

The State Health Plan PPO for Medicare-eligible retirees

Welcome

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

MCSC is responsible for implementing State Health Plan PPO benefits and future changes in benefits. 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.

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

As of Jan. 1, 2009, following are the cost-share changes to your benefit plan:

	Cost-share change
<ul style="list-style-type: none">• Deductible	Increase to \$300 individual/\$600 family
<ul style="list-style-type: none">• Emergency room copayment	Increase to \$50 (waived if admitted)
<ul style="list-style-type: none">• Office visits• Physician consultations• Chiropractic office visits• Chiropractic spinal manipulations• Urgent care visits• Medical eye exams• Medical hearing exam	Increase to \$15 copayment

If you have any questions about your State Health Plan PPO coverage after reading this book, please call the State of Michigan Customer Service Center.

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

How to reach us

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

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

- Have your ID card handy so you can provide your contract and group numbers. If you are writing, include this information in your letter.
- To ask if a particular service is covered, please have your physician provide you with the five-digit procedure code. If your planned procedure does not have a code, please obtain from your provider a complete description of the service. Please also include the diagnosis.
- To inquire about a claim, please provide the following:
 - Patient's name
 - Provider's name (such as the doctor, hospital or supplier)
 - Date the patient was treated
 - Charge for the service
 - Type of service (for example, an office visit)
- When writing to us, please send copies of your bills, other relevant documents and any correspondence you have received from us. Make sure you keep your originals.
- Include your daytime telephone number on all of your letters.

Calling

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

In and outside Michigan.....**1-800-843-4876**

Special servicing numbers

Anti-fraud hotline.....	800-482-3787
BlueHealthConnection.....	877-922-9355
BlueCard®.....	800-810 BLUE (2583)
Hearing-impaired customers	TTY 1-800-240-3050
Human organ transplant program.....	800-242-3504
Case management.....	800-768-6787
The SUPPORT program.....	800-321-8074
Individual coverage servicing department.....	888-642-2276
State of Michigan Office of Retirement Services	
Lansing area.....	517-322-5103
Toll free.....	800-381-5111

Writing

Please send all correspondence to:

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

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

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

For specific eligibility information and assistance, retired employees may contact:

Office of Retirement Services
P.O. Box 30171
Lansing, MI 48909-7671

Visiting

Our Customer Service Center is open Monday through Friday from 8 a.m. to 6 p.m. We are closed on holidays.

BCBSM State of Michigan Customer Service Center

232 S. Capitol Avenue
Lansing, MI

Alpena

135 W. Chisholm St.

Detroit

500 E. Lafayette Blvd.

Flint

4520 Linden Creek Parkway
Suite A

Grand Rapids

86 Monroe Center

Holland

259 Hoover Blvd., Suite 160

Jackson

1000 N. Wisner St., Suite 5

Mt. Pleasant

1620 S. Mission

Marquette

415 S. McClellan Ave.

Muskegon

1034 E. Sternberg Road

Portage

2255 W. Centre Ave.

Port Huron

2887 Kraft Rd., Suite 200

Saginaw

4300 Fashion Square Blvd.
Suite 100

Traverse City

1769 S. Garfield Ave.

Utica

6100 Auburn Road

Internet access

BCBSM home page bcbsm.com

BCBSM page for SOM members..... bcbsm.com/som

Anti-fraud..... bcbsm.com/antifraud

BlueHealthConnection sm bcbsm.com

State of Michigan..... michigan.gov

Healthy Blue Xtras* healthybluextras.com

* Access to these websites requires registration at the bcbsm.com Member Secured Services portal.

How the health care plan works

Your health coverage continues when you or your covered dependents become eligible for Medicare by providing you Medicare Supplemental benefits. These benefits supplement Medicare so that you enjoy the same covered services as non-Medicare members.

You become eligible for Medicare coverage at age 65. If you are disabled or if you have end stage renal disease, you will be eligible for Medicare at an earlier age. This means that the health plan will only pay the supplemental portion of your health services. To limit your out-of-pocket expenses, you should enroll in both Medicare Part A and Part B when you first become eligible. Regardless of your age, you should enroll in Part A and Part B if you or your dependents are recognized by Social Security as being disabled or diagnosed with end stage renal disease.

If you do not enroll in both Part A and Part B of Medicare when eligible, your health plan coverage will be adjusted as if Medicare coverage was in place. In this case, the plan will not reimburse that portion of an expense normally covered by Medicare. This may result in limited or no payment, or retroactive adjustment to claims.

More information is available in the next section, *Medicare and Supplemental Coverage*, and from Medicare through your local Social Security office. You can also visit **medicare.gov**.

Medicare and supplemental coverage

The State Health Plan PPO means that PPO benefits apply to you, but the PPO network of providers does not.

Medicare is a federal government program that provides health benefits to people age 65 and older, and to persons of all ages with certain disabilities. To receive Medicare Supplemental coverage through the State Health Plan PPO, you must select Medicare Part A (hospital insurance) and Part B (medical insurance). Your supplemental benefits expand your Medicare coverage so that you enjoy the same covered services as before you enrolled in Medicare. Your supplemental plan also pays the Medicare annual deductible and Medicare coinsurance (Medicare's term for copay) amounts for services covered under the State Health Plan PPO.

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

Medicare eligibility and enrollment

Generally you are eligible for Medicare coverage at age 65. When you reach age 65, your PPO health coverage automatically converts to Medicare supplemental coverage. This means that the health plan will only pay for the supplemental portion of your health services. **If you are eligible for Medicare coverage but decline it, then you will be responsible for paying the portion of health care costs that Medicare would normally pay.**

If you choose the original Medicare plan (Parts A and B), it is equally important to enroll in both Part A **and** Part B at the same time. There is no financial advantage in delaying enrollment in Part B. In fact, you may face higher Part B premiums for each year you postpone enrollment. The Medicare Part B premium increases 10 percent for each year you delay coverage.

Members with end stage renal disease

If you or a dependent are disabled or diagnosed with end stage renal disease, you may be entitled to Medicare benefits sooner than age 65. When you are approved for Medicare disability benefits, you must notify BCBSM. Your coverage will be converted to Medicare supplemental.

It is important to accept both Part A and Part B coverage. If you are eligible for Medicare disability coverage and decline or delay enrollment in Part B, the health plan will only pay the supplemental portion of your health services.

For more information about Medicare, contact your local Social Security Administration office.

Selecting Your Medicare Provider

When you select hospitals, doctors or other medical providers, always ask if they accept assignment of Medicare claims. This means they will not bill you for the difference between their charge and the Medicare-approved amount. These providers will also file your Medicare claims for you.

To find out if a particular provider accepts Medicare assignment, check directly with the provider or call **800-MEDICARE**. To find a Medicare provider in a particular area, call the local Medicare administrator, or visit **medicare.gov**. You can obtain the number of the local Medicare administrator by calling **800-MEDICARE**.

