Blue Cross Blue Shield Blue Care Network of Michigan

Confidence comes with every card.®

State of Michigan

Your Benefit Guide

State Health Plan PPO

Medical and Behavioral Health/Substance Use Disorder Benefits for Employees

January 1, 2027

Table of Contents

Welcome 1

Contact information 1

Your ID card 3

Eligibility 3

Explanation of cost-share 4

Medical Benefits

- Your medical benefits, A-Z 6
- Benefit summary 29
- What is not covered 32
- Selecting providers when using your State Health Plan PPO 33
- Virtual Care 35
- TruHearing® 35
- Care when you travel 36
- Value-added resources at no cost to you 37
- Coordination of benefits 38
- Explanation of Benefits 39
- Filing claims 40
- Medicare coverage 40

Behavioral Health/Substance Use Disorder Benefits

- Behavioral health/substance use disorder benefits (BH/SUD) 43
- Your behavioral health/substance use disorder benefits, A–Z 44
- Benefit summary 48
- What is not covered 50
- Other behavioral health resources 51
- Selecting Behavioral Health and Substance Use Disorder Providers 53

Your right to file an appeal or grievance 55

External review 58

Glossary 61

Welcome

Welcome to the State Health Plan PPO (SHP PPO), a self-insured benefit plan administered by Blue Cross under the direction of the Michigan Civil Service Commission (MCSC). To be eligible for coverage under the SHP PPO, you must reside in the U.S. or its territories. Additional information on eligibility can be found on page 3 of this booklet.

MCSC is responsible for implementing these benefits and any future benefit changes. Blue Cross provides certain services on behalf of MCSC through an administrative-service-only contract. Your benefits are administered by Blue Cross but will be paid using funds from MCSC.

Blue Cross is committed to providing you with excellent value and quality service and we want you to understand your health coverage. With this in mind, we have designed this booklet as an easy-to-read guide to your benefits. Please read through it to get an understanding of which health care services are covered and when you are responsible for out-of-pocket costs.

You can access this book as well as other State Health Plan materials online anytime at **www.bcbsm.com/som**.

Contact information

You can call or write the Blue Cross Customer Service Center when you have questions about your benefits and claims.

Blue Cross Blue Shield of Michigan

To help us serve you better, here are a few things to remember.

- Have your Blue Cross ID card handy so you can provide your enrollee and group numbers.
- To ask about a medical or hearing claim, provide the following:
  - Enrollee's name
  - Enrollee's ID number
  - Member's name
  - Provider's name
  - Date the patient was treated
  - Charge for the service
- When writing to us, include copies (not originals) of your bills, any correspondence you may have received from us and other relevant documents. Keep your original bills and documents for your files.
- Include your daytime telephone number on all your letters.

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

Calling

We're available by phone Monday through Friday from 7 a.m. to 7 p.m. We are closed on holidays.

Customer Service (for all claim and benefit questions) **1-800-843-4876**

Blue Cross Behavioral Health
(for BH/SUD services 24 hours a day, 7 days a week) **1-866-503-3158**

Telehealth through Virtual Care **1-800-835-2362**

State of Michigan Employee Service Program (ESP) **1-800-521-1377**

Anti-fraud hotline **1-800-482-3787**

Hearing-impaired customers ..... **TTY 711**

Human organ transplant program **1-800-242-3504**

Blue Cross' network of Blue plan providers ..... **1-800-810-BLUE-(2583)**

Writing

Please send all correspondence to:

State of Michigan Customer Service Center
Blue Cross Blue Shield of Michigan
232 S. Capitol Avenue, L04A
Lansing, MI 48933-1504

Online

bcbsm.com/som — Blue Cross' site for State of Michigan retirees
For benefit materials, the State of Michigan claim form and disabled dependent application

bcbsm.com/find-a-doctor — Blue Cross' provider search tool
To find a participating health care provider or facility

State of Michigan

For eligibility questions:

