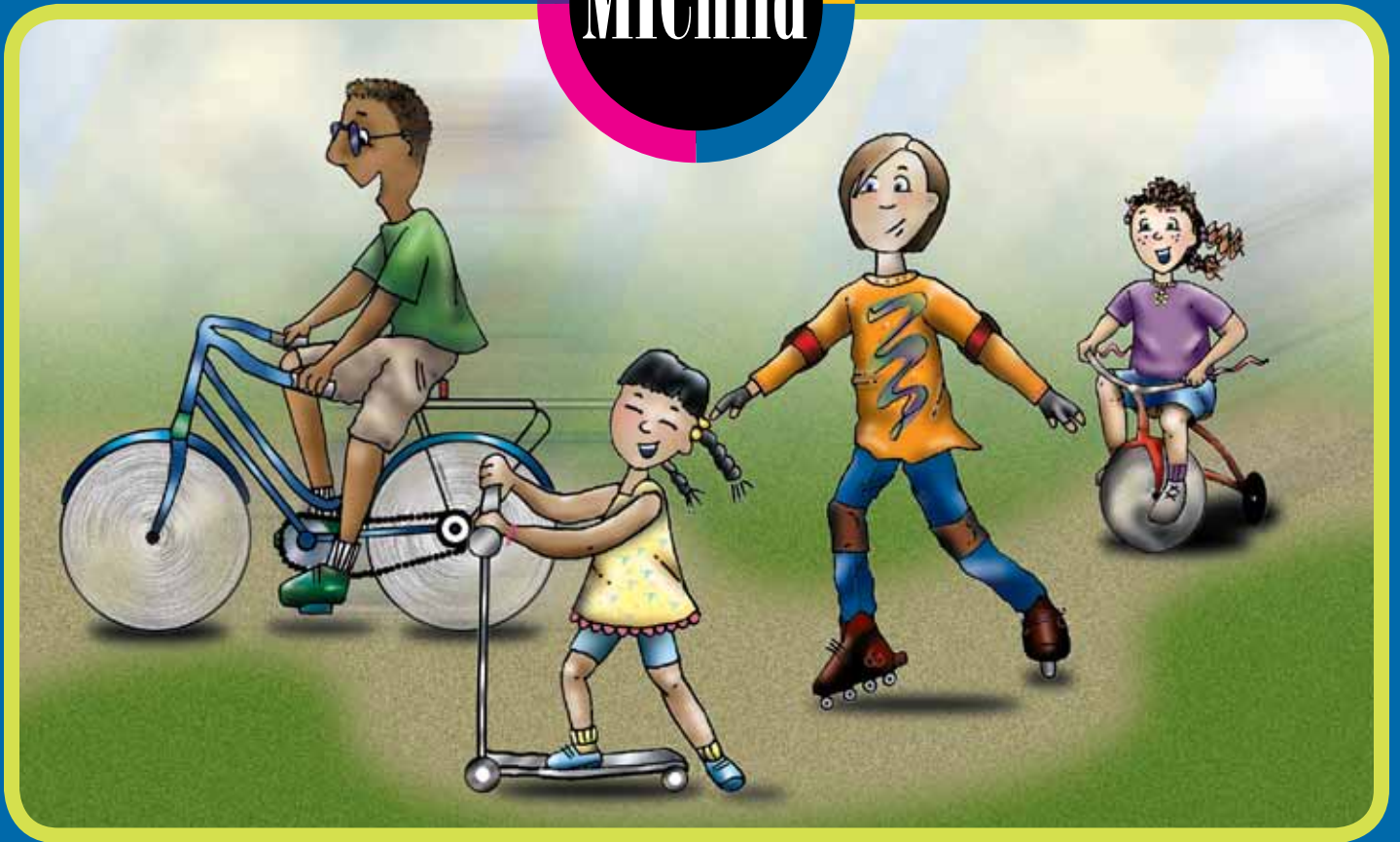


PPO Health Care Plan Member Handbook

MIChild



Blue Cross
Blue Shield
of Michigan

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

THANK YOU

for choosing Blue Cross Blue Shield of Michigan's PPO plan as your child's health care plan.

This handbook describes your child's health care plan. Please read it. Make sure you understand what's

covered, how often it's covered, and if you have to pay anything.

If you have any questions about

the health care plan after reading this book, please call us before your child receives health care services at 800-543-7765.

Again, welcome to Blue Cross Blue Shield of Michigan. We're happy to have you as part of the Blues family.



How to reach us

By phone

Call us toll-free at **800-543-7765**, Monday through Friday, 8:30 a.m. to 5 p.m.

By letter

Be sure to include your child's name and contract number when you write us at:

Lansing Service Unit
Blue Cross Blue Shield of Michigan
P.O. Box 80380
Lansing, MI 48909-0380

Special services

Anti-Fraud Hotline..... 800-482-3787

BlueHealthConnection® 800-775-BLUE (2583)

Hearing-Impaired Customers
with TDD Equipment 800-240-3050

Human Organ Transplant Program 800-242-3504

Heritage Vision Plans 800-252-2053

Web site address

bcbsm.com

See the back cover for a list of walk-in service centers.

Welcome to the MIChild health plan

Thank you for choosing Blue Cross Blue Shield of Michigan's PPO plan for your child's health care needs.

This *PPO Health Care Plan Member Handbook* will show you how to use your child's health plan. It tells about your child's medical, vision, hearing and prescription drug benefits. It also explains dental care benefits if you chose BCBSM for your child's dental coverage.

We offer tips and other helpful things for you to know in this book. Watch for boxes like those below.

Please read this book before your child needs to go to a doctor or dentist. To learn more about your child's benefits, please look at the charts starting on page 17. If you want to know more, ask for a BCBSM MIChild certificate. To get a copy, please call Customer Service at 800-543-7765.

You can take your child to any BCBSM PPO doctor or a dentist in our network. To find one near you, visit our Web site at bcbsm.com or call Customer Service at 800-543-7765.

Thank you again for choosing BCBSM. We hope your child enjoys a lifetime of good health.

important!

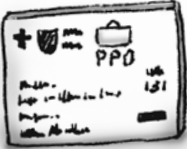
Look for boxes like this for information you'll need to use the MIChild health plan.

tip:


Look for boxes like this for helpful suggestions.

How to get the most from the plan


You'll get the most from your child's BCBSM PPO plan if you do the following:



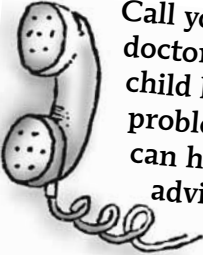
Keep your child's BCBSM ID card with you
 Show it at the doctor's office, hospital, or anywhere your child gets treated.



Choose PPO doctors and hospitals
 You'll pay less (or nothing) if your child goes to a PPO doctor or hospital. The BCBSM PPO network is large. All general hospitals in Michigan are in the BCBSM PPO network. Always ask your child's doctor if he or she is in the PPO network. You can find a PPO doctor by visiting the BCBSM Web site at bcbsm.com, or by calling BCBSM at 800-543-7765.




Make sure your child gets checkups
 BCBSM's health and dental care plans work to keep your child well. Plan a checkup for your child with the PPO doctor while your child is healthy. This way, your child's doctor gets to know you and your child. The plan pays for services to keep your child healthy.

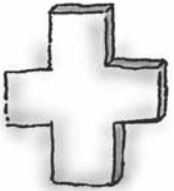


Call your doctor first
 Call your child's PPO doctor first when your child has a health problem. The doctor can help you or give you advice over the phone.

Know your child's benefits
 What you don't know about your child's health and dental care plan could cost you money. Use this book so you'll know which services are covered and which are not. Learn what *in-network* and *out-of-network* mean and when you'll have to pay for services. Get to know your child's benefits before a health problem happens.



Use emergency rooms only for emergencies
 When your child has a serious medical problem, the emergency room is the best place to go. But when the problem isn't serious call your BCBSM PPO doctor or BlueHealthConnection® for help.



Call BlueHealthConnection® with questions

Use BlueHealthConnection along with what your child's doctor says when you have a question about your child's health.

Call **800-775-BLUE (2583)** to talk with a nurse.

BlueHealthConnection®

Immunize!

Make sure your child gets his or her shots to stay healthy. Use the handy chart on page 16 in this book to keep on track.

Age	2 Months	4 Months	6 Months	12-15 Months	18-24 Months	4-6 Years	11-16 Years
Hib	DTaP	DTaP	DTaP	HepA	DTaP	DTaP	Td
Polio	IPV	IPV	IPV	IPV	IPV	IPV	IPV
HepB	HepB	HepB	HepB	HepB	HepB	HepB	HepB
MMR	MMR	MMR	MMR	MMR	MMR	MMR	MMR
MMR2							
Tdap							
Tdap/IPV							

See page 16

Blue365® helps you make healthy choices

Blue365 is a program that helps members make healthy choices every day. It provides special member discounts.

It also gives access to health and wellness resources.

Blue365 has four main categories: Health and wellness, family care, financial well-being and travel.

Check your child's medical bills

Doctor's offices and hospitals can make mistakes, so look at your child's bills closely. Make sure the bill is for services your child got. If you find a mistake, let the doctor or hospital know about it right away.

If you think your doctor or hospital is billing us for services your child didn't get, or that someone else is using your child's card, call our Anti-Fraud Department at **800-482-3787**.

No one else will know that you've called.

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MEMBER RIGHTS AND RESPONSIBILITIES

As a member of the MIChild PPO health plan, you can choose to take your child to any BCBSM PPO doctor. If you have more than one doctor, ask them to talk or write to each other about your child's care.

You have the following rights and responsibilities:

Member Rights*:

- To get quality health care
- To get information about what health care services are covered
- To get information about your health care providers
- To work with your doctors to make health care decisions
- To discuss all treatment options with your doctor, even those that are not covered by MIChild or are expensive
- To say that you don't want certain care
- To file a complaint or appeal if you have problems with payments for health care services
- To be treated with dignity and respect
- To receive necessary health care on time
- To have your medical records kept confidential and your privacy protected
- To make suggestions about member rights and responsibilities policies
- To ask for and receive information regarding physician incentive plans

Member Responsibilities:

- Follow the advice of your doctors
- Keep appointments and give advance notice to doctors if you cannot make them
- Give your doctor complete, honest information about your child's medical history and any illness he or she may have at the time of the appointment so the doctor can give the care your child needs
- Pay your doctor for services that are not covered
- Follow rules about getting care from doctors who are in the PPO network or getting a referral to a doctor who is not in the network if that is needed
- Tell MIChild about any membership changes that may affect your child's health care insurance
- Understand your child's health problems so you and the doctors can set treatment goals for him or her

*BCBSM is committed to complying with all requirements concerning member rights.

MICChild membership information

To start

Call MICChild at **888-988-6300** if you have any questions about your child's membership information or to report any important changes to your child's name, address, phone number or other important information.

Changing your child's records

Tell MICChild about any changes to your family, like:

- Marriage
- Death
- Birth
- Adoption
- Name changes
- Address changes
- The child goes into the military
- The child goes to prison
- The child goes to a hospital for a mental condition or disability
- The child is able to get another insurance

tip:

Call MICChild at **888-988-6300** if:

- You have any changes that may affect your child's health care insurance
- Your family gets larger or smaller
- You want to take your child out of the MICChild program

Proof of coverage

When your child's MICChild health plan ends, he or she will get proof that MICChild once covered him or her. Give this proof to your child's new health plan to see if the new plan will cover illnesses your child may have had before being part of the new plan.

Ending your child's coverage

Your child is in MICChild for one year, unless:

- You don't pay the MICChild bill
- The child goes to prison or a place for the mentally disabled
- The child moves from Michigan
- The child dies
- The child gets Medicaid
- The child turns 19 years old
- The child can get another insurance



To take your child out of the MICChild program, call **888-988-6300**.

Other MICChild services

BCBSM doesn't provide mental health and drug abuse care for your child. Call MICChild at **888-988-6300** if your child needs mental health or drug abuse help, or if you have any questions about these services.

General information

Your child's ID card

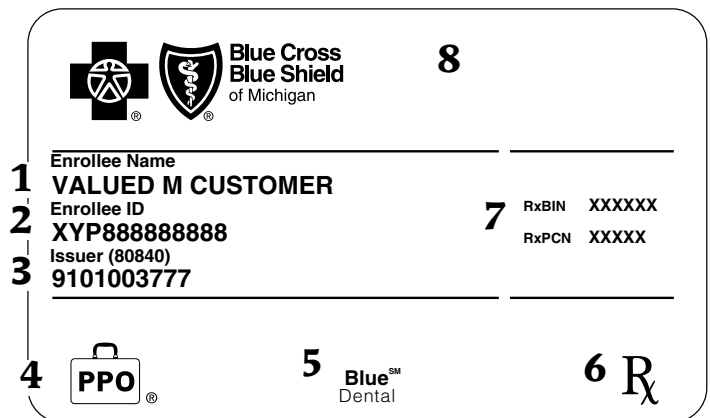
You'll get a BCBSM ID card after your child joins the PPO plan. Use it when your child needs to go to a doctor, hospital, dentist or needs a prescription filled. The numbers on the card, especially the "enrollee ID," are used to check your child's benefits. Each child gets his or her own ID card. Only the child whose name appears on the card can use the MICHild care plan.

Here are some tips about your child's ID card:

- Always take the ID card with you when your child needs health or dental care or needs a prescription.
- Only the child who's enrolled in this plan can use the ID card. It's against the law to let anyone else use it.
- Call us right away if your child's ID card is lost or stolen. You can get a new card free.

If your child's card is lost or stolen and your child needs care, give your child's "enrollee ID" to the physician, dentist or hospital.

- 1 This is the name of the person who holds your contract.
- 2 Enrollee ID identifies your record in our files.
- 3 Issuer number identifies Blue Cross Blue Shield of Michigan.
- 4 A suitcase may appear here, which informs providers about your travel benefits.
- 5 A dental plan logo will appear here.
- 6 A drug plan logo will appear here.
- 7 A drug plan number will appear here.
- 8 A product name may appear here.



Your child's ID card includes a magnetic stripe on the back. It includes information from the front of the card and your child's birth date. It does not contain any benefit or health information.

The back of the ID card also includes helpful phone numbers.

Paying benefits

To understand your child's health plan, you'll need to know some common insurance language.

Under your child's health insurance, the services and supplies that we'll pay for are called **benefits**. For example, if your child has a broken leg we'll pay for your child's X-ray, which is a service, and we'll pay for crutches, which are supplies. When we say that a **benefit is covered**, we mean that we'll pay some or all of the bill for that service or supply. The amount we'll pay for a benefit is called the **approved amount**. If a **benefit is not covered**, we won't pay anything for it.

For some of your child's benefits, you may have to pay a little every time your child gets care. This is called a copayment or copay. For example, you'll have to pay a copayment (20% of what we'll pay, or our approved amount) if you take your child to see a doctor that's not in our PPO network. Another example is that you'll have to pay 50% of what we'd pay for a private duty nurse. We'll pay the rest if it's a covered service.

important!

Benefits (services and supplies we may pay for):

- **Covered benefit** – We'll pay some or all of the bill for the service or supply.
- **Not covered benefit** – We won't pay any of the bill. You'll be responsible for paying the entire service or supply.
- **Approved amount** – The amount we'll pay for a service or supply.
- **Copayment (copay)** – The amount you may have to pay when your child gets care.

Customer service

Call your BCBSM Customer Service office when you have a question about your child's benefits. We've listed the phone number below and on the inside front cover of this book. The addresses of our walk-in service sites are on the back of this book.

tip:

Call BCBSM's Customer Service at 800-543-7765 if you have any questions.

To get the best service when you contact us, remember:

- Have your child's contract number.
- If you have a question about care that your child has already received, be ready to tell us:
 - Your child's name
 - Your child's doctor's name
 - When your child was treated
 - Type of service (like "office visit")
 - Charge for each service
- When you write to us, please put your child's contract number on each page. Keep a copy for your records of everything you've sent us.
- When you come into a BCBSM customer service office, please bring a copy of all of your child's bills, forms and anything else that you think will help us solve your child's health care payment problem.



Continuing BCBSM coverage on your own

When your child can't be in the MICHild health care plan anymore and doesn't qualify for Medicaid, you may have other options. Your child can still get some of the services paid for by changing to a health plan called Group Conversion that's just for him or her. The plan may not pay for all of the services that the MICHild plan does.

BCBSM offers Group Conversion. To see if your child can be put into one of these plans, send a letter to BCBSM no more than 30 days after the MICHild plan ends.

For more information on how to apply for these BCBSM plans, call BCBSM at **800-543-7765**.

Make sure this information is correct. If not, call BCBSM.

Explanation of benefits

We'll send you an explanation of benefit payments form every time we get a claim under your child's contract number. The EOB form isn't a bill. It's more like a receipt. The EOB shows what we've paid and what you may have to pay. If we didn't pay for something, the EOB will tell you why.

Please read the EOB carefully. It's very important that you let us know if your child didn't get the services that are listed on it, or if there are any problems.

Here's a sample of how your child's EOB may look:

EXPLANATION OF BENEFIT PAYMENTS
THIS IS NOT A BILL

Statement Date: 06/14/01

||||| 31295-000
KXZKX XLXZXBXQH Z
0110 LXVDHXL M
WHITE LK MI 48383-1419

Your Customer Service Phone Number Is:
NATIONWIDE TOLL-FREE 1-800-543-7765

Send Written Inquiries to this Address:
BLUE CROSS BLUE SHIELD OF MICHIGAN
LANSING SERVICE UNIT
P.O. BOX 80380
LANSING MI 48909-0380

Group Name: MICHILD
Group Number: 31295-000
Subscriber Name: KXZKX XLXZXBXQH Z
Contract Number: 111254406
Coverage: HOSPITAL/PHYSICIAN

See your Health Care Benefits Certificate or Benefits Guide for details on contract coverage.

Patient Name or Initial: BRXXV
Patient Birth Month/Year: 10/86

Summary of Balances (See Detail on Services)

Name of Hospital, Physician or Provider	Total Provider Charges	(-) Less BCBSM Paid	(-) Less Participating Provider Savings	(-) Less Other Insurance Paid	(=) Equals Your Balance*
PONTIAC GENERAL	57.00	40.20	16.80	0.00	0.00
Totals:	\$ 57.00	\$ 40.20	\$ 16.80	\$ 0.00	\$ 0.00

* Note: The amount in the "Equals Your Balance" column includes any copayments, deductibles, sanctions and non-covered charges.

Summary of Deductibles and Copayments (These totals are based on our information to date and may not reflect all outstanding claims.)

Totals for: BRXXV 01/01/01 to 12/31/01

Deductible required for year: \$ 0.00
Deductible applied year to date: \$ 0.00

Detail on Services Contract Number: 111254406 Patient: BRXXV

Service Date (From/To): 03/13/01	Total Charge.....	\$ 57.00
Claim Received on: 05/16/01	Amount approved by BCBSM for this service.....	40.20
Provider Name: PONTIAC GENERAL	Minus copayment.....	0.00
Provider Status: PARTICIPATING	BCBSM processed on 05/16/01 and paid provider.....	40.20
Referring Provider:	Savings because provider participated with BCBSM.....	16.80
Service Type: FIRST AID CARE	Total Covered.....	\$ 57.00
Procedure: EMERGENCY DEPT VISIT		
Procedure Code: 99282		
Claim Number: 75368732762	Your Balance: (Highlighted Amounts)	\$ 0.00



This is an example of how much you'd have to pay the doctor.

How your child's PPO plan works

Here's how the BCBSM PPO plan works. To understand your child's health insurance, you'll need to know some PPO insurance language.

Under your child's PPO health insurance, a **PPO network** provider has agreed to take care of patients in BCBSM's PPO plan. When your child needs medical care, call a doctor in our **PPO network**. These include adolescent and Indian health centers. **PPO network** providers **participate** with BCBSM.

Some doctors or hospitals **participate** with BCBSM but **aren't** in the **PPO network**. These doctors and hospitals are called **out-of-network providers**.

Preventive care services (like checkups and immunizations) aren't covered if they are provided by a doctor who is not in the PPO network.

Some doctors or hospitals do not **participate** with BCBSM. These are called **nonparticipating providers**. Providers that don't **participate** with BCBSM have not signed an agreement with us. If your child receives services from a **nonparticipating provider**, you may have to pay the doctor or hospital directly. You may then have to send a claim to BCBSM. We'll pay you up to 80% of the amount we would have paid if the provider participated with BCBSM.

To find a BCBSM PPO network doctor or hospital:

1. Call BCBSM's customer service office at **800-543-7765**.
2. Visit the BCBSM Web site at **bcbsm.com**.
3. Ask your child's doctor or hospital if they're part of BCBSM's PPO network.
4. Use the BCBSM MICHild Provider Directory.

tip:

You don't have to let BCBSM know if you want to change doctors.

BCBSM PPO network doctors and hospitals

To get benefits at the in-network level, your child must go to a doctor or hospital that belongs to BCBSM's PPO network. Network doctors have made an agreement with BCBSM to take our approved amount as the full payment. This means that you only pay for services that aren't covered by your child's plan.



Section 3: HOW YOUR CHILD'S PPO PLAN WORKS

Here are some examples that show how your child's plan works.

In-network (PPO)		
If this happens	and	then all of these will happen
Your child goes to a doctor or hospital	The doctor or hospital is part of the PPO network	<ul style="list-style-type: none"> – Your child is treated and BCBSM pays for covered services. – You file no claim forms. – You pay nothing.
Out-of-network (PPO) with a referral		
If this happens	and	then all of these will happen
Your child goes to a doctor or hospital	<ul style="list-style-type: none"> a. The doctor or hospital is part of the PPO network, but b. Suggests another doctor or hospital that isn't part of the PPO network 	<ul style="list-style-type: none"> – Before your child receives services, your child's PPO doctor or hospital must give you a written referral for your child and you must give the referral to the new doctor. – Your child is treated and BCBSM pays for covered services. You file no claim forms. – You pay nothing.
Out-of-network (not PPO network, but participates with BCBSM)		
If this happens	and	then all of these will happen
Your child goes to a doctor or hospital	<ul style="list-style-type: none"> a. The doctor or hospital is not part of the PPO network b. You don't have a written referral but c. The doctor or hospital participates with BCBSM 	<ul style="list-style-type: none"> – Your child is treated for covered services. – You file no claim forms. – You pay the doctor or hospital 20% of our approved amount.
Out-of-network (not PPO network and does not participate with BCBSM)		
If this happens	and	then all of these will happen
Your child goes to a doctor or hospital	<ul style="list-style-type: none"> a. The doctor or hospital is not part of the PPO network b. The doctor or hospital does not participate with BCBSM 	<ul style="list-style-type: none"> – Your child is treated for covered services. – You pay the entire bill. – You file the claim forms. – We will pay you up to 80% of the amount we would have paid the doctor or hospital if the doctor or hospital had been participating with BCBSM. – If a hospital doesn't participate with BCBSM or their local BCBS Plan, we'll only pay for emergencies. (If it's not an emergency, we won't pay anything. See page 8 for rules about approved emergency care.) – You'll have to pay any difference between what we've agreed to pay and what the doctor or hospital has actually charged.

Service providers that are not in BCBSM's PPO network

We don't have any PPO networks for some health care provider types. If your child receives services from these provider types, **you may not have to pay anything if the provider participates with BCBSM.** These provider types may include:

- Ambulance companies
- Ambulatory surgical facilities
- Private duty nurses
- Nurse anesthetists
- Nurse midwives
- Nurse practitioners
- Home health care
- Optometrists*

If these services are needed, be sure to contact BCBSM's customer service office at **800-543-7765** for more information.

Out-of-network payment limit

Once you've paid \$2,000 per child in one calendar year because an out-of-network doctor or hospital (for general services) treated your child, you don't have to pay any more for the rest of that year. But you can't use the following to add up to the \$2,000:

- Private duty nursing copays
- Charges for services that aren't covered
- Doctor's and hospital's charges that are more than the amount we've approved

Emergency care

We know that medical emergencies happen. But you can be ready for them by knowing your child's emergency coverage before he or she needs them. Start by keeping these phone numbers handy:

- Your child's doctor's office
- Your child's doctor's after-office hours
- The closest emergency room
- Poison control center (**800-222-1222**)
- Ambulance or paramedic rescue squad if 911 services are not available in your area
- BlueHealthConnection (**800-775-2583**)

What's emergency care?

When your child needs emergency care for a serious medical condition, take him or her to any hospital or call 911. How can you tell if the medical condition is an emergency? If your answer is yes to any of the following questions, then it's an emergency.

- Did it happen suddenly?
- Was it something that you didn't expect, like an accident?
- Is the condition dangerous enough that if your child isn't treated immediately, it'll cause serious injury or threaten his or her life?



*Medical services only

We'll cover emergency care for two types of problems:

Accidental injuries – When your child is hurt so badly that he or she may stay sick or die. Examples include broken bones, sprains, severe cuts, poisoning and burns.

Medical emergencies – When your child suddenly gets so sick that you think he or she may die. Examples may include sudden pain.

If you're not sure that it's an emergency, call your doctor for advice. If your doctor isn't available, you can always call BlueHealthConnection at **800-775-BLUE (2583)**.

How much we'll pay for emergency care

Emergency care at a hospital that participates with Blue Cross

If your child goes to the hospital for a true emergency, in or out of Michigan, we'll pay the Blue Cross Blue Shield participating doctors and hospital. You won't have to pay anything.

If your child stays in the hospital, you won't have to pay anything for services as long as they are provided by a PPO doctor.

If your child goes to the hospital and it isn't a true emergency, we'll pay little or none of the bill. You'll have to pay some or all of the total bill.

Emergency care at a hospital that does not participate with Blue Cross

Only services needed to treat an accidental injury or medical emergency are covered at hospitals that do not participate with BCBS. If services received at a hospital that does not participate with BCBS are not for an emergency, they are not covered.

If your child goes to the hospital for a true emergency, we'll pay some of the emergency room bill even if the hospital does not participate with BCBS.

However, if your child stays in the nonparticipating hospital after being treated in the emergency room, we'll pay:

- Up to \$70 a day for a general hospital
- Up to \$15 a day for a specialty hospital




Emergency care at an outpatient location that does not participate with Blue Cross

If your child receives emergency care at an outpatient location that does not participate with BCBS, we'll pay up to \$25 per condition.

We'll pay \$25 for an ambulance. You'll have to pay the rest.

With your BCBSM PPO health care plan, you choose what's best. The following examples will guide you through some of your choices.





Preventive care by a doctor that's in the BCBSM PPO network

<p>Michael needs a checkup.</p> <p>Dr. Jones is in the PPO network.</p> <p>I'll make an appointment for him to see Dr. Jones in his office.</p>	<p>Hello. I'd like to bring my son in for a well-child exam.</p> <p>Does the doctor still take BCBSM PPO?</p> <p>Yes. Good, we can come in tomorrow.</p> 	<p>AT THE DOCTOR'S OFFICE...</p> <p>Hi Michael. I'm Dr. Jones. I'm glad your mom brought you in for a checkup. Now I can get to know you while you're healthy. I'll be happy to answer any questions you and your mom may have.</p> 	<p>May I see your child's insurance ID card?</p> <p>Your child has BCBSM PPO. The doctor is a part of their PPO network, so you have nothing to pay and no forms to send.</p> 
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What happened...

BCBSM paid for Michael's checkup because his mom took him to a doctor that was in our PPO network. Michael's mother knew Dr. Jones was in the PPO network because she checked the BCBSM Web site and asked the doctor.

Preventive care by a doctor that's not in the BCBSM PPO network

<p>Regina needs a checkup for daycare.</p> <p>I'll just take her to the doctor up the street, Dr. Savinski.</p> <p>I'll give her a call.</p>	<p>Hello. I'd like to bring my daughter in for a checkup.</p> <p>Yes, we can come in tomorrow.</p> 	<p>AT THE DOCTOR'S OFFICE...</p> <p>Hi Regina, I'm Dr. Savinski. I'm glad your mom brought you in for a checkup. Let's check you out.</p> 	<p>May I see your child's insurance ID card?</p> <p>I'm sorry, we don't take BCBSM PPO.</p>  <p>Oh no. Because I didn't take my daughter to a doctor in the PPO network, her checkup isn't covered. Now we'll have to pay the whole bill.</p> 
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What happened...

Regina's checkup wasn't covered because Regina didn't go to a PPO network doctor. Her mother didn't check with the doctor's office. She didn't even call the Customer Service phone number on the back of the BCBSM ID card for a PPO doctor near home. **Preventive care services** (like well-child exams) **aren't covered if your child goes to a doctor that's not in the PPO network.** Regina and her parents have to pay the whole bill.

Office visit with a doctor that's in the BCBSM PPO network

William needs to see a doctor for his cold.

I looked in the BCBSM PPO directory and found Dr. Patel.

I'll call and make an appointment.

Hello. My grandson needs to see a doctor. He has a terrible cold. Yes, we can come in this afternoon.



AT THE DOCTOR'S OFFICE...

Hi William. I'm Dr. Patel. I'm glad your grandfather brought you in today. Let's see what's wrong.



May I see your child's insurance ID card?

*Your child is covered under the BCBSM PPO. Because the doctor accepts the BCBSM PPO, **you don't have to pay anything.***

We'll file your claim directly with BCBSM, so you don't have any forms to complete.



What happened...

We covered William's office visit because William went to Dr. Patel, a doctor that's in the BCBSM PPO network. This means William's services were in-network. William's grandfather knew Dr. Patel was in the PPO network because he looked in the directory.

Office visit with a doctor that's not in the BCBSM PPO network

Darlene needs to see a doctor for her cold. I'll call and make an appointment.

Hello. I'd like to bring my daughter in to see the doctor. She has a terrible cold. Okay, we'll see you this evening.



AT THE DOCTOR'S OFFICE...

Hi Darlene. I'm Dr. Franklin. Let me check you out.



May I see your child's insurance ID card? We don't take BCBSM PPO, so you'll have to pay the 20% copay. But because we do participate with BCBSM, we'll send the claim in to Blue Cross.

What happened...

Darlene's office visit was covered at the out-of-network level because the doctor isn't a Blue Cross PPO network doctor. But Darlene did go to a doctor who participates with BCBSM. This means the doctor has already agreed with BCBSM to file all members' claims. Darlene's parents **will have to pay the 20% copay.**

Choosing a doctor or hospital

Your child's health plan gives you choices. You can take your child to a BCBSM PPO doctor or hospital – or to any doctor or hospital. You choose every time your child needs help.

Before your child gets sick

Take your child to a PPO doctor as soon as the PPO benefits start. You don't need to wait until your child gets sick. Your child is covered for preventive services to keep him or her healthy, such as well-child exams and immunizations, when these services are provided by PPO doctors in their offices.

This first doctor visit gives the doctor the chance to look over your child's medical records while you get a chance to ask important questions like, "How do I find you after office hours? What should I do in an emergency?"

tip:

Any time you make an appointment, let the office know that your child has BCBSM's PPO plan, and have your child's BCBSM ID card handy. Remember to take the Blue Cross ID card to your appointment.

When your child needs to go to a doctor

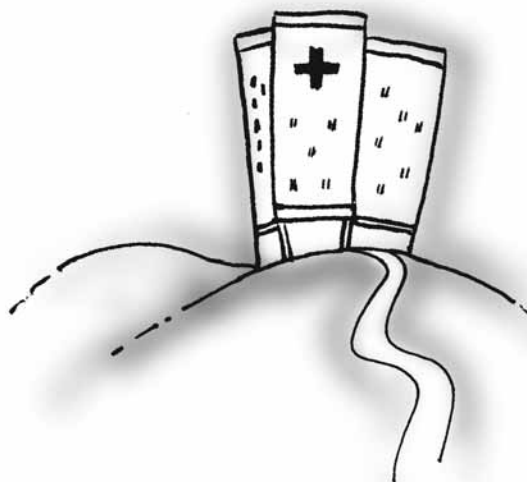
- Pick a doctor that's in our PPO provider network.
- Make an appointment with the doctor.

You don't have to pick just one doctor for your child's care. And you don't have to let us know when you want to change doctors. If you want to make sure a doctor is in our PPO network, just call BCBSM at 800-543-7765 or visit our Web site at bcbsm.com.

When your PPO doctor recommends that your child see a specialist

- Ask your doctor to recommend a specialist, or
- Pick a specialist from our PPO provider network.
- Ask your PPO doctor for a written referral if the specialist isn't in the PPO network.
- Make an appointment with the specialist.

You may take your child to a specialist who's not in the PPO network. **If you go to a specialist who is not in the PPO network without getting a referral from a PPO doctor, you will have to pay your out-of-network copay. If a specialist doesn't participate with BCBSM, you may have to pay more.**



When your child needs to go to a hospital

Take your child to a hospital that's in our PPO provider network. That way, your child's covered services are paid.

Continuing care when your child's doctor is no longer in the PPO network

Doctors retire, move or otherwise stop being part of our PPO network. If this happens, your doctor should let you know that he or she is no longer in our PPO network.



If you have a problem choosing another doctor, please call the BCBSM Customer Service office for help.

You and your doctor may want to continue your child's care after the doctor is no longer in the PPO network. You may do so under certain conditions for a limited time. Your child may keep seeing the doctor:

- For 90 days after the doctor tells you he or she is not in the PPO network
- If your child is pregnant, until the baby is born
- If your child is terminally ill, for the rest of his or her life

In these cases:

- Your child is treated for covered services.
- You file no claim forms.
- You pay nothing.

If you want to stay with a doctor although he or she is no longer in our network and none of these conditions apply, call BCBSM Customer Service at **800-543-7765** and ask a representative how much it will cost you to use the doctor.

BlueCard® PPO program takes care of your child outside of Michigan

When your child needs medical care outside of Michigan, use BCBSM's BlueCard PPO program. Simply call the toll-free number on the back of your child's ID card and we'll tell you where to find the nearest Blue PPO doctor.



important!

You can't use the BlueCard PPO program for prescription drug or dental services.

For these services, continue to use your child's BCBSM ID card.

To use the BlueCard PPO program, just follow these steps:

- Call 800-810-BLUE (2583) and tell customer service that your child needs help to find a doctor or hospital away from home through the BlueCard PPO program. (This phone number is on the back of your child's BCBSM ID card.)
- Tell the representative where your child will need medical care (city and state).
- Ask for the name of the nearest PPO doctor or hospital.
- When you get to the doctor's office or hospital, show your child's BCBSM ID card.
- Tell the doctor or hospital your child is covered under the BlueCard PPO program.

When your child receives services from a doctor or hospital that's in a Blue Cross Blue Shield PPO plan, you won't have to pay anything.

If customer service tells you that there isn't a PPO or participating doctor or hospital in the area where your child needs medical care, you won't have to pay any out-of-network copays.

important!

If your child goes to a doctor or hospital that's not part of BlueCard PPO, you may need to send the receipts to us.

Keep your child healthy

Take your child to the same doctor

It's important to have one doctor your child sees on a regular basis. Let the doctor get to know your child, what illnesses your child has had, and what your child is like. That way the doctor can help your child stay well.

Live healthy to stay healthy

The best way to protect your child's health is to help him or her live a healthy life. Make sure that your child eats healthy foods, exercises every day, wears a seat belt and doesn't do things that could hurt or make him or her sick.

Focus on keeping healthy

Make sure your child's immunizations are up to date and take him or her for routine exams.

Use your child's doctor as your health care guide

The doctor is the best person to tell you or your child about health care problems.

Be health-smart

If your child is ill, follow your child's doctor's advice and make sure your child takes his or her medicine the right way.

Ask questions

Feel free to ask your child's doctor questions. Know when to make follow-up office visits, why tests are necessary, or if a medicine has side effects. You can also call BlueHealthConnection at **800-775-BLUE (2583)** for more information.

If your child's doctor recommends putting your child in the hospital or recommends surgery, ask if there are any other choices.

Asking questions makes you aware of the options. Discuss the choices with your child's doctor so you can make a wise decision.

Keep your child healthy

Use the “extra” services in your child’s PPO plan

The PPO plan has free services to help your child stay healthy. Some of these services can give you information and advice to help you and your child make good health care choices. These services should never be used instead of talking to your child’s PPO doctor. These services include:

BlueHealthConnection®

Suppose your daughter has asthma or another serious illness. You’re working with her doctor, but you want to know what else you can do to help her. Who can you ask?

Or it’s 5 a.m. and your son wakes up with a stomachache. Should you take him to the emergency room now, or wait until the doctor’s office opens in a few hours?

Whether your child is healthy or has a serious illness, BlueHealthConnection has nurses available to help you make decisions on how to get your child healthy and stay healthy. Call BlueHealthConnection at **800-775-BLUE (2583)** to speak with a nurse 24 hours a day, 365 days a year.

Although you shouldn’t use BlueHealthConnection instead of a doctor, the nurses can send you information on many health care topics or talk with you about your child’s health problems, such as asthma or diabetes. They can help you:

- Work with your child’s doctors
- Understand your child’s health problem
- Make decisions
- Find ways to lead your child to a healthier life, such as weight loss programs

Blue365®

Blue365 helps you make healthy choices every day. It provides special member discounts. It also give you access to Web seminars and tools. Blue365 has four main categories:

Health and wellness – Find out about discounts at fitness and weight-loss centers. These include Curves®, Weight Watchers®, Jenny Craig® and Gold’s Gym®. You can also get discounts on other services like acupuncture and massage.

Family care – Find support in selecting care for a parent or other loved one. You can get a discount subscription to Seniorlink, a phone and Web-based elder care management program.

Financial well-being – Find resources for Medicare and long-term care insurance.

Travel – Blue365 provides discounts at partner hotels. It also has information on BlueCard Worldwide®, travel tips, shots and passports.

Find out more about Blue365 at bcbsm.com/blue365.

MIChild publications

Health Education newsletters

We want to make sure that your child enjoys a healthy life. So, we have a newsletter called *Mighty Mix* especially for MIChild families. Each newsletter features special sections for parents, children, and teens and young adults.

MIChild families also receive *Living Healthy* magazine, which is sent to all BCBSM members three times a year.

Keep your child healthy

Use this chart to keep track of your child’s immunizations. The list can change each year, so check with your PPO doctor or BlueHealthConnection® to find out what shots your child needs.

2009 Immunization Schedule

Vaccine ▼	Age ►	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19-23 months	2-3 years	4-6 years	7-10 years	11-12 years	13-18 years
														Preteen Check	
Hepatitis B (HepB)		HepB	HepB			HepB			HepB Series						
Rotavirus (Rota) (severe diarrhea)				Rota	Rota	Rota									
Diphtheria, Tetanus, Pertussis (DTaP and Tdap)				DTaP	DTaP	DTaP		DTaP				DTaP		Tdap	Tdap
Haemophilus influenzae type b (Hib) (meningitis, pneumonia)				Hib	Hib	Hib	Hib								
Pneumococcal (PCV) (ear infections, meningitis, blood infection)				PCV	PCV	PCV	PCV			PPV (Pneumococcal Polysaccharide Vaccine)					
Inactivated Poliovirus (IPV)				IPV	IPV		IPV					IPV	IPV Series		
Influenza							Influenza (yearly)								
Measles, Mumps, Rubella (MMR)							MMR					MMR	MMR Series		
Varicella (chicken pox)							Varicella					Varicella	Varicella Series		
Hepatitis A (HepA)							HepA (2 doses)			HepA Series					
Meningococcal (MCV4)												MCV4		MCV4	MCV4
Human Papillomavirus (HPV)														HPV (3 doses)	HPV Series

Recommended age
 Catch-up immunization
 Certain high-risk groups

Recommended by the Advisory Committee on Immunization Practices, the Academy of Pediatrics and the American Academy of Family Physicians.

MICHild PPO benefits

Now that you have an idea of how your child's PPO plan works, please look at the chart that begins on this page for your child's benefits.

The chart is an outline of covered services for your child under MICHild. The chart doesn't include everything there is to know about his or her benefits. The details are in the BCBSM MICHild certificate. If you have any questions about your child's coverage, or if you would like a MICHild certificate, call BCBSM at 800-543-7765. All in-network and out-of-network percentages listed are for the BCBSM approved amounts.

A licensed doctor or practitioner must do all of the services. Make sure it's a BCBSM PPO doctor or hospital so that you won't have to pay anything.*

*Except for private duty nursing.

Preventive services (Covered in-network only. No referrals allowed.)

Benefits	In-Network	Out-of-Network
Routine baby and child exam**	Covered – 100% Unlimited visits a year until age 2 1 visit per calendar year for ages 2 to 19	Not covered
GYN exam**	Covered – 100%, one a calendar year	Not covered
Pap smear – lab only	Covered – 100%, one a calendar year	Not covered
Immunizations***	Covered – Birth to age 19	Not covered
Blood lead testing	Covered – 100%, one a calendar year	Not covered

Note: The percentages are how much we'll pay of the approved amount for in-network and out-of-network coverage.

**Also covered if a certified nurse practitioner does the exam.

***We'll pay for the immunizations approved by the American Academy of Pediatrics. These may change every year. Ask your PPO doctor or call BCBSM at 800-543-7765 to see which ones are approved for that year.

important!

Preventive services are covered only in PPO doctors' offices (not in hospital locations).

Physician services

Benefits	In-Network	Out-of-Network
Treatment by an M.D. or a D.O. in the doctor's office. Includes seeing a specialist like a dermatologist. Also office consultations****	Covered – 100%	Covered – 80% if medically necessary
Outpatient and home visits	Covered – 100%	Covered – 80% if medically necessary
Chemotherapy, including chelation therapy	Covered – 100%	Covered – 80%

****Also covered if it's with a certified nurse practitioner.

Emergency medical care (for accidental injuries or life-threatening medical conditions)

Benefits	What We'll Pay In-Network	What We'll Pay Out-of-Network
Hospital emergency room	Covered – 100%	Covered – 100%
Physician's office	Covered – 100%	Covered – 100%
Ambulance transportation – ground and air	Covered – 100%	Covered – 100% when medically necessary

Diagnostic services

Benefits	What We'll Pay In-Network	What We'll Pay Out-of-Network
Laboratory and pathology tests	Covered – 100%	Covered – 80%
X-rays and diagnostic tests, such as EKGs. Preauthorization required for CAT and PET scans, MRIs and MRAs	Covered – 100%	Covered – 80%
Radiation therapy	Covered – 100%	Covered – 80%

Maternity care and related services

Benefits	What We'll Pay In-Network	What We'll Pay Out-of-Network
Delivery and nursery care*	Covered – 100%	Covered – 80%
Pre- and postnatal care*	Covered – 100%	Covered – 80%
Termination of pregnancy**	Covered – 100%	Covered – 80%
	Covered only to save the mother's life, or in cases of rape or incest	
Family planning (including birth control education)	Covered – 100%	Covered – 80%
Birth control ***	Covered – 100%	Covered – 80%

* Maternity services provided by physician or certified nurse midwife. Mother and newborn may stay in the hospital for 48 hours after a normal delivery or for 96 hours after a C-section.

** Expectant mothers should call 888-988-6300 to determine if they qualify for Healthy Kids.

*** Includes devices, insertion and injections, and birth control prescriptions.

important!

Mental health or drug abuse treatment in or out of the hospital isn't covered by Blue Cross Blue Shield of Michigan. Read the letter that MICHild sent to your child for the name of your child's Community Mental Health Board or call MICHild at 888-988-6300.

Hospital care

Benefits	What We'll Pay In-Network	What We'll Pay Out-of-Network
Semi-private room, inpatient physician care, regular nursing care, hospital services, medicines and supplies*	Covered – 100%	Covered – 80%
	Unlimited days	Unlimited days
Inpatient consultations	Covered – 100%	Covered – 80%

* Includes preadmission testing within 72 hours of inpatient admission.

Surgical services

Benefits	What We'll Pay In-Network	What We'll Pay Out-of-Network
Surgery, including all related surgical services, anesthesia and surgical assistance	Covered – 100%	Covered – 80%
Second surgical opinion consultations	Covered – 100%	Covered – 80%

Alternatives to hospital care (services must be provided by BCBSM-approved providers)

Benefits	What We'll Pay Participating	What We'll Pay Nonparticipating
Hemodialysis**	Covered – 100%	Not covered
Home hemophilia care – medications and medical supplies billed by an approved hospital or doctor	Covered – 100%	Not covered
Home health care visits for skilled nursing care, physical, occupational and speech therapy, home health aid, diet guidance and social services.	Covered – 100%	Not covered
	Up to 120 days per calendar year for services provided through a Medicare-certified home health care agency	
Home infusion therapy (must be medically necessary)	Covered – 100%	Not covered
Skilled nursing facility care	Covered – 100%	Not covered
	Up to 120 days per admission with a 90-day renewal period	
Hospice care	Covered – 100%	Not covered
	Limited to 210 days, two periods of 90 days and one period of 30 days during patient's lifetime	

**If your child has end-stage renal disease, he or she is eligible for Medicare. If your child is eligible for Medicare only because of ESRD, BCBSM will pay first for the ESRD treatment for up to 33 months. Medicare will pay the rest during that time. At the end of the 33 months, Medicare will pay first and BCBSM will pay the rest.

Section 6: MICHILD PPO BENEFITS

Human organ transplants*

Benefits	What We'll Pay In-Network	What We'll Pay Out-of-Network
Liver, partial-liver, heart, lung, heart-lung, lobar lung, pancreas, simultaneous pancreas-kidney, small intestine, combined small intestine-liver	Covered – 100% of approved amount in BCBSM-designated transplant facilities Up to one million dollars per organ transplant type	Not covered
Kidney, cornea and skin	Covered – 100%	Covered – 80%
Bone marrow – subject to program guidelines	Covered – 100%	Covered – 80%
Donor hospital, surgical, lab, and X-ray expenses	Covered – 100% - unless donor has health care coverage for transplants	Not covered

* Must be performed at a BCBSM-designated transplant facility during the transplant benefit period. Call the BCBSM Human Organ Transplant program at 800-242-3504 to confirm a facility's participation status. Transplants of artificial organs are not covered. The total payment for all services combined for each specified organ transplant are limited to a \$1 million lifetime maximum.

Other services

Benefits	What We'll Pay In-Network	What We'll Pay Out-of-Network
Allergy testing and therapy	Covered – 100%	Covered – 80%
Acupuncture – up to 20 visits per calendar year for these conditions when performed by an M.D. or D.O.: sciatica, neuritis, post herpetic neuralgia, tic douloureux, chronic headaches (migraines), osteoarthritis, rheumatoid arthritis, myofascial complaints (neck and lower back pain)	Covered – 100%	Covered – 80%
Ambulance services – must be medically necessary	Covered – 100%	Covered – 80%
Chiropractic spinal manipulations – up to 24 visits per calendar year	Covered – 100%	Covered – 80%
Outpatient physical therapy – either in an outpatient dept. of a hospital, freestanding physical therapy facility, or doctor's or independent licensed physical therapist's office	Covered – 100% in approved setting Up to 60 combined physical therapy, outpatient speech and occupational therapy visits per calendar year	Covered – 80%
Outpatient speech and occupational therapy – only in an outpatient dept. of a hospital, or freestanding physical therapy facility**	Covered – 100% Up to 60 combined physical therapy, outpatient speech and occupational therapy visits per calendar year	Same as in-network
Oral surgery – pulling out impacted teeth or roots, treatment of broken jaws or wounds, cysts, apicoectomy, and other gum and mouth tissues	Covered – 100%	Covered – 80%

** We do not pay for speech or occupational therapy services in a doctor's office.

Other services (con't)

	What We'll Pay In-Network	What We'll Pay Out-of-Network
Temporomandibular Joint Syndrome (TMJ) or Jaw-Joint Disorder – only surgery directly related to the jaw joint to change child's bite or position of the jaw, X-rays, and anthrocentesis (injection procedures)	Covered – 100%	Covered – 80%
Durable medical equipment including diabetic supplies	Covered – 100%	Covered – 100%
Prosthetic and orthotic appliances*	Covered – 100%	Covered – 100%
Private-duty nursing	Covered – 50%	Covered – 50%
Weight-loss programs – when prescribed by a physician because the child is morbidly obese. Up to \$300 lifetime maximum. Must submit paid receipts to BCBSM.	Covered – 100%	Covered – 100%

* Includes adjusting and replacing eligible appliances only when due to wear, growth or change of patient's condition. A doctor who's fully accredited must supply limb replacements by the American Board of Certification in Orthotics and Prosthetics, Inc. Call BCBSM at 800-543-7765 for information about a doctor's status.

Deductibles, copays and dollar maximums for medical care

	What We'll Pay In-Network	What We'll Pay Out-of-Network
Deductibles	None	None
Fixed copays	None	None
Percent copay	None for general services; 50% for private-duty nursing	20% copay for general services; 50% copay for private-duty nursing
Out-of-pocket copayment maximum (a calendar year)	None	\$2,000 per member, no family maximum
Dollar maximum	None for general services; \$300 weight loss program; \$1 million per transplant type	None

Section 6: MICHILD PPO BENEFITS

Vision services

Benefits	What We'll Pay Participating	What We'll Pay Nonparticipating
Vision exam and glaucoma test – once every 12 months	Covered – 100%	25% plus \$5 copay (unless for second exam by a medical doctor when recommended by a vision specialist)
Eyeglass frames (wire, plastic or metal) once every 24 months* OR every 12 months when the child's prescription changes	Covered – 100%	BCBSM pays \$14 maximum Combined copay for both lenses and frames: \$7.50
Eyeglass lenses – once every 24 months* OR every 12 months when the child's prescription changes	Covered – 100%	Combined copay for both lenses and frames: \$7.50 Single vision: \$13/pair Bifocal: \$20/pair Trifocal: \$24/pair Special lenses: 50% of the charge or 75% of the average amount paid to participating doctors/ vision care specialists, whichever is less Additional charges: Plastic lenses: \$3/pair Rose tints #1 and #2: \$3/pair Prism lenses: \$2/pair
Medically necessary contact lenses – once every 24 months* OR every 12 months when the child's prescription changes (must be therapeutic, not for cosmetic purposes)	Therapeutic contact lenses Covered – 100%	Therapeutic contact lenses Reimbursed at \$96/pair

* During the 24-month period, we'll pay for either eyeglasses or therapeutic contact lenses, but not both.

Note: All percentages represent the approved amount of participating or nonparticipating coverage. If the doctor or specialist you select doesn't participate, then you'll have to pay whatever is left from what we paid and what the doctor charged.

If your child chooses more expensive frames, the doctor or vision care specialist may charge you the difference between the usual retail charge for covered frames and the more expensive frames.

Prescription drug coverage

Benefits	What We'll Pay Participating Pharmacy	What We'll Pay Nonparticipating Pharmacy
<ul style="list-style-type: none"> Federal legend drugs State-controlled drugs Needles and syringes Select over-the-counter drugs 	Covered – 100% from a Michigan Preferred Rx pharmacy or a MedImpact participating pharmacy	75% of approved amount, but 100% for emergency pharmacy services
Home delivered prescription drugs	Covered – 100% 90-day supply from Medco	

Note: Some prescriptions may require prior authorization.

Hearing care coverage

Benefits	What We'll Pay Participating	What We'll Pay Nonparticipating
Audiometric exam – once every 36 months	Covered – 100%	Not covered
Hearing aid evaluation and conformity test – once every 36 months	Covered – 100%	Not covered
Hearing aids – once every 36 months	Covered – 100%	Not covered

Note: Must be prescribed by a physician specialist and performed by a participating provider specialist.

Dental care

For members of the BCBSM Dental program, we'll pay up to \$600 for the following services for each child each calendar year.

Service	Coverage
<ul style="list-style-type: none"> • 1 initial exam per dentist/office • 2 routine checkups • 2 cleanings • Bitewing X-rays once in 12 consecutive months • Fluoride treatments under age 14 <p>Also:</p> <ul style="list-style-type: none"> • Diagnostic tests • Space maintainers under age 14 • Dental sealants on first and second permanent molars • Consultation by a second dentist not providing treatment • Exams and treatment for an emergency condition 	Covered – 100%*
Restorative services – fillings of amalgam, plastic composite or similar materials and stainless steel crowns	Covered – 100%*
Simple extractions	Covered – 100%*
Endodontic services – pulpotomy for primary teeth	Covered – 100%*
Emergency treatment for temporary relief of pain	Covered – 100%*

*When participating providers perform services.

Vision care coverage

Taking care of your child's eyes now will help keep or improve his or her eyesight. Make sure he or she has regular eye exams. Your child is covered for eye exams, eyeglasses and therapeutic contact lenses that are medically necessary. Your vision plan is administered for BCBSM by Heritage Vision Plans.

Choosing your child's eye doctor

When your child needs eye care, it's important to find out if the doctor or specialist is in the vision network. Like your child's PPO medical care plan, your child's eye care plan also has a network of doctors and vision care specialists.

Participating doctors and specialists

If your child goes to a participating eye doctor or specialist:

- Your child is treated for covered services.
- You file no claim forms.
- You won't have to pay anything for covered services.
- We pay the doctors.

To find a participating eye doctor or specialist near you, check the Heritage Vision Plans Web site at heritagevisionplans.com* or call Heritage Vision Plans at 800-252-2053. Contact Heritage Vision Plans if there is not a participating provider in your area.

Doctors and specialists not in the vision network

You won't have to pay anything for covered services if the doctor or specialist is in the network. But if the doctor does not participate, then:

You may have to pay

- We'll pay you 75 percent of what we would have paid for an eye test or an exam. We'll also deduct the \$5 copayment from that amount.
- You'll have to pay whatever is left from what we paid and what the doctor charged.

Look at the MICHild benefit chart for details on your child's vision care benefits.



important!

We'll only pay for standard eyeglass frames. If your child chooses designer frames, you'll have to pay the difference between the price of the designer frames and what we would pay. Always ask your eye doctor to show you and your child the frames that we'll pay for in full. You'll have to pay for lenses that aren't standard lenses.

*BCBSM does not control this Web site or endorse its general content.

Hearing care coverage

Your child's hearing care coverage will help find out if your child has a hearing problem – and will pay for hearing aids.

Choosing your child's hearing doctor

When your child needs hearing care, it's important to find out if your hearing care doctor participates with BCBSM. **We'll pay hearing benefits only when your child goes to a participating provider, such as a doctor, audiologist or hearing aid dealer.** For the names of these providers, check the BCBSM Web site at bcbsm.com or call BCBSM Customer Service at 800-543-7765.

How your child's hearing coverage works

We'll pay 100 percent of the following prescribed hearing care benefits only when your child gets services from participating providers:

1. Audiometric exam – Measures your child's hearing and includes tests for air and bone conduction, speech reception and speech discrimination.
2. Hearing aid evaluation – Determines what type of hearing aid is best for your child.
3. Hearing aids – Have to be prescribed and include types worn in-the-ear, behind-the-ear, or on the body.
4. Conformity test – Checks how well the hearing aid is working and how well it fits.



Prescription drug coverage

What's covered

We'll pay for your child's medicines when a doctor prescribes them. This includes:

- Drugs that according to federal or state law must be labeled "Rx only"
- Select over-the-counter drugs prescribed by a physician. You can find a current list of these drugs at [bcbsm.com/member/prescription_drugs](https://www.bcbsm.com/member/prescription_drugs). Look under *Prior Authorization/Step Therapy* and *Pharmacy Initiatives*. Or you can call Customer Service at 800-543-7765.
- Insulin that's used with a needle and syringe
- Needles and syringes given out with insulin or drug therapy (Your child can get needles and syringes that aren't given out with insulin from a BCBSM supplier as long as there's a doctor's prescription. Call 800-543-7765 for help with finding a supplier.)
- Birth control prescribed by a physician

A pharmacy may fill the prescription with as much as your child will have to take for up to 34 days or, if it's a drug that your child takes all the time, 100 doses – whichever is more.

What's not covered

The following aren't covered:

- Any drug entirely taken where it is prescribed
- Drugs given on the spot (doctor's samples, etc.)
- Refills for more than the doctor prescribed
- Refills for a drug that was prescribed more than a year ago
- Most over-the-counter drugs available without a prescription

Generic drugs

A generic drug is a medicine that can be made by more than one drug company and sold under more than one name. However, the ingredients in the generic drug must be the same as the ingredients in the brand-name drug.

If you obtain a brand-name drug when it has a generic available, you must pay the difference between the cost of the brand-name drug and the cost of the generic drug. However, if your doctor requests and receives approval from BCBSM for a brand-name drug and writes "DAW" (dispense as written) on the prescription, you will not be charged the difference between the cost of the brand-name drug and the cost of the generic.

Prior authorization

Prior approval, or preauthorization, of select prescription drugs must be obtained from BCBSM before we will consider them for payment. If your doctor does not request preauthorization, or if BCBSM does not approve the request, we will not pay for the drug and you will have to pay 100 percent of the approved amount.

We will pay for these select prescription drugs if both of the following are met:

- Your doctor requests preauthorization and demonstrates that the select prescription drug meets BCBSM's preauthorization criteria
- We approve the request

Choosing your pharmacy

You can have your child's prescriptions filled at a network or non-network pharmacy. The choice is yours. We encourage you to find a network pharmacy so you won't have to pay anything. Since 98 percent of the pharmacies in Michigan are in the network, call a pharmacy near you and ask them if they participate with BCBSM.

Network pharmacy

There are about 2,300 BCBSM participating pharmacies in Michigan. Outside of Michigan, there are about 58,000 pharmacies across the U.S. that participate through the MedImpact national network. Network pharmacies will file claims for you and receive payment directly from us.

When your prescriptions are filled through a network pharmacy, we'll pay 100 percent of the approved amount. You don't have to pay anything.

Non-network pharmacy

Pharmacies that aren't part of the Preferred Rx or MedImpact network are called non-network. If you go to a non-network pharmacy, you will have to pay the full price of the prescription. Then, to get your money back, you'll have to send a claim to MedImpact. The pharmacist will not send your claim to MedImpact for payment. BCBSM will send you only 75 percent of the approved amount. However, if the prescription is for emergency services, BCBSM will send you the full approved amount.

important!

If your pharmacist needs help, he or she may call 800-437-3803 and select either prompt 1 for Michigan pharmacies or prompt 3 to be transferred to MedImpact. Please note, this phone number is only for pharmacies to call.

Mail-order prescription drugs

Ordering prescription drugs by mail is a fast and easy way to make sure your child doesn't run out of the medication he or she always has to take. You can mail your prescriptions to the mail-order pharmacy, or your child's doctor can phone in or fax the prescription orders. Refills on your child's mail-order prescriptions can be ordered by mail, telephone or the Internet.

When your child's doctor prescribes a drug through mail order you can order up to a 90-day (3 months) supply of medicine from Medco. There's no charge to you and no claim forms to complete. Your child's medication is mailed to your home, postage-paid, within 14 business days from the date you mailed the order.

If you have questions, call Medco at 800-903-8346. You can also visit their Web site at medco.com to order refills, check on the status of your child's mail order prescriptions, or request postage-free mail-order envelopes.

Specialty drugs

Some drugs may need special handling. These drugs are called specialty drugs. They are used to treat complex conditions, including:

- Asthma
- Cancer
- Hepatitis C
- HIV/AIDS
- Organ transplants
- Psoriasis
- Rheumatoid arthritis

A list of these drugs is available on bcbsm.com, or you can call Customer Service at 800-543-7765 to get a list. To order these specialty drugs by mail, contact OptionCare, the BCBSM specialty mail order pharmacy. You can download an OptionCare order form from bcbsm.com, or you can call OptionCare at 866-515-1355 to order.

Dental care coverage

important!

This section applies to your child only if you have chosen BCBSM as your child's dental plan provider.

Choosing your child's dentist

When your child needs dental care, it's important to find out whether or not your doctor participates with BCBSM's dental care plan. You may take your child to any participating BCBSM Traditional dentist or any dentist in the DenteMax network. For a DenteMax provider, just look on the BCBSM Web site at bcbsm.com or call a customer service representative at **800-543-7765** to find a participating dentist in your area. You will obtain the greatest savings for non-covered services from a DenteMax provider.

Participating dentists

Non-DenteMax dentists can participate on a per-claim basis. When a dentist participates, he or she will accept our approved amount as full payment. This means that you won't have to pay anything for covered services. Therefore, it's important to ask before every service your child receives if your child's dentist participates with BCBSM. Participating dentists also file your claims and we will pay them directly. You'll have to pay only for any services that aren't covered.

Nonparticipating dentists

If your child's dentist doesn't participate with BCBSM's dental care plan and doesn't accept what we'll pay for the service:

- You may have to pay the entire bill.
- You may have to complete and send claim forms to BCBSM.
- We'll send the payment directly to you.
- You'll have to pay for any difference between what we've agreed to pay and what the doctor actually charges.

What's covered

BCBSM's dental care plan will pay up to \$600 per contract per year. Please refer to the dental benefit chart on page 24 of this handbook. More detailed dental benefit information is available in the BCBSM MICHild dental certificate. If you have any questions about your child's coverage, or if you would like a MICHild certificate, please call BCBSM at **800-543-7765**.



What's limited or not covered

- Fluoride treatment and space maintainers for children age 14 and older
- Prosthodontic services (replacements for missing parts of the mouth and jaw)
- Orthodontic services (dental braces) unless they are a covered medical benefit
- Periodontal services (gum diseases)
- Endodontic services (pulp diseases) unless they are a covered medical benefit
- Oral surgery procedures unless they are a covered dental benefit. (Surgical extractions are not a covered dental benefit. Surgical extractions may be considered a medical benefit.)
- Your child can have only two dental exams within 12 months

Deciding on your child's dental benefits before treatment

Your child's dentist will probably suggest a plan to take care of your child's teeth. This could be just a list of exams your child should have or more services if necessary. If more services are suggested, your child's dentist can send the suggestions to us to "predetermine" the costs before your child's care begins. We'll let the dentist know how much we'll pay for the plan or suggest a different plan.

We look at the plan before services begin so you and your child's dentist can agree on the care based on what we'll cover. Dentists usually use this review for services that are not an emergency, or are difficult, such as crowns. A predetermination does not guarantee payment.

Other treatment plans

Sometimes your child's dental condition can be taken care of in more than one way. If you still want a treatment that costs more than the one we've suggested, you can take what we'd pay for our suggested treatment and apply it to the cost of the treatment you select. You'll have to pay the difference. You should talk with your child's dentist about these treatments so you fully understand what you'll have to pay.

Tips for great dental care*

Your child's smile is important. Follow these tips to keep your child's teeth and gums healthy:

Brush at least twice a day

– after breakfast and before bedtime.
Brushing properly breaks down plaque.

Brush all of their teeth,

not just the front ones. Spend some time on the teeth along the sides and in the back. Brush away from the gums.

Take time while brushing.

Spend at least three minutes each time they brush. If they have trouble keeping track of time, use a timer or play a recording of a song they like to help pass the time.

Use a toothbrush with soft bristles.

The package will say if they're soft.

Use a new toothbrush

every three months.

Learn how to floss their teeth,

which is a very important way to keep them healthy. Slip the dental floss between each tooth and up along the gum line. The floss gets rid of food that's hidden where a toothbrush can't get it.

Tips for a great dental visit*

Go to the dentist

Brushing and flossing is very important, but they aren't enough. Children should also visit the dentist twice a year.

Go to the dentist as soon as your child is covered

Your child's dental care benefits offer preventive care and regular dental checkups. Dental problems can begin early. That's why the earlier the visit, the better the chance of preventing dental problems.

Be positive

Be careful about using scary words. Checkups and 90 percent of first visits don't have anything to do with "hurt," so don't even use the word! Answer all your child's questions positively. Keep an ear out for scary stories from friends and siblings.

Introductions

Consider a "getting to know you" visit to introduce your child to the dental office before the first appointment.

Explain

Explain before the visit that the dentist is a friend and will help keep your child's teeth healthy.

Questions?

List in advance your questions about your child's dental health on such topics as home care, injury prevention, diet and snacking, fluoride and tooth development.

Decisions?

Give your child some control over the dental visit. Such choices as "The red toothbrush or the green one?" will make the visit more enjoyable.

Let's talk

Let the dentist and your child talk with each other so they can build a relationship. You and the dentist can talk after the examination.

Be rested

Ask for an appointment time when you know your child will be alert and rested.

What to do if your child has a toothache?

Call your dentist and arrange an office visit as soon as possible. To help your child feel better, rinse his or her mouth with water and give your child a cold compress or ice wrapped in a cloth.

A good example

Read your child a story about a character who had a good dental visit. Ask the dental office for suggested reading.

* American Academy of Pediatric Dentistry

Good dental care starts early*

Good dental care should start before your baby even gets teeth. Just as adult teeth are meant to last a lifetime, baby teeth are meant to last until the permanent teeth are ready to come in. Your child's teeth are used for chewing food properly, speaking clearly and to help promote self-esteem. They also make room in the jaw for adult teeth. This helps keep teeth from being crooked or crowded.

Here's a handy list to follow to make sure your child has a lifetime of good, healthy teeth:

<p>Birth to 6 months</p>	<ul style="list-style-type: none"> • Clean your child's mouth and gums with a soft cloth after feedings and at bedtime. • Keep feedings on a schedule. • If you must put your baby to sleep with a bottle, use nothing but water. Milk, formula or fruit juice can destroy your child's teeth. • Never dip a pacifier in anything sweet. It can lead to serious tooth decay.
<p>6 to 12 months (First baby teeth appear)</p>	<ul style="list-style-type: none"> • Begin to brush your baby's teeth after each feeding and at bedtime with an infant toothbrush using a nonfluoridated infant tooth and gum cleaner. • Do not let your child swallow fluoridated toothpaste. At this young age it can discolor your child's permanent teeth when they come in. • Take your child to see the dentist for an exam.
<p>12 to 24 months (Most baby teeth are in)</p>	<ul style="list-style-type: none"> • Follow the dentist's suggestions for exams and cleanings. • Continue using nonfluoridated infant toothpaste.
<p>2 to 6 years</p>	<ul style="list-style-type: none"> • Start to use fluoridated toothpaste only when the child has learned to spit it out and is able to rinse afterward. • Although you should be making sure your child brushes and flosses, children older than 6 should be expected to brush their teeth. • You should still make sure your child's mouth is clean, but let your child do as much as he or she can and wants. • Begin flossing where teeth touch. • Visit your child's dentist for regular cleanings.
<p>6 to 12 years</p>	<ul style="list-style-type: none"> • Begin making your child brush his or her own teeth, with you watching. Usually, 8-year-old children can brush on their own and 10-year-old children can floss. • Your child should brush the way the dentist suggests.
<p>Children of all ages</p>	<ul style="list-style-type: none"> • Your child will need sealants for adult teeth. • Continue fluoride as your child's dentist suggests. • Change your child's toothbrush every three months. • Brush at least twice a day, after breakfast and before bed.

* American Academy of Pediatric Dentistry

When you need to file your child's claims

Only claims for nonparticipating hospitals, doctors and dentists

When your child uses his or her benefits, a claim must be filed before we can pay. **BCBSM PPO and participating hospitals, doctors, and DenteMax and participating dentists should automatically file all claims for your child.** All you need to do is show your child's ID card. However, nonparticipating hospitals, doctors and dentists may or may not file a claim for you. If they don't, you'll need to file the claim to get paid.

important!

File your child's claims right away. For some of the services, you must file the claim within six months for it to be paid.

important!

You can send us cash register receipts, cancelled checks or money-order stubs along with your detailed bill, but we must have the detailed billing statement too.

How to file your child's claims

Follow these steps to file your child's claim:

1. Ask your child's hospital, doctor and dentist for a detailed bill. It must list the following:
 - Your child's name
 - Your child's contract number from his or her ID card
 - Doctor's name, address, phone number and federal tax ID number
 - Date and description of services
 - Diagnosis (type of illness or injury)
 - If your child was in the hospital, the dates your child was put into and released from the hospital
2. Completely fill out a claim form.* If you don't have one, you may get one by calling our Customer Service department at **800-543-7765** from 8:30 a.m. to 5 p.m. Monday through Friday. If you are sending in claims for more than one child, complete a separate form for each child.
3. Sign and date each claim form.
4. Make a copy of everything for your files.
5. Mail the originals to us at:

Lansing Service Unit
Blue Cross Blue Shield of Michigan
P.O. Box 80380
Lansing, MI 48909-0380

We'll pay you directly. The check will be in your child's name.

*Contact Heritage Vision Plans for vision claims.

Your appeals process

If you disagree with a benefit payment

We try to process and pay your child's claims quickly and correctly. Most questions or concerns about how we paid or did not pay your child's claim can be answered through a phone call to one of our customer service representatives. If any or all of your child's claim for a benefit service isn't covered, we'll write you a letter telling you why. If you still disagree with us, you have the right to appeal.*

Your appeal rights under Michigan's Public Acts

Blue Cross Blue Shield of Michigan must follow the rules under Michigan Public Acts 350 and 251. If you believe we have not acted according to the rules in Section 402 or 403 of Public Act 350, you have the right to appeal, on behalf of your child. We've included the exact language of the law at the end of this book. Public Act 350 also gives you the process to follow to express and resolve your concerns within BCBSM.

Once you've gone through this process, if you don't agree with the outcome, Public Act 251 allows you to take your concerns to state officials for their review. Michigan Public Act 251 of 2000 gives you the right to request an outside review from the Commissioner of Financial and Insurance Services if we have unfairly not allowed or limited or stopped your child from being admitted into a hospital, not made care available, or not allowed continued stay or other health care services. Normally, you must go through the standard review steps within BCBSM before you can request an outside review.

Step 1: Seek resolution within BCBSM*

Your rights under Public Act 350

Standard internal grievance procedure

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

The standard internal grievance procedure is:

- A. You or your authorized representative must send us a written statement explaining why you disagree with our determination on your request for benefits or payment.
- B. Mail your written grievance to the address found in the top right-hand corner of the first page of your explanation of benefit payments form or to the address contained in the letter we send you to notify you that we have not approved a benefit or service you are requesting.

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

*Your vision appeals must first go to Heritage Vision Plans for resolution. If your appeals are not resolved, you may contact BCBSM.

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

Mail your request to:

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

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

- D. If you disagree with our final determination or if we fail to provide it to you within 35 days of the date we received your original written grievance, you may request an external review from the Michigan Commissioner of Financial and Insurance Services.

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

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

Expedited internal grievance procedure

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

The procedure is as follows:

- A. You may submit your child's expedited internal grievance request by telephone. The required physician's statement that your condition qualifies for an expedited grievance can also be submitted by telephone at 313-225-6800.

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

- B. If you do not agree with our decision, you may, within 10 days of receiving it, request an expedited external review from the Michigan Commissioner of Financial and Insurance Services.

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

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

Step 2: Seek resolution through Michigan officials

Your rights under Public Act 251

Standard external review procedure

Once you have exhausted our standard internal grievance procedure, you or your authorized representative has the right to request an external review from the Commissioner.

The standard external review process is as follows:

- A. Within 60 days of the date you either received our final determination or should have received it, send a written request for an external review to the Commissioner.
- B. Mail your request, including the required forms that we will supply to you, to:

Health Plans Division
Office of Financial and Insurance Regulation
P.O. Box 30220
Lansing, MI 48909

If your request for external review concerns a medical issue and is otherwise found appropriate for external review, the Commissioner will assign an Independent Review Organization consisting of independent clinical peer reviewers to conduct the external review. You will have an opportunity to provide additional information to the Commissioner within seven days after you submit your request for an external review. We must provide documents and information considered in making our final determination to the Independent Review Organization within seven business days after we receive notice of your request from the Commissioner.

The assigned Independent Review Organization will recommend within 14 days whether the Commissioner should uphold or reverse our determination. The Commissioner must decide within seven business days whether or not to accept the recommendation and will notify you. The Commissioner's decision is the final administrative remedy under the Patient's Right to Independent Review Act.

If your request for external review is related to non-medical issues and is otherwise found appropriate for external review, the Commissioner's staff will conduct the external review.

The Commissioner's staff will recommend whether the Commissioner should uphold or reverse our determination. The Commissioner will notify you of the decision, and the Commissioner's decision is your final administrative remedy under Public Act 350.

Expedited external review procedure

If a physician substantiates orally or in writing that your child has a medical condition for which the time frame for completion of an expedited internal grievance would seriously jeopardize your child's life or health or would jeopardize your child's ability to regain maximum function and if you have filed a request for an expedited internal grievance, you may request an expedited external review from the Commissioner. You may file a request for an expedited external review only when you think we have wrongfully denied, terminated or reduced coverage for a health care service prior to your child having received that health care service.

The expedited external review process is:

Within 10 days of your receipt of our denial, termination or reduction in coverage for a health care service, you or your child's authorized representative may request an expedited external review from the Commissioner.

To do so in writing, mail your request (including the required forms we will supply to you) to:

Health Plans Division
Office of Financial and Insurance Regulation
P.O. Box 30220
Lansing, MI 48909

To do so by telephone, call the following toll free number: 877-999-6442.

Immediately after receiving your request, the Commissioner will decide if it's appropriate for external review and assign an Independent Review Organization to conduct the expedited external review. If the Independent Review Organization decides that you do not have to first complete the expedited internal grievance procedure, it will review your request and recommend within 36 hours whether the Commissioner should uphold or reverse our determination.

The Commissioner must decide within 24 hours whether or not to accept the recommendation and will notify you. The Commissioner's decision is the final administrative remedy under the Patient's Right to Independent Review Act.

important!

If you believe that we have not acted according to the rules in Section 402 or 403 of Public Act 350, you have the right to appeal. The sections below provide the exact language in the law.

What we may not do

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

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

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

The things we cannot do under this section are:

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

Section 403 of Public Act 350 of 1980

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

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

This handbook is not a contract. It is intended as a brief description of benefits. Every effort has been made to ensure the accuracy of the information within. However, if statements in this description differ from the MICHild certificate, then the terms and conditions of the certificate prevail.

The coverage is provided pursuant to a contract entered into between the Michigan Department of Community Health and BCBSM and shall be construed under the jurisdiction and according to the laws of the state of Michigan.



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

Walk-in service centers

Blue Cross Blue Shield of Michigan has many conveniently located walk-in service centers to assist you with any questions you may have about your health coverage. You may visit one of our service centers from 9 a.m. to 5 p.m. Monday through Friday, unless otherwise noted.



<p>Detroit 500 E. Lafayette Blvd. (downtown, three blocks north of Jefferson)</p>
<p>Flint 4520 Linden Creek Parkway, Suite A</p>
<p>Grand Rapids 86 Monroe Center N.W. (former Steketee Building)</p>
<p>Holland 259 Hoover Blvd., Suite 160 (near U.S. 31 and Eighth St.)</p>
<p>Lansing 1403 S. Creyts Road (1/4 mile south of I-496, Creyts Road exit)</p>
<p>Marquette 415 S. McClellan Ave. (up on the hill) 8:30 a.m. to 5 p.m.</p>
<p>Portage 8175 Creekside Dr. (1.5 miles east of U.S. 131 in the Creekside Commons Office Park)</p>
<p>Port Huron 2887 Krafft Road, Suite 200 (Court of Flags Mall next to the Secretary of State)</p>
<p>Southfield 27000 W. 11 Mile Road (near Inkster Road)</p>
<p>Traverse City 1769 S. Garfield Ave. (across from Cherryland Center)</p>
<p>Utica 6100 Auburn Road (diagonally across from AAA building)</p>