible Out-of-network – 80% 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	In-network – 90% after deductible Out-of-network – 80% after deductible

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

Dialysis services	In-network – 90% after deductible Out-of-network – 80% 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. Services must be billed by a hospital or freestanding ESRD facility participating with BCBSM and must meet the following conditions:

- The treatment must be arranged by the patient’s attending physician and the physician director or a committee of staff physicians of a self-dialysis training program.
- The owner of the patient’s home must give the hospital prior written permission to install the equipment.

We pay for:

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

We do not pay for:

- Services provided by persons under contract with the hospital, agencies or organizations assisting in the dialysis or acting as “back-ups,” including hospital personnel sent to the patient’s home
- Electricity or water used to operate the dialyzer
- Installation of electric power, a water supply or a sanitary waste disposal system
- Transfer of the dialyzer to another location in the patient’s home
- Physician services not paid by the hospital

Facility services

We pay for medically necessary facility services provided to treat patients with chronic, irreversible kidney disease. The following services are covered:

- Use of the freestanding end stage renal disease facility
- Ultrafiltration
- Equipment
- Solutions
- Routine laboratory tests
- Drugs
- Supplies
- Other medically necessary services related to dialysis treatment

Diagnostic tests and radiation services	**In-network – 90% after deductible** **Out-of-network – 80% 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; medical, prosthetic and orthotic supplies – SUPPORT Program	**SUPPORT provider – 100%** **Non-SUPPORT provider – 80% of approved amount (plus the difference between charge and approved amount)**

You have coverage through the SUPPORT (Select Utilization of Providers for Prosthetic, Orthotic and Rehabilitative Technology) program for medical equipment, prosthetic and orthotic appliances and medical supplies.

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

In Michigan

The SUPPORT program is available only in Michigan and applies to items prescribed by a physician. You purchase or rent these items from an independent medical supplier for use at home. The program does not apply to items you use during a hospital stay or receive from your doctor. If you obtain medical equipment and supplies from a physician's office or hospital, these supplies are covered under your medical or inpatient hospital benefits by BCBSM, not the SUPPORT program, and are subject to different cost-sharing requirements. If you use a non-SUPPORT supplier, you will pay out-of-pocket costs equal to 20 percent of the BCBSM approved amount, plus the difference in cost between the supplier's charge and the BCBS approved amount.

Out of Michigan

The SUPPORT network does not apply outside of Michigan. For the rental or purchase of medical equipment and supplies, and prosthetic and orthotic supplies elsewhere in the United States, you can minimize your out-of-pocket expenses by using suppliers that participate with the local BCBS Plan.

Diabetic supplies

Some diabetic supplies are covered under SUPPORT. Diabetic supplies covered under SUPPORT include:

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

Not covered through the SUPPORT program

The following are not covered through the SUPPORT program:

- Comfort and convenience items, such as air purifiers and air conditioners
- Deluxe equipment, such as motorized wheelchairs, unless medically necessary and required so the patient can operate the equipment themselves
- Exercise and hygienic equipment
- Non-medical equipment
- Routine maintenance expenses, such as the cost of batteries
- Self-help devices such as elevators
- Equipment that is not reasonable and necessary in the care or treatment of illness or injury (i.e., safety equipment, home or vehicle modification)

(Many individual DME services have quantity restrictions or limitations, depending on the service provided.)

Emergency care	**$200 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. Initial examination must occur within 48 hours of the injury or 72 hours of the medical emergency.

Your coverage provides payment for the initial examination and treatment of accidental injuries and conditions determined by BCBSM 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" on page 26 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 NSHP 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.

Hearing care	See following for cost-share amounts.

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 Blues 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% Nonparticipating provider in Michigan – Not covered

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% Nonparticipating provider in Michigan – Not covered

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 Nonparticipating provider in Michigan – Not covered

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	In-network – $20 Out-of-network – 80% after deductible

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% Nonparticipating provider in Michigan – Not covered

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 Nonparticipating provider – Not covered

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.

We pay the following covered services 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 infusion therapy (HIT)	Participating provider – 90% after deductible Nonparticipating provider – Not covered

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 pay for services rendered by a nonparticipating provider.

Home visits	In-network – 90% after deductible Out-of-network – 80% after deductible

Home visits by a physician are covered.