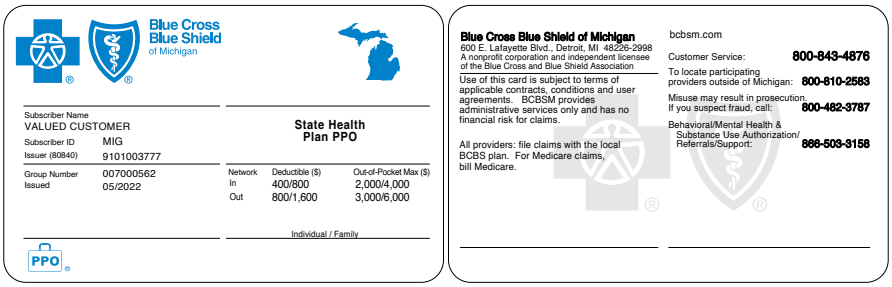
MI HR Service Center
P.O. Box 30002
Lansing, MI 48909
Toll Free: 1-877-766-6447
Fax: 1-517-241-5892

For benefit questions:

Michigan Civil Service Commission
Employee Benefits Division
P.O. Box 30002
Lansing, MI 48909
Toll free: 1-800-505-5011

Your ID card

Your Blue Cross ID card is issued once you enroll for coverage in the SHP PPO. This ID card is applicable for your medical and behavioral health/substance use disorder benefits. Present this ID card every time you need services. Your card will look like the one below.



1st line: **Subscriber Name** is the name of the person who holds the contract. All communications are addressed to this name. Only the enrollee's name appears on the ID card. However, the cards are for use by all covered members.

2nd line: **Subscriber ID** identifies your records in our files.

The **alpha prefix** preceding the enrollee ID number identifies that you have coverage through the SHP PPO.

3rd line: **Issuer** identifies you as a Blue Cross member. The number 80840 identifies our industry as a health insurance carrier.

4th line: **Group Number** tells us you are a Blue Cross group member through the State of Michigan.

Note: This sample ID card includes the individual and family in-network and out-of-network deductible and out-of-pocket maximum amounts.

The suitcase tells providers about your travel benefits. For additional information, go to page 36.

On the back of your ID card, you will find:

- Blue Cross's toll-free customer service telephone numbers to call us when you have a claim or benefit question, or when you need a behavioral health/substance use disorder authorization or referral.

If you or anyone in your family needs an ID card, log in to your account at **bcbsm.com** or call our Customer Service Center for assistance.

- If your card is lost or stolen, call us. You can still receive services by giving the provider your Enrollee ID number to verify your coverage while your new set of cards is on its way.
- You can also log in to your account at **bcbsm.com** to access your virtual ID card. This is a great way to show your coverage to a provider using your mobile phone.

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

Eligibility

To be eligible for coverage under the SHP PPO, you must reside in the U.S. or its territories. For more information about the State of Michigan's eligibility requirements for employee health insurance coverage, visit **www.michigan.gov/employeebenefits**.

In the event you lose your coverage

You can purchase an individual plan from Blue Cross Blue Shield of Michigan, or coverage from the Health Insurance Marketplace. If you'd like information about which individual plan is best for you, contact a Blue Cross Blue Shield Health Plan Advisor at 855-237-3500 or visit **bcbsm.com/stayblue**.

For more information on plans on the Health Insurance Marketplace, visit **healthcare.gov**.

Explanation of cost-share

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

Deductibles

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

The deductible is considered an embedded structure. An embedded structure means that one member cannot meet the full family deductible. Additionally, this means one individual member cannot contribute in excess of the individual deductible toward the family deductible. In the case of two or more members in a family contract, the deductible paid by all members will be combined to satisfy the family deductible.

Certain medical benefits can be rendered before your deductible is fulfilled. For example, there is no deductible for in-network office visits, office consultations, telehealth visits, urgent care visits, emergency room visits, osteopathic and chiropractic spinal manipulations, medical eye exams and medical hearing exams.

Certain behavioral health and substance use disorder benefits can also be rendered before your deductible is fulfilled. For example, emergency room services and some telehealth visits.

For details on the services that do or do not require fulfillment, please refer to the benefit summary chart or benefit explanation in this booklet.

Coinsurance

After you have met your deductible, you are responsible for a percentage of the Blue Cross allowed amount that is determined by whether you receive services in-network or out-of-network. Coinsurance is not the same as your deductible.

Copayments

Copayment is a fixed dollar amount that you pay at the time of a health care service such as an in-network office visit.

Out-of-pocket maximum

The out-of-pocket maximum (OOPM) is the dollar amount you pay in deductible, copayment, and coinsurance during the calendar year. Once you satisfy your OOPM the SHP PPO will cover 100% of the allowed amount for covered services including coinsurances for behavioral health, substance use disorder and prescription drug copays under the State Prescription Drug plan. Certain coinsurance, deductible and other charges cannot be used to meet your OOPM. These coinsurance, deductible and other charges are:

- Out-of-network coinsurance
- Out-of-network deductible
- Charges for noncovered services
- Charges in excess of our approved amount
- Deductibles or copayments required under other Blue Cross coverage

The OOPM is considered an embedded structure. An embedded structure means that one member cannot meet the family OOPM. Additionally, this means one individual member cannot contribute in excess of the individual OOPM toward the family OOPM. In the case of two or more members, the OOPM paid by all members will be combined to satisfy the family OOPM.

State Health Plan PPO

Medical Benefits

Your medical benefits, A-Z

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

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

When seeking services, keep in mind that in-network PPO providers have an agreement to provide services through the Blue Cross PPO program. Out-of-network providers do not have an agreement with Blue Cross to provide services through the Blue Cross PPO program. Before you make an appointment with an out-of-network provider, you will need to find out if they are a participating or a nonparticipating provider with Blue Cross. If they participate, you will be responsible for the out-of-network deductible and coinsurance. If they are nonparticipating, you may be responsible for the out-of-network deductible and coinsurance plus the difference between the charges and the Blue Cross-approved amount. See each section of this benefit guide for any exclusions.

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

Covered up to a maximum of 20 visits in a calendar year when performed by an acupuncturist or a licensed physician (MD or DO), or supervised and billed by a licensed physician (MD or DO).

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

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

Note: Services received by a non-participating acupuncturist are not covered.

Allergy tests and treatments	**In-network – Covered 90% after deductible**	**Out-of-network – Covered 80% after deductible**

Allergy testing, including survey and therapeutic injections, are covered when performed by or under the supervision of a physician. Coverage also includes:

- Allergy extract and extract injections
- Intradermal, scratch and puncture tests
- Patch and photo tests
- Bronchial challenge tests

Benefits are not payable for:

- Fungal or bacterial skin tests, such as those given for tuberculosis or diphtheria
- Self-administration, over-the-counter medications
- Psychological testing, evaluation or therapy for allergies
- Environmental studies, evaluation or control

Ambulance services	**Covered 90% after deductible (No network required)**

You are covered for ambulance services to transport a patient to the nearest medical facility capable of treating the patient's condition.

To be covered, the services must be:

- Medically necessary because transport by any other means would endanger the patient's health
- Prescribed by a physician (when used for transferring a patient)
- Provided in a vehicle qualified as an ambulance and part of a licensed ambulance operation
- Used to transport only the patient to a hospital or to transfer the patient from a hospital to another treatment location such as another hospital, skilled nursing facility or the patient's home

Air or water ambulance is also covered if it meets the criteria above and the patient's emergent condition requires air or water transport rather than ground ambulance. Air or water ambulance providers must be licensed to provide air or water ambulance services and **not** as a commercial air carrier.

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

Ambulatory surgery facility	**In-network – Covered 90% after deductible**	**Out-of-network – Covered 80% after deductible**

Coverage is provided for medically necessary facility services provided by a Blue Cross participating ambulatory surgery facility. A patient must be under the care of a licensed doctor of medicine, osteopathy, podiatry or oral surgery to be admitted to an ambulatory surgery facility. The services must be directly related to performing surgical procedures identified by Blue Cross as covered ambulatory surgery.

Anesthesia	**Covered 90% after deductible**

Medically necessary anesthesia services are a covered benefit under the State's medical plan regardless if the diagnosis is medical or behavioral health. Anesthesia services for Electro-Convulsive Therapy (ECT) is covered under the State's behavioral health and substance use disorder plan.

Bariatric surgery	**In-network – Covered 90% after deductible**	**Out-of-network – Covered 80% after deductible**

Bariatric surgery is covered when you meet certain conditions related to morbid obesity.

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

Coverage includes whole blood, blood derivatives, blood plasma or packed red blood cells and supplies used for administering the services, as well as the cost of drawing and storing self-donated blood intended for scheduled surgery.

Breast reconstruction surgery	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

Surgery is covered for:

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

Cardiac rehabilitation (Phase I and Phase 2)	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

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

Cataract surgery	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

Cataract surgery and first lens implants are covered.

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

Covered services provided by a certified nurse midwife include:

- Gynecological exam
- Health maintenance exam
- Injections
- Normal vaginal delivery when provided in:
  - An inpatient hospital setting
  - A hospital-affiliated birthing center that is owned and operated by a participating state-licensed and accredited hospital, as defined by Blue Cross
- Pre-natal care
- Post-natal care

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

Services are covered when performed by a certified nurse practitioner if the services are within their scope of licensure.

Chelation therapy	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

Chelation therapy is used as a treatment for acute mercury, iron, arsenic, lead, uranium, plutonium and other forms of toxic metal poisoning.

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

Your benefits for chemotherapy are payable in a hospital, outpatient department of a hospital, or in a physician's office. Benefits include the administration and cost of chemotherapy drugs when they are:

- Ordered by a physician for the treatment of a specific type of disease
- Approved by the Food and Drug Administration for use in chemotherapy treatment
- Provided as part of a chemotherapy program

You are also covered for:

- Physician services to administer the chemotherapy drug, **except** those taken orally
- The chemotherapy drug administered in a medically approved manner
- Other FDA-approved drugs classified as:
  - Anti-emetic drugs used to combat the toxic effects of chemotherapeutic drugs
  - Drugs used to enhance chemotherapeutic drugs
  - Drugs to prevent or treat the side effects of chemotherapy treatment
- Infusion pumps used for the administration of chemotherapy, administration sets, refills and maintenance of implantable or portable pumps and ports

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

Chiropractic mechanical traction and massage therapy	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

Chiropractic mechanical traction as well as massage therapy are included with physical, occupational and speech therapy for a combined maximum of 90 visits. Massage therapy is only payable as part of the overall physical therapy treatment plan. Massage therapy alone, either as a one-time service or as a series of massages over time is not a covered benefit. Massage therapy performed by a massage therapist must be supervised by a chiropractor and be part of a formal course of physical therapy.

Chiropractic office visits	In-network – Covered $20 copay	Out-of-network – Covered 80% after deductible

Coverage includes office visits for:

- New patient: 1 visit every 36 months
- Established patient: 1 visit per calendar year

Chiropractic spinal manipulation	In-network – Covered $20 copay	Out-of-network – Covered 80% after deductible

Coverage includes spinal manipulation of the spine if medically necessary to correct a subluxation. 24 visits per calendar year. Note: Maintenance therapy is not a covered benefit.

Chiropractic X-rays	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

Covered for accidental injuries.

Clinical trials	Covered 90% after deductible in designated facilities when pre-approved

Oncology clinical trials:
Coverage is provided for a study conducted on a group of patients to determine the effect of a cancer treatment. This includes Phase I, Phase II, Phase III and Phase IV.

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

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

- The inpatient admission and length of stay must be medically necessary and pre-approved. No retroactive approvals will be granted.
- The services must be performed at a National Cancer Institute (NCI)-designated cancer center or an affiliate of an NCI-designated center.
- The treatment plan, also called "protocol," must meet the guidelines of the American Society of Clinical Oncology statement for clinical trials.

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

Please call the Blue Cross Customer Service Center for additional information on specified oncology clinical trials.

Approved clinical trials for other life-threatening diseases or conditions:
Please call the Blue Cross Customer Service Center for additional information and requirements for specific, approved clinical trials for other life-threatening diseases or conditions.

Consultations – hospital	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

Medical consultations are payable when a physician requires assistance in diagnosing or treating a medical condition.

What is not covered
Consultations and/or pre-anesthesia evaluations are not payable when billed with one of the following diagnostic conditions:

- Experimental
- Obesity
- Research
- Routine
- Routine foot care
- Screening
- Psychological
- Staff consultations required by a facility's or program's rules

Note: Hospital outpatient consultations rendered by your primary care physician will be covered under the State's medical plan regardless if the diagnosis is medical or behavioral health. Hospital outpatient consultations rendered by a behavioral health provider will be considered for payment based on the guidelines in the Behavioral Health and Substance Use Disorder section of this benefit guide.

Consultations – office	In-network – Covered $20 copay	Out-of-network – Covered 80% after deductible

In a physicians' office setting, services are covered when they are performed by a physician whose advice or opinion is requested by another physician or other appropriate source for further evaluation of the patient and generally includes exam of patient, patient's record and written report.

Note: Office consultations rendered by your primary care physician will be covered under the State's medical plan regardless if the diagnosis is medical or behavioral health. Office consultations rendered by a behavioral health provider will be considered for payment based on the guidelines in the Behavioral Health and Substance Use Disorder section of this benefit guide.

Consultations – pre-surgical	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

When your physician recommends surgery, you have the option of having a pre-surgical consultation with another physician who is a doctor of medicine, osteopathy, podiatry or an oral surgeon.

You may obtain pre-surgical consultations if the surgery will take place in an inpatient or outpatient hospital setting or ambulatory surgery facility and is covered under the SHP PPO.

You are limited to three pre-surgical consultations for each surgical diagnosis. The three consultations consist of a:

- Second opinion – a consultation to confirm the need for surgery
- Third opinion – allowed if the second opinion differs from the initial proposal for surgery
- Nonsurgical opinion – given to determine your medical tolerance for the proposed surgery

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

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

Cosmetic surgery	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

Cosmetic surgery is payable only for:

- Correction of deformities present at birth. Congenital deformities of the teeth are not covered
- Correction of deformities resulting from cancer surgery, including reconstructive surgery after a mastectomy
- Conditions caused by accidental injuries
- Traumatic scars

Note: Physician services for cosmetic surgery are **not payable** when services are primarily performed to improve appearance.

Dental surgery	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

Dental surgery performed on an inpatient basis is covered if a patient has a medical condition that makes it unsafe for dental treatment to be performed in the office setting. Surgery must be performed by an MD or DO. Dental procedures performed by a DDS must be billed to the dental program.

Dental surgery is payable **only** for:

- Multiple extractions or removal of unerupted teeth, alveoplasty or gingivectomy when a hospitalized patient has a dental condition that is adversely affecting a medical condition and treatment of the dental condition is expected to improve the medical condition
- Surgery directly to the temporomandibular joint (jaw joint)
- Arthrocentesis performed for the treatment of temporomandibular joint (jaw joint) dysfunction

Dental treatment (accidental dental – emergency only)	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

Accidental dental services are covered to provide relief of pain and discomfort following an injury, as well as repair of those injuries. These services must be completed within six months of the initial injury to be payable under the SHP PPO. An accidental injury is defined as an external force to the lower half of the face or jaw that damages or breaks sound natural teeth, periodontal structures (gums) or bone. Injury as a result of chewing or biting is not considered an accidental injury.

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

Determination of refractive state	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

Determination of refractive state is necessary for obtaining glasses and is covered under these circumstances:

- A provider must identify your refractive state to determine an injury, illness or disease
- An ophthalmologist or an optometrist must determine the refractive date for corrective lenses
- Your refractive state is determined as part of a surgical procedure

Diabetic supplies	Participating provider – Covered 100%	Nonparticipating provider – Covered 80% of approved amount (plus, the difference between charge and approved amount)

The SHP PPO covers blood sugar testing monitors, blood sugar and urine test strips, lancet devices and lancets, blood sugar control solutions, and diabetic therapeutic shoes.

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

Self-management diabetic training is considered medically necessary depending on diagnosis by an MD or DO who is managing your diabetic condition. Medical necessity may be a significant change with long-term implications in the symptoms or conditions that necessitate changes in self-management. Medical necessity can also be a significant change in medical protocol or treatment.

Diagnostic tests and radiation services	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

Coverage includes physician services for diagnostic and radiation services to diagnose and treat disease, illness, pregnancy or injury through:

- Diagnostic radiology that includes X-rays, ultrasound, radioactive isotopes, and MRI and CAT scans of the head and body when performed for an eligible diagnosis
- Laboratory and pathology tests
- Diagnostic tests which include EKGs, EEGs, EMGs, thyroid function tests, nerve conduction and pulmonary function studies

- Radiation therapy, which includes radiological treatment by X-ray, isotopes or cobalt for a malignancy
- Medically necessary mammography
- Position emission tomography (PET) scans

Services must be provided by your physician or by another physician, if prescribed by your physician.

Note: All medically necessary diagnostic services are covered under the State's medical plan regardless if the diagnosis is medical or behavioral health.

Dialysis services – facility	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

Coverage includes medically necessary services provided to treat patients with chronic, irreversible kidney disease are payable.

The following services are covered:

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

Dialysis services – home	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

Dialysis services (hemodialysis and peritoneal dialysis), supplies and equipment are payable when provided in the home to treat chronic, irreversible kidney failure. Services must be billed by a hospital or freestanding End Stage Renal Disease facility participating with Blue Cross and must meet the following conditions:

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

Covered services:

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

What is not covered

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

Durable medical equipment; prosthetic and orthotic, and medical supplies	Participating provider – Covered 100%	Nonparticipating provider - Covered 80% of approved amount (plus, the difference between charge and approved amount)

Coverage includes items like oxygen, CPAP and related respiratory equipment and supplies, ostomy supplies, and parenteral and enteral nutrition therapy, wheelchairs, walkers, canes, crutches and hospital beds ordered by a doctor or other health care provider for use in the home. Some items must be rented.

Emergency care	$200 copay for emergency room (waived if admitted as inpatient)

Your benefit plan covers the sudden and unexpected condition that threatens life or could result in serious bodily harm if prompt medical attention is not received. The patient's condition must be such that failure to obtain care or treatment could reasonably result in significant impairment to bodily functions, permanent health condition is placed in jeopardy, or condition could result in death. Initial examination must occur within 48 hours of the injury or 72 hours of the medical emergency.

Copayment is waived only if the patient is admitted as inpatient. Observation care is not considered an inpatient admission. For more information on how observation care is covered, please go to the Observation care benefit.

Your coverage provides payment for the initial examination and treatment of accidental injuries and conditions determined by Blue Cross to be medical emergencies.

What is not covered

- Follow-up care
- Chronic conditions unless an acute, life-threatening attack occurs
- Care and treatment once you are stabilized
- Continuation of care beyond that needed to evaluate or stabilize your condition in an emergency department

Note: Emergency care not resulting in a hospital admission is covered under the State's medical plan regardless if the diagnosis is medical or behavioral health or substance use disorder.

End Stage Renal Disease (ESRD)	See "Dialysis services" for additional benefit information.

ESRD is a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life. You may become entitled to Medicare based on ESRD. Benefits on the basis on ESRD are for all covered services, not only those related to the kidney failure condition. Eligible individuals should contact Social Security to enroll in Medicare.

Medicare is the secondary payer to the State Health Plan for individuals entitled to Medicare solely based on ESRD for a coordination period of 30 months. After the 30-month coordination period ends, the State Health Plan is secondary, and Medicare is your primary plan.

Dual entitlement

If you have dual entitlement to Medicare **and** have the SHP PPO benefits, the following conditions apply:

- If you first become eligible to enroll in Medicare because of ESRD and subsequently also become entitled to Medicare because of Disability or Age, the ESRD guidelines continues to apply. The State Health Plan is primary through the end of the 30-month coordination period. At the end of the 30-month coordination period, Medicare becomes the primary payer of benefits, even if Medicare would otherwise be secondary under the Working Aged or Disability guidelines.

- If you are entitled to Medicare based on ESRD and entitled based on Working Aged or Disability, the following Medicare guidelines apply:
  - If you are a Working Aged or a Disabled individual in your first month of dual entitlement, the State Health Plan is primary through the end of the 30-month coordination period. At the end of the 30-month coordination period, Medicare becomes the primary payer of benefits.
  - If you are already entitled to Medicare based on age or disability and you are not actively working in the first month of dual entitlement, Medicare is your primary plan.

Foot care	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

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

Hearing care

Your hearing care coverage is designed to identify hearing problems and provide benefits for corrective hearing problems. Hearing benefits are covered only when services are received from a participating provider and are payable once every 36-months, unless significant hearing loss occurs earlier and is certified by your physician. An example of severe hearing loss would be when a person wearing the hearing aid cannot distinguish normal speech 25 percent of the time.

All out-of-state providers are paid the amount that is approved by the local Blue Cross Blue Shield Plan.

Hearing care: Audiometric examination	Participating provider – Covered 100%	Nonparticipating provider - Not covered

Audiometric examinations must be performed by a participating physician-specialist, audiologist, or hearing aid dealer. Covered services include tests for measuring hearing perception relating to air conduction, bone conduction, speech reception threshold and speech discrimination and providing a summary of findings.

Hearing care: Hearing aid evaluation and conformity test	Participating provider – Covered 100%	Nonparticipating provider – Not covered

Evaluation and test must be prescribed by a physician and performed by a participating physician-specialist, audiologist, or hearing aid dealer.

Hearing care: Hearing aids	Participating provider – Covered 100% for standard and binaural aids	Nonparticipating provider – Not covered

Hearing benefits are payable once every 36 months, unless significant hearing loss occurs earlier and is certified by your physician. An example of severe hearing loss would be when a person wearing the hearing aid cannot distinguish normal speech 25 percent of the time. Coverage includes payment for standard or binaural hearing aids. Deluxe hearing aids are covered up to the amount paid for standard hearing aids. You are liable for the balance of the cost.

Hearing care: Medical hearing clearance exam	In-network – $20 copay	Out-of-network – Covered 80% after deductible

You are covered for exams to evaluate sensory neural and conductive hearing losses. Services must be provided prior to receiving hearing aids. Exams may include a basic hearing screening, which is a brief evaluation done during a routine office visit.

For members 17 years or younger, the exam is required for each hearing aid purchase. For members over age 17, the exam is only required on the initial hearing aid purchase.

Hearing care: Ordering and fitting of the hearing aid	Participating provider – Covered 100%	Nonparticipating provider – Not covered

Includes basic hearing aids in-the-ear, behind-the-ear, and worn on the body with ear molds, if necessary, as well as dispensing fees for the normal services required for fitting the hearing aid.

Your hearing care coverage does not cover:

- A hearing aid ordered while the patient is a member, but delivered more than 60 days after the patient's coverage terminates
- Additional charges for unusual or cosmetic equipment such as canal, one half shell or low profile hearing aids (sometimes called "deluxe" hearing aids) that exceed the amount Blue Cross pays for a basic hearing aid
- All hearing care services and supplies provided by a nonparticipating provider
- Medical clearance examination to determine possible loss of hearing (covered under medical benefit)
- Repairs and replacement of parts including batteries and ear molds
- Replacement of hearing aids that is lost or broken, unless this occurs after 36 months, when benefits are renewed
- The trial and testing of different makes and models of hearing aids when the tests are not supported by the results of the most recent audiometric examination
- Charges for audiometric examinations, hearing aid evaluation tests, conformity tests and hearing aids which are not necessary, according to professionally accepted standards of practice, or which are not prescribed by the physician-specialist
- Charges for spare hearing aids
- Examinations related to medical-surgical procedures such as tonsillectomies or myringotomies
- Two hearing aids ordered on different dates. These are not considered binaural hearing aids

Hemophilia	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

Your benefit covers human antihemophilic factor to reduce the incidence of bleeding episodes and resultant joint damage for individuals who have severe hemophilia A or B.

Home health care	Participating provider – Covered 90% after deductible	Nonparticipating provider – Not covered

Your home health care benefit covers services when the service is prescribed by an attending physician and provided and billed by a participating home health care agency. The physician must certify that the home health care services are being used instead of inpatient hospital care, and that the patient is confined to the home due to illness. This means that transporting the patient to a health care facility, physician's office or hospital for care and services would be difficult due to the nature or degree of the illness.

Covered services include:

- Skilled nursing care provided or supervised by a registered nurse employed by the home health care agency
- Social services by a licensed social worker, if requested by the patient's attending physician
- Physical therapy, speech and language pathology services and occupational therapy are payable when provided for rehabilitation

If equipment for therapy and speech evaluation cannot be taken to the patient's home, therapy and speech evaluation in an outpatient department of a hospital or a freestanding outpatient physical therapy facility are covered, and are subject to the physical, speech and occupational therapy 90-visit maximum.

Your home health care coverage does not cover:

- Custodial care, non-skilled care rest therapy and care in nursing or rest home facilities
- Health care services provided by persons who are not legally qualified or licensed to provide such services
- General housekeeping services
- Transportation to or from a hospital or other facility

Home infusion therapy (HIT)	Participating provider – Covered 90% after deductible	Nonparticipating provider – Not covered

Home infusion therapy services are covered whether or not you are confined to the home. To be eligible for home infusion therapy services, your condition must be such that home infusion therapy is:

- Prescribed by the attending physician to manage an incurable or chronic condition or treat a condition that requires acute care if it can be safely managed in the home
- Medically necessary
- Given by participating HIT providers

Services include:

- Drugs required for HIT
- Nursing services needed to administer HIT and treat home infusion therapy-related wound care
  Note: Nursing services must meet Blue Cross's medical necessity guidelines to be payable.
- Durable medical equipment, medical supplies and solutions needed for home infusion therapy
  Note: Except for chemotherapeutic drugs, HIT is only covered under the home health care benefit.

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

Home visits by a physician are covered.

Hospice care	Participating provider – Covered 100%	Nonparticipating provider – Not covered

Hospice services are health care services provided to a member who is terminally ill. Services must be provided by a participating hospice program. While regular benefits for conditions related to the terminal illness are not in force while hospice benefits are being used, benefits for conditions unrelated to the terminal illness remain in effect. Hospice services include meetings with the hospice staff for a maximum of 28 visits for preadmission counseling, evaluation, education and support services. Hospice services also include routine home care.

Hospital services

- Inpatient care provided by a:
  - Participating hospice inpatient unit
  - Participating hospital contracting with the hospice program or
  - Skilled nursing facility contracting with the hospice program

- Short-term general inpatient care when the patient is admitted for pain control or to manage symptoms. (These services are payable if they meet the plan of care established for the patient.)
- Five days of occasional respite care during a 30-day period
- Physician services by a member of the hospice interdisciplinary team
- Nursing care provided by, or under the supervision of, a registered nurse
- Medical social services by a licensed social worker, provided under the direction of a physician
- Counseling services to the patient and to caregivers, when care is provided at home
- Blue Cross - approved medical appliances and supplies (these include drugs and biologicals to provide comfort to the patient)
- Blue Cross - approved durable medical equipment furnished by the hospice program for use in the patient's home
- Physical therapy, speech and language pathology services and occupational therapy when provided to control symptoms and maintain the patient's daily activities and basic functional skills
- Bereavement counseling for the family after the patient's death

Physician services

Services provided by the attending physician (not part of the hospice team) to make the patient comfortable and to manage the terminal illness and related conditions.

Hospice care is limited to a maximum amount that is reviewed and adjusted periodically. Please call the Blue Cross State of Michigan Service Center for information about the current maximum amount.

Your hospice services coverage does not cover:

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

Hospice respite care	Participating provider – Covered 100%	Nonparticipating provider – Not covered

Your coverage includes a short-term relief for in-home hospice caregivers. Your benefits pay for patient transport and up to five consecutive days of inpatient care at a Blue Cross-approved nursing facility or hospital. You can get respite care more than once, but only on an occasional basis.

Hospital care – facility services	In-network – Covered 100%	Out-of-network – Covered 80% after deductible

Your benefit covers office visits when rendered in an outpatient hospital setting for the medically necessary diagnosis or treatment of an injury or sickness.

Hospital care – inