Member Handbook and **Certificate of Coverage**

A guide for Blue Cross Complete of Michigan members

Blue Cross complete of Michigan

Confidence comes with every card.®

mibluecrosscomplete.com

January 30, 2024

Contents

Welcome to Blue Cross Complete of Michigan

Blue Cross Complete has a contract with the Michigan Department of Health and Human Services to provide health care services to Medicaid Enrollees. We work with a group of doctors and specialists to help meet your needs.

This handbook is your guide to the services we offer. It will also give you helpful tips about Blue Cross Complete. Please read this book and keep it in a safe place in case you need it again. If you need another copy, it is available upon request and free of charge by contacting Customer Service. You can also access this handbook on our website at **mibluecrosscomplete.com**.

Interpreter Services

We can get an interpreter to help you speak with us or your doctor in any language. We also offer our materials in other languages. Interpreter services and translated materials are free of charge. Call Customer Service for help getting an interpreter or to ask for our materials in another language or format to meet your needs. Blue Cross Complete complies with all applicable federal and state laws with this matter.

¿Habla español? Por favor contacte a al Servicios al Miembro.

Hearing and Vision Impairment

TTY/TDD services are available free of charge if you have hearing problems. The TTY/TDD line is open 24/7 by calling **1-888-987-5832**.

We provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, transcription services, and assistive listening devices. We offer the Member Handbook and other materials in Braille and large print upon request and free of charge. Call Customer Service at **1-800-228-8554** (TTY: **1-888-987-5832**) to request materials in a different format to meet your needs.

Blue Cross Complete makes sure services are provided in a culturally competent manner to all members:

- With limited English proficiency
- Of diverse cultural and ethnic backgrounds
- With a disability
- Regardless of gender, sexual orientation, or gender identity

Important Numbers and Contact Information

Customer Service Toll-Free Help Line	1-800-228-8554 24 hours a day, seven days a week
Customer Service Help Line TTY/TDD	1-888-987-5832 24 hours a day, seven days a week
Website	mibluecrosscomplete.com
Address	Blue Cross Complete of Michigan Suite 1300 4000 Town Center Southfield, MI 48075
24 Hour Toll-Free Emergency Line	911
24 Hour Toll-Free Nurse Help Line	1-888-288-1724 (TTY: 1-888-987-5832) 24 hours a day, seven days a week
Pharmacy Customer Service	1-888-288-3231 (TTY: 1-888-988-0071) 8:30 a.m. to 6 p.m., Monday through Friday
Transportation Services (non-emergency)	1-888-803-4947 (TTY: 711) Residents of Wayne, Oakland, or Macomb counties contact ModivCare at: 1-866-569-1902.
Dental Services	1-844-320-8465 (TTY: 711) 9 a.m. to 5 p.m., Monday through Friday
Vision Services	Customer Service 1-800-228-8554 TTY: 1-888-987-5832 24 hours a day, seven days a week
Mental Health Services	Customer Service 1-800-228-8554 TTY: 1-888-987-5832 24 hours a day, seven days a week
To file a complaint about a health care facility	Customer Service 1-800-228-8554 TTY: 1-888-987-5832 24 hours a day, seven days a week
To file a complaint about Medicaid services	Customer Service 1-800-228-8554 TTY: 1-888-987-5832 24 hours a day, seven days a week
To request a Medicaid Fair Hearing	1-877-833-0870

Grievance and Appeals	Customer Service 1-800-228-8554 TTY: 1-888-987-5832 24 hours a day, seven days a week
To report suspected cases of abuse, neglect, abandonment, or exploitation of children or vulnerable adults	1-855-444-3911
To report Medicaid fraud and/or abuse	1-855-232-7640 (TTY: 711)
To find out information about domestic violence	National Domestic Violence Hotline 1-800-799-7233 24 hours a day, seven days a week
To find information about urgent care	24-hour Nurse Help Line 1-888-288-1724 TTY: 1-888-987-5832 24 hours a day, seven days a week
Rapid Response Outreach Team	1-888-288-1722 (TTY: 1-888-987-5832) 8 a.m. to 7 p.m., Monday through Thursday 8 a.m. to 5 p.m., Friday
Privacy Practices	1-800-228-8554
Durable Medical Equipment	Northwood Inc. 1-800-667-8496
Outpatient Lab Services	Joint Venture Hospital Laboratories 1-800-445-4979 jvhl.org
Tobacco Quit Program	1-800-QUIT-NOW (1-800-784-8669) TTY: 1-888-229-2184
Diabetic Supplies	J&B Medical Supply 1-800-737-0045 TTY: 1-888-896-6233
Michigan ENROLLS	1-888-367-6557
Michigan Beneficiary Help Line	1-800-642-3195 or TTY: 866-501-5656.
MIChild Program	1-888-988-6300
MDHHS office locations and phone numbers	michigan.gov/mdhhs/inside-mdhhs/county-offices
Women, Infants and Children (WIC)	1-800-942-1636
Bright Start® Maternity Program	1-888-288-1722 TTY: 1-888-987-5832

Outreach Team (health education and resources)	1-888-288-1722 TTY: 1-888-229-2182
Free service to find local resources. Available 24/7	211
Social Security Administration	1-800-772-1213 TTY/TDD: 1-800-325-0778
In an emergency	911
Suicide and Crisis Lifeline	988

Your State Issued Medicaid ID Card

When you have Medicaid, the Michigan Department of Health and Human Services will send you a mihealth card in the mail. The mihealth card does not guarantee you have coverage. Your provider will check that you have coverage at each visit. You may need your mihealth card to get services that Blue Cross Complete does not cover. Always keep this card even if your Medicaid coverage ends. You will need this card if you get coverage again.

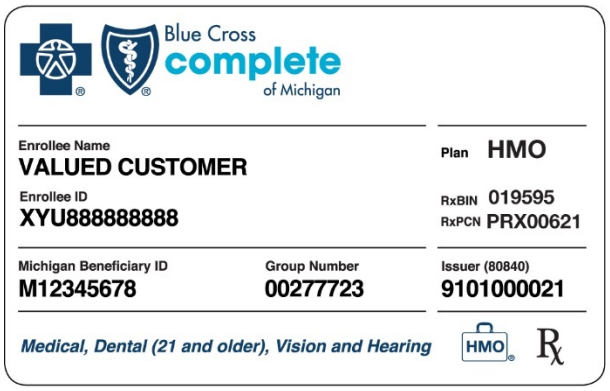
If you have questions about this coverage or need a new mihealth card, you should call the Beneficiary Help Line at **1-800-642-3195**. This number is located on the back of your mihealth card.

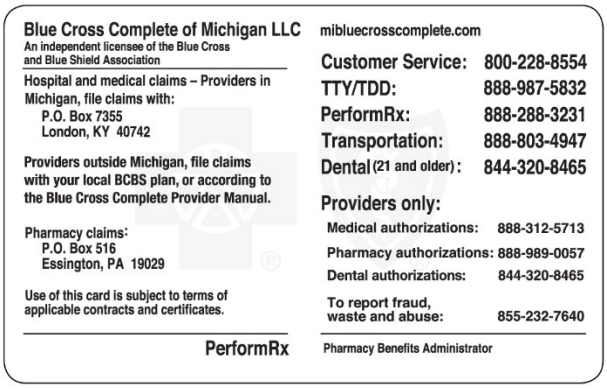
It is important to keep your contact information up to date so you don't lose any benefits. Any changes in phone number, email, or address should be reported to MDHHS. You can do this by calling your local MDHHS office or by visiting **www.michigan.gov/mibridges**. If you do not have an account, you can create one by selecting "Register". Once in your account, when reporting changes, please make sure you do so in both the profile section and the report changes area.

Your Blue Cross Complete Member ID Card

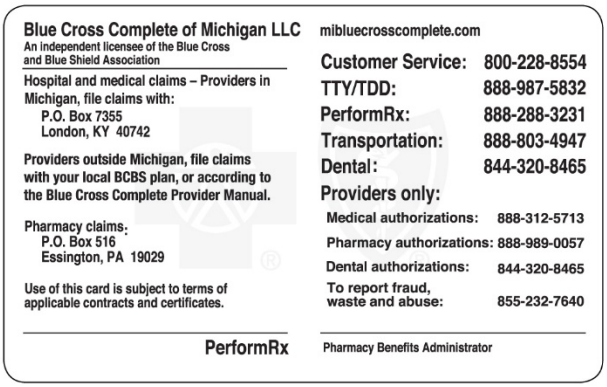
You should have received your Blue Cross Complete ID card in the mail. Call us if you have not received your card or if the information on your card is wrong. Each member of your family in our plan should have their own Member ID card.

Blue Cross Complete Medicaid Member ID Card





Blue Cross Complete Healthy Michigan Plan Member ID Card



If you have questions about this coverage or need a new Blue Cross Complete Member ID card, you should call Customer Service at **1-800-228-8554**, 24 hours a day, seven days a week (TTY: **1-888-987-5832**).

Healthy Michigan Plan members and Medicaid members ages 21 and older – your member ID card also acts as your Dental ID card.

Important ID Card Notes

- Carry both cards with you at all times and show them each time you go for care.
- Make sure all of your information is correct on both cards
- Call your local MDHHS office to change your records if your name or address changes
- When getting care you may be asked to show a picture ID. This is to make sure the right person is using the card
- Do not let anyone else use your cards

Getting Help from Customer Service

Our Customer Service Department can answer all of your questions. We can help you choose or change your doctor, find out if a service is covered, replace a lost ID card, find out how to appeal something we denied, find out how to file a grievance when you are unhappy with your care, help you understand written materials, and more. You can call us anytime.

Contact Us

You may call us at **1-800-228-8554**, 24 hours a day, seven days a week. TTY users, call **1-888-987-5832**.

For **urgent** medical concerns regarding you or your child's health after hours, we can connect you to our medical 24-hour Nurse Help Line for assistance. Call **1-888-288-1724** (TTY: **1-888-987-5832**).

Our Website

You can visit our website at **mibluecrosscomplete.com** to access online services such as:

- Our Find a Doctor, Pharmacy, Dentist or Doula search tool
- Accessing your Member Portal
- Learning about your benefits and how to access them
- Finding assistance through the Community Resource Hub

Confidentiality

Your privacy is important to us. You have rights when it comes to protecting your health information. Blue Cross Complete recognizes the trust needed between you, your family, and your providers. Blue Cross Complete staff have been trained in keeping strict member confidentiality.

Manage Your Digital Health Records/Member Mobile Application

Access your account anytime, anywhere. The Blue Cross Complete mobile app keeps you up-to-date on your health care information. You can update your member information. You can also find doctors and hospitals. And, you can see a list of your current medications. To download our app, search for "**BCCMI**" in the App Store® and Google Play™.

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Transition of Care

If you're new to Blue Cross Complete, you may be able to keep your doctors and services for at least 90 days from your enrollment date. Examples include medical, behavioral health, and pharmacy services.

If you are pregnant, you can stay with your doctor through the pregnancy and post-partum period.

If you are a Blue Cross Complete member and your doctor no longer participates with us, you can continue to see your doctor if you are receiving treatment for certain chronic diseases.

We will not approve continued care by a non-participating doctor if:

- You only require monitoring of a chronic condition
- The doctor has a restriction and you might be at risk
- The doctor is not willing to continue your care
- Care with the non-participating doctor was started after you enrolled with Blue Cross Complete
- The doctor does not meet Blue Cross Complete policies or criteria

Blue Cross Complete will help you choose new doctors and help you get services in our network. Your doctor may call Customer Service if they want to be in our network.

If you are receiving Children's Special Health Care Services (CSHCS), please contact us for help transitioning your care services.

Please contact us at **1-888-288-1722** (TTY: **1-888-987-5832**) to request transition of care services or if you have any questions about your care.

Choosing A Primary Care Provider

When you enroll in our plan, you will need to choose a primary care provider (PCP). Your PCP is the health care provider or doctor who takes care of all your health needs. You can choose a different doctor for each family member or you can choose one doctor for the whole family.

You can choose one of the following provider types as your primary care provider:

- General practice doctor
- Family practice doctor
- Nurse Practitioner
- Internal medicine doctor
- Pediatrician doctor
- OB/GYN doctor

If you do not choose a doctor within 30 days of enrollment, we will select one for you. You can change your doctor anytime.

You do not need a referral to see an in-network pediatrician or OB/GYN provider for routine and preventive health services.

You can use our Provider Directory to find doctors and specialists that are in our network. The Provider Directory lists addresses, office hours, languages spoken, and information about accessibility. It is located at **mibluecrosscomplete.com/findadoctor**. You can view or print the provider directory from the website. You can also request a copy of our provider directory, free of charge, by calling **1-800-228-8554** (TTY: **1-888-987-5832**). Remember provider information changes often. Visit our website for the most up-to-date information. Call Customer Service if you need help finding a doctor.

You can also get medical care from these types of medical providers: Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHCs), Indian Health Care Providers (IHCPs) (as applicable).

If you have certain health care needs, you may be able to choose a specialist as your primary care provider. Talk to your doctor or call Customer Service for more information.

Make sure you ask the provider office if they participate in the Blue Cross Complete network.

Finding a provider

If the doctor you have now is in our network, he or she can be your Blue Cross Complete doctor. If your current doctor isn't in the Blue Cross Complete network, you must choose a Blue Cross Complete doctor. For help choosing your doctor, call Customer Service.

Our online provider search

Maybe you prefer a doctor who speaks a certain language or who is from a background or culture similar to yours. You may want to choose a doctor who is close to your home. Maybe you need a doctor who has evening or weekend hours, or offers telehealth.

The best place to start looking for a doctor is on our website. Our online provider search includes our network doctors, specialists and facilities. For our primary care doctors, the search also includes any foreign languages the doctor speaks and if he or she is accepting new patients.

You can also download and use our member mobile app to find a doctor. To get the mobile app, visit the Google™ Play or Apple App® Store. Search for the Blue Cross Complete mobile app by typing **"BCCMI"** in the search bar. The app is available for free.

Getting Care from Your Doctor

Your primary care provider's office should be your main source for medical health. You should see your PCP for preventive checkups. Call your PCP's office to make an appointment or if you have questions about your medical care. If you need help setting up an appointment, please call us at **1-800-228-8554** (TTY: **1-888-987-5832**).

Your visit is important. Please be on time. Call the office as soon as you can if you cannot make it to your visit. You can set up a new visit when you call to cancel. Some offices will not see you again if you do not call to cancel.

Getting Care from a Specialist

You can get specialty care from a Blue Cross Complete provider without a referral. If you have special health care needs or a chronic health problem like diabetes or renal disease, you may be able to have a specialist take care of you as your PCP. Talk to your provider or call Customer Service for more information.

Out-of-Network Services

You must get most of your care from providers in our provider network. Customer Service can help you find a provider in our network.

If we do not have a doctor or specialist in our provider network in your area who can give you the care you need, or if we do not have a provider that can see you timely, we will get you the care you need from a provider outside our network. This is called an out-of-network referral.

We will only cover the services by an out-of-network provider if we are unable to provide a necessary and covered service in our network and if you have approval before your appointment. We will coordinate payment with the out-of-network provider. We also ensure that the cost to you is no greater than it would be if the service was provided in-network.

Out of County Services

Blue Cross Complete must approve any out-of-network services before you get them. If a Blue Cross Complete doctor is unable to provide these services, Blue Cross Complete will cover the services by an out-of-network doctor. A prior authorization is not required for emergency medical services. We'll cover them until a network doctor can provide them.

Out of State Services

All services out of the state require prior authorization. You may get emergency or other medically necessary authorized care outside our service area, including out of the state. If you do, you may need to pay for the services and ask Blue Cross Complete to pay you back, also called reimbursement. To be reimbursed, you must send us a form, your bills and payment receipts. Customer Service can send you the forms and give you information.

Out of Country Services

Health care services provided outside the country are not covered by Blue Cross Complete.

Physician Incentive Disclosure

You may request the following provider incentive and compensation arrangement information from Blue Cross Complete:

- Whether we use a physician incentive plan that affects the use of referral services
- The type of incentive arrangements in place with providers
- Whether stop-loss protection arrangements afford providers financial relief for high-cost members, when appropriate

To request this information, call Customer Service.

Prior Authorization

Some services and medications will need to be approved before you or your child can get them. This is called Prior Authorization (PA). Your doctor needs to fill out a Prior Authorization Request Form and send it to us if you need care that requires PA. We must approve the PA request before you get the care. If we do not approve the service, we will notify the doctor and send you a written notice of the decision.

Getting a Second Opinion

If you do not agree with your doctor's plan of care for you, you have the right to a second opinion. There is no additional cost to you for a second opinion from a Blue Cross Complete network provider. Second opinions do not require prior authorization from us. Please call Customer Service to learn how to get a second opinion.

Information About Your Covered Services

It is important you understand the benefits covered under your plan. As a Blue Cross Complete member you do not have to pay co-pays for covered services under Medicaid or the Healthy Michigan Plan. See the Cost Sharing and Copayments section for more information.

If there are any significant changes to the covered services outlined in this handbook, we will notify you in writing at least 30 days before the date the change takes place.

This list of benefits and exclusions may not be a complete list. More benefits not listed here may be available. Limits and exclusions may apply to each item on this list. Your Certificate of Coverage (COC) has the complete list of covered care. The COC is included with this handbook.

Make sure a service is covered before the service is done. You may have to pay for services not covered by Blue Cross Complete under the Medicaid program.

Blue Cross Complete does not deny reimbursement or coverage for services on any moral or religious grounds.

Telehealth/Telemedicine services

Telehealth/Telemedicine care is a convenient way to get care for a variety of common illnesses without having to go to the emergency room or urgent care. For non-emergency issues, including the flu, allergies, rash, upset stomach, and much more, you can connect with a doctor through your phone or computer to receive care where you are, when you need it. Doctors can diagnose, treat, and even prescribe medicine, if needed. Call your doctor's office to see if they offer telehealth services or contact Customer Service for more information.

Blue Cross Complete members also have access to MDLive®, a 24/7 telehealth service that allows users to communicate directly with a health care provider to help treat a variety of non-emergency medical conditions, such as sinus infections, the flu and rashes. Providers can prescribe medication if needed. This may be a good option if your doctor doesn't have an appointment soon enough, or if you don't feel well enough to leave home.

Members can access and register for MDLive by:

- Downloading the MDLive app from the Google Play™ store or the App Store®
- Visiting **mdlive.com/bcc***
- Calling **1-833-599-0443** (TTY: **1-800-770-5531**)
- Texting **TELEDR** to **635483**

**Blue Cross Complete does not own or control this website*

Covered services include:

Blue Cross Complete covers many preventive care services. These services are recommended by national organizations, including the United States Preventive Services Task Force. We want you to get and stay well. To help you do that, we cover preventive and routine medical services, and offer health education programs such as:

- Doctor and specialist visits, including visits to chiropractors, podiatrists and nurse practitioners
- Regular or annual well visits
- Vaccines, including the flu vaccine and the COVID-19 vaccine
- COVID-19 testing and treatment
- Lab work, X-rays and other imaging services
- Allergy testing, treatment and injections
- Family planning, including birth control
- HIV/AIDS testing and treatment of sexually transmitted diseases
- Services you may get at Federally Qualified Health Centers
- Gender affirmation services
- Health education programs, including disease management and tobacco cessation
- Nutritional counseling for members who are part of the Maternal Infant Health Program, or for those receiving nutrition in a hospital setting, where it is their sole means of nutrition
- Medically necessary weight reduction services
- Emergency and urgent care services
- Rehabilitative therapy, including cardiac rehab, physical, speech and occupational therapies

Hospital and surgical care

When you need non-routine care or have an emergency, we cover most hospital care, surgery and lab work. This includes:

- Outpatient surgical services (this is when you don't stay overnight at a hospital)
- Chemotherapy and other drug treatments for cancer
- Dialysis and treatment of kidney disease, including end-stage renal disease
- Cost of a shared hospital room
- Lab work, X-rays, imaging services, therapies and other medical supplies while you're in the hospital
- Surgeries, including organ transplants

Gender affirmation services

Blue Cross Complete covers medically necessary gender affirmation services, including pharmacy treatments and surgery, for members clinically diagnosed with gender dysphoria. For coverage of gender affirmation surgical procedures, the medical necessity determination must include a mental health evaluation.

We also cover mental health services, including telehealth visits, to help you feel your best. Customer Service can help you find a network mental health provider, or you can visit **mibluecrosscomplete.com/findadoctor**.

Chiropractic services

Medically necessary chiropractic services must be provided by an in-network provider. For members under age 18, prior authorization is required.

Pharmacy Services

Your pharmacy benefit covers most generic medicines. Your benefit also covers some over-the-counter medicines when you have a prescription. Our online drug search includes all the medicines we cover. The drug search lists our guidelines for these drugs, such as any quantity limits, if prior authorization is needed, if the medicine is a generic or brand name drug, and more. You can find the drug search at **mibluecrosscomplete.com/pharmacy**.

We may cover up to a 34-day supply of most medicines, unless otherwise noted on the Common Formulary. If you have questions, call Pharmacy Customer Service. In special circumstances, we'll allow one early refill per medication per year. For example, if you've lost your medication or if you are planning to travel.

Brand name and generic drugs

Your pharmacy will fill your prescriptions with the generic version when one is available, unless otherwise noted on the Common Formulary. Generic drugs are as good as brand-name drugs. They're approved by the FDA. To be approved, they must have the same active ingredient, strength and form, and act the same in your body as the brand medicine. Generic medicines have to be made to the same strict standards as the brand medicine. They may have a different color and shape, but these are the only differences.

If your doctor feels the brand-name version is medically necessary and can't be substituted with the generic version, he or she must ask Blue Cross Complete to authorize the brand-name version.

Medication prior authorization

Sometimes your doctor may need to ask us to cover a medicine before it's prescribed. When your doctor does this, he or she asks Blue Cross Complete for prior authorization. Members must sometimes meet certain conditions, try other medicines, have certain medical conditions or be a certain age before we can cover some medicines. Sometimes, these requirements are set by the state of Michigan. Another reason your doctor may ask for prior authorization is if he or she would like to prescribe a medicine for a reason other than the drug's original purpose.

If a drug isn't covered

The *Michigan Managed Medicaid Common Formulary* is available at **michigan.gov/mcopharmacy**. The Blue Cross Complete formulary is also available at **mibluecrosscomplete.com/pharmacy**.

If a drug is not on the *Preferred Drug List* or *Specialty Drug Guide*, it may not be covered by Blue Cross Complete. This might include drugs that are specifically excluded from Michigan's Medicaid program.

If your doctor would like to prescribe a medicine that isn't covered, he or she will ask Blue Cross Complete for prior authorization. You or your doctor can ask Blue Cross Complete to add a medicine to our list of covered drugs. To do this, write to us at:

Blue Cross Complete Pharmacy Management
Suite 1300
4000 Town Center
Southfield, MI 48075

Blue Cross Complete will review the drug and determine if it will be added to the list of covered drugs. If you have any questions about prescriptions or your prescription benefit, call Pharmacy Customer Service.

Annual COVID-19 and flu vaccines

COVID-19 is a virus that causes symptoms such as fever, cough, body aches and more. Like the flu, COVID-19 can cause mild illness, but can also make some people severely ill. There are vaccines available for COVID-19 and the flu at no cost. These vaccines can help lessen the severity of your illness, or prevent you from getting sick in the first place. You can get both vaccines at the same time. You can get them at your doctor's office or a local pharmacy. To find a pharmacy or provider who is able to administer the COVID-19 or flu vaccine, visit **vaccines.gov**. You can also call your provider to ask if they carry the flu or COVID-19 vaccine.

Dental Services

Dental care is important. You should see your dentist every six months for a check-up and cleaning. The dentist you see regularly is your dental home. Your dental home is your first call for any oral health concerns.

We offer dental coverage to all beneficiaries ages 19 and above enrolled in Healthy Michigan Plan, as well as all enrollees ages 21 and older, enrolled in Medicaid. We are contracted with DentaQuest to provide your dental benefits. For more information about your dental benefits, see the Blue Cross Complete Dental Guidebook, available to download at **mibluecrosscomplete.com/dental**.

If you have any questions about your dental services, please contact Dental Customer Service at **1-844-320-8465**, 9 a.m. to 5 p.m., Monday through Friday. TTY users call **711**.

Covered dental services include:

Blue Cross Complete covers dental care, including dental exams, cleanings and extractions.

- Routine exams and cleanings every six months
- Four bitewing X-rays every year
- Full-mouth X-rays once every five years
- One filling per tooth every two years
- Emergency exams, no more than twice a month
- Sealants, once every three years
- Topical fluoride up to age 21, twice a year
- Fluoride varnish up to age 21, twice a year
- Crowns, once every five years on the same tooth
- Root canal therapy
- Retreatment of previous root canal, once per tooth per lifetime
- Periodontal evaluation, once every 12 months
- Periodontal maintenance, once every six months
- Complete and partial dentures, once every five years per arch

Periodontal services, including scaling and root planing require the dentist to submit a prior authorization request to Blue Cross Complete. Blue Cross Complete will send written notice to the dentist and to the member if the requested treatment is denied.

Please note: Children under age 21 and enrolled in Medicaid are automatically enrolled into the **Healthy Kids Dental program**. The two plans available are Blue Cross Blue Shield of Michigan and Delta Dental of Michigan. You will get an identification card and Member Handbook from the dental plan you are enrolled in. If you are enrolled in this program, please refer to your Healthy Kids Dental Member Handbook for information on your dental benefits. You can also call the Michigan Beneficiary Helpline at **1-800-642-3195** for help.

Blue Cross Blue Shield of Michigan
Michigan Health Insurance Plans | BCBSM
Phone: 800-936-0935

Delta Dental of Michigan
Individual Dental Plans | Delta Dental of Michigan (deltadentalmi.com)
Phone: 866-696-7441

Transportation Services

Non-Emergency

Your Medicaid benefit provides options for transportation. We provide transportation free of charge for doctor's visits, lab visits, non-emergency hospital services, prescription pick-up, dental services covered by your Medicaid health plan, and other covered services. In some cases, we may provide bus tokens or if you have your own vehicle or someone else to drive you, you can request mileage reimbursement.

Please call ModivCare at **1-888-803-4947** (TTY: **711**) for more information and to schedule a ride. Please call two days before an appointment so we can make sure we have someone available to transport you. You can request same-day transportation for an urgent non-emergency appointment.

Have this information ready when you call:

- Your name, Medicaid ID number and date of birth
- The address and phone number of where you will be picked up
- The address and phone number of where you are going
- Your appointment date and time
- The name of your provider

Members with any special needs (wheelchair accommodations, oxygen resources, etc.) will want to schedule transportation as early as possible in order to meet your needs with the appropriate vendor.

Please be sure to call us as soon as possible if you need to cancel.

Find more information, including how to schedule a ride online, at **mibluecrosscomplete.com/transportation**.

Emergency

If you need emergency transportation, call **911**.

Vision Services

Eye care is an important part of your overall health. To make sure your eyes are healthy and help you see the best you can, we cover the following services:

- One eye exam every 24 months
- One pair of glasses every 24 months
- Eye glass frames
- Contact lenses

You do not need a referral to get eye care. If you need glasses or an eye exam, call Customer Service. You can also call a provider from our list of vision providers. For medical eye problems, talk to your doctor.

Hearing Services

How well you hear affects your quality of life. We cover services and supplies for the diagnosis and treatment of diseases of the ear, including:

- Hearing exams
- Medically necessary hearing aid evaluations and fittings
- Medically necessary hearing aids

If you need a hearing exam or think you need hearing aids, call Customer Service. You can also call a provider from our list of hearing providers.

Obstetrics and Gynecology Care

You may get routine obstetrics and gynecology (OB/GYN) care and other health services, including routine and preventive services from any provider in our network. You don't need a referral or prior authorization. This includes getting routine care from your OB/GYN even if they aren't your primary care doctor.

To make sure you get the care you need to be at your best for you and your family, we cover:

Family Planning	Prenatal and postpartum care
Pregnancy testing	Midwife services in a health care setting
Birth control and birth control counseling	Delivery care

HIV/AIDS testing and treatment of sexually transmitted diseases	Parenting and birthing classes
Pregnancy and maternity care, including the Maternal Infant Health Program	Mammograms and breast cancer services, such as treatment and reconstruction
Doula Services	Pap tests
Depression Screening	

Family Planning Services

Family planning care is covered. Both men and women can get this care. Family planning is an important part of staying healthy. You can get family planning information from your doctor, OB/GYN, or a Family Planning Center. You do not need a referral from your doctor for this care. Please contact Customer Service as soon as you discover you are pregnant to help maximize the support and benefits available to you.

Family planning services include:

- Counseling to help you decide when to have children
- Help to decide how many children to have
- Birth control services and supplies
    - (It is recommended to get a Pap test and chlamydia test before getting birth control)
- Sexually transmitted disease testing and treatment
- Testicular and prostate cancer screening

Pregnancy Services

If you are pregnant, early and regular checkups can help protect you and your baby's health. Care should start within the first 12 weeks of pregnancy. Oral care is also important for you and your baby while you are pregnant. Routine dental care can be done during pregnancy. Please call Customer Service and your local MDHHS office as soon as you find out you are pregnant so we can provide support.

Bright Start® pregnancy program

Our Bright Start® program is especially for our pregnant members. We want to make sure you have all you need for a healthy pregnancy and baby. Bright Start will help you learn about pregnancy and prepare for delivery. Members who are in the program can also reach out to or work with a case manager when they have questions. Members will have access to baby showers we're hosting or sponsoring, diaper incentives, and breast pumps.

To learn more, call Bright Start at **1-888-288-1722** and select **option 2**. TTY users call **1-888-987-5832**.

Keys to Your Care® text messaging program

Text **BCCMOM** to **85866** to join the Keys to Your Care® text messaging program. We'll send you text messages every week during your pregnancy and for the first few months after your baby is born. Text message topics include:

- How to join our Maternal Infant Health Program for in-home services
- Tips for eating right and avoiding certain foods
- The importance of utilizing your dental benefit during pregnancy
- Scheduling free rides to your doctor's appointments
- Joining a tobacco quit program if you smoke
- Preparing for your baby's arrival
- Labor signs and symptoms
- Important information to know after your baby is born

If you have questions about the Keys to Your Care text messaging program, call our Bright Start program at **1-888-288-1722** and select **option 2**. (TTY: **1-888-987-5832**).

Quitting smoking will help you and your baby. You can join the Tobacco Quit Program at no cost. Because you're pregnant, you'll receive more counseling calls and one dedicated quit coach. You can also earn rewards for keeping appointments.

Doula services

Pregnant members are covered for doula services from Medicaid-enrolled doulas. Doulas provide non-clinical physical, emotional and educational support. Members can receive up to six total visits from a doula during the pregnancy and postpartum periods, and one visit for birth. Doula services should be provided in person. However, prenatal and postpartum services may be delivered via telehealth. Members can find a doula in their area at **mibluecrosscomplete.com/findadoctor**. Check that your doula accepts Medicaid. Or members can call Bright Start® at **1-888-288-1722**, 8 a.m. to 4:30 p.m. Monday through Friday. TTY users should call **1-888-987-5832**.

Smiling Stork program

Expectant moms ages 19 and older will be enrolled in the Smiling Stork program. Watch your mail for important tips about what you should know about your oral health and pregnancy. Be sure to tell your dentist if you're pregnant. Dental care during pregnancy is safe and recommended for the health of you and your baby.

Your dental home is where you go to see a dentist every six months. This is especially important when you're pregnant. If you have questions about your dental home, dental benefits, or would like to change your dental home, call Blue Cross Complete's Dental Customer Service at **1-844-320-8465** (TTY: **711**). Or visit **mibluecrosscomplete.com/dental**.

Postpartum Care

It's important to take care of yourself after you have a baby. You should have a postpartum checkup 7 to 84 days after your pregnancy. We cover this exam.

The doctor may check your blood pressure and your weight. They may talk to you about birth control, feeding options, and provide other postpartum counseling. You can also talk to your doctor about any new feelings you may have.

When you have your baby, let us know. Call your local MDHHS office so your records can be updated. Also call Customer Service to report the change. This starts the process of signing your baby up for health care services.

Your baby is covered by your health plan at the time of birth. Make sure you tell us the day you gave birth, your baby's name, and your baby's Medicaid ID number that you get from your local MDHHS office. We will send a member ID card for your baby within 30 days after we get this information. Call Customer Service if you need help.

Change in Family Size

When you experience a change in family size, contact Customer Service to let us know and we will be able to assist you. A change in family size includes marriage, divorce, childbirth, adoption and/or death. Please reach out to your local MDHHS office if there is a change in family size.

Maternal Infant Health Program (MIHP)

The MIHP is a home visiting program for women and infants to promote healthy pregnancies, positive birth outcomes, and healthy infant growth and development. MIHP covered services include:

- Prenatal teaching
- Childbirth education classes
- Nutritional support, education, and counseling
- Breastfeeding or formula feeding support
- Help with personal problems that may complicate your pregnancy
- Newborn baby assessments
- Referrals to community resources and help finding baby cribs, car seats, clothing, etc.
- Support to stop smoking
- Help with substance abuse
- Personal care or home help services

Call Customer Service for more information on how you can access these services.

Children's Health

Children change a lot as they grow. They should see their doctor at least once a year to check their growth, even if they are healthy. This is known as a well-child visit. Well-child visits are a good time for you to ask questions about your child's health and how it can be better. Children can see a pediatrician for routine preventive care and well-child visits without a referral. Children up to three years old are recommended to have a developmental screening done with their doctor once a year. Babies from birth through 15 months need at least six well-child visits. These visits often are at these ages:

3-5 days	2 weeks	1 month
2 months	4 months	6 months
9 months	12 months	15 months

It is important for your child to get a blood lead test once before age one and again before age two. Children who are at risk or who are high risk should be checked more often. These children should be tested at least one time per year. Children who are high risk are those who have had lead poisoning in the past. This includes children who live in old homes or apartments. Lead poisoning can happen even if you do not live in an older home. Lead can be found in paint, soil, ordinary dust, playgrounds, and toys, as well as other places. Have your child tested for lead poisoning so that it may be treated. If untreated, lead poisoning can lead to disabilities and behavioral problems. This simple test will help keep your little one on track!

Teenagers should also receive annual well-child visits. At these visits, teens will have their height, weight and BMI checked. Providers can talk about health, safety and preventive measures that are useful to teens. Required immunizations can also be given at these visits.

Early Periodic Screening, Diagnosis and Treatment (EPSDT)

EPSDT is a special healthcare program for children under 21 years of age who are covered by Medicaid. Under EPSDT, children and teens enrolled in Medicaid receive all recommended preventive services and any medical treatment needed to promote healthy growth and development.

EPSDT checkups include:

Well-care visits	Physical and mental developmental/behavioral assessments
Health history and physical exam, including school and sports physicals	Crucial lab tests, including lead screening
Developmental screening	Nutrition assessment

Health education guidance	Immunizations
Hearing, vision, and dental screening assessment	Follow-up services

Children's Special Health Care Services

If your child has a serious, chronic medical condition, they may be eligible for Children's Special Health Care Services (CSHCS). CSHCS provides extra support for children and some adults who have special health care needs. This is in addition to the medical care coordination from Blue Cross Complete.

There is no cost for this program. It doesn't change your child's Blue Cross Complete benefits, service, or doctors. CSHCS provides services and resources through the following resources through the following agencies.

Starting October 1, 2023, eligibility for CSHCS expanded to include members up to age 26. Previously, members would age out at 21 years old. Members with sickle cell, hemophilia or cystic fibrosis are eligible regardless of age.

MDHHS Family Center for Children and Youth with Special Health Care Needs

This center provides a parent support network and training programs. It may also provide financial help for conferences about special needs and more. If you have questions about this program, call the CSHCS Family Phone Line at **1-800-359-3722** from 8 a.m. to 5 p.m. Monday through Friday.

Local County Health Department

Your local county health department can help you find local resources. These may include parent support groups, adult transition help, childcare, vaccines and more. For help finding your local county health department, visit your county's website or **michigan.gov**. Call Customer Service for assistance.

Children's Special Needs Fund

The Children's Special Needs fund helps families get items not covered by Medicaid or CSHCS. These items promote the health, mobility, and development of your child. They may include wheelchair ramps, van lifts and mobility equipment. To see if you qualify for help from this fund call **1-517-241-7420**.

CSHCS member transitioning to adulthood

We can help members who have special health care needs on how to plan a successful move from pediatric health care to adult health care services.

Preventive Health Care for Adults

Preventive health care for adults is important to Blue Cross Complete. You should have a wellness exam each year to prevent and detect health problems. It is important to find and treat health problems early. Make sure to schedule an appointment and ask your doctor to check:

- Blood pressure
- Cholesterol
- Diabetes
- Body Mass Index
- Blood sugar
- Depression Screening
- Prostate and Colorectal Screenings

You can also ask your doctor about:

- Immunizations
- HIV testing and treatment of sexually transmitted diseases
- Hepatitis C testing

Preventive health is also about making the right choices for good health habits. Seeing your doctor for routine care is a good preventive health habit that keeps you healthy. We have programs to help you make good preventive health choices for yourself and your family.

You can improve you and your family's health by taking responsibility and following healthy behaviors. Getting needed yearly preventive care is the first step. Some other things you should and should not do to take control of your health are listed below.

Things you should do:	Things you should **not** do:
• Eat healthy • Exercise • Get enough sleep • Manage your stress • Don't smoke or use tobacco • Don't use drugs or drink alcohol • Go to the dentist for regular cleanings and preventive services • Visit your doctor each year for yearly preventive care	• Eat foods high in fat, sugar, and salt • Live an inactive lifestyle • Hold in your feelings or emotions if you're feeling stressed or depressed • Use drugs, alcohol, or tobacco • Forget to set up your dentist visits for regular cleanings and preventive services • Forget to set up a yearly visit to your doctor • Avoid going to the doctor

Hepatitis C

Treatment is available for Hepatitis C. Hepatitis C is a liver infection caused by the Hepatitis C virus. It's spread through contact with blood from an infected person, even amounts too small to see. People with Hepatitis C often don't feel sick or show symptoms. When symptoms do appear, they're often a sign of advanced liver disease. It's important to get tested (screened) for Hepatitis C before it becomes severe, when it's easier to treat. All adults should be screened for Hepatitis C at least once. If you're high risk, you may need to be tested more than once. Pregnant beneficiaries should be screened during each pregnancy.

For members under age 21, the screening is covered under the Early and Periodic Screening, Diagnosis and Treatment program, or EPSDT. This includes coverage of any medically necessary follow-up services and referrals.

Diabetes Prevention Program

The Diabetes Prevention Program is a program from the Michigan Department of Health and Human Services. Members who are at risk of developing diabetes can join the program online or in person. There is no cost to join for Medicaid members.

Trained lifestyle coaches will teach participants how to eat a balanced diet, add exercise into their daily routine, deal with stress and challenges, and stay on track with their plan. The goal of the program is for members to achieve at least 150 minutes of physical activity each week and a 5 to 7% weight loss.

To qualify for the program, you must meet the following criteria:

- Be enrolled in Michigan Medicaid or the Healthy Michigan Plan
- Be at least 18 years old
- Be overweight or obese
- Have never been diagnosed with Type 1 or Type 2 diabetes
- Not be pregnant
- Have a recent blood test showing prediabetes, have a history of gestational diabetes or score high on a prediabetes risk test from the Centers for Disease Control

To learn more or join the program, visit **michigan.gov/mdhhs/keep-mi-healthy/chronicdiseases/diabetes/people-with-prediabetes**. Or call Blue Cross Complete's Rapid Response Outreach Team at **1-888-288-1722** from 8 a.m. to 7 p.m. Monday through Thursday, and 8 a.m. to 5 p.m. Friday. TTY users, call **1-888-987-5832**.

Hospital Care

Hospital care is for care like delivering a baby or taking care of a bad sickness. It also covers care you would get in the hospital, like lab tests or X-rays. Your doctor sets up your hospital care if you need it. A different doctor at the hospital may fill in for your doctor to make sure you get the care you need if an emergency happens.

You should call your doctor as soon as you are admitted (checked in) to the hospital if it was not arranged by your doctor. Ask a family member or friend to call for you if you cannot. It is important to call your doctor right away and set up a visit within seven days of being sent home. You can talk about and arrange your care after you leave the hospital during this follow-up visit.

Emergency Care

Emergency care is for a life-threating medical situation or injury that a reasonable person would seek care right away to avoid severe harm. Here are some examples of emergencies:

Convulsions	Broken bones
Uncontrollable bleeding	Loss of consciousness (fainting or blackout)
Chest pain	Jaw fracture or dislocation
High fever	Tooth abscess with severe swelling
Serious breathing problems	Knife or gunshot wounds

If you believe you have an emergency, call **911** or go to the emergency room. You do not need an approval from Blue Cross Complete or your doctor before getting emergency care. You can go to any hospital. Be sure to follow up with your doctor to make sure you get the right follow-up care and services.

Urgent Care and after-hours care

Urgent care centers and after-hours clinics are helpful if you need care quickly but can't see your primary care doctor. You don't need a referral or prior authorization to go to an urgent care center or after hours-clinic in our network.

These places can treat illnesses that should be cared for within 48 hours, such as the flu, high fevers, or a sore throat. They can also treat ear infections, eye irritations and low back pain. If you fell and have a sprain or pain, it can be treated at an urgent care center.

If you aren't sure if you need urgent care, call your doctor. They may be able to treat you in their office.

Routine Care

Routine care is for things like:

- Yearly wellness exams
- School physicals
- Health screenings
- Immunizations
- Vision and Hearing Exams
- Lab tests

Your doctor should set up a visit within 30 business days of request.

Mental Health and Substance Abuse Services

We want you to feel your best, including your mental and emotional feelings. To help you, we cover short-term treatment for mental or emotional needs. This applies to members with mild to moderate mental health services. These visits may be with a network therapist, such as a counselor, licensed clinical social worker or psychologist. Telehealth may be an option for you. Talk to your mental health provider to learn more.

Treatment for long term, severe mental conditions, or severe emotional disturbances for children, as well as inpatient and intensive outpatient treatment must be arranged through the local Community Mental Health Services Program (CMHSP) agency. CMHSP can also help refer you to the right local agency when you or a family member has problems or concerns about drugs or alcohol.

If you feel you have a substance abuse problem, we encourage you to seek help. If you need help getting services, call your doctor or Customer Service.

Signs and symptoms of substance abuse:

- Failure to finish jobs at work, home, or school
- Being absent often
- Performing poorly at work or school
- Using alcohol or drugs when it is dangerous. This includes while driving or using machines.
- Having legal problems because of drinking or drug use
- Needing more of the substance to feel the same effects
- Failing when trying to cut down
- Failing when trying to control the use of the substance
- Spending a lot of time getting the substance
- Spending a lot of time using the substance
- Spending a lot of time recovering from the substance's effects
- Giving up or reducing important social, work, or recreational activities because of substance use
- Continuing to use the substance even though it has negative effects

If you have questions about your mental health or substance abuse benefits call Customer Service. You can also call your local CMHSP agency.

If you need emergency care for a life-threatening condition, or if you're having thoughts of suicide or death, go to the nearest emergency room or call 911. You can also call the Suicide and Crisis Lifeline by dialing 988. Help is available for you now.

Home Health Care, Skilled Nursing Services and Hospice Care

Sometimes, you may need long-term care. To help you get the care you need, we may cover:

- Short-term nursing home services up to 45 days in a nursing facility (long-term care is provided by the State of Michigan)
- Home health care services for members who are homebound
- Supplies and equipment related to home health care
- Hospice care

Hospice care must be approved and arranged by your primary care doctor and Blue Cross Complete. Care must take place in the Blue Cross Complete service area.

Care Coordination

Do you have a chronic health problem or disability, such as asthma, diabetes or sickle cell anemia? Do you have barriers that are causing you issues with accessing your care? Do you see multiple providers or need special care? It's easy to feel overwhelmed with being in charge of your care if you have many health issues and see many providers. It can add more stress to your daily life. We are here to help you!

Our goal is to offer personalized care coordination services to help guide you through health care. We have nurses, care coordinators, social workers, and other health experts to help you get the best care possible from your care team.

The care coordination program focuses on you and your needs. We help you reduce the barriers you are having accessing your care by linking you to services and resources near you to help improve your health. We also assist you in reducing your barriers by helping to arrange care with your care team and providers. This ensures you are able to better manage your health and improve your quality of life.

How Can Care Coordination Help You?

If you are eligible, you will be assigned your own care coordinator. This person helps you address and eliminate barriers that cause you issues with obtaining care by:

- Completing assessments and reviewing medications
- Making a plan of care to help you identify and meet your health goals
- Linking you with services and community resources near you, including the local health departments
- Helping you better control your healthcare needs
- Collaborating with your providers
- Taking a person-centered approach in the management of your care needs by supporting you and your care team with understanding the medical and behavioral health benefits

Call Customer Service for more information about the care coordination program.

Community Health Navigators (CHN)

Community Health Navigators are the front-line public health workers within the community, assisting members with navigating health care. CHNs serve as a bridge between health care and social services by building trusting relationships.

CHNs' full range of services include:

- Meeting face to face to improve your access to health care
- Helping others find providers and set up visits
- Finding local support like food and housing
- Teaching ways to live a healthy life
- Helping with provider follow-up visits after going to the hospital or emergency room
- Helping set up rides for medical or pharmacy visits

Contact Customer Service for more information.

Durable medical equipment

Some medical conditions need special equipment. Durable medical equipment we cover includes:

- Equipment such as nebulizers, crutches, wheelchairs, and other devices
- Disposable medical supplies, such as ostomy supplies, catheters, peak flow meters and alcohol pads
- Diabetes supplies, such as lancets, test strips, insulin needles, blood glucose meters and insulin pumps.
- Prosthetics and orthotics – Special note: Prosthetics replace a missing body part, such as a hand or leg. They may also help the body function. Orthotics correct, align, or support body parts that may be deformed.

To get durable medical equipment, you need a prescription from your doctor. You may also need prior authorization from us. You must get your item from a network provider. To find network durable medical equipment providers, call Customer Service.

Benefits Monitoring Program

We participate in MDHHS' Benefits Monitoring Program. This program helps ensure you're using the correct benefits and services to manage your care. If the services you use aren't needed for your health condition, we'll enroll you in this program. We'll teach you the proper use of medical services and help you get services from appropriate providers.

Examples of things that could get you enrolled in this program include:

- Going to the emergency room when it's not an emergency
- Seeing too many different doctors instead of your primary care doctor
- Getting more medicines than may be safe
- Activity that may indicate fraud

Using the right health services in the right amount helps us make sure you're getting the very best care.

Tobacco Cessation

We want to help you quit smoking. If you smoke, talk to your doctor about quitting. If you are pregnant and smoke, quitting now will help you and your baby. Your doctor can help you. Blue Cross Complete can also help you. To get more information, call Customer Service. We cover the following services to help you:

- Therapy and counseling services, group or individual
- Educational materials
- Prescription inhalers or nasal sprays used to stop smoking
- Non-nicotine drugs
- Over-the-counter items to help you stop smoking
    - Patches
    - Gums
    - Lozenges

Pregnant women will receive more counseling calls and one dedicated quit coach. You can also earn rewards for keeping appointments.

Cost Sharing and Copayments

A copayment (sometimes called "co-pay") is a set dollar amount you are required to pay as your share of the cost for a medical service or supply. Blue Cross Complete does not require you to pay a copayment or other costs for covered services under the Medicaid or Healthy Michigan Plan program.

You must go to a doctor in Blue Cross Complete's Medicaid network, unless otherwise approved. If you go to a doctor that is not in Blue Cross Complete's Medicaid network and did not get approval to do so, you may have to pay for those services. You should not receive a bill from your doctor for covered services within the plan's network. If you have questions about how copays may apply to you, call Customer Service at **1-800-228-8554**, 24 hours a day, seven days a week. TTY users, call **1-888-987-5832**.

Services Covered by Medicaid, not Blue Cross Complete

Blue Cross Complete does not cover all services that you may be eligible for as a member of Medicaid.

Services Covered by State of Michigan Medicaid

The following services are covered by the State of Michigan Medicaid program. You must use your mihealth card to get this care. If you have questions about these services talk with your doctor or your local Department of Health and Human Services. You can also contact the Michigan Beneficiary Helpline at **1-800-642-3195**.

- Services provided by a school district and billed through the Intermediate School District
- Inpatient hospital psychiatric services
- Outpatient partial hospitalization psychiatric care
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility beyond 45 days)
- Behavioral health services for Enrollees meeting the guidelines under Medicaid Policy for serious mental illness or severe emotional disturbance
- Substance Abuse Care including:
    - Screening and assessment
    - Detox
    - Intensive outpatient counseling
    - Other outpatient care
    - Methadone treatment

Your State of Michigan Medicaid benefit provides options for transportation to and from these visits. If you need transportation to or from an appointment, and live in Wayne, Oakland, and Macomb counties, call ModivCare at **1-866-569-1902** to arrange a ride. If you do not live in Wayne, Oakland, or Macomb counties, contact your local MDHHS office.

MDHHS office locations and phone numbers may be found at **michigan.gov/mdhhs/inside-mdhhs/county-offices**.

Non-Covered Services

- Elective abortions and related services
- Experimental/investigational drugs, biological agents, treatments, procedures, devices, or equipment
- Elective cosmetic surgery
- Services for the treatment of infertility

New Technology

Health care and technology consultants advise Blue Cross Complete on changes in medical practice and technology. This helps Blue Cross Complete decide which new services to cover. This is how Blue Cross Complete maintains benefits coverage. Please see your *Certificate of Coverage* for more information.

Healthy Behaviors

You may be eligible to participate in a healthy behavior incentive program. To get more information, call Customer Service at **1-800-228-8554**, 24 hours a day, seven days a week. TTY users, call **1-888-987-5832**.

Rights and Responsibilities

You have rights and responsibilities as our member. Our staff will respect your rights. We will not discriminate against you for using your rights. This Medicaid Health Plan and any of its affiliated providers will comply with the requirements concerning your rights.

You have the Right to:

- Receive information about your health care services
- Be treated with dignity and respect
- Receive Culturally and Linguistically Appropriate Services (CLAS)
- Have your personal and medical information kept private
- Participate in decisions regarding your health care, including the right to refuse treatment and express preferences about treatment options
- A candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Request and receive a copy of your medical records, and request those be amended or corrected
- Be furnished with health care services consistent with State and federal regulations
- Be free to exercise your rights without adversely affecting the way the Contractor, providers, or the State treats you
- To file a grievance, to request a State Fair Hearing, or have an external review, under the Patient's Right to Independent Review Act
- Be free from other discrimination prohibited by State and federal regulations
- Receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and your ability to understand

- Receive Federally Qualified Health Center and Rural Health Center services
- To request information regarding provider incentive arrangements including those that cover referral services that place the Provider at significant financial risk (more than 25%), other types of incentive arrangements, and whether stop-loss coverage is provided
- To request information on the structure and operation of Blue Cross Complete
- To make suggestions about our services and providers
- To make suggestions about member rights and responsibilities policy
- To request information about our providers, such as: license information, how providers are paid by the plan, qualifications, and what services need prior approval

You have the Responsibility to:

- Review this handbook and Blue Cross Complete's Certificate of Coverage
- Make and keep appointments with your Blue Cross Complete doctor
- Treat doctors and their staff with respect
- Protect your Medicaid ID cards against misuse
- Contact us if you suspect fraud, waste, or abuse
- Give your Health Plan and your doctors as much info about your health as possible
- Learn about your health status
- Work with your doctor to set care plans and goals
- Follow the plans for care that you have agreed upon with your doctor
- Live a healthy lifestyle
- Make responsible care decisions
- Contribute towards your health by taking responsibility, including appropriate and inappropriate behavior.
- Apply for Medicare or other insurance when you are eligible.
- Report changes to your local MDHHS office if your contact info (like your address or phone number) changes
- Report changes that may affect your Medicaid eligibility to your local MDHHS office (like changes in income or changes to your family size). You can call your local MDHHS office or go to **newmibridges.michigan.gov**.

Nondiscrimination Policy

Blue Cross Complete of Michigan complies with applicable federal civil rights laws, including:

- Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80
- The Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91
- The Rehabilitation Act of 1973
- Title IX of the Education Amendments of 1972 (regarding education programs and activities)
- Titles II and III of the Americans with Disabilities Act; and section 1557 of the Affordable Care Act

Blue Cross Complete does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity or gender expression. Blue Cross Complete of Michigan does not exclude people or treat them differently because of race color, national origin, age, disability, sex, sexual orientation, gender identity or gender expression.

Please note:

- Blue Cross Complete is not contracting as the agent of the Blue Cross and Blue Shield Association.
- No person, entity or organization other than Blue Cross Complete will be held accountable or liable to you for any of Blue Cross Complete's obligations created under the contract. Blue Cross Complete is solely responsible for its own debts and other obligations.

Quality improvement programs

Our quality improvement programs help doctors give you appropriate care. This handbook gives you information about these programs and our clinical practice guidelines. To request this information, call Customer Service. You can ask for information about our:

- HEDIS® scores
- CAHPS® scores
- Clinical practice guidelines
- Quality Improvement program, which includes our goals and progress

Grievances and Appeals

We want you to be happy with the services you get from Blue Cross Complete and our providers. If you are not satisfied, you can file a grievance or appeal.

Grievances are complaints that you may have if you are unhappy with our plan or if you are unhappy with the way a staff person or provider treated you. Appeals are complaints related to your medical coverage, such as a treatment decision or a service that is not covered or denied. If you have a problem related to your care, talk to your provider. Your provider can often handle the problem. If you have questions or need help with the appeal process, call Blue Cross Complete at **1-800-228-8554** (TTY: **1-888-987-5832**).

Grievance Process

We want to know what is wrong so we can make our services better. If you have a grievance about a provider or about the quality of care or services you have received, let us know right away. If you aren't happy with us or your provider, you can file a grievance at any time. Blue Cross Complete has special procedures in place to help members who file grievances. We will do our best to answer your questions or help to resolve your concern. Filing a grievance will not affect your health care services or your benefits. These are examples of when you might want to file a grievance.

- Your provider or a(n) Blue Cross Complete staff member did not respect your rights.
- You had trouble getting an appointment with your provider in an appropriate amount of time.
- You were unhappy with the quality of care or treatment you received.
- Your provider or a(n) Blue Cross Complete staff member was rude to you.
- Your provider or a(n) Blue Cross Complete staff member was insensitive to your cultural needs or other special needs you may have.

You can file your grievance on the phone by calling Blue Cross Complete at **1-800-228-8554** (TTY: **1-888-987-5832**). You can also file your grievance in writing via mail or fax at:

Member Grievances
Blue Cross Complete
P.O. Box 41789
North Charleston, SC 29423

In the grievance letter, give us as much information as you can. For example, include the date and place the incident happened, the names of the people involved and details about what happened. Be sure to include your name and your Medicaid member ID number. You can ask us to help you file your grievance by calling **1-800-228-8554** (TTY: **1-888-987-5832**). We will let you know when we have received your grievance. We may contact you for more information.

At any time during the grievance process, you can have someone you know represent you or act on your behalf. This person will be your "representative." If you decide to have someone represent you or act for you, inform Blue Cross Complete in writing with the name of your representative and their contact information.

If you send a written grievance, we'll let you know within two business days that we received it. Your grievance will be addressed within 30 calendar days of submission. We will send you a letter of our decision. We may extend the time frames for grievances up to 14 calendar days if you request an extension. Or, we may extend the time frame if we need more information and the extension is in your best interest. If we extend the time frame, we'll give you a prompt verbal notice of the extension and follow up with a letter within two calendar days of our decision to extend the time frame.

Appeal Process

An appeal is a way for you to ask for a review of our actions. If we decide that a requested service or item cannot be approved, or if a service is reduced or stopped, you will get an "Adverse Benefit Determination" letter from us.

This letter will tell you the following:

- The adverse benefit determination the contractor has made or intends to make
- Your right to be provided upon request and free of charge, copies of all documents, records, and other information used to make our decision.
- What action was taken and the reason for it
- Your right to file an appeal and how to do it
- Your right to ask for a State Fair Hearing and how to do it
- Your right in some circumstances to ask for an expedited appeal and how to do it
- Your right to ask to have benefits continue during your appeal, how to do it, and when you may have to pay for the services

You may appeal within 60 calendar days of the date on the Adverse Benefit Determination letter. If you want your services to stay the same while you appeal, you must say so when you appeal, and you must file your appeal no later than 10 calendar days from the date on the Adverse Benefit Determination. The list below includes examples of when you might want to file an appeal.

- Not approving or paying for a service or item your provider asks for
- Stopping a service that was approved before
- Not giving you the service or items in a timely manner
- Not telling you of your right to freedom of choice of providers
- Not approving a service for you because it was not in our network

You can file your appeal on the phone by calling Blue Cross Complete at **1-800-228-8554** (TTY: **1-888-987-5832**). You can also file your appeal in writing via mail or fax at:

Member Appeals
Blue Cross Complete
P.O. Box 41789
North Charleston, SC 29423

Fax: 1-2866-900-4482

You have several options for assistance. You may:

- Call Customer Service and we will assist you in the filing process
- Ask someone you know to assist in representing you. This could be your primary care provider or a family member, for example.
- Choose to be represented by a legal professional.

To appoint someone to represent you, either: 1) send us a letter informing us that you want someone else to represent you and include in the letter their contact information or, 2) fill out the Authorization of a Member Representative Form. You may call and request the form or find it on our website at **mibluecrosscomplete.com/important-information/advance-directives**.

We will send you a notice saying we received your appeal. We will tell you if we need more information and how to give us such information in person or in writing. A provider with the same or similar specialty as your treating provider will review your appeal. It will not be the same provider who made the original decision to deny, reduce, or stop the medical service.

Blue Cross Complete will send our decision in writing to you within 30 calendar days of the date we received your appeal request. Blue Cross Complete may request an extension up to 14 business days in order to get more information before we make a decision. You can also ask us for an extension if you need more time to get additional documents to support your appeal.

We will call you to tell you our decision and send you and your authorized representative the Notice of Internal Appeal Decision. The Notice of Internal Appeal Decision will tell you what we will do and why.

If Blue Cross Complete's decision agrees with the Notice of Adverse Benefit Determination, you may have to pay for the cost of the services you got during the appeal review. If Blue Cross Complete's decision does not agree with the Notice of Adverse Benefit Determination, we will approve the services right away.

Things to keep in mind during the appeal process:

- At any time, you can provide us with more information about your appeal, if needed.
- You have the option to see your appeal file.
- You have the option to be there when Blue Cross Complete reviews your appeal.

How Can You Expedite Your Appeal?

If you or your provider believes our standard timeframe of 30 calendar days to make a decision on your appeal will seriously jeopardize your life or health, you can ask for an expedited appeal by writing or calling us. If you write to us, please include your name, member ID number, the date of your Notice of Adverse Benefit Determination letter, information about your case, and why you are asking for the expedited appeal. We will let you know within 24 hours if we need more information. Once all information is provided, we will call you within 72 hours from the time of your request to inform you of our decision and will also send you and your authorized representative the Notice of Internal Appeal Decision.

How Can You Withdraw an Appeal?

You have the right to withdraw your appeal for any reason, at any time, during the appeal process. However, you or your authorized representative must do so in writing, using the same address as used for filing your appeal. Withdrawing your appeal will end the appeal process and no decision will be made by us on your appeal request. Blue Cross Complete will acknowledge the withdrawal of your appeal by sending a notice to you or your authorized representative. If you need further information about withdrawing your appeal, call Blue Cross Complete at **1-800-228-8554** (TTY: **1-888-987-5832**).

What Happens Next?

After you receive the Notice of Internal Appeal Decision in writing, you do not have to take any action and your appeal file will be closed. However, if you disagree with the decision made on your appeal, you can take action by asking for a State Fair Hearing from the Michigan Office of Administrative Hearings and Rules (MOAHR) and/or asking for an External Review under the Patient Right to Independent Review Act (PRIRA) from the Michigan Department of Insurance and Financial Services (DIFS). You can choose to ask for both a State Fair Hearing and an External Review or you may choose to ask for only one of them.

State Fair Hearing Process

You, your representative, or your provider can ask for a State Fair Hearing with MOAHR. You must do this within 120 calendar days from the date of your appeal denial notice. A Request for Hearing form will be included with the notice of appeal decision that you receive from us. It has instructions that you will need to review. If you asked for services to continue in your health plan appeal and want to continue your services during the State Fair Hearing process, you must ask for a State Fair Hearing within 10 calendar days of the date on the decision notice. If you do not win this hearing, you may be responsible for paying for the services

provided to you during the hearing process. You can also ask for a State Fair Hearing if you do not receive a decision from us within the required time frame.

Call Blue Cross Complete at **1-800-228-8554** (TTY: **1-888-987-5832**) if you need a hearing request form sent to you. You may also call to ask questions about the hearing process. You will get a written notice of hearing from MOAHR telling you the date and time of your hearing. Most hearings are heard by telephone, but you can ask to have a hearing in person. During the hearing, you will be asked to tell an administrative law judge why you disagree with our decision. You will get a written decision within 90 calendar days from the date your request for hearing was received by MOAHR. The written decision will explain if you have additional appeal rights.

If the standard timeframe for review would jeopardize your life or health, you may be able to qualify for an expedited State Fair Hearing. If you qualify for one, MOAHR must give you an answer within 72 hours. However, if MOAHR needs to gather more information that may help you, it can take up to 14 more calendar days.

If you have any questions, you can call MOAHR at **1-800-648-3397**.

External Review of Appeals

You, your representative, or your provider can ask for an external review with DIFS under the Patient's Right to Independent Review Act – PRIRA. You must do this within 127 calendar days from the date of your appeal denial notice. An External Review form will be included with the notice of appeal decision that you receive from us. It has instructions that you will need to review. DIFS will send your appeal to an Independent Review Organization (IRO) for review. A decision will be mailed to you in 14 calendar days of accepting your appeal. You can also ask for an External Review if you do not receive a decision from us within the required time frame. You, your Authorized Representative, or your doctor can also request a fast appeal decision from DIFS within 10 calendar days after receiving a final determination. DIFS will send your appeal to an IRO for review. You will have a decision about your care within 72 hours. During this time period, your benefits will continue.

Send your request to:

Department of Insurance and Financial Services (DIFS)
Office of Research, Rules, and Appeals – Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720

Or call: **1-877-999-6442**
Fax: **1-517-284-8838**
Online: https://difs.state.mi.us/Complaints/ExternalReview.aspx

Community-Based Supports and Services

We want to provide efficient and appropriate care in a timely manner. We also connect our members to community resources.

- Do you and your family struggle with having enough to eat?
- Do you need help finding a place to stay, or do you need heating assistance?
- Do you need a ride to your doctors' appointments?
- Do you need help with employment?

If you answered yes to any of the above questions, we can help. We know it's difficult to get to your doctor for important health screenings or other care when you're facing these challenges. If you're struggling with a similar problem, or need assistance, reach out to your care manager. If you don't have a care manager, and need help please call the Rapid Response Outreach Team at **1-888-288-1722**, 8 a.m. to 7 p.m., Monday through Thursday, or Friday from 8 a.m. to 5 p.m. TTY users should call **1-888-987-5832**.
You can also access resources at the following:

- Online through our website: mibluecrosscomplete.com/resources
- Online through the State of Michigan portal: **newmibridges.michigan.gov**
- Online through the Michigan 2-1-1 website: **mi211.org**

You can also get help with resources or other health care questions at our Wellness and Opportunity Center in Detroit. You can drop in or call your care manager to schedule an appointment. The Wellness Center is open Tuesday through Thursday from 9 a.m. to 5 p.m. at:

Durfee Innovation Society
Suite 305/307
2470 Collingwood St.
Detroit, MI 48206
Use the elevator or stairs to find us on the third floor.

Women, Infants, and Children (WIC)

WIC is a free program that provides a combination of nutrition education, supplemental foods, breastfeeding promotion and support, and referrals to health care. Call **1-800-262-4784** to find a WIC clinic near you or call Customer Service for assistance.

Mission GED program

Eligible members can have support to earn their high school equivalency diploma through the Mission GED program. You'll work with a Blue Cross Complete coach who'll connect you with resources to prepare and, when you're ready, provide vouchers so you can take the test at no cost. For more information, call Blue Cross Complete's Rapid Response Outreach Team at **1-888-288-1722** (TTY: **1-888-987-5832**) Monday through Thursday, 8 a.m. to 7:00 p.m., or Friday, 8 a.m. to 5 p.m.

Mission GED is an AmeriHealth Caritas social determinant of life program. AmeriHealth Caritas is an independent company providing administrative services to Blue Cross Complete of Michigan.

Care Management

We offer a care management program for members with chronic and/or complex health conditions. This is a voluntary program that allows you to talk with a care coordinator about your health care. A care coordinator helps you:

- Coordinate care between health care providers
- Set personal goals to manage your medical conditions
- Talk to your doctors or other providers when you need help
- Understand your medical conditions
- Access community-based supports, services, and resources

If you are interested in joining this program, please call Customer Service to be connected with a care coordinator.

Make Your Wishes Known: Advance Directives

Blue Cross Complete supports your right to file an "Advance Directive" according to Michigan law. This document is a written statement of your wishes for medical care. It explains, in advance, what treatments you want or don't want if you have a serious medical condition that prevents you from telling your provider how you want to be treated.

The state of Michigan only recognizes an advance directive called a *durable power of attorney for health care*. To create one, you will need to choose a patient advocate. This person carries out your wishes and makes decisions for you when you cannot. It is important to pick a person that you know and trust to be your advocate. Make sure you talk with the person to let them know what you want.

Talk to your family and primary care physician about your choices. File a copy of your advance directive with your other important papers. Give a copy to the person you designate as your patient advocate. Ask to have a copy placed in your medical record.

Call Customer Service for more information and the forms you need to write an advance directive. You can also visit **mibluecrosscomplete.com/important-information/advance-directives**.

If your wishes aren't followed or if you have a complaint about how your provider follows your advance directive, you may file a complaint with:

Department of Licensing & Regulatory Affairs
BPL/Investigations & Inspections Division
P.O. Box 30670 Lansing,
MI 48909-8170
Call: 517-373-9196
Or click below:
https://www.michigan.gov/lara/bureau-list/bpl
Click on *File a Complaint*

If you have complaints about how Blue Cross Complete follows your wishes, you may call the state of Michigan's Department of Insurance and Financial Services. Call toll-free at **1-877-999-6442** or go to **michigan.gov/difs**.

Help Identify Health Care Fraud, Waste and Abuse

Medicaid pays doctors, hospitals, pharmacies, clinics, and other health care providers to take care of adults and children who need help getting medical care. Sometimes, providers and patients misuse Medicaid resources. Unfairly taking advantage of Medicaid resources leaves less money to help other people who need care. This is called fraud, waste, and abuse.

Fraud

Fraud is purposefully misrepresenting facts. Here are some examples of fraud:

- Using someone else's member ID card
- Changing a prescription written by a doctor
- Billing for services that were not provided
- Billing for the same service more than once

Waste

Waste is carelessly or ineffectively using resources. It is not a violation of the law, but it takes money away from health care for people who need it. Here are some examples of waste:

- Using transportation services for non-medical appointments
- Doctors ordering excessive or unnecessary testing
- Mail order pharmacies sending you prescriptions without confirming you still need them

Abuse

Abuse is excessively or improperly using those resources. Here are some examples of abuse:

- Using the emergency room for non-emergent health care reasons
- Going to more than one doctor to get the same prescription
- Threatening or offensive behavior at a doctor's office, hospital, or pharmacy
- Receiving services that are not medically necessary

You can help

We work to find, investigate, and prevent health care fraud. You can help. Know what to look for when you get health care services. If you get a bill or statement from your doctor or an Explanation of Benefit Payments statement from us, make sure:

- The name of the doctor is the same doctor who treated you
- The type and date of service are the same type and date of service you received
- The diagnosis on your paperwork is the same as what your doctor told you

Health care fraud is a felony in Michigan. Being involved in fraud or abuse can put your benefits at risk or make other legal problems. If you suspect fraud, waste, and abuse has taken place, please report it. You do not have to give your name.

If you notice any problems or want to report fraud or abuse, write to:

Blue Cross Complete Special Investigations Unit
P.O. Box 018
Essington, PA 19029

Or call toll-free: **1-855-232-7640** (TTY: **711**)

Or email: **FraudTip@mibluecrosscomplete.com**.

You may also report or get more information about health care fraud by writing:

Office of the Inspector General
P.O. Box 30062
Lansing, MI 48909

Or call toll-free: **1-855-MI-FRAUD** (**1-855-643-7283**)

Or visit: **michigan.gov/fraud**. Information may be left anonymously

Helpful Definitions

These managed care definitions will help you better understand certain actions and services throughout this handbook.

Appeal: An appeal is the action you can take if you do not agree with a coverage or payment decision made by your Medicaid Health Plan. You can appeal if your plan:

Denies your request for:

- A healthcare service
- A supply or item
- A prescription drug that you think you should be able to get

Reduces, limits, or denies coverage of:

- A healthcare service
- A supply or item
- A prescription drug you already got

Your plan stops providing or paying for all or part of:

- A service
- A supply or item
- A prescription drug you think you still need

Does not provide timely medical services

Copayment: A set amount you may be required to pay as your share of the cost for a medical service or supply. This may include:

- A doctor's visit
- Hospital outpatient visit
- Prescription drug

Durable Medical Equipment: Equipment and supplies ordered by a healthcare provider for everyday or extended use. This may include:

- Oxygen equipment
- Wheelchairs
- Crutches
- Blood testing strips for diabetics

Emergency Medical Condition: An illness, injury, or condition so serious that you would seek care right away to avoid harm.

Emergency Medical Transportation: Ambulance services for an emergency medical condition.

Emergency Room Care: Care given for a medical emergency when you think that your health is in danger.

Emergency Services: Review of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services: Medical services that your plan doesn't pay for or cover.

Grievance: A complaint that you let your plan know about. You may file a grievance if you have a problem calling the plan or if you're unhappy with the way a staff person or provider treated you. A grievance is not the way to deal with a complaint about a treatment decision or a service that is not covered or denied (see Appeal).

Habilitation Services and Devices: Health care services that help a person keep, learn, or improve skills and functioning for daily living. These services can be done inpatient or outpatient and may include:

- Physical and occupational therapy
- Speech-language pathology
- Services for people with disabilities

Health Insurance: Health insurance is a type of coverage that pays for medical and/or drug costs for people. It can pay the person back for costs from illness or injury. It can also pay the provider directly. Health insurance requires the payment of premiums (see premium) by the person getting the insurance.

Home Health Care: Healthcare services that a healthcare provider decides you need in your home for treatment of an illness or injury. Home health care helps you regain independence and become as self-sufficient as you can.

Hospice Services: Hospice is a special way of caring for people who are terminally ill and provide support to the person's family.

Hospitalization: Care in a hospital that needs admission as an inpatient and could require an overnight stay. An overnight stay for you to be looked after could be outpatient care.

Hospital Outpatient Care: Care in a hospital that usually does not need an overnight stay.

Medical Health Plan: A plan that offers healthcare services to members who meet State eligibility rules. The State contracts with certain Health Maintenance Organizations (HMO) to provide health services for those who are eligible. The State pays the premium on behalf of the member.

Medically Necessary: Healthcare services or supplies that meet accepted standards of medicine needed to diagnose or treat:

- An illness
- Injury
- Condition
- Disease or
- Symptom

Network: Health care providers contracted by your plan to provide health services. This includes:

- Doctors
- Hospitals
- Pharmacies

Network Provider/Participating Provider: A healthcare provider that has a contract with the plan as a provider of care.

Non-Participating Provider/Out-of-Network Provider: A healthcare provider that *does not* have a contract with the Medicaid Health Plan as a provider of care.

Physician Services: Healthcare services provided by a person licensed under state law to practice medicine.

Plan: A plan that offers health care services to members that pay a premium.

Preauthorization: Approval from a plan that is required before the plan pays for certain:

- Services
- Medical equipment or
- Prescriptions

This is also called prior authorization, prior approval, or precertification. Your plan may require preauthorization for certain services before you receive them. This excludes an emergency.

Premium: The amount paid for health care benefits every month. Medicaid Health Plan premiums are paid by the State on behalf of eligible members.

Prescription Drug Coverage: Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs: Drugs and medications that require a prescription by law by a licensed Provider.

Primary Care Provider: A licensed physician, nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides and manages your health care services. This can also be called a Primary Care Physician. Your primary care provider is the person you see first for most health problems. They make sure that you get the care you need to keep you healthy. They also may talk with other doctors and healthcare providers about your care and refer you to them.

Provider: A person, place or group that's licensed to provide health care like doctors, nurses, and hospitals.

Referral: A request from a PCP for his or her patient to see another provider for care.

Rehabilitation Services and Devices: Rehabilitative services and/or equipment ordered by your doctor to help you recover from an illness or injury. These services can be done inpatient or outpatient and may include:

- Physical and occupational therapy
- Speech-language pathology
- Psychiatric rehabilitation services

Skilled Nursing Care: Services in your own home or in a nursing home provided by trained:

- Nurses
- Technicians
- Therapists

Specialist: A licensed physician specialist that focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Urgent Care: Care for an illness, injury, or condition bad enough to seek care right away but not bad enough that it needs emergency room care.

Notice of Privacy Practices

We care about your privacy. This section explains how we get and use your information.

We get personal and medical information about you when you enroll in a health plan. It includes your date of birth, gender and other information. We also get bills, data about your health care and reports from your doctor.

This information helps us give you health care coverage. It also helps us pay provider claims for your care. We will always treat your information as private. Your information will only be collected and used as explained in our *Notice of Privacy Practices*.

This information, along with the forms you need to control who can see your information, is on our website. You can also ask Customer Service for copies of this information.

Your information. Your rights. Our responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your rights		
You have the right to:	• Get a copy of your health and claims records. • Correct your health and claims records. • Request confidential communication. • Ask us to limit the information we share.	• Get a list of those with whom we've shared your information. • Get a copy of this privacy notice. • Choose someone to act for you. • File a complaint if you believe your privacy rights have been violated.

Your choices		
You have some choices in the way that we use and share information as we:	• Answer coverage questions from your family and friends. • Provide disaster relief.	• Communicate through mobile and digital technologies. • Market our services and sell your information.

Our uses and disclosures		
We may use and share your information as we:	• Help manage the health care treatment you receive. • Run our organization. • Pay for your health services. • Administer your health plan. • Coordinate your care among various health care providers. • Help with public health and safety issues.	• Do research. • Comply with the law. • Respond to organ and tissue donation requests and work with a medical examiner or funeral director. • Address worker's compensation, law enforcement and other government requests. • Respond to lawsuits and legal actions.

Your rights	**When it comes to your health information, you have certain rights.**
	This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. • Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment or our operations. • We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why. • We will include all the disclosures except for those about treatment, payment and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost- based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us at **1-800-228-8554** or **TTY 1-888-987-5832.** • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling **1-877-696-6775**, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your choices	**For certain health information, you can tell us your choices about what we share.**
	If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends or others involved in payment for your care. • Share information in a disaster relief situation. • Share information with you through mobile and digital technologies (such as sending information to your email address or to your cell phone by text message or through a mobile app). If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information with others (such as to your family or to a disaster relief organization) if we believe it

	is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. However, we will not use mobile and digital technologies to send you health information unless you agree to let us do so. The use of mobile and digital technologies (such as text message, email or mobile app) has a number of risks that you should consider. Text messages and emails may be read by a third party if your mobile or digital device is stolen, hacked or unsecured. Message and data rates may apply.
In these cases we never share your information unless you give us written permission:	• Marketing purposes. • Sale of your information.

Our uses and disclosures	**How do we typically use or share your health information?** We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	We can use your health information and share it with professionals who are treating you.	**Example:** A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.
Run our organization	We can use and disclose your information to run our organization and contact you when necessary. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.	**Example:** We use health information about you to develop better services for you.
Pay for your health services	We can use and disclose your health information as we pay for your health services.	**Example:** We share information about you to coordinate payment for your health services.

Administer your plan	We may disclose your health plan information for plan administration.	**Example:** We share health information with others who we contract with for administrative services.
Coordinate your care among various health care providers	Our contracts with various programs require that we participate in certain electronic Health Information Networks ("HINs") and/or Health Information Exchanges ("HIEs") so that we are able to more efficiently coordinate the care you are receiving from various health care providers. If you are enrolled/enrolling in a government sponsored program, such as Medicaid or Medicare, please review the information provided to you by that program to determine your rights with respect to participating in an HIN or HIE.	**Example:** We share health information through an HIN or HIE to provide timely information to providers rendering services to you.

How else can we use or share your health information? We are allowed or required to share your information in other ways — usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.
For more information, see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues	We can share health information about you for certain situations such as: • Preventing disease. • Helping with product recalls. • Reporting adverse reactions to medications. • Reporting suspected abuse, neglect or domestic violence. • Preventing or reducing a serious threat to anyone's health or safety.
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner or funeral director when an individual dies.

Address workers' compensation, law enforcement and other government requests	We can use or share health information about you: • For workers' compensation claims. • For law enforcement purposes or with a law enforcement official. • With health oversight agencies for activities authorized by law. • For special government functions such as military, national security and presidential protective services.
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.
Additional restrictions on use and disclosure	• Certain federal and state laws may require greater privacy protections. Where applicable, we will follow more stringent federal and state privacy laws that relate to uses and disclosures of health information concerning HIV/AIDS, cancer, mental health, alcohol and/or substance abuse, genetic testing, sexually transmitted diseases and reproductive health.

Our responsibilities

Blue Cross Complete takes our members' right to privacy seriously. To provide you with your benefits, Blue Cross Complete creates and/or receives personal information about your health. This information comes from you, your physicians, hospitals and other health care services providers. This information, called protected health information, can be oral, written or electronic.

- We are required by law to maintain the privacy and security of your protected health information.
- We are required by law to ensure that third parties who assist with your treatment, our payment of claims or health care operations maintain the privacy and security of your protected health information in the same way that we protect your information.
- We are also required by law to ensure that third parties who assist us with treatment, payment and operations abide by the instructions outlined in our Business Associate Agreement.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the terms of this notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request and on our website, and we will mail a copy to you.

Effective date of this notice: Feb. 1, 2017

Certificate of Coverage

Blue Cross Complete of Michigan LLC is an independent licensee of the Blue Cross and Blue Shield Association.

Certificate of Coverage

Visit our website at
mibluecrosscomplete.com

Appendix A

1. General conditions

1.01 This *Certificate of Coverage* is issued to persons who have enrolled in Blue Cross Complete through the Michigan Department of Health and Human Services. By enrolling and accepting this Certificate, the Member agrees to abide by the rules of Blue Cross Complete as explained in this Certificate.

1.02 Blue Cross Complete of Michigan is a State-approved health maintenance organization. Blue Cross Complete is an independent licensee of the Blue Cross Blue Shield Association. The Association allows Blue Cross Complete to use the Blue Cross Blue Shield service mark in Michigan. Blue Cross Complete is not a contracted agent of the Association. Only Blue Cross Complete can be held accountable or liable to its members for the obligations within this contract. Blue Cross Complete is solely responsible for its own debts and other obligations.

1.03 This *Certificate of Coverage* states the terms of enrollment, membership, and coverage for which a Medicaid recipient may receive Blue Cross Complete health benefits. Appendix A lists the benefits that members may receive. It also includes limitations and exclusions.

1.04 GOVERNING LAWS: This Certificate is made and shall be interpreted under the laws of the state of Michigan.

1.05 WAIVER BY AGENTS: No agent or person, except an authorized officer of Blue Cross Complete, can waive any conditions or restrictions of this Certificate. No agent or person can bind Blue Cross Complete by making a promise or representation, or by giving or receiving any information. No change in this Certificate is valid unless amended in writing and signed by an authorized officer.

1.06 POLICY AND PROCEDURES: Blue Cross Complete may adopt reasonable policies, procedures, rules, and interpretations to promote the orderly and efficient administration of this Certificate.

1.07 ASSIGNMENT: All rights of a Member to receive benefits and services are personal, granted only to the Member, and may not be assigned to a third party.

1.08 HEADINGS: The headings and captions in this Certificate are not to be considered as part of the Certificate and are inserted only for convenience.

1.09 NOTICE: Any notice given by Blue Cross Complete in this Certificate shall be given to members in writing. The notice will be hand-delivered, or mailed with postage prepaid by BCC and addressed to the member(s) at the address of record on file with Blue Cross Complete.

1.10 LEGAL ACTIONS: No action for recovery may be brought regarding this policy prior to 60 days after providing written proof of loss as required by this policy. No such action shall be brought after three years following the time written proof of loss is required to be furnished.

2. Definitions

2.01 AMBULATORY SURGERY means surgery performed in an operating room at a hospital or freestanding surgical center without overnight admission. Procedures routinely performed in physicians' offices are not considered ambulatory surgery.

2.02 APPROVED FACILITY means a facility that provides medical or other services to Blue Cross Complete Members and has entered into an agreement with Blue Cross Complete to do so.

2.03 ATTENDING PHYSICIAN means any physician who, upon appropriate referral by a primary care physician or authorization by Blue Cross Complete, is responsible for the care of Blue Cross Complete Members in inpatient hospital or ambulatory surgery facilities.

2.04 AUTHORIZED SERVICE means any health care service which is a benefit under the Certificate and which has been provided or arranged by a primary care physician or his or her designee and/or authorized by the Blue Cross Complete Medical Director to be provided by another provider. An authorized service may be referred to in this document as a covered service.

2.05 BENEFITS are the health care services described in this *Certificate of Coverage* and required under Michigan law or by MDHHS.

2.06 CERTIFICATE OF COVERAGE (or Certificate) is the statement of covered benefits, including the terms of enrollment and covered services. *Certificate of Coverage* may also be referred to as the Certificate.

2.07 CONTRACT consists of the Blue Cross Complete *Certificate of Coverage*, including: General Conditions, Definitions, Limitations and Exclusions in its entirety, member ID cards, forms and questionnaires completed by the Member. The contract also consists of any authorized amendments, riders, or endorsements.

2.08 CONTRACT YEAR means the 12-month period beginning with the effective date of the contract between MDHHS and Blue Cross Complete.

2.09 CONTRACTED HOSPITAL means a hospital which has signed a contract with Blue Cross Complete or on whose behalf a contract has been signed to provide covered services to Blue Cross Complete Members in accordance with the terms and conditions of the contract. A contracted hospital also may be referred to as a participating hospital or a network hospital.

2.10 CONTRACTED PHYSICIAN means a physician who has signed a contract with Blue Cross Complete or on whose behalf a contract has been signed. A Contracted Physician may be employed by a contracted hospital or may participate in a physician group or PHO which has signed a contract to provide covered services to Blue Cross Complete Members. A Contracted Physician also may be referred to as a participating physician or a network physician.

2.11 CONTRACTED PROVIDER means a provider who has signed a contract with Blue Cross Complete or on whose behalf a contract has been signed to provide covered services to Blue Cross Complete Members in accordance with the terms and conditions of the contract. A contracted provider also may be referred to as a participating provider.

2.12 COVERED SERVICE(S) means the comprehensive health care services delivered under the terms and conditions for their delivery described in the *Certificate of Coverage*.

2.13 CUSTODIAL CARE is provided by persons without professional health care skills or training, primarily for the purpose of meeting personal needs such as bathing, walking, dressing, and eating.

2.14 DURABLE MEDICAL EQUIPMENT is equipment that is able to withstand repeated use, is customarily used to serve a medical purpose, and is not useful to a person in the absence of illness or injury. Examples include canes, crutches, and bed rails.

2.15 EFFECTIVE DATE is the date the Member is entitled to receive covered services pursuant to this Contract as determined by MDHHS.

2.16 EMERGENCY SERVICES means Medically necessary services provided to an enrollee with sudden, acute severe medical symptoms or severe pain that could likely result in:

- Serious harm to the enrollee's health, or in the case of a pregnant woman, her health or her unborn child's health,
- Serious damage to a body function, organ, or part.

Further, emergency services means covered inpatient and outpatient services that are as follows:

- Furnished by a provider qualified under this title.
- Needed to evaluate or stabilize an emergency medical condition.

2.17 ENROLLEE is an individual determined by MDHHS to be entitled to receive health care services under this *Certificate of Coverage*.

2.18 EXPERIMENTAL, INVESTIGATIONAL OR RESEARCH MEDICAL, SURGICAL CARE DRUG, DEVICE, TREATMENT, OR PROCEDURE

This means a drug, device, treatment, or procedure meeting one or more of the following criteria:

- It cannot be lawfully marketed, without the approval of the U.S. Food and Drug Administration and such approval has not been granted at the time of its use or proposed use; or
- It is the subject of a current investigational new drug or new device application on file with the FDA; or
- It is being provided pursuant to a Phase I or Phase II clinical trial or as the experimental or research arm of a Phase III clinical trial; or
- It is being provided pursuant to a written protocol describing the determination of safety, efficacy or efficiency in comparison to conventional alternatives.
- It is described as experimental, investigational or research by informed consent or patient information documents; or
- It is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the FDA or the Department of Health and Human Services (HHS) or successor agencies, or of a human subjects (or comparable) committee; or
- The predominant opinion among experts as expressed in the published authoritative medical or scientific literature is that further experiment, investigation or research is necessary in order to define safety, toxicity, effectiveness or efficiency compared with conventional alternatives.

(Antineoplastic drug therapy shall be provided in accordance with Michigan law.)

2.19 FEE SCHEDULE means the schedule of fees that Blue Cross Complete pays to contracted providers for services and benefits under this Certificate.

2.20 HEARING AID is an electronic device worn for the purpose of amplifying sound and assisting the physiological process of hearing.

2.21 HOMEBOUND means a medical condition that prevents the patient from leaving home.

2.22 HOME HEALTH AGENCY is an organization licensed or certified pursuant to the laws of the state of Michigan as a home health agency and which has entered into an agreement with Blue Cross Complete to provide covered services to Members.

2.23 HOME HEALTH CARE means part-time skilled health care provided for homebound Members in the home for the treatment of an illness or injury, for medical conditions which are not long-term or chronic in nature.

2.24 HOSPICE CARE means services that are primarily used to provide pain relief, symptom management, and supportive services to the terminally ill and their families.

2.25 Blue Cross Complete of Michigan is authorized by the state of Michigan to arrange for the provision of health care services as a health maintenance organization.

2.26 Blue Cross Complete of Michigan is the name of the health care plan described in this *Certificate of Coverage*. Blue Cross Complete of Michigan may be referred to in this document as Blue Cross Complete, Plan, Health Plan or as the Medicaid Plan.

2.27 MEDICAID FAIR HEARING PROCESS means a process that exists at the Michigan Department of Health and Human Services that a Member may use to raise any concerns about any Blue Cross Complete decision under this Certificate. The Medicaid Fair Hearing Process is described in the *Member Handbook*.

2.28 MEDICAL DIRECTOR is a Michigan licensed physician designated by Blue Cross Complete to provide medical management and related services on behalf of Blue Cross Complete. As used in the Certificate, the term shall include any individual designated by the Medical Director to act on his or her behalf.

2.29 MEDICALLY NECESSARY means services and supplies furnished to a Member when and to the extent the Blue Cross Complete Medical Director or his or her designee determines that they satisfy all of the following criteria:

- They are medically required and medically appropriate for the diagnosis and treatment of the Member's illness or injury.
- They are consistent with professionally recognized standards of health care.
- They do not involve costs that are excessive in comparison with alternative services that would be effective for the diagnosis and treatment of the Member's illness or injury.

The fact that a physician may have prescribed, ordered, recommended, or approved the provision of certain services to the Member does not necessarily mean that such services satisfy the above criteria.

2.30 MEMBER means an individual entitled to receive benefits under this Certificate.

2.31 Through the MEMBER APPEALS PROGRAM a member can submit a concern about Blue Cross Complete, its providers or health care professionals. The MAP provides for a response following the procedures described in the *Member Handbook*.

2.32 NONAUTHORIZED SERVICE means any health care service, which hasn't been provided or arranged by the primary care physician or his or her designee or hasn't been authorized by Blue Cross Complete to be provided by another provider.

2.33 NONCOVERED SERVICE means any health care service excluded as a benefit under this Certificate.

2.34 NONPLAN PROVIDER means any health care professional or provider who is not party to a contract with Blue Cross Complete to provide services to Medicaid members.

2.35 OFF-LABEL means the use of a drug prescribed for uses other than those stated in the labeling approved by the United States Food and Drug Administration.

2.36 ORTHOTIC DEVICE is an external device which is designed to correct or assist in the prevention of a bodily defect either of form or function.

2.37 PLAN means the Blue Cross Complete Medicaid Plan.

2.38 POST STABILIZATION care services means covered services, related to an emergency medical condition that are provided after a Member is stabilized in order to maintain the stabilized condition, or, to improve or resolve the enrollee's condition.

2.39 PRESCRIPTION means any physician or licensed practitioner order for a medicinal substance which under the Federal Food, Drug, and Cosmetic Act is required to bear on the packaging label the following legend: "Caution: Federal Law prohibits dispensing without a prescription."

2.40 A Primary Care Physician (PCP) is the contracted doctor who provides or coordinates a Member's health care through referrals to other providers, professionals, or facilities. A PCP's specialty may be Family Practice, General Practice, Internal Medicine, OB-GYN, or Pediatrics. A specialist may act as a PCP when the Member's medical condition should be managed by a specialist and when approved by Blue Cross Complete.

2.41 PROSTHETIC DEVICE is a device which aids body functioning or replaces a limb or body part.

2.42 RESTORATIVE HEALTH SERVICES means intermittent or short-term rehabilitative nursing care that may be provided in or out of a health care facility.

2.43 SERVICE AGREEMENT is the contract between Blue Cross Complete of Michigan and the Michigan Department of Management and Budget, Acquisition Services, which establishes the scope of benefits being purchased, the criteria for eligibility, as well as the underwriting and administrative agreements between the parties.

2.44 SERVICE AREA means the geographical area in which Blue Cross Complete is authorized by state authorities to provide or arrange for the provision of health services to Members by network providers.

2.45 SKILLED CARE is a service recommended by a doctor that requires the special skills of qualified technical or health personnel. The care must be provided directly by or under the supervision of skilled nursing or rehab personnel. This assures the safety of the Member and ensures the medically desired result is reached.

2.46 SKILLED NURSING FACILITY is an institution which has been licensed by the state of Michigan and certified by Medicaid to provide skilled care nursing services.

2.47 SPECIALIST is a physician to whom a Blue Cross Complete Member has been referred by the Blue Cross Complete primary care physician or his or her designee and/or Blue Cross Complete for special consultation or treatment.

2.48 TELEMEDICINE means the use of electronic media, such as a phone or video call, to link patients with health care professionals in different locations.

3. Eligibility

3.01 MEMBERS – To be eligible to enroll, a person must:

- Be eligible for Medicaid or Healthy Michigan Plan as determined by MDHHS,
- Have a Medicaid status that is permitted by MDHHS to enroll in an HMO, and
- Reside within the service area.

3.02 In all cases, final determination of Blue Cross Complete eligibility is made by MDHHS.

4. Enrollment requirements

4.01 The categories of Medicaid-eligible persons who may enroll in HMOs are determined by MDHHS.

4.02 Newborns of Medicaid-eligible women are automatically enrolled in Blue Cross Complete effective with date of birth if the mother is a Blue Cross Complete Member at the time of delivery.

5. Disenrollment

5.01 If a member wishes to disenroll, he/she must follow the procedures set forth by MDHHS. Disenrollment information is available upon request from the Customer Service department.

5.02 All rights to benefits stop on the effective date of disenrollment, without prejudice to claims for services rendered prior to the effective date of disenrollment. If the member is a patient of an acute care facility at the time of disenrollment, Blue Cross Complete will cover the stay until the date of discharge. The disenrollment date is determined by MDHHS.

5.03 Blue Cross Complete may submit a request to the Michigan Department of Health and Human Services requesting a special disenrollment of a member if the member acts in a violent or threatening manner not resulting from the member's special needs (as prohibited in the Disenrollment Discrimination section of the Medicaid contract). The effective disenrollment date for an approved request will be determined by MDHHS. It must be within 60 days from the date MDHHS receives the complete request from the plan and no later than 30 days following resolution of the appeal.

5.04 Special disenrollments will occur only to the extent consistent with the rules and regulations of MDHHS.

6. Effective date of coverage

6.01 All eligible, enrolled members will be covered under this Certificate on the date agreed upon between MDHHS and Blue Cross Complete.

7. Blue Cross Complete Member rights and responsibilities

7.01 RIGHTS AND RESPONSIBILITIES

Member rights will be honored by all Blue Cross Complete staff and affiliated providers.
Member rights:

- Understand information about your health care
- Get required care as described in this book
- Be treated with dignity and respect
- Receive culturally and linguistically appropriate services, or CLAS
- Privacy of your health care information, as outlined in this handbook
- Treatment choices, in spite of cost or benefit coverage
- Fully join in making decisions about your health care
- Refuse to accept treatment
- Voice complaints, grievance or appeals about Blue Cross Complete and its services, benefits, providers and care
- Get clear and easy to understand written information about Blue Cross Complete's services, practitioners, providers, rights and responsibilities policies
- Review your medical records and ask that they be corrected or amended
- Make suggestions regarding Blue Cross Complete's rights and responsibilities policies
- Be free from any form of abuse, being restrained or secluded, as a means of coercion, discipline, convenience or retaliation when receiving services
- Receive information on available treatment options and alternatives presented in a manner appropriate to the enrollee's condition and ability to understand
- Request and receive:
  - The Blue Cross Complete *Provider Directory*
  - The professional education of your providers, including those who are board certified in the specialty of pain medicine for evaluation and treatment
  - The names of hospitals where your physicians are able to treat you
  - The contact information for the state agency that oversees complaints or corrective actions against a provider
  - Any authorization, requirements, restrictions or exclusions by service, benefit or a specific drug
  - The information about the financial agreements between Blue Cross Complete and a participating provider

Member responsibilities:

- Know your Blue Cross Complete Certificate
- Know your *Member Handbook* and all other provided materials
- Call Customer Service with any questions
- Seek services for all nonemergency care through your primary care physician, except as otherwise stated in this Certificate
- Use the Blue Cross Complete network
- Be referred and approved by Blue Cross Complete and your primary care physician for out-of-network services
- Make and keep appointments with your primary care physician
- Contact your doctor's office if you need to cancel an appointment
- Be involved in decisions regarding your health
- Behave in a proper and considerate manner to providers, their staff, other patients and Blue Cross Complete staff
- Tell Blue Cross Complete of address changes, any changes for your dependents' coverage and any other health coverage
- Protect your card against misuse
- Call Customer Service right away if your card is lost or stolen
- Follow your doctor's instructions regarding your care

- Make treatment goals with your physician
- Contact Blue Cross Complete Anti-fraud Unit if you suspect fraud

For more information, members may contact Customer Service.

7.02 PRIMARY CARE PHYSICIAN SELECTION AND CONTINUITY OF CARE

Upon enrollment, and by the effective date, the Member shall select a primary care physician for each member of the family. Blue Cross Complete reserves the right to choose a primary care physician for the Member if he/she does not indicate a physician selection. Blue Cross Complete will use prescribed guidelines to make such a selection.

Adult members may change their primary care physician or that of their enrolled child by submitting a request to Blue Cross Complete. Foster parents must contact the child's MDHHS case worker to change the child's primary care physician. Normally, a change will take effect days on the day Blue Cross Complete receives the request. Blue Cross Complete may limit the number of times a member can change PCPs without cause in a year.

If a member's PCP leaves the Blue Cross Complete network for any reason other than failure to meet Blue Cross Complete's quality standards or fraud, a Member who is undergoing an ongoing course of treatment with that physician may be eligible to receive treatment from that physician as follows:

- For as many as ninety (90) days after the Member receives notice that the contracted physician is leaving Blue Cross Complete's network.
- If the Member is in her second or third trimester of pregnancy at the time of her obstetrician's termination from the Blue Cross Complete network, she may continue with the terminated physician through post-partum care (i.e., the regular post-partum visit) directly related to that pregnancy.
- If the Member has been receiving care for a terminal illness, the member may continue to receive care from the treating physician for the terminal illness for the remainder of his or her life. All other care must be provided by contracted providers.

Continuity of care applies only if it is authorized by Blue Cross Complete unless stated otherwise in this Certificate. The departing physician must also agree to:

- Accept payment from Blue Cross Complete at the rates in place before the termination.
- Follow Blue Cross Complete's standards for maintaining quality health care.
- Provide Blue Cross Complete with medical information related to the care provided.
- Comply with Blue Cross Complete's policies and procedures, including those related to utilization review, referrals, prior authorization and treatment plans.

7.03 A Member enrolls in Blue Cross Complete knowing that providers are responsible for determining treatment. A Member may refuse procedures recommended by a doctor. If the refusal of a recommended procedure is due to lack of agreement between the doctor and patient and creates a barrier to care, the health plan may help the member change their doctor. If the Member refuses to accept recommended treatment or procedures and no alternatives exist, the Member shall be advised.

7.04 MEMBER APPEALS PROGRAM

Blue Cross Complete has set up a mechanism for receiving, processing, and resolving Member appeals and grievances relating to the benefits or the operation of Blue Cross Complete. This is fully described in the Blue Cross Complete Medicaid Plan *Member Handbook*, "Part 10: If you have a concern." Members will receive a copy of the *Member Handbook* describing the Member Appeals Program when they enroll with Blue Cross Complete, and may receive additional copies at any time by telephone request to Customer Service at the number listed below.

There is a time limit on filing an appeal. You must file within 60 days of the problem or denial. Contact us for a form to do this. You may also file an appeal request verbally. If you have questions, please call Customer Service at 1-800-228-8554 (TTY: 1-800-649-3777).

7.05 MEMBER IDENTIFICATION CARDS

Having possession of the Blue Cross Complete Member Identification Card confers no right for benefits under this Certificate. To be entitled to benefits, the holder of the card must meet and maintain all MDHHS requirements.

A Member shall report loss or theft of the Member Identification Card to Blue Cross Complete immediately upon discovery of loss or theft.

7.06 FORMS AND QUESTIONNAIRES

Members shall complete and submit to Blue Cross Complete such forms and medical questionnaires as requested. Members warrant that all information completed by them is true, correct, and complete to the best of their knowledge.

7.07 BENEFITS, POLICIES, AND PROCEDURES

The Member is responsible for becoming familiar with and following Blue Cross Complete Medicaid Plan benefits, policies, and procedures.

7.08 HEALTH MANAGEMENT PROGRAM

Enrolling in Blue Cross Complete entitles the Member to participate in Blue Cross Complete's Health Management Program which includes health promotion activities, health education activities, disease management programs, and case management programs.

7.09 MEMBERSHIP RECORDS

Blue Cross Complete will keep membership records. Blue Cross Complete is not liable for any obligation dependent upon information to be supplied by the Member prior to receipt in satisfactory form. Incorrect information furnished may be corrected if Blue Cross Complete has not acted to its prejudice by relying on it.

7.10 AUTHORIZATION TO RECEIVE INFORMATION

Member authorizes, subject to applicable confidentiality requirements, providers to disclose information about his or her care, treatment and physical condition to Blue Cross Complete. The member also permits Blue Cross Complete to copy his or her records.

8. Member's role in policy making

8.01 BOARD OF MANAGERS AND CONSUMER ADVISORY COMMITTEE

As provided by law, at least one member of the Blue Cross Complete Board of Managers shall consist of an adult enrollee elected by persons enrolled in Blue Cross Complete. Each member will receive a list of Blue Cross Complete's Board of Managers with the enrollee board member identified. Changes in board membership shall be reflected in Blue Cross Complete's newsletter. Member(s) may contact Blue Cross Complete for information on becoming a member of the Board of Managers. In addition, Blue Cross Complete has a Member Advisory Council that serves as the consumer advisory committee and reports to the Board of Managers. The Member Advisory Council is made up of at least one adult enrollee, one family member or legal guardian of an enrollee, and one consumer advocate.

8.02 REGULAR COMMUNICATION

Members shall receive Blue Cross Complete's newsletter which will provide information regarding current policy, policy changes, and how best to take advantage of the Blue Cross Complete Plan services.

9. Payment for coverage

9.01 MDHHS is responsible for making premium payments to Blue Cross Complete for all Medicaid members. Payments shall be made in accordance with the terms of the agreement between Blue Cross Complete and MDHHS.

10. Claim provisions

10.01 It is not expected that a Member will make payments to any participating provider for benefits under this Certificate. However, if the Member provides evidence satisfactory to Blue Cross Complete that he/she has made payment to a contracted authorized provider in exchange for benefits, and that payment is the responsibility of Blue Cross Complete, the Member shall be reimbursed by Blue Cross Complete if an itemized bill and original evidence of payment (canceled check, cash receipt, etc.) is received by Blue Cross Complete no later than one year from the date of service. Receipts may be submitted to:

Blue Cross Complete
Attention: Claims
P.O. Box 7355
London, KY 40742

11. Coordination of benefits and subrogation

Other party liability

Blue Cross Complete does not pay claims or coordinate benefits for services which are not provided or authorized by a Blue Cross Complete physician and which are not benefits under this Certificate, except as otherwise stated in this Certificate.

11.01 GENERAL PROVISION

Blue Cross Complete will provide each of its Members with full benefits to the limit of this Certificate. However, a Member may not receive duplicate benefits, or benefits greater than the actual expenses incurred or Blue Cross Complete's fee schedule amount, whichever is less. Duplicate coverage does not extend Blue Cross Complete benefits beyond the limits of this Certificate.

The Member shall execute and deliver such instruments and take action as Blue Cross Complete may require to implement the provisions of this section. The Member shall do nothing to prejudice the rights given Blue Cross Complete by this provision without its prior written consent.

Benefits are not provided under this Certificate if any expenses to or on behalf of a member are paid or payable under the provisions of any other insurance, service benefit or reimbursement plan, including: Medicare, Worker's Compensation, Employer's Liability Law, or No Fault Automobile Insurance.

11.02 COORDINATION OF BENEFITS

Blue Cross Complete will follow the coordination of benefits guidelines of MDHHS.

All medical bills must first be submitted to the primary insurance carrier. Blue Cross Complete will generally be the payer of last resort.

11.03 SUBROGATION

If the Member has a right of recovery from person or organization for any benefits or supplies covered under this contract (except from a Member's health insurance coverage, subject to the coordination of benefits provisions), the Member, as a condition to receiving benefits under this contract, will:

- Authorize Blue Cross Complete to be subrogated to the Member's rights of recovery, to the extent only of the benefits provided including the right to bring suit in the Member's name at the sole cost and expense of Blue Cross Complete.

In the event a suit instituted by Blue Cross Complete on behalf of the Member results in monetary damages awarded in excess of the cash value of actual benefits provided by Blue Cross Complete, Blue Cross Complete shall have the right to recover costs of suit and attorney fees out of the excess, to the extent of the cost of such fees.

11.04 RIGHT OF PAYMENT AND RECOVERY

If Blue Cross Complete has provided benefits under the contract but another plan should pay, Blue Cross Complete has the right to deny payment or seek the reasonable cash value of each service from the other plan.

11.05 RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

Under the terms of this section, Blue Cross Complete may need to release or get Member information which it deems to be necessary. A Member who claims benefits under the contract must provide Blue Cross Complete with that information. This includes notifying Blue Cross Complete of any change in other insurance coverage.

12. Out-of-area coverage

12.01 Members are entitled to out-of-area coverage for urgent and emergent medical care. Emergency care doesn't require a referral or prior authorization.

Routine out-of-area or out-of-network care requires prior authorization by Blue Cross Complete. Services approved by Blue Cross Complete to be received outside the state of Michigan will be administered consistent with the requirements of MDHHS and through BlueCard, a Blue Cross Blue Shield Association Program. Health care services provided outside the country are not covered by Blue Cross Complete. For more information, please call Customer Service.

13. Term and termination

13.01 TERM

This Certificate shall continue in effect from the effective date as long as the Member is eligible according to MDHHS and as long as Blue Cross Complete is contracted with the state of Michigan as a qualified health plan for the Medicaid program.

13.02 TERMINATION FOR CAUSE

Coverage for a Member may be terminated for cause, subject to reasonable notice and the consent of MDHHS for:

- Violent/Life-Threatening situations including physical acts of violence; physical or verbal threats of violence made against Blue Cross Complete-affiliated providers, Blue Cross Complete staff, or the public at Blue Cross Complete locations; or where stalking situations exist.

NOTE: On or after the effective date of termination for cause, premium payments received on behalf of such terminated Member for periods following the termination date shall be refunded to MDHHS. Blue Cross Complete shall however, make reasonable attempts to transfer care of patients terminated from the Plan to other providers.

13.03 LOSS OF ELIGIBILITY

MDHHS will notify Blue Cross Complete if the Member is no longer eligible for coverage under the contract as specified in Section 3, Eligibility.

13.04 CESSATION OF OPERATIONS

In the event of cessation of operations or dissolution of Blue Cross Complete, this Certificate may be terminated immediately by order of proper authority. Blue Cross Complete may be obligated for services as prescribed by law or proper order.

14. Benefits

14.01 Members can get the services described under the terms and conditions of this Certificate. Blue Cross Complete primary care physicians need to provide care to Blue Cross Complete Members, except as noted.

When needed, the Member's PCP will refer the member to a specialist. Usually, the specialist will participate with Blue Cross Complete. Blue Cross Complete has no liability or obligation for any benefits received by Members from other doctors, hospitals or entity unless requested in advance by the doctor or prior approved by Blue Cross Complete.

Certain exceptions apply (e.g., emergency services, routine obstetrical and gynecological services). If you have not chosen a Blue Cross Complete pediatrician to be your child's PCP and want to take your child to a Blue Cross Complete pediatrician, you can do so without a referral. Blue Cross Complete may assign that doctor to be your child's PCP.

You don't pay for services covered by Blue Cross Complete, when they are medically necessary and arranged by your PCP. The following is a list of those services, which are also listed in the Handbook:

- Blood lead testing for members under age 21
- Breast cancer services – services to treat breast cancer as required by federal and state women's health and cancer protection acts. These include diagnostic, outpatient treatment and rehabilitative services.
- Breast pumps; personal use, double-electric
- Chiropractic services
- Dental services for members ages 21 and up. Members under 21 years of age are covered by the Healthy Kids Dental program administered by the Michigan Department of Health and Human Services.
- Diagnostic laboratory, X-ray and other imaging services
- Doctor office visits
- Doula services during pregnancy, postpartum and delivery
- Emergent and urgent care services
- Family-planning services
- Gender affirmation services
- Health education – disease management programs
- Hearing examinations and hearing aids for all members
- Home health services and skilled nursing home services when medically necessary. (You can use these after you leave the hospital or instead of going to the hospital. Your primary care physician will help you arrange these services.)
- Hospice services (if you request)
- Hospital services requiring an overnight stay, including:
  - Cost of a semi-private room (sharing a room with one other person)
  - Doctor services
  - Surgical services
  - Anesthesia (medication to relax or put you to sleep before surgery)
  - X-rays
  - Laboratory services
- Long-term acute care hospital services
- Maternal Infant Health Program - for pregnant women and infants who are enrolled in a health plan. The program offers free rides to medical visits and childbirth or parenting classes. During scheduled home visits, a health professional will help with health matters that can affect pregnancy, including:
  - Asthma
  - Depression and anxiety
  - High blood pressure
  - High blood sugar
  - Smoking
  - Alcohol or drug use
  - Getting health care while the member is pregnant (prenatal care)
  - Finding food or a place to live
  - Concerns about abuse or violence
- Medical equipment and supplies, durable
- Mental health and substance use disorder services – outpatient visits for mild or moderate mental health treatment
- Midwife services – when provided by a certified nurse midwife in a health care setting
- Nurse practitioner services – when provided by a certified pediatric or family nurse
- Out-of-network services – when authorized by Blue Cross Complete, except as otherwise stated in this Certificate

- Parenting and birthing classes
- Physical exams – routine or annual physical exams
- Podiatric (foot specialist) services, when medically necessary
- Practitioner services – such as those provided by physicians and specialists
- Pregnancy care – including prenatal and postpartum care (before and after birth)
- Prescriptions and pharmacy services
- Prosthetics and orthotics
- Rehabilitative or restorative services – intermittent or short term, in a nursing facility for up to 45 days
- Rehabilitative or restorative services in a place of service other than a nursing facility
- Renal disease services – end stage
- Restorative or rehabilitative services in a health care location other than a nursing facility.
- Sexually transmitted disease treatment
- Smoking and tobacco cessation treatment, including drugs and behavioral support (tobacco quit program)
- Specialist visits
- Surgical services – not requiring an overnight hospital stay
- Telemedicine, also known as telehealth services
- Therapy – physical, speech and language, occupational
- Transplant services
- Transportation – by ambulance and other emergency medical transport
- Transportation – to nonemergency covered medical services
- Vaccinations (covered vaccinations do not require prior authorization if provided by local health departments.)
- Vision – routine services
- Weight-reduction services, including bariatric surgery, if medically necessary
- Well-baby and well-child care – Early Periodic Screening Diagnosis and Treatment Program for persons under age 21

Healthy Michigan Plan enrollees

The covered services provided to Healthy Michigan Plan enrollees under this contract include all those listed above and the following services:

- Habilitiative services
- Expanded dental services

Your primary care physician can help you get the Blue Cross Complete services you need. Customer Service can also answer questions about your benefits.

15. Healthy Michigan Plan benefits

15.01 The Healthy Michigan Plan is a program operated under an 1115 Waiver approved by the Centers for Medicare & Medicaid Services to provide Medicaid coverage to all adults in Michigan with incomes up to and including 133 percent of the federal poverty level.

This certificate sets the terms and conditions of coverage and describes the health care services that are covered for Members under the Healthy Michigan Plan. The covered services provided to Healthy Michigan Plan enrollees under this contract include all those listed above and the following services:

15.02 OUT-OF-POCKET COSTS

Out-of-pocket refers to the two types of payments members may make for their health services. It includes contributions and copays. The amount may change if members adopt healthy behaviors.

Out-of-pocket costs cannot exceed 5% of a member's income, as mandated by the Michigan Department of Health and Human Services.

15.03 CONTRIBUTIONS

The Healthy Michigan Plan requires people with annual incomes between 100% and 133% percent of the federal poverty level to contribute 2% of their annual income.

15.04 COPAYS

Some covered services have a copay. Copays and contributions are paid through a member's MI Health account to Blue Cross Complete. Only members ages 21 and older have copays.

The chart below outlines copay amounts.

Covered services	**Copay*** Income less than or equal to 100% FPL	**Copay*** Income more than 100% FPL
Physician office visit (including freestanding urgent care centers)	$2	$4
Pharmacy	$1 preferred $3 non-preferred	$4 preferred $8 non-preferred
Vision care visits	$2	$2
Dental care visits	$3	$4
Hearing aids	$3 per aid	$3 per aid
Chiropractic visits	$1	$3
Podiatry visits	$2	$4
Emergency room visit for non-emergencies (no copay for emergency services)	$3	$8
Outpatient hospital visit	$2	$4
Inpatient hospital visit (does not apply to emergent admissions)	$50	$100

**Copay amounts subject to change*

These groups are exempt from copay requirements:

- Beneficiaries under age 21
- Individuals residing in a nursing facility
- Individuals receiving hospice care
- Native American Indians and Alaskan Natives consistent with Federal regulations at 42 CFR 447.56(a)(1)(x)
- Beneficiaries dually eligible for Healthy Michigan Plan and Children's Special Health Care Services

There are no copays for:

- Emergency services
- Family planning products or services
- Any pregnancy-related products or services or if you are pregnant
- Services related to preventive care
- Services related to chronic conditions, such as heart disease and diabetes
- Services received at a Federally Qualified Health Center, Rural Health Clinics, or Tribal Health Centers.
- Mental health specialty services and supports provided/paid through the Prepaid Inpatient Health Plan / Community Mental Health Services Program
- Mental health services provided through state psychiatric hospitals, the state Developmental Disabilities Center, and the Center for Forensic Psychiatry

- Services related to program-specific chronic conditions. A list of these conditions can be found online at **michigan.gov/healthymichiganplan**.

15.05 Dental services

Diagnostic, preventive, restorative, prosthetic and medically/clinically necessary oral surgery services, including extractions, are covered for all Healthy Michigan Plan members.

15.06 Habilitative services

Habilitative services help a person keep, learn or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech language pathology and other services.

15.07 Exclusions

Medicare and other federal or state government programs

- If you obtain Medicare coverage, you will be disenrolled from the Healthy Michigan Plan.

Appendix A

Part 1: Schedule of Benefits

Coverage is only available for services and benefits provided or arranged by the PCP. These services must be needed and approved by Blue Cross Complete. Exceptions do apply. Only services that are medically necessary as determined by the BCC Medical Director or his or her designee are benefits under this Certificate. Blue Cross Complete will only pay for covered services.

A-1. Basic health services

GENERAL CONDITIONS

Physician and consultation services provided or arranged by the primary care physician are covered under this section. Certain exceptions apply; (see emergency services and routine obstetrical and gynecological services). Covered professional services include:

A-1.01 Office visits provided by the Member's primary care physician or a specialist to whom a Member is referred by the primary care physician.

A-1.02 Routine and periodic age/gender specific examinations by the Member's primary care physician.

A-1.03 Women have open access to contracted obstetricians and gynecologists contracted OB-GYNs for annual well woman exams and other routine care and services. However, a referral from a PCP is required before a member may see a specialist for ongoing care.

A-1.04 Pediatric care including well-child care, diagnosis and treatment of illness and injury, and services provided by the Early and Periodic Screening Diagnosis and Treatment Program (EPSDT) as defined by MDHHS.

A well-child examination may include:

- A health and developmental history
- A developmental and behavioral assessment
- Age-appropriate physical examination
- Height and weight measurements and age-appropriate head circumference
- Blood pressure testing for children aged three and older
- Immunization review and administration of appropriate immunizations
- Depression screening
- Behavioral/Social/Emotional screening
- Maternal depression screening
- Newborn bilirubin
- Health education including anticipatory guidance
- Nutritional assessment
- Hearing, vision, and dental assessments, including fluoride varnish and fluoride supplements for infants and children
- Lead toxicity screening for children ages one to five, with blood sample testing for lead levels as indicated, and all related follow-up services
- Tuberculin testing and related laboratory services
- An interpretive conference and appropriate counseling for parents/guardians
- Hepatitis C screening, including information about treatment options, how to prevent transmission to others and drug treatment, if needed

The following EPSDT program services are also covered:

- Diagnosis and treatment for defective vision, including glasses
- Relief of dental pain and infections, restoration of teeth and maintenance of dental health, including dental sealants and fluoride varnish
- Diagnosis and treatment for hearing defects, including hearing aids

- Health care, diagnosis, treatment or other services to correct or improve defects, physical or mental illnesses and conditions discovered during a screening
- Hepatitis B infection risk assessment and any necessary follow-up services
- Hepatitis C screening, including information about treatment options, how to prevent transmission to others and drug treatment, if needed

The following EPSDT services are covered for adolescents:

- Hearing risk assessment
- Tobacco, alcohol or drug use assessment
- Depression and suicide risk screening beginning at age 12
- Screening for Dyslipidemia once between 17 and 21 years of age
- Sexually transmitted infections beginning at age 11
- HIV screening beginning at age 11 and once between 15 and 18 years of age
- Sudden cardiac arrest and sudden cardiac death risk assessment beginning at age 11

If you have not chosen a Blue Cross Complete pediatrician to be your child's PCP and want to take your child to a Blue Cross Complete pediatrician for general pediatric services, including well-child care, you can do so without a referral. Blue Cross Complete may re-assign that pediatrician to be your child's PCP.

A-1.05 Pediatric and adult immunizations in accordance with accepted medical practice.

A-1.06 Surgery during inpatient hospital admission or ambulatory surgery as provided or arranged for by the primary care physician or specialist.

A-1.07 Hospital visits as part of the continued supervision of covered care.

A-1.08 Physician or health professional services including those of anesthesiologists, pathologists, radiologists, and other medical specialists as may be required.

A-1.09 Services for diagnostic evaluation and assessment of infertility are covered, but limited to techniques and procedures approved by Blue Cross Complete. In-vitro fertilization, artificial insemination, intrauterine insemination, reversal of voluntary sterilization, and treatment for infertility are excluded.

A-1.10 Family planning services, birth control and associated physical exams are covered. A family planning doctor or pharmacy can provide condoms to members. Members may self-refer to clinics for these services.

A-1.11 Adult sterilization procedures when performed by a Blue Cross Complete participating provider. Primary care physician referral is required. Sterilization reversals are excluded.

A-1.12 Abortion is covered if it will save the mother's life. Elective abortions are covered if the pregnancy is from a rape or incest. Such elective abortions need a referral by the PCP. Treatment for unexpected issues after an elective abortion is covered. Treatment for spontaneous, incomplete or threatened abortions and ectopic pregnancies is also covered.

A-1.13 Physician services for care before and after the birth are covered. Members may self-refer to a Blue Cross Complete obstetrical or OB-GYN doctor for routine care. These services include prenatal care for low-risk pregnancies. Travel restrictions may apply to coverage of deliveries at the discretion of the approved doctor.

A-1.14 Pregnant members are covered for doula services from Medicaid-enrolled doulas. Doulas provide physical, emotional and educational support. Members can receive up to six total visits from a doula during the pregnancy and postpartum periods, and one visit for birth. Doula services should be provided in person. However, prenatal and postpartum services may be delivered via telehealth.

A-1.15 Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under this law, insurers may not limit benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. Services will be paid for a shorter stay if the provider lets the mother or newborn leave the hospital earlier. Under the law, health insurance companies may not make the later cost of a stay more expensive than the early part of a stay.

In addition, health insurance companies may not require a physician or health care provider to get authorization for prescribing a hospital stay of up to 48 hours (or 96 hours). To use select clinicians or facilities, or to reduce costs, you may be asked to get authorization ahead of time. For information, contact Blue Cross Complete.

A-1.16 RECONSTRUCTIVE SURGERY/PROCEDURES

Reconstructive surgery is performed on the body in order to improve/restore bodily function or correct deformities resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes. Any such procedures must be recommended by the Member's primary care physician and prior authorized by Blue Cross Complete in order to be covered benefits, except as otherwise stated in this Certificate.

Blue Cross Complete provides coverage for established, medical necessary diagnostic, outpatient treatment and rehabilitative services to diagnose and treat breast cancer, as well as the below listed services following a medically necessary mastectomy:

- Reconstruction of the breast;
- Surgery on the other breast to achieve the appearance of symmetry;
- Prostheses; and
- Treatment of physical complications during any stage of the mastectomy, including lymphedemas.

A-2. Preventive services

A-2.01 Routine services such as screenings, vaccinations and well-visits, including:

- Doctor and specialist visits, including chiropractors, podiatrists and nurse practitioners
- Regular or annual well visits
- Vaccines
- Lab work, X-rays and other imaging services
- Allergy testing, treatment and injections
- Family planning, including birth control
- HIV/AIDS testing and treatment of sexually transmitted diseases
- Services from Federally Qualified Health Centers
- Health education programs, including disease management and tobacco cessation
- Nutritional counseling for members who are part of the Maternal Infant Health Program, or when provided in a hospital setting
- Medically necessary weight reduction services, including bariatric surgery
- Emergency and urgent care services
- Rehabilitative therapy, including cardiac rehab, physical, speech and occupational therapies

A-3 Hospital services

Inpatient hospital services and ambulatory surgery are covered services when:

- Admission is ordered by the primary care physician and authorized by Blue Cross Complete; and
- Admission occurs on or after the effective date of this Certificate.

A-3.01 Room and board in a semi-private room.

A-3.02 Private room accommodations only when deemed medically necessary by the Member's attending physician.

A-3.03 All covered services deemed medically necessary by the attending physician.

A-3.04 Delivery and postpartum care.

A-3.05 Use of special care units, including specialized intensive and coronary care units, when deemed medically necessary; and operating or other surgical treatment rooms.

A-3.06 Anesthesia, laboratory, and pathology services.

A-3.07 Chemotherapy, antineoplastic drug therapy as required by Michigan law, and hemodialysis.

A-3.08 Diagnostic tests performed in the hospital in conjunction with the Member's ambulatory surgery or admission to the hospital.

A-3.09 Oxygen and gas therapy, drugs and biological solutions, medical and surgical supplies and equipment, and radioisotopes while in the hospital.

A-3.10 Special diets; radiation therapy, physiotherapy, respiratory therapy, physical, occupational, speech therapy, and other forms of professional therapies while in the hospital.

A-3.11 Whole blood and blood products, including their administration. Fees incurred for voluntary blood giving in autologous transfusion programs are covered.

A-3.12 In-hospital professional care covered services of health professionals, including any medical specialist whose services are covered and deemed medically necessary and ordered by the Member's primary care physician and/or attending physician.

A-4. Emergency services and related services

A-4.01 Definition: Medically necessary services provided to an enrollee for sudden, acute medical symptoms and severe pain that without care could result in:

- Serious harm to the enrollee's health, or in the case of a pregnant woman, her health or her unborn child's health,
- Serious harm to body function, organ, or parts.

Further, emergency services means covered inpatient and outpatient services that are as follows:

- Furnished by a provider that is qualified to furnish these services under this title.
- Needed to evaluate or stabilize an emergency medical condition.

Poststabilization care is covered care that maintains or improves a medical condition after a Member has been stabilized.

Examples of emergency conditions might include but are not necessarily limited to: unusual chest pain or problem breathing; puncture wound or nonstop bleeding; suspected fracture or broken bone; severe bites, burns or blows to the head; and sudden loss of strength or sensation in arms or legs.

Referrals or prior authorization are not required for emergency care. Members may go to any emergency facility.

A-4.02 Procedure: If the Member considers his or her condition to be so serious or life threatening that delay in seeking treatment might cause death, severe injury or serious impairment, the Member should call 911 or seek help from the nearest medical facility as soon as possible.

If they can, Members should contact their primary care physician for medical advice. A Member who can't reach his or her primary care physician may contact Blue Cross Complete for assistance at 1-800-228-8554 24 hours a day, seven days a week.

Members should contact their primary care physician within 24 hours after seeking emergency services (or as soon as they can) to arrange for follow-up medical care.

Follow-up care after an emergency is routine, scheduled care that must be coordinated with the Member's primary care physician.

A-4.03 Ambulance/Emergency Transportation: When necessitated by a need for emergency services as defined above, appropriate ambulance transportation to the nearest hospital where emergency care and treatment or other necessary services can be provided is a covered benefit.

A-4.04 Transportation: When medically necessary nonemergent transportation is provided to members to obtain covered services according to Blue Cross Complete guidelines for nonemergency medical treatment.

A-4.05 Transfers: Ambulance transportation between hospitals when authorized by Blue Cross Complete shall be covered. When a Member receives medical care from a nonparticipating hospital or

facility, Blue Cross Complete may require a Member to be transferred from the nonparticipating hospital or facility to a participating hospital when the Member's medical condition permits.

A-5. Diagnostic and therapeutic services and tests

A-5.01 Diagnostic and therapeutic laboratory, pathology and radiology services and other procedures for the diagnosis or treatment of disease, injury, or medical condition are covered when ordered by the Member's physician and/or arranged by Blue Cross Complete.

Limited psychological testing shall be covered under this section for purposes of assessing developmental status and/or as an outcome measure related to rehabilitation.

A-5.02 Certain genetic assessment services are covered but limited to techniques and procedures approved by Blue Cross Complete.

A-5.03 Allergy tests, treatment, and injections are covered.

A-6. Home health services

A-6.01 Home health services are provided to Members who are homebound due to an illness or injury. Services must be provided or arranged by the Member's doctor or designee. Prior approval is needed. Services must be provided by a Blue Cross Complete contracted provider. Treatment must be intermittent.

Covered home health care includes professional nursing services and skilled care. Home health aides are also covered. Personal care or home help services are not covered. Drugs and biological solutions, surgical dressings and medical supplies that are considered medically necessary for the proper care and treatment of the Member's condition are covered.

A-7. Equipment to support home care

A-7.01 Equipment for home care may be covered when medically necessary. This includes hospital equipment, monitors, and other items used in the home to avoid hospital care and that needs daily oversight from a professional or technician. Equipment must come from an approved provider and ordered by the Member's doctor or designee. Equipment must come from an approved provider, be ordered by the Member's PCP or his designee, and be approved by Blue Cross Complete.

A-8. Physical, occupational, and speech services

A-8.01 Physical, occupational and speech therapy in an outpatient facility is paid up to 36 times in a 90-day period. Outpatient physical and occupational therapy in the home are paid up to 24 visits in 90-days. All services must be requested by a Blue Cross Complete doctor and approved by Blue Cross Complete.

A-9. Cardiac rehabilitation services

A-9.01 Short-term cardiac rehabilitation therapy, when ordered by the primary care physician or his or her designee, authorized by the Blue Cross Complete Medical Director and provided by a participating provider, is a benefit under this Certificate.

A-10. Skilled nursing facility

A-10.01 Short-term restorative services up to 45 days in a 12-month rolling period from first admission of skilled care provided in a nursing home are covered benefits if medically necessary and arranged and approved by Blue Cross Complete. Long-term custodial care is not covered. Those receiving long-term custodial care, as determined by MDHHS, will be disenrolled.

Skilled nursing home visits by doctors as part of continued care are covered. The Member must require skilled care on a daily basis and the services must be provided in a skilled nursing facility. Custodial care is not covered.

Ambulance transportation between a skilled nursing facility and hospital when approved by Blue Cross Complete is covered.

A-11. Hospice

A-11.01 Hospice services are covered when requested by the Member and arranged and approved by Blue Cross Complete. Room and board is included when provided in a nursing home or hospital. Members who have elected the hospice benefit will not be disenrolled after 45 days in a nursing home as otherwise permitted by MDHHS.

A-11.02 Members under 21 years of age may receive hospice care concurrently with curative treatment of the Member's terminal illness. This allows the Member or Member's representative to elect the hospice benefit without forgoing any curative service to which the Member is entitled under Blue Cross Complete for treatment of the terminal condition. The need for hospice care must be certified by a physician and the hospice medical director. Blue Cross Complete will reimburse for the curative care separately from the hospice services. Blue Cross Complete will not reimburse for these types of treatments when they are used palliatively. As such they are the responsibility of the hospice and must be included in the per diem cost.

A-12. Hearing examination and hearing aids

A-12.01 Hearing examinations to determine whether a hearing problem exists are a covered benefit for members. Services provided under this section are covered when medically necessary and in accordance with Medicaid requirements. Services must be ordered by the Member's primary care physician and provided by a participating audiologist.

A-12.02 Hearing aids are covered for members. When a hearing aid is recommended following a hearing examination conducted while a Member of Blue Cross Complete, the following is covered for each Member once each fifth benefit year:

- Hearing aid examination to evaluate the Member for the specific type or brand of hearing aid needed;
- One single hearing aid unit (or one per ear if medically necessary) including earphone (receiver or oscillator), ear mold, necessary cords, tubing, and connections. The hearing aid unit must be a conventional amplification device. It must also be an in-the-ear, behind-the-ear or on-the-body type, and identified as basic to the Member's amplification requirements;
- Fitting of the hearing aid including one follow-up visit to evaluate the performance of the hearing aid and determine its conformance to prescription; and
- For all members, batteries, maintenance, and repair for hearing aids are covered.

A-12.03 Payment: The amount that would be paid by Blue Cross Complete for a conventional hearing aid unit may be applied toward an upgraded aid, if desired by the Member.

A-13. Durable medical equipment, prosthetics and orthotics

A-13.01 Services provided under this section are covered when medically necessary and in accordance with Medicaid requirements. Equipment or devices under this section must:

- Meet established Blue Cross Complete medical necessity screening criteria, and be appropriate for use in the home,
- Be ordered by a Blue Cross Complete-contracted physician,
- Be authorized by Blue Cross Complete, and
- Be obtained through a Blue Cross Complete-contracted DME provider.

A-13.02 Prosthetic devices which aid body functioning or replace a limb or body part and their fitting are covered benefits. Replacement prostheses needed because of growth or normal wear are also covered. Wigs, prosthetic hair, or hair transplants are not covered benefits. Orthotic devices used to correct a defect of body form or function are covered. Orthotics used for stabilization due to medical reasons having the potential to functionally benefit members are covered benefits. Over-the-counter or custom-fitted braces are not covered benefits.

Prosthetic and orthotic equipment or devices under these sections must:

- Meet established Blue Cross Complete medical necessity screening criteria,
- Be ordered by a Blue Cross Complete contracted physician,
- Be authorized by Blue Cross Complete, and
- Be obtained through a Blue Cross Complete contracted P&O provider.

A-13.03 Blue Cross Complete reserves the right to require use of the least costly medically effective durable medical equipment and prosthetic or orthotic devices.

A-14. Disposable medical items and other medical supplies

A-14.01 Items in this section are covered when medically necessary and follow Medicaid rules. Disposable items that are included are urological and ostomy supplies, peak flow meters, alcohol wipes, Betadine, and diabetic supplies. Supplies used in home health care are also covered when ordered by a contracted doctor, approved by Blue Cross Complete and obtained by a Blue Cross Complete contracted provider.

A.14.02 The diabetic management supplies listed below are covered when medically necessary and in accordance with Medicaid requirements.

- Insulin needles and syringes.
- Lancets, test strips, and control solutions.
- Urine strips when medically indicated.
- Blood glucose monitors and batteries.
- External insulin pumps and insulin pump supplies for diabetic patients who on the basis of blood tests are determined not producing insulin themselves.

A-15. Special provisions applicable to organ and tissue transplants

A-15.01 Services provided under this section are covered when medically necessary and in accordance with Medicaid requirements. Organ and tissue transplants which are not considered to be experimental as defined in this Certificate and performed at a Blue Cross Complete contracted facility will be considered on a case-by-case basis when:

- Blue Cross Complete medical necessity screening criteria are met,
- Recommended by a transplant committee at a Blue Cross Complete contracted provider, and
- Approved by Blue Cross Complete's Medical Director.

These types of transplants include: kidney transplants, small bowel transplants, heart transplants, heart-lung transplants, lung transplants, pancreas transplants, cornea transplants, liver transplants, and bone marrow transplants. Organ and tissue transplant procedures, which are considered experimental by Blue Cross Complete, are excluded.

Blue Cross Complete will pay for the hospital, surgical, lab, and X-ray services incurred by a nonmember donor for an approved transplant to a member unless the donor has insurance for such expenses. Blue Cross Complete will not pay donor costs for a nonmember recipient.

A-16. Health services by nonplan providers

A-16.01 Health services rendered by non-plan providers must be requested in writing in advance by the Member's primary care physician and authorized in writing in advance by the Blue Cross Complete Medical Director, except as otherwise stated in this Certificate.

A-17. Mental health and substance use disorder services

A-17.01 Outpatient treatment for mild to moderate health conditions is covered when medically necessary and within the scope of this Certificate. This benefit does not support long-term psychotherapy treatment.

Members may call Blue Cross Complete Customer Service for help locating a provider.

A-18. Oral surgical services

A-18.01 The Member is covered for the following oral surgical services:

- Emergency surgery of the jaw or maxillofacial area due to trauma, accident or injury;
- Diagnosis and treatment of cysts, and benign and malignant tumors of the maxilla, mandible and adjacent structures;
- Hospital and medical expenses for extractions, which must be performed in a hospital as a result of an underlying critical medical condition; and
- Medically necessary medical or surgical management of internal derangements of the jaw as determined by the contracted physician and authorized by Blue Cross Complete.

A-19. Oral health screening and fluoride varnish

A-19.01 As part of the well-child visit (EPSDT), the member is covered for an oral health screen at age 12 months and will be referred to a dentist if dental care is needed.

Fluoride varnish treatments for children up to age 21 are covered. Fluoride may be applied to teeth up to two times a year.

A-20. Chiropractic services

A-20.01 When considered medically necessary and provided by a contracted provider, chiropractic coverage is limited to:

- Manual spinal manipulation and
- Radiological (X-ray) services provided by a chiropractor, limited to no more than one set of X-rays of the spine per year.
- For members under age 18, authorization is required.

A-21. Vision

A-21.01 Routine eye examinations by a Blue Cross Complete-affiliated vision care provider to determine the need for vision correction are covered. One exam is covered every two years.

A-21.02 One pair of clear corrective lenses of any focal type, and eyeglass frames are covered at Blue Cross Complete affiliated vision providers every two years. Sunglasses are not covered.

A-21.03 Replacements for eyeglasses that are lost, broken, or stolen are covered twice per year for members under age 21, and once per year for members age 21 and over.

A-21.04 Contact lenses are covered if the member has a vision problem that cannot be adequately corrected by eyeglasses.

A-22. Podiatry services

A-22.01 Podiatry services that are medically necessary.

A-23. Dental services

A-23.01 Preventive, diagnostic and restorative dental services are a covered benefit for Medicaid members 21 years and older and for all Healthy Michigan Plan members. Members under 21 receive dental services under the Healthy Kids Dental program administered by the Michigan Department of Health and Human Services.

A-23.02 Routine exams and cleanings every six months

A-23.03 Four bitewing X-rays every year

A-23.04 Full-mouth X-rays once every five years

A-23.05 One filling per tooth every two years

A-23.06 Emergency exams, no more than twice a month

A-23.07 Sealants, once every three years

A-23.08 Topical fluoride up to age 21, twice a year

A-23.09 Fluoride varnish up to age 21, twice a year

A-23.10 Crowns, once every five years on the same tooth

A-23.11 Root canal therapy

A-23.12 Retreatment of previous root canal, once per tooth per lifetime

A-23.13 Periodontal evaluation, once every 12 months

A-23.14 Periodontal maintenance, once every six months

A-23.15 Complete and partial dentures, once every five years per arch

A-23.16 Periodontal services, including scaling and root planing, require the dentist to submit a prior authorization request to Blue Cross Complete. Blue Cross Complete will send written notice to the dentist and to the member if the requested treatment is denied.

A-24. Prescription drugs and medicine

A-24.01 Medications that are covered when ordered by a Blue Cross Complete contracted physician are listed in the Blue Cross Complete Preferred Drug List.

A-24.02 Medications covered when obtained at a Blue Cross Complete contracted pharmacy.

A-24.03 Injectable insulin, insulin syringes and needles, contraceptive medications, diaphragms and IUDs are covered Blue Cross Complete benefits.

A-24.04 Certain over-the-counter medicines are covered with a prescription.

A-24.05 All prescriptions are limited to a 34-day supply.

A-24.06 Generic substitution is required when an equivalent generic drug is available and appropriate. Prior authorization is required for coverage of brand products where a generic equivalent is available.

A-24.07 Prior authorization, quantity limits or other restrictions may be required for some medications for coverage.

A-24.08 Off-label prescriptions of drugs approved by the United States Food and Drug Administration are covered, as well as supplies medically necessary to administer the drug.

A-25. Gender affirmation services

A-25.01 Blue Cross Complete covers medically necessary gender affirmation/confirming medical, surgical and pharmacologic treatments and procedures for beneficiaries clinically diagnosed with gender dysphoria. For coverage of gender affirmation surgical procedures, the medical necessity determination must include a mental health evaluation.

A-26. Telemedicine services

A-26.01 Telemedicine services, also called telehealth services, can satisfy the requirement for face-to-face contact between a patient and health care provider for services that can be appropriately provided via a phone or video call.

Part 2: Schedule of limitations and exclusions

Services received by a Member that are not approved by their doctor or approved by Blue Cross Complete, and/or not provided by participating providers or facilities, are not covered benefits. (Certain exceptions apply; e.g., Emergency Services, Section A-3.) All nonmedically necessary expenses tied to excluded services and benefits are not covered.

Even if the Member's doctor recommends these services, Blue Cross Complete excludes services, technology, or drugs which are experimental or being used for experimental purposes, including those approved by the FDA for testing or study on humans. Any service, technology, or drug may not be covered by Blue Cross Complete if it is not recognized as safe and effective for its intended use. Antineoplastic drug therapy is a covered benefit in accordance with Michigan law. For more information, call Customer Service.

A-27. Limited and excluded services

A-27.01 DENTAL SERVICE

Except as indicated in A-23, and services rendered as part of EPSDT, dental service is excluded. Healthy Kids Dental services for members under age 21 are administered by the Michigan Department of Health and Human Services.

A-27.02 SERVICES NOT MEDICALLY NECESSARY

Determination of medical necessity will be a judgment of the Blue Cross Complete Medical Director consistent with the Medicaid program requirements. Except as expressly provided herein, services which are not medically necessary are not covered under this Certificate.

A-27.03 SERVICES REQUIRED BY OTHERS

Except as provided in Section A-1, office visits, examinations, treatment, drug testing, employment-related examinations, and other services that are required by third parties to document health status or for other required purposes are not benefits.

A-27.04 ELECTIVE COSMETIC SURGERY/PROCEDURES

Cosmetic surgery to change the way you look is not covered. If it's done at the same time as surgery for a medical issue, it's not covered unless Blue Cross Complete determines that it's medically necessary. Hair transplants are not covered.

A-27.05 CUSTODIAL OR DOMICILIARY CARE

Custodial or domiciliary care is excluded.

A-27.06 PRIVATE DUTY NURSING SERVICES

Private duty nursing services are excluded.

A-27.07 NONMEDICAL SERVICES

Nonmedical services such as on-site vocational rehabilitation and training or work evaluations, home or worksite environmental evaluations, or related employee counseling are excluded.

A-27.08 EXPERIMENTAL/INVESTIGATIONAL DRUGS, PROCEDURES OR EQUIPMENT

All experimental/investigational drugs, procedures or treatment are excluded.

A-27.09 OTHER NONSTANDARD MEDICAL PROCEDURES

Procedures and treatments which are not considered standard practice by Blue Cross Complete or which are primarily educational in nature are not covered, e.g., biofeedback, acupuncture, hypnosis, PMS, dyslexia, caregiver training programs; extended behavior modification programs for chronic mental illness; exercise programs, etc.

A-27.10 PERSONAL AND CONVENIENCE ITEMS

Personal and convenience items are excluded.

A-27.11 OTHER COVERAGES

Treatment is excluded for any injury or sickness on which and to the extent any benefit settlements, benefit payments, awards, or damages are received or payable under Worker's Compensation, any insurance plan, or state or federal legislation, Community Mental Health Agencies or other third party payer.

A-27.12 MENTAL HEALTH

Treatment for chronic mental health is excluded except for an acute episode. Long-term psychotherapy is not a benefit. Partial hospitalization in a care program is not covered. Inpatient psychiatric care is not covered. Court ordered examinations to determine competence and the costs of expert witness testimony as to the mental condition of a Member are excluded.

A-27.13 SUBSTANCE ABUSE SERVICES

Substance abuse care is not covered. Substance abuse services are available to Members through their local substance abuse agencies. If you need assistance, please contact Customer Service.

A-27.14 REPRODUCTIVE SERVICES

Reversal of voluntary sterilization, including tubal reanastamosis, is not a benefit. Services for treatment of infertility are not covered.

Assisted Reproductive Technologies (ART) including, but not limited to: artificial insemination, intrauterine insemination, in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), donor egg/donor sperm programs, cryology, micromanipulation, and any related diagnostic and therapeutic services unique to these technologies are excluded from coverage.

A-27.15 AUTOMOBILE ACCIDENTS

Benefits are not provided for services for treatment of any automobile related injury for which the Member's health care expenses are covered under an automobile insurance policy (see Section 11).

A-27.16 WEIGHT REDUCTION

Programs for weight loss and weight control are not covered. There is some coverage when life-endangering problems caused by weight exist. If conservative weight control options have failed, other options may be approved. Your doctor must get prior approval from Blue Cross Complete.

A-27.17 FORMS

Physician and professional staff time required for the completion of forms unrelated to medical care provided is excluded.

A-27.18 CHARGES FOR MISSED OR NO-SHOW APPOINTMENTS

Fees imposed by a health care facility for a missed or no-show appointment are not covered by Blue Cross Complete and are the financial responsibility of the patient.

A-27.19 ROUTINE FOOT CARE

Podiatry services that are not medically necessary.

A-27.20 VISION SERVICES

Not covered except as indicated in A-20.

A-27.21 SPECIAL FOOD AND NUTRITIONAL SUPPLEMENTS

Food and food supplements are not covered, except for enteral feedings when they are the sole means of nutrition or when used as part of the Maternal Infant Health Program (MIHP).

A-27.22 DURABLE MEDICAL EQUIPMENT, PROSTHETICS, AND ORTHOTICS

Excluded from coverage are: replacement and/or repair of any covered item due to misuse, loss or abuse; experimental items; comfort and convenience items such as, but not limited to, over-bed tables, electric heat pads, exercise equipment, adjusta-beds, air conditioners or purifiers, whirlpools, and elevators. Also excluded under this section are any durable medical equipment, prosthetics and orthotics excluded from coverage by MDHHS.

A-27.23 SECOND OPINIONS

Members may get a second opinion about treatment a Blue Cross Complete doctor thinks the member should get. Members may seek prior authorization for a second opinion with an out-of-network or out-of-state provider. A second opinion with an in-network provider often doesn't require prior authorization. Members interested in seeking a second opinion can call Customer Service for assistance.

A-27.24 PHYSICAL EXAMINATIONS REQUIRED FOR SCHOOL, CAMP, OR MARRIAGE LICENSE APPLICATIONS

Physical examinations for school, for camp registration, or in connection with a marriage license application are excluded.

A-27.25 ELECTIVE ABORTIONS

Elective abortions are not covered unless the pregnancy is the result of rape or incest, and requires referral by the primary care physician. Treatment for medical complications occurring as a result of an elective abortion is covered.

A-27.26 SELECT PRESCRIPTION DRUGS

Blue Cross Complete does not provide coverage for certain types of medications and medical supplies. The following drugs are not provided through Blue Cross Complete unless otherwise specified by the formulary:

- Drugs that require prior authorization, but are not prior authorized by Blue Cross Complete before the drug is dispensed
- Drugs used to promote smoking cessation that are not on the Michigan Pharmaceutical Product List (MPPL)
- Vitamins and mineral combinations unless prescribed for end stage renal disease, pediatric fluoride supplementation, prenatal care or children enrolled in Children's Special Healthcare Services
- Drugs used for the symptomatic relief of cough and colds
- Cosmetic drugs or drugs used for cosmetic purposes
- Drugs used for infertility
- Drugs used for sexual dysfunction
- Drugs used for the treatment of substance abuse
- Drugs used for anorexia or weight loss (unless authorized)
- Food supplements and standard infant formulas
- Drugs that are not approved by the FDA
- Drugs used for experimental or investigational purposes
- Drugs prescribed specifically for medical studies
- Prescriptions filled after you are no longer a Blue Cross Complete member
- Prescriptions that provide more than a 34-day supply beyond your termination date, except for oral contraceptives
- Drugs included as a health care medical benefit, such as vaccines and other injectable drugs that are normally administered in a physician's office
- Drugs covered by another plan, including Medicare Part D
- New drugs not yet added to the formulary
- Drugs recalled by the labelers, and drugs discontinued past one year ago
- Drugs acquired without cost to the providers or included in the cost of other services or supplies
- Drugs used for HIV (coverage is provided by the state of Michigan)
- Drugs used for certain types of mental illness (coverage is provided by the state of Michigan)
- Compounded products that contain bulk powders (unless authorized)
- Prescriptions that have been adulterated or are fraudulent

Some drugs provided by the state of Michigan are not covered by Blue Cross Complete. Members may refer to michigan.fhsc.com for more information about these drugs.

- Drugs used for HIV infection
- Drugs used for seizure disorders
- Drugs used for sleep disorders
- Drugs used for mental health

A-27.27 LAW ENFORCEMENT CUSTODY

Care rendered while the Member is in the custody of law enforcement officials, except for off-site inpatient hospitalization consistent with MDHHS policy, are excluded.

A-27.28 ILLEGAL SERVICES

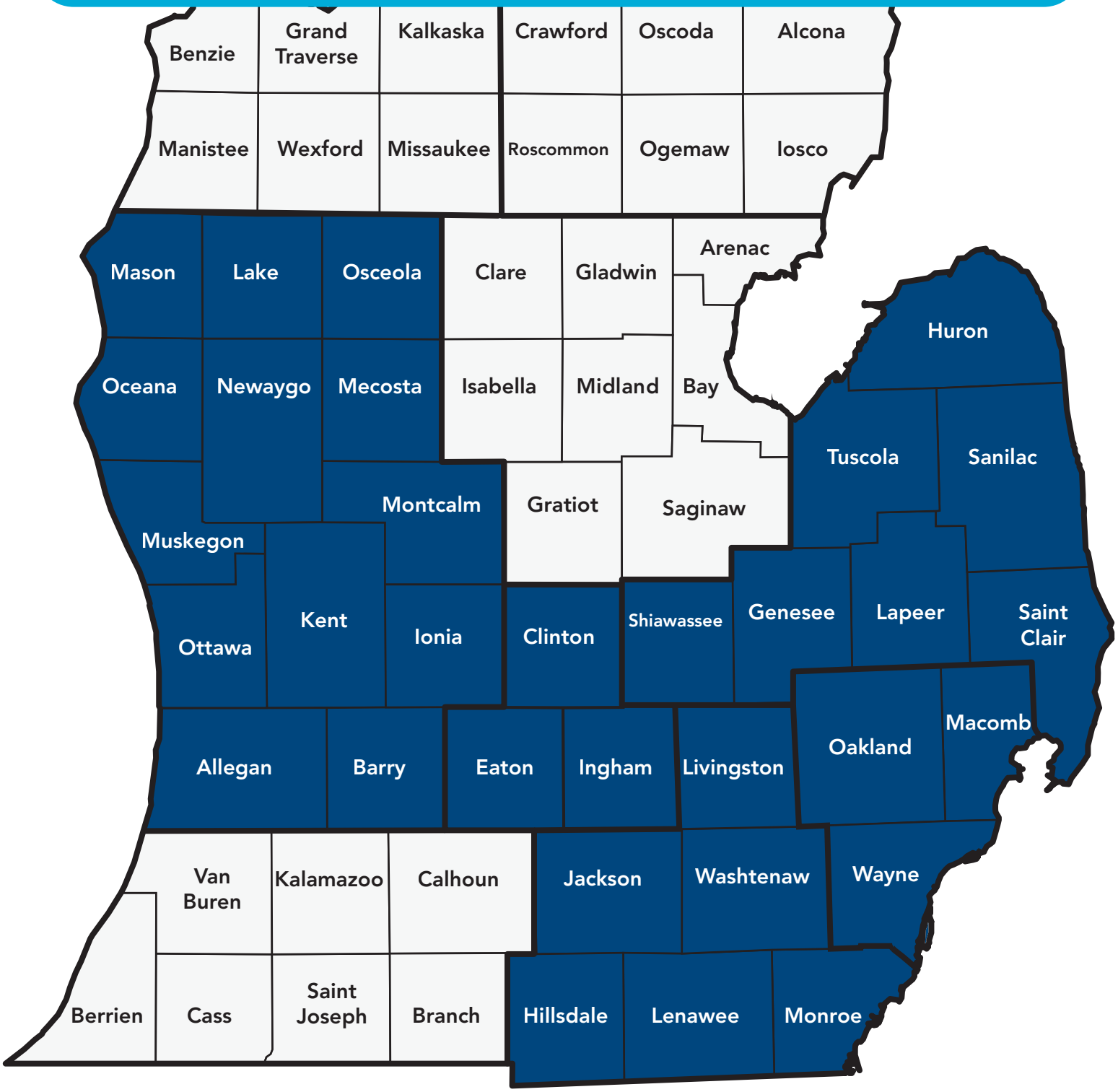
Services that are illegal are excluded.

A-27.29 COURT RELATED SERVICES

Pretrial or court testimony and the preparation of court related reports are excluded.

Blue Cross complete of Michigan

Service Area



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