Hospice care	BCBSM or Medicare-certified hospice program – 100% Nonparticipating – Not covered

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 State of Michigan 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 Out-of-network – 80% 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 Out-of-network – 80% 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 (specified)	Covered – 100% in designated facilities

Specified human organ transplants are covered when performed in a designated facility. All services must be pre-certified. We pay for transplantation of the following organs:

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

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

When directly related to the transplant, we pay for:

- Facility and professional services
- Anti-rejection drugs and other transplant-related prescription drugs, during and after the benefit period, as needed. Payment will be based on BCBSM's approved amount.
- Immunization against certain common infectious diseases during the first 24 months post-transplant (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 pay for 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 pay for 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)	**See below for cost-share**

The NSHP 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	**Covered – 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 preapproved.
  — Infusion of colony stimulating growth factors

- Harvesting (including peripheral blood stem cell pheresis) and storage of the donor's bone marrow, peripheral blood stem cell and/or umbilical cord blood, if the donor is:
  - A first degree relative and matches at least four of the six important HLA genetic markers with the patient or
  - Not a first degree relative and matches five of the six important HLA genetic markers with the patient. (This provision does not apply to transplants for sickle cell anemia 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 pay for 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**	**In-network – 90% after deductible** **Out-of-network – 80% 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	**In-network – 90% after deductible** **Out-of-network – 80% 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	**In-network – 90% after deductible** **Out-of-network – 80% after deductible**

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

Maternity care	**In-network – 90% after deductible** **Out-of-network – 80% after deductible**

You have coverage for pre- and post-natal services, including services provided by a physician attending the delivery. Maternity care benefits are also payable when provided by a certified nurse midwife.

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

NOTE: The baby must be eligible for coverage and must be added to your contract within 31 days of the birth. Please review the Eligibility section of this booklet, or contact the MI HR Service Center for details.

Medical eye exams	**In-network – $20** **Out-of-network – 80% after deductible**

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

Medical supplies	**SUPPORT Program provider – 100%** **Non-SUPPORT Program provider – 80% of approved amount, plus the difference between the supplier's charge and the approved amount**

Medical supplies and dressings for use in the home are covered when prescribed by a physician for the treatment of a specific medical condition. See the SUPPORT program for details.

Office visits and office consultations	**In-network – $20** **Out-of-network – 80% after deductible**

We pay for office visits and consultations.

Optical services	In-network – 90% after deductible Out-of-network – 80% 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	In-network – $20 Out-of-network – 80% after deductible

Coverage is provided for osteopathic manipulation.

Physical, occupational and speech therapy	In-network – 90% after deductible Out-of-network – 80% 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 up to 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

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** **Out-of-network – 80% 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.

Private duty nursing	Covered – 80% after deductible (No network required)

Covered when the patient's medical condition necessitates 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 State of Michigan Customer Service Center before receiving services.

Skilled nursing care	Covered – 90% after deductible (No network required)

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

We pay up to a maximum of 120 days, for each benefit period, in a SNF for general conditions. 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 pay for 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	In-network – 90% after deductible Out-of-network – 80% 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	In-network – 90% after deductible Out-of-network – 80% after deductible

Coverage is provided for a study conducted on a group of patients to determine the effect of a treatment. This includes:

- Phase II – a study conducted on a number of patients to determine whether the treatment has a positive effect on the disease or condition as compared to the side effects of the treatment.
- Phase III – a study conducted on a much larger group of patients to compare the results of a new treatment of a condition to the results of conventional treatment. Phase III gives an indication as to whether the new treatment leads to better, worse or no change in outcome.

Coverage also includes antineoplastic drugs for the treatment of stages II and III breast cancer and all stages of ovarian cancer when they are provided following an approved Phase II or III clinical trial.

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

Covers antineoplastic drugs for the treatment of stages II and III breast cancer and all stages of ovarian cancer when they are provided following an approved phase II or III clinical trial.

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

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

- The inpatient admission and length of stay must be medically necessary and preapproved. No retroactive approvals will be granted.
- The services must be performed at a National Cancer Institute (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.

The patient must be an eligible BCBSM member with hospital, medical and surgical coverage.

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

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

Surgery	**In-network – 90% after deductible** **Out-of-network – 80% 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 NSHP 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 NSHP 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)	In-network – 90% after deductible Out-of-network – 80% 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	In-network – $20 Out-of-network – 80% after deductible

Non-emergency treatments are covered at independent urgent care facility, after-hour physician group practices and some PPO hospitals and their affiliated urgent care locations.

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	See SUPPORT program 800-321-8074

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.

What is not covered

In addition to the exclusions listed with the benefit, the following services are not covered under the NSHP 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

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 NSHP 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 NSHP PPO is primary, then full benefits under the plan will be paid. If the NSHP 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 NSHP 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 NSHP 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 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
   - 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 State of Michigan Customer Service Center.
3. Mail the claim form and itemized statement to the BCBSM State of Michigan 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

The NSHP PPO 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 NSHP PPO 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:

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 NSHP 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**.

New State Health Plan PPO
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 State of Michigan 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:

Office of Financial and Insurance 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:

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

If by telephone, call toll-free number: **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.mi.gov/documents/Regulation_5_128248_7.18.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 NSHP 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.

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. This can be either a fixed-dollar or a percentage amount.

Covered services are services, treatments or supplies identified as payable under the NSHP 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 NSHP PPO.

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

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

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

Durable medical equipment (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 acute care or specialized treatment, such as substance abuse treatment, 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 NSHP 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.

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 NSHP 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 NSHP PPO.

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