Providers that do not accept Medicare assignment

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

Providers that do not accept Medicare assignment are required by law to file a claim with Medicare for you. However, **this does not mean they accept Medicare assignment. These providers may also bill you for their charges in excess of Medicare's approved amount and the Medicare deductible and coinsurance, up to 115 percent of Medicare's approved amount.** If your doctor does not accept assignment, you are responsible for paying the provider's entire bill. Medicare will reimburse you based on its approved amount. Any additional amounts you must pay above the Medicare-approved amount **will not** be reimbursed through your Medicare supplemental coverage.

Coordinating Medicare and your supplemental coverage

When you enroll in Medicare, it becomes your primary coverage and will determine if the service rendered is a benefit and, if so, the approved amount for the service. When you enroll or become eligible for Medicare, the State Health Plan PPO is your secondary coverage that supplements Medicare and provides some services that may not be covered under Medicare Part A or Part B. For the following services you need to be sure to see a BCBSM participating provider.

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

Your Medicare ID card

Always present both your Medicare card and Blue Cross Blue Shield of Michigan card to hospitals, facilities, doctors and other health care providers before receiving services. This way, you will ensure that the provider has all the necessary information to submit claims to the appropriate place.

Line 1: Enrollee Name is the name of the person who holds the contract. All communications are addressed to this name.

Line 2: Enrollee ID identifies your records in our files
The **alpha prefix** preceding the enrollee ID number identifies that you have coverage through the SHP PPO.

LINE 3: Issuer No. identifies you as a Blue Cross Blue Shield of Michigan member. The number 80840 identifies our industry as a health insurance carrier.

Line 3: Group No. 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 inquiry.

Here are some tips about your ID card:

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

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

Eligibility guidelines

When are you eligible?

You are eligible as a retiree for Medicare coverage on the day your pension begins. This is known as your “eligibility date.”

You can continue your coverage without interruption if:

- You retired under the Defined Contribution Plan
- You receive an immediate pension benefit under one of the following:
 - State Employees’ Retirement Act
 - State Police Retirement Act

You can also enroll in the State Health Plan if you were previously enrolled in a State-sponsored Health Maintenance Organization and you receive an immediate pension benefit.

What makes a dependent eligible?

Eligible dependents include your spouse and any of your unmarried children until the end of the month in which they turn 19. In addition to being unmarried, children must meet the following conditions to be considered eligible. They must be:

- Your children by birth or legal adoption who are in your custody and dependent on you for support. You will need to provide proof of dependency.
- Your children by birth or legal adoption who do not reside with you, but are your legal responsibility for the provision of medical care (for example, children of divorced parents).

In the case of legal adoption, a child is eligible for coverage as of the date of placement. Placement occurs when you become legally obligated for the total or partial support of the child in anticipation of adoption. A sworn statement with the date of placement or a court order verifying placement is required.

Your dependent’s coverage will automatically terminate on the last day of the last month for which you made any required dependent premium contribution *and*:

- When your dependent no longer meets the definition of an eligible dependent (You must immediately notify the Office of Retirement Services if you divorce because ex-spouses are not eligible for coverage.)
- When the entire group or the group dependent contract is discontinued
- When your coverage terminates

Under certain circumstances, you can continue coverage for dependent children past the age of 19. For more information please see the section on *Continuing coverage for dependents*.

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.
- Already covered on another State of Michigan Health Plan
No person can be covered by more than one State of Michigan Health Plan.

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

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

If you choose to maintain separate coverage, your child or children can only be listed on one plan, not both. This applies even if you are divorced.

If an actively employed spouse separates from State service, takes a leave of absence or becomes laid off, he or she may enroll in the retiree's State Health Plan PPO if he or she:

- Meets dependent eligibility requirements

- Notifies his or her human resources office and the ORS of the intent to transfer enrollment before departing from State service

You also cannot claim a new spouse as a dependent if you are receiving benefits as the surviving spouse of a State employee or retiree.

Applying for coverage

To apply for State Health Plan PPO coverage or to ensure uninterrupted coverage, you will need to submit a retiree *Group Insurance Application* to the ORS. To request the form, call the ORS at the telephone number on page 104 of this booklet.

Mail the completed form to:

Office of Retirement Services
P.O. Box 30171
Lansing, MI 48909-7671

If you are a defined contribution retiree, you will also need to complete a *Defined Contribution Plan Notice of Retiree Group Insurance Eligibility* form. You can also obtain this form from the ORS.

You must decide within 31 days *after* your eligibility date whether you will enroll in the plan. If you choose not to enroll within this timeframe, your coverage, and that of your eligible dependents, will not be effective until six months after the first day of the month in which the ORS receives your completed application.

However, the six-month waiting period can be waived, and coverage can begin within 31 days after your completed application is received, if:

- You get married

Within 30 days of your marriage, send a letter of notification to the ORS that includes your new spouse's name, date of birth, Social Security number and Medicare information. Include a copy of your marriage license.
- You need to enroll in the plan because you or your dependents are losing coverage from another group plan. Those losing coverage must be eligible for State Health Plan PPO to be enrolled in it.

To receive consideration, please submit your application with a letter from the employer that states:

- Who was covered under the plan
- Why coverage is ending
- The date the coverage ends

The address for ORS can be found on the previous page.

Changing coverage

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

- You get married or divorced
- An eligible child is born, adopted or moves into your home
- Your spouse begins or ends employment
- Your spouse changes from part-time to full-time (or vice versa) or takes an unpaid leave of absence resulting in a significant change in your coverage
- There is a significant change in your or your spouse's coverage through your spouse's non-State of Michigan employer plan
- Your dependent 19- to 25-year-old child has returned to school

To make mid-year enrollment changes, notify the ORS, in writing within 31 days of the date of the event. The changes in coverage will be effective retrospectively to the qualifying event *after* the ORS receives the written request for change and documentation of the qualifying event.

The address for ORS is on the previous page.

Continuing coverage for dependents

State Health Plan coverage will automatically continue for a dependent who is to receive an immediate monthly pension benefit from the State of Michigan you are your death.

Dependents of defined contribution retirees will be entitled to continue coverage through the retiree group.

If your dependent is not going to receive a monthly pension benefit following your death, his or her coverage will end 30 days following your death.

If your dependent's enrollment in the State Health Plan is canceled, he or she may be eligible for continuing coverage. We have detailed the options on the following pages.

Continuing coverage for dependent children

If your coverage is **still active** but your dependent child no longer meets the eligibility criteria outlines in the section *What makes a dependent eligible?*, your dependent child can remain on your coverage if he or she is:

- Unmarried and between the ages of 19 and 25
- Dependent on you for financial support
- A student who regularly attends school

This coverage will continue until the end of the month in which the child turns 25 if he or she remains eligible. Coverage for these dependents will be the same as yours.

Continuing coverage for incapacitated children

Incapacitated children are those who are unable to earn a living because of mental retardation or physical disability and must depend on their parents for support and maintenance. If your enrolled dependent is deemed an incapacitated child, the 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 coverage before the end of the month in which the child turns 19. To apply for continuation coverage, contact the ORS for a BCBSM application card.

Continuing coverage under COBRA

Your dependents may also be eligible for continuing coverage under the federal law known as COBRA. COBRA requires the State of Michigan to offer eligible dependents of retirees continued group insurance coverage. COBRA applies to:

- Surviving dependents who will lose the retiree group coverage in the case of your death
- Spouses who lose coverage because of divorce or legal separation
- Children who no longer meet dependent eligibility requirements under the State Health Plan

If your eligible dependents choose COBRA, they may continue State of Michigan coverage for up to 36 months by paying the full monthly premium (including the share that was paid by the State) directly to the State of Michigan.

To apply for continuation of coverage, your eligible dependents must submit an *Application for Continuation of Insurance Benefits* (form MDCS-1499) to the Employee Benefits Division no later than 60 days from the date of your death, or the date coverage ended, whichever is later and whichever applies.

The address for the Employee Benefits division is:

**Office of the State Employer
Employee Benefits Division
P.O. Box 30026
Lansing, MI 48909**

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 under BCBSM group conversion

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

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

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

To ensure continuous coverage, your dependents must submit a written request for group conversion coverage to Blue Cross within 30 days from the date they are no longer eligible for State Health Plan coverage **or** within six months before the COBRA coverage ends.

For additional information on how to apply for BCBSM conversion coverage please call our individual billed servicing department at **877-469-2583**. Customer service representatives are available Monday through Friday, 8:30 a.m. to 5 p.m.

Discontinuing coverage

You can voluntarily cancel your State Health Plan coverage or your dependent's coverage at any time by writing to the ORS. Include your signature and Social Security number.

The cancellation effective date will be the last day of the month in which a premium (or dependent contribution) is paid.

In the event of divorce, the cancellation date is the date of the divorce.

Certificate of creditable coverage

The Health Insurance Portability and Accountability Act of 1996 requires all health plans to provide a certificate of creditable coverage to any individual who loses health coverage. The certificate rules help ensure that coverage is portable, which means

that once a person has coverage, he or she can use it to reduce or eliminate any pre-existing condition exclusion periods that might otherwise apply when changing coverage. When your coverage through your employer ends, you will receive a certificate of coverage.

Coordination of benefits

Coordination of benefits is how group health care plans and insurance carriers coordinate benefits when members are covered by more than one plan. Under COB, group health care plans and insurance carriers work together to make sure members receive the maximum benefits available under their plans. Your State Health Plan PPO requires that your benefit payments be coordinated with those from another group plan for services that may be payable under both plans.

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

How COB works

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

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

- If a group health plan does not have a coordination of benefits provision, that plan is primary.
- If husband and wife have their own coverage, the husband's health coverage is primary when he receives services and the wife's coverage is primary when she receives services.
- If a child is covered under both the mother's and the father's plan, the plan of the parent (or legal guardian) whose birthday is earlier in the year is primary.

If the child's parents are divorced, benefits will be paid according to any court decree. If no such decree exists, benefits are determined in the following order unless a court

order places financial responsibility on one parent:

1. Custodial parent
2. Stepparent (if remarried)
3. Noncustodial parent
4. Noncustodial stepparent (if remarried)

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

Processing your COB claims

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

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

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

Keeping your COB information updated

After enrollment, we will periodically send you a COB questionnaire to update your coverage information. Please complete and return this questionnaire so that 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.

Care out of the country

Medicare does not pay for care out of the country. The State Health Plan PPO will only pay for services for emergency and unexpected illness for residents of the United States traveling in foreign countries. In addition, coverage applies only if:

- The hospital is accredited.
- The physician is licensed.

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

Your State Health Plan PPO benefits

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

Payment of your State Health Plan PPO benefits, including deductibles, is based on a calendar year beginning January 1 and ending December 31.

Dollar maximums

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

Out-of-pocket costs

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

Deductibles

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

Deductible	Per calendar year*
Individual	\$300
Family	\$600

* As of 1/1/09

Deductibles are required each calendar year.

Any amount you pay toward your deductible during the fourth quarter (October through December) will carry over and be applied to your deductible the following year.

Copayments and Coinsurances

After you have met your deductible, you are responsible for copayments or coinsurances with one exception. There are no required deductibles for office visits. A copayment is the set dollar amount that you are responsible for paying for specific medical services, such as doctor's visits. A coinsurance is a percentage you are responsible for paying for a medical service.

Copayment and coinsurance amounts are noted below.

Copayments/ coinsurances	
Fixed-dollar copayment	\$15 for office visits, office consultations, chiropractic office visits, urgent care, medical eye exams and medical hearing exams
	\$50 emergency room (waived if admitted)
Percentage coinsurance	10% for private duty nursing and acupuncture

Annual copayment maximums

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

	Out-of-pocket maximum
Individual	\$1,000
Family	\$2,000

You are only required to pay the above amount in copayments each year. After you have paid **\$1,000 per member** or **\$2,000 per family** in-network and out-of-network coinsurances, you do not have to pay any more in-network copayments for the remainder of that year.

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

- Private duty nursing copayments
- Fixed dollar copayments
- Deductibles (in-network or out-of-network)
- Charges for non-covered services
- Charges in excess of our approved amount
- Deductibles or copayments required under other BCBSM coverage

Medical necessity for hospital services

Unless otherwise specified, a service must be medically necessary to be covered by the State Health Plan PPO. Medical necessity for the payment of hospital services requires that all of the following conditions be met:

- The covered service is for the treatment, diagnosis or symptoms of an injury, condition or disease.
- The service, treatment or supply is appropriate for the symptoms and is consistent with the diagnosis.
- “Appropriate” means the type, level and length of care, treatment or supply and setting are needed to provide safe and adequate care and treatment.
- For inpatient hospital stays, acute care as an inpatient must be necessitated by the patient’s condition because safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.
- The services are not mainly for the convenience of the member or health care provider.
- The treatment is not generally regarded as experimental or investigational by BCBSM.
- The treatment is not determined to be medically inappropriate by the Utilization Management and Quality Assessment programs.

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

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

Pain management

BCBSM considers pain management an integral part of a complete disease treatment plan. We provide coverage for the comprehensive evaluation and treatment of diseases, including the management of symptoms such as intractable pain that may

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

Hospital coverage

Medicare is your primary carrier. They process your claims first. Contact Medicare about your primary coverage. BCBSM is your supplemental carrier. BCBSM processes your claims after Medicare. Below is a description of your supplemental benefits.

What you pay for covered services
Annual deductible

Inpatient hospital benefits

Your coverage includes the following inpatient hospital services at a participating hospital:

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

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

- **General medical care days** — You have an unlimited number of inpatient days available for the diagnosis and treatment of general medical conditions. This includes admissions for:
 - **Maternity and nursery care** — Includes delivery room costs, birthing center services, and routine nursery care for a newborn during an eligible mother's hospital stay.

After the hospital stay, the newborn is covered as a dependent child, but

only if you add the child to your coverage within 31 days of birth.

Under federal law, BCBSM generally cannot restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. However, the attending physician may, after consulting with the mother, discharge the mother or the newborn earlier. BCBSM also cannot require a provider to obtain authorization for prescribing a length of stay not in excess of the 48-/96-hour minimum.

- **Cosmetic surgery** — Includes correction of birth defects, conditions resulting from accidental injuries, deformities resulting from certain surgeries, such as breast reconstruction following mastectomies.
- **Dental surgery** — Includes removal of impacted teeth or multiple extractions **only** when a concurrent hazardous medical condition, diagnosed by a physician, exists. The inpatient stay must be considered medically necessary to safeguard the life of the patient during the dental surgery.
- **Diagnostic and radiology services** — The following diagnostic and radiology services are covered during a hospital admission:
 - **CAT and MRI scans** — Includes scans of the head and body when required for eligible diagnoses and when performed in a facility approved by BCBSM.
 - **Diagnostic tests** — Includes EKGs, EMGs, EEGs, thyroid function tests and nerve conduction studies required in the diagnosis of an illness or injury.
 - **Therapeutic radiology** — Includes radiological treatment by X-ray, isotopes or cobalt for a malignancy.
 - **Diagnostic radiology** — Includes ultrasounds and X-rays required for the diagnosis of an illness or injury.
- **Hospital services and supplies** — The following services and supplies are covered during a hospital admission when needed:
 - **Anesthesia** — Includes administration, cost of equipment, supplies and the services of a hospital anesthesiologist when billed as a hospital service.

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

Outpatient hospital benefits

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

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

The service must be:

- Medically necessary because transport by any other means would endanger the patient's health

- Prescribed by a physician (when used for transferring a patient)
- Provided in a vehicle qualified as an ambulance and part of a licensed ambulance operation

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

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

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

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

- **Sterilization** — This benefit applies to both males and females. A medical reason is not required.
- **Termination of pregnancy**
- **Infertility treatment** – Infertility treatments are **not** included. This includes the following services:
 - Specific fertility treatments or procedures including inpatient and outpatient surgical procedures, labs and radiographs
 - Treatments and diagnostic tests for infertility problems
 - Artificial insemination

- Embryo transfer
- Experimental/investigational fertility services
- In vitro-fertilization
- Reversal of voluntary sterilization
- Services associated with excluded services

- **Hemodialysis** — Hemodialysis services are covered to treat acute kidney failure and end stage renal disease. Patients can receive treatment in the inpatient or outpatient department of a hospital, in a licensed facility or at home. (For more information on home hemodialysis services see the *Alternatives to hospital care* section of this book.)

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

- **Physical, occupational and speech therapy** — Your physical, occupational and speech therapy services are payable when provided in the outpatient department of a participating facility and clinic. When the services are rendered in a physician's office, the Medicare cap applies.

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

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

Examples of covered services are:

- Therapy prescribed to restore musculoskeletal functioning
- Therapy used in conjunction with a treatment program to accelerate the

healing of an acute injury or illness involving the muscles or joints

Physical therapy is also covered when provided in:

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

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

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

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

Your benefit covers therapy for:

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

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

- Long-standing, chronic conditions such as arthritis
- Massage therapy
- Developmental conditions or learning disabilities for members over the age of 6

- Health club membership or spa membership
- Congenital or inherited speech abnormalities for members over the age of 6
- Inpatient hospital admissions principally for speech or language therapy

Other outpatient hospital benefits

Emergency medical care

What you pay for covered services
\$50 (waived if admitted)

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

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

Urgent care services

What you pay for covered services
\$15

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

Medical necessity for physician services

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

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

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

Physician and other professional services

Preventive services

What you pay for covered services
\$0 up to the yearly dollar maximum of \$1,500

Your coverage pays for the preventive services listed below when they are received from participating providers.

Health maintenance exam — This includes a comprehensive history and physical exam. It also includes the following laboratory and radiology procedures when performed as a routine screening:

- Chemical profile
- Complete blood count
- Urinalysis
- Chest X-ray
- EKG/ECG

Diabetes screening (supplies covered separately) – Two screening tests per year for a diagnosis of pre-diabetes; one screening per year if previously tested but not diagnosed or if never tested

Annual gynecological exam — Covered one per calendar year

Pap smears — Covers laboratory services for one routine Pap smear per calendar year

More frequent Pap smears are covered for the following conditions:

- Previous surgery for vaginal, cervical or uterine malignancy
- Presence of a suspected lesion in the vaginal, cervical or uterine areas
- Post-surgery

Pelvic/gynecological exam screening – Covered one per calendar year

Well-baby and child care — Number of visits as follows:

- Six visits for children zero through 12 months
- Six visits for children 12 months through 24 months
- Two visits per birth year for children 24 months through 48 months
- One visit each birth year for children 48 months through 15 years

Colorectal screenings — Beginning at age 50, members should have **one** of these screenings:

- A fecal occult blood test every year *and* a flexible sigmoidoscopy every five years or
- A colonoscopy every 10 years or
- A double contrast barium enema every five to 10 years (This benefit is not subject to the preventive services dollar maximum.)

Prostate specific antigen screening — One per calendar year

Fecal occult blood test – Every year beginning at age 50

Flexible sigmoidoscopy – Every five years beginning at age 50

Hepatitis C screenings — There is no age limit.

Immunizations — Age 19 and over

The following preventive services do not count toward your \$1,500 annual maximum.

Immunizations — Birth to age 18

Colonoscopy – One every 10 years

Digital rectal exam – One every five to 10 years beginning at age 50

Abdominal aortic aneurysm screening – One per lifetime

Mammography (annual screening) – One per calendar year, no age limit

Double contrast barium enema – One every five to 10 years beginning at age 50

Glaucoma tests – Covered once annually for high risk groups:

- African Americans age 50 and older
- Hispanic Americans age 65 and older
- Diabetes Mellitus
- Family history of glaucoma

Flu shot — There is no age limit. Also covered when given by a visiting nurse agency or a health department

Pneumococcal shot – There is no age limit. Also covered when given by a visiting nurse agency or a health department

Zostavax (Shingles) – For adults age 60 and older. Also covered when given by a visiting nurse agency or a health department

Meningitis shot – There is no age limit. Also covered when given by a visiting nurse agency or a health department

Hepatitis B shot – Covered. Limited to one series of three schedule dosages over an eight-month period

Yellow Fever shot – There is no age limit. Also covered when given by a visiting nurse agency or a health department.

Surgical services

What you pay for covered services

Annual 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 subject to the following payment limitations:

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

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

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

Breast reconstruction surgery is covered for:

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

Dental surgery performed on an inpatient basis is covered only for the removal of

impacted teeth or multiple extractions. The patient must be hospitalized for the surgery because a concurrent medical condition, diagnosed by a physician, exists. The inpatient admission for the dental surgery must be considered medically necessary to safeguard the life of the patient.

Benefits are limited to services performed by an MD or DO, including anesthesia services, and services billed by the facility.

Dental procedures performed by a DDS must be billed to the dental program.

Cataract surgery and first lens implants are covered.

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

Termination of pregnancy is also covered.

Additional surgical services covered

Technical surgical assistance — TSA is a covered benefit for certain major surgeries that require surgical assistance by another physician. TSA is covered inpatient and outpatient, and in approved ambulatory surgery facilities.

Anesthesia — Services for giving anesthesia are payable to a physician other than the operating or assisting physician, and to certified registered nurse anesthetists. We do not pay for local anesthetics.

Some medical surgeries performed by a DDS

Inpatient medical care

What you pay for covered services
Annual deductible

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

Inpatient and outpatient consultations

What you pay for covered services

Annual deductible

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

Emergency care

What you pay for covered services

\$50 (waived if admitted)

Your coverage provides payment for the initial examination and treatment of accidental injuries and conditions determined by BCBSM to be medical emergencies. Services associated with the initial examination will be subject to the copayment. The copayment is waived if the patient is admitted. Nonparticipating providers may bill you the difference for additional services. Initial examination must occur within 48 hours of the injury or 72 hours of the medical emergency. (Please see the **Glossary** for definitions of these terms.)

Diagnostic and radiation services

What you pay for covered services

Annual 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, EMGs, EEGs, thyroid function tests,

nerve conduction and pulmonary-function studies

- Radiation therapy, which includes radiological treatment by X-ray, isotopes or cobalt for a malignancy

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

Digital mammography is covered.

Allergy testing

What you pay for covered services
Annual deductible

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

Acupuncture

What you pay for covered services
10% after annual deductible

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

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

- Sciatica
- Neuritis
- Postherpetic neuralgia

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

Dental work

What you pay for covered services
Annual deductible

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

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

Treatment for Temporomandibular Joint Syndrome or jaw-joint disorder

What you pay for covered services
Annual 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)

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

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

Foot care

What you pay for covered services
Annual deductible

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

Radial keratotomy

What you pay for covered services
Annual deductible

Radial keratotomy is covered only when all of the following criteria are met and when services are preformed by a BCBSM participating physician.

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

Maternity care

What you pay for covered services
Annual deductible

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

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

Infertility treatments are **not** included. This includes the following services:

- Specific fertility treatments or procedures including inpatient and outpatient surgical procedures, labs and radiographs
- Treatments and diagnostic tests for infertility problems
- Artificial insemination
- Embryo transfer
- Experimental/investigational fertility services
- In vitro-fertilization
- Reversal of voluntary sterilization
- Services associated with excluded services

Physician office services

What you pay for covered services

\$15 copayment in physician's office, urgent care, office consultations, chiropractic office visits, medical eye exam and medical hearing exams.

Annual deductible for outpatient and home services.

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

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

Certified nurse practitioner

What you pay for covered services

Annual deductible

Participating CNPs receive direct reimbursement for covered services. For nonparticipating CNP, payment is sent to the subscriber.

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

- A physician's office
- Outpatient clinic

- Outpatient department of a hospital
- The home
- Urgent care setting

Chiropractic spinal manipulation

What you pay for covered services
10% after annual deductible*

10% after annual deductible*

* Chiropractic services are paid based on location and diagnosis.

Your coverage for chiropractic services includes:

- Unlimited chiropractic manipulation
- Limited physical therapy (applied against physical, occupational and speech therapy maximum)
- Chiropractic traction (applied against physical, occupational and speech therapy maximum)

Chiropractic X-rays

What you pay for covered services
Annual deductible

Annual deductible

Chiropractic X-rays are covered.

Chiropractic office visits

What you pay for covered services
\$15 copayment

Your coverage for chiropractic services includes the following:

- One new patient office call every 36 months and one established patient office call each calendar year

A new patient is one who has not been seen by the same provider in 36 months.

Second surgical and pre-surgical opinion

What you pay for covered services
Annual deductible

Second surgical and pre-surgical opinions are covered. They are voluntary and not required for any specific surgeries.

Sleep studies

What you pay for covered services
Annual deductible

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

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

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

Hearing care

What you pay for covered services
\$0*

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

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

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

Choosing your hearing provider

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

The types of eligible hearing providers include:

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

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

What is covered under your hearing care benefits

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

Then, within six months, you must receive the following services from a provider:

- **Audiometric examination** — measures hearing ability, including tests for air and bone conduction, speech reception and speech discrimination
- **Hearing aid evaluation** — determines what type of hearing aid should be prescribed to compensate for loss of hearing
- **Ordering and fitting of the hearing aid** — includes in-the-ear, behind-the-ear, and basic hearing aids worn on the body, with ear molds, if necessary, as well as dispensing fees for the normal services required for fitting the hearing aid
- **Conformity test** — evaluates the performance of a hearing aid and its conformity to the original prescription after it has been fitted

Time limitation

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

What is not covered under your hearing care benefit

Your hearing care coverage **does not** cover:

- Your medical clearance examination to determine possible loss of hearing. (This is covered under your medical benefit and is subject to the \$15 copayment.)
- A hearing aid ordered while the patient is a member, but delivered more than 60 days after the patient's coverage terminates
- Replacement of hearing aids that are lost or broken, unless this occurs after 36 months, when benefits are renewed
- Repairs and replacement of parts including batteries and ear molds
- Additional charges for eye-glass type hearing aids (sometimes called "deluxe" hearing aids) that exceed the amount BCBSM pays for a basic hearing aid
- Additional charges for digital-controlled programmable hearing devices (sometimes called "deluxe" hearing aids) that exceed the amount BCBSM pays for a basic hearing aid
- Additional charges for unusual or cosmetic equipment such as canal, one-half shell or low profile hearing aids (sometimes called "deluxe" hearing aids) that exceed the amount BCBSM pays for a basic hearing aid
- Hearing aids that do not meet Food and Drug Administration and Federal Trade Commission requirements

Alternatives to hospital care

Home hemodialysis program

What you pay for covered services
Annual deductible

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

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

Home hemophilia program

What you pay for covered services
Annual deductible

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

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

Home health care program

What you pay for covered services
Annual deductible

The physician must certify that the patient is confined to the home due to illness and that home health care services are being used instead of inpatient hospital care. The physician must also prescribe and submit a detailed treatment plan to the agency. Once the agency accepts the patient into its program, the following services are covered when billed by the agency:

- Home health aide services if the patient is receiving skilled nursing care or physical or speech therapy and the health care agency has identified a need for the patient to have these services

These services may include assistance with activities of daily living such as bathing, dressing, meal preparation and feeding.

- Social services and nutritional guidance when requested by the patient's physician
- Physical, speech and occupational therapy
- Nursing care by a licensed practical nurse or a licensed vocational nurse when the services of a registered nurse are unavailable

The State Health Plan PPO does **not** pay for:

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

- Custodial or nonskilled care

Home infusion therapy

What you pay for covered services

Annual deductible

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

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

Skilled nursing care

What you pay for covered services

Annual deductible

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

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

Your benefit includes coverage for:

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

The benefit renews 90 days after discharge.

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

The State Health Plan PPO does **not** pay for:

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

Integrated disease and case management

What you pay for covered services
No charge

Integrated disease and case management are voluntary services through which care is provided outside a hospital setting. Disease and case management services provide telephone-based management to members with high risk conditions or who may be at risk for future complications as a result of their condition. Case management may involve onsite as well as telephone-based intervention.

How it works

Patients in the program are assigned a nurse care manager who coordinates services. The programs employ teams of experienced physicians, nurses and social workers to work with the patient, the family and the physician to provide individualized and professional assistance. Nurse care managers conduct health assessments and work with the patient and his or her physician to design an individualized treatment plan.

Nurse case managers can assist and support the patient and the physician or care provider with the following:

- Coordination of health care services
- Education about the patient's condition and disease process
- Information on facilities that participate with Blue Cross Blue Shield
- Referrals to a variety of community resources for emotional, financial and other support services
- Facilitating the delivery of medical supplies and equipment prescribed by the doctor
- Guidance and support about end of life issues

As the patient receives medical services, the nurse case manager:

- Reviews the patient's health care needs

- Continues to help the patient understand his or her treatment options
- Keeps in contact with the patient about his or her progress between physician visits

Who benefits from disease and case management

State Health Plan PPO members with these and other complex conditions may benefit from case management services:

- Strokes
- Ventilator weaning and management
- Cancer
- Complex wound management
- Multiple trauma
- Spinal cord injuries
- Diabetes
- Serious lung conditions
- Heart disease
- Neurologic conditions
- Organ transplants
- Premature or high-risk infants
- End-of-life care

Patients can refer themselves or be referred by a friend, family member, benefit representative, hospital, or physician.

For more information about disease and case management, please call 800-768-6787. Representatives are available Monday through Friday from 8 a.m. to 5 p.m. Eastern time.

Hospice care

What you pay for covered services
\$0 up to lifetime maximum

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

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

Electing hospice benefits

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

When the patient elects to enter the program, the hospice benefits will replace the patient's State Health Plan PPO benefits for conditions relating to the terminal illness. The hospice benefits will be more specific to the patient's needs and may include alternative services that provide more appropriate care. However, services for medical conditions **unrelated** to the terminal illness are covered according to your State Health Plan PPO coverage.

The patient may cancel, in writing, all hospice benefits at any time. When services are canceled, the patient's regular coverage resumes.

Hospice services

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

The following benefits are payable under the hospice program:

- Nursing care when provided by or under the supervision of a registered nurse

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

The following services are **not** covered:

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

Physical, occupational and speech therapy

What you pay for covered services
Annual deductible

Your benefit covers physical, occupational and speech therapy.

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

Physical therapy is payable when provided in:

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

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

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

Examples of covered services are:

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

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

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

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

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

Your benefit covers therapy for:

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

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

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

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

Physical therapy, occupational therapy and speech and language pathology services

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

Durable medical equipment, prosthetic and orthotic and supplies

What you pay for covered services
\$0

You have coverage under the SUPPORT Program for medical equipment and supplies. SUPPORT stands for Select Utilization of Providers for Prosthetic, Orthotic and Rehabilitative Technology.

Medical equipment and supplies obtained in Michigan

The SUPPORT program is available only in Michigan and applies to items prescribed by a physician that you purchase or rent from an independent medical supplier for use at home. It does not apply to items you use during a hospital stay or receive from your doctor.

If you use a supplier that participates with Medicare and the SUPPORT network, you will pay nothing for covered items. However, if you obtain items from a supplier that participates with Medicare, but does not participate with the SUPPORT network, you will be responsible for the entire amount not covered by Medicare.

If you choose not to use the SUPPORT network, you will be responsible for additional out-of-pocket costs. For services provided by a non-network supplier you will be responsible for 20 percent of the approved amount plus the difference between the supplier's charge and the approved amount.

**If you use the SUPPORT network,
you pay nothing for covered items.**

Medical equipment and supplies obtained outside Michigan

The SUPPORT network does not apply beyond Michigan. For medical equipment and supplies elsewhere in the United States, you can minimize your out-of-pocket expenses by using suppliers that participate with the local Blue Cross Blue Shield Plan. If you use a supplier that does not participate with the local Blue Cross Blue Shield plan, you may be required to pay the difference between the approved amount and the provider's charge.

If you use a supplier that participates with the local Blue Cross Blue Shield plan, you will be required to pay for the prescribed products, and then file a claim with BCBSM. BCBSM will only reimburse you 20 percent of the BCBSM-approved amount.

Covered items through a medical supplier

Types of equipment, supplies and services include:

- Durable medical equipment used in your home, such as hospital beds, wheelchairs, walkers, canes and oxygen equipment
- Medical supplies such as glucometer strips, colostomy supplies, adult disposable diapers, surgical stockings
- Orthotic devices such as leg braces, back braces and ankle or wrist supports
- Prosthetic devices such as artificial limbs and mastectomy supplies
- Respiratory equipment such as oxygen concentrators and apnea monitors

The items you obtain through SUPPORT can be delivered to your home at no charge or you can go to any retail SUPPORT outlet.

Diabetic supplies and medications

Some diabetic supplies are covered under SUPPORT, while others are covered under your prescription drug benefit. Diabetic supplies covered under SUPPORT include:

- Blood-testing strips used with glucometers
- Glucometers to test blood sugar

- Insulin pump and supplies
- Lancets and lancing device used with glucometers

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

- **Renting equipment** — For rental equipment, a new prescription must be written when the current prescription expires.

If the rental fee exceeds the purchase price based on your physician's estimated duration of need, you will be advised to purchase rather than rent the equipment.

- **Purchasing equipment** — Your benefit includes purchasing equipment only when it is less expensive than continued rental. The purchase of new and used equipment is covered provided the equipment is purchased only from a professional supplier.
- **Repairing equipment** — Repair costs are covered on purchased equipment when the condition is due to normal wear and tear.
- **Replacing equipment** — The replacement of purchased equipment is covered when there is loss or irreparable damage of your equipment or a change in your condition or size.
- **Contraceptive devices** — Covers one per year physician-prescribed contraceptive devices such as diaphragms or IUDs and their insertion.
- **Wigs** — You have a lifetime maximum of \$300 for wigs, wig stands and supplies, such as adhesives. This benefit is for those who need wigs because of cancer or alopecia. There is no deductible or copayment up to the \$300 lifetime maximum. Replacements available for children due to growth.

Human organ transplants

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

In some cases, BCBSM must approve the transplant.

Organ and tissue transplants

What you pay for covered services
Annual deductible

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

- Cornea
- Kidney
- Skin
- Bone marrow (as described below)

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

Bone marrow transplants

What you pay for covered services
Annual deductible

Bone marrow transplants involve replacing the bone marrow of a patient with bone marrow or peripheral blood stem cells. The replacement bone marrow may be from a donor (an **allogeneic** transplant) or removed from you before treatment and then returned (an **autologous** transplant). Bone marrow transplants are only covered when the transplant is pre-approved by BCBSM and must be received at a BCBSM-designated transplant facility. Preauthorization is a process that allows physicians and other professional providers to determine, before treating a patient, if BCBSM will cover the cost of a proposed service.

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

- Acute lymphocytic leukemia
- Acute non-lymphocytic leukemia
- Aplastic anemia

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

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

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

Solid human organ transplants

What you pay for covered services
Designated facility
Annual deductible

Solid human organ transplants are only covered when the transplant is pre-approved, or what we call “preauthorized,” by BCBSM and must be received at a BCBSM-designated transplant facility.

Preauthorization is a process that allows physicians and other professional providers to determine, before treating a patient, if BCBSM will cover the cost of a proposed service.

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

Solid transplants include transplants of the:

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

All payable human organ transplant services, except anti-rejection drugs and other transplant-related prescription drugs, must be provided during the benefit period. The

benefit period begins five days before, and ends one year after, the organ transplant.

The total payment for all services combined for each solid organ transplant type is limited by a \$1 million lifetime maximum.

Please call the BCBSM Human Organ Transplant Program for additional information on human organ transplants. The hours are Monday through Friday from 8 a.m. to 5 p.m. The telephone number is **800-242-3504**.

Other covered services

What you pay for covered services unless otherwise noted
Annual deductible

Your coverage also includes the following services:

- **Insulin pumps**
- **Blood** — Includes the cost of drawing and storing self-donated blood intended for your scheduled surgery
- **Oxygen and other therapeutic gases** — Oxygen, and equipment to administer the oxygen, are covered when prescribed by a physician and medically necessary.
- **Medical supplies** — Medical supplies and dressings for use in the home, are covered when prescribed by a physician for the treatment of a specific medical condition.
- **Dental services to treat accidental injuries** — An external force must have caused the injury. Injuries resulting from biting or chewing are not covered.

- **Specified oncology clinical trials** — Covers antineoplastic drugs for the treatment of stages II and III breast cancer and all stages of ovarian cancer when they are provided following an approved phase II or III clinical trial

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

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

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

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

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

- **Eye and ear examinations** – Covered for the diagnosis and treatment of an illness, injury or disease, including medical clearance examinations

There is a \$15 copayment for medical clearance examinations.

- **Optical services following cataract surgery** — Your benefits include the examination and fitting of one pair of contact lenses when prescribed by a physician following cataract surgery and obtained within one year of the surgery. Cataract sunglasses are not covered.
- **Chelation therapy** — Payable based on certain medical guidelines and diagnoses

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

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

Private duty nursing

What you pay for covered services
10% after annual deductible

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

Nonskilled care or care provided by a nurse who ordinarily resides in the patient's home or is a member of the immediate family is not covered.

Services must be prescribed by a physician and provided by a registered or licensed practical nurse. The attending physician must complete a certification statement each month the patient is required to have private duty nursing care.

To avoid incurring expenses for private duty nursing services that are not payable, we

recommend you call or write the BCBSM State of Michigan Customer Service Center before receiving private duty nursing services.

What is not covered under the State Health Plan PPO

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

- Care and services available at no cost to you in a veteran, marine or other federal hospital or any hospital maintained by any state or governmental agency
- Medically necessary services received on an inpatient basis that can be provided safely in an outpatient or office location
- Custodial care, rest therapy and care in nursing or rest home facilities
- Dental surgery other than for the removal of impacted teeth or multiple extractions when the patient must be hospitalized for the surgery because a concurrent medical condition exists
- Treatment of Temporomandibular Joint Syndrome and related jaw-joint problems by any method other than as specified in this benefit book
- Hospital admissions that begin **before** the effective date of coverage
- Hospital admissions that begin **after** the coverage termination date
- Medical services or supplies provided or furnished **before** the effective date of coverage or **after** the coverage termination date
- Health care services provided by persons who are not legally qualified or licensed to provide such services
- Routine hospital outpatient care requiring repeated visits for the treatment of chronic conditions
- Hospitalization principally for:
 - Observation
 - Diagnostic evaluation
 - Physical therapy

- X-ray or lab tests
- Reduction of weight by diet control (with or without medication)
- Basal metabolism tests
- Electrocardiography
- Items for the personal comfort or convenience of the patient
- Premarital or pre-employment exams
- Reverse sterilization
- Services and supplies that are not medically necessary according to accepted standards of medical practice
- Treatment of occupational injury or disease that the State of Michigan is obligated to furnish or otherwise fund
- Care and services received under another certificate offered by BCBSM or another Blue Cross Blue Shield Plan
- Care and services payable by government-sponsored health care programs, such as Medicare or TRICARE, formerly CHAMPUS, for which a member is eligible

These services are not payable even if you have not signed up to receive the benefits provided by such programs.

- Cosmetic surgery and related services solely for improving appearance, except as specified in this handbook
- Treatment of a condition caused by military action or war, declared or undeclared
- Services, care, devices or supplies considered experimental or investigative
- Services for which a charge is not customarily made
- Services for which the patient is not obligated to pay or services without cost
- Dialysis services after 33 months of ESRD treatment
- Services that are not included in your plan coverage documents
- Transportation and travel except as specified in this benefit book
- Services rendered for gender reassignment

Filing BCBSM claims

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

To file your own claim, follow these steps:

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

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

You will receive payment directly from BCBSM. The check will be in the patient's name.

Filing claims for services received outside the United States

Submit claims as noted above for emergency services received outside the United

States, using the guidelines under the Care Out of the Country section of this book.

Your right to file an internal grievance

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

Internal grievances

Standard internal grievance procedure

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

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

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

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

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

Mail your request to:

Conference Coordination Unit

Blue Cross Blue Shield of Michigan
P.O. Box 2459
Detroit, MI 48231-2459

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

- In addition to the information found above, you should also know:
 - You may authorize in writing another person including, but not limited to, a physician to act on your behalf at any stage in the standard internal grievance procedure.
 - Although we have 35 days within which to give you our final determination, you have the right to allow us additional time if you wish.
 - You may obtain copies of information relating to our denial, reduction or termination of coverage for a health care service for a reasonable copying charge.

Expedited internal grievance procedure

The procedure is as follows:

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.**

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

Call the expedited grievance hot line: (313) 225-6800

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

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

Sections 402 and 403 of Public Act 350

What we may not do

The sections below provide the exact language in the law.

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

- Misrepresent pertinent facts or certificate provisions relating to coverage
- Fail to acknowledge promptly or to act reasonably and promptly upon communications with respect to a claim arising under a certificate
- Fail to adopt and implement reasonable standards for the prompt investigation of a claim arising under a certificate
- Refuse to pay claims without conducting a reasonable investigation based upon the available information
- Fail to affirm or deny coverage of a claim within a reasonable time after a claim has been received
- Fail to attempt in good faith to make a prompt, fair and equitable settlement of a claim for which liability has become reasonably clear
- Compel members to institute litigation to recover amounts due under a certificate by offering substantially less than the amounts due
- Attempt to settle a claim for less than the amount which a reasonable person would believe was due under a certificate, by making reference to written or printed advertising material accompanying or made part of an application for coverage
- Make known to the member administrative hearing decisions in favor of

members for the purpose of compelling a member to accept a settlement or compromise in a claim

- Attempt to settle a claim on the basis of an application that was altered without notice to, knowledge or consent of the subscriber under whose certificate the claim is being made
- Delay the investigation or payment of a claim by requiring a member, or the provider of health care services to the member, to submit a preliminary claim and then requiring subsequent submission of a formal claim, seeking solely the duplication of a verification
- Fail to provide promptly a reasonable explanation of the basis for a denial of a claim or for the offer of a compromise settlement
- Fail to promptly settle a claim where liability has become reasonably clear under one portion of the certificate in order to influence a settlement under another portion of the certificate

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

The things we cannot do under this section are:

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

corporation and another health care corporation, health maintenance organization or other person

What we must do

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

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

Other general information

Coordination of benefits

Coordination of benefits is how group health care plans and insurance carriers coordinate benefits when members are covered by more than one plan. Under COB, group health care plans and insurance carriers work together to make sure members receive the maximum benefits available under their plans. Your State Health Plan *PPO* requires that your benefit payments be coordinated with those from another group plan for services that may be payable under both plans.

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

Coordinating Medicare with the health plan and other group coverage

If you or one of your covered dependents is eligible for Medicare and are also covered by another group health care plan, your health care benefits are coordinated as follows:

- When the patient is the State of Michigan retiree and also has coverage as an active employee of an employer with 20 or more employees — the active coverage has the first obligation to pay for health care expenses. Medicare will pay benefits second. The State Health Plan will pay benefits third.
- When the patient is the State of Michigan retiree and is covered as a dependent under his or her working spouse's group health care plan with 20 or more employees — the spouse's group health care plan has the first obligation to pay for health care expenses. Medicare will pay benefits second. The State Health Plan will pay benefits third.
- When the patient is the State of Michigan retiree and is covered as a dependent under his or her spouse's retirement group health care plan — Medicare has the first obligation to pay for health care expenses (except for the first 30 months if you have end stage renal disease). The State Health Plan will pay benefits second. The group plan covering the patient as a spouse will pay benefits third.

- When the patient is the spouse of the State of Michigan retiree and is eligible for Medicare — Medicare has the first obligation to pay for health care expenses. The group plan covering the patient as a subscriber will pay benefits second. The State Health Plan will pay benefits third.
- When the patient is the dependent (and entitled to Medicare) — Medicare has the first obligation to pay for health care expenses. The group plan that will pay benefits second is the plan of the parent whose birthday falls earlier in the year. If the birth dates are identical, the plan that has covered the dependent the longest is the secondary plan.

The maximum amount payable under all plans is limited to 100 percent of the Medicare-approved amount.

Processing your COB claims

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

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

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

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.

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

Allogeneic (Allogenic) transplant is a procedure using another person's bone marrow or peripheral blood stem cells to transplant into the patient (including syngeneic transplants when the donor is the identical twin of the patient).

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

Approved amount is the lower of the provider's billed charge or the Medicare maximum payment amount, whichever is lower.

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

Approved hospital is a hospital that meets all applicable local and state licensure

and certification requirements, is accredited as a hospital by state or national medical or hospital authorities or associations, and has been approved as a provider by BCBSM or an affiliate of BCBSM.

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

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

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

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

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

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

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

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

Coinsurance is the amount you may be required to pay for services after you pay any plan deductibles. This is a percentage. You have to pay this amount after you pay the deductible.

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

Copayment is the amount you pay for each medical service, like a doctor's visit. A copayment is a flat dollar amount. Example: \$10.

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

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

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

Deductible is the amount you must pay out-of-pocket for health care services, before your insurance begins to pay. A type of cost sharing in which the individual pays a specified amount for covered services before the health plan pays benefits.

Dependent is a person who is eligible for health care coverage on another individual's contract (a spouse or child eligible for coverage).

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

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

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

Emergency first aid is the initial exam and treatment of conditions resulting from accidental injury.

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

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

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

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

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

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

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

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

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

Medical necessity, unless otherwise specified, is a service that must be medically necessary in order to be covered by the State Health Plan PPO.

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

- The covered service is for the treatment, diagnosis or symptoms of an injury, condition or disease.
- The service, treatment or supply is appropriate for the symptoms and is consistent with the diagnosis.
 - “Appropriate” means the type, level and length of care, treatment or supply and setting are needed to provide safe and adequate care and treatment.
 - For inpatient hospital stays, acute care as an inpatient must be necessitated by the patient’s condition because safe and adequate care cannot be received as an outpatient or in a less intense medical setting.
- The services are not mainly for the convenience of the member or health care provider.
- The treatment is not generally regarded as experimental or investigational by BCBSM.
- The treatment is not determined to be medically inappropriate by the Utilization Management and Quality Assessment programs.

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

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

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

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

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

Member is any person eligible for health care services under the State Health Plan *PPO*. This includes the subscriber and any eligible dependents listed in BCBSM membership records.

Medicare is the federally funded program that pays for medical services to United States citizens age 65 or older, or persons of any age who are permanently disabled.

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.

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

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

Peripheral blood stem cell transplant is a procedure where blood stem cells are obtained by pheresis and infused into the patient's circulation.

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

Physical therapy is **not** covered when services are principally for the general good and welfare of the patient (for example, developmental therapy or activities to provide general motivation) and when there is no improvement expected in the patient's condition.

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

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

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

Routine services are procedures or tests that are ordered for a patient without direct relationship to the diagnosis or treatment of a specific disease or injury.

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

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

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

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

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

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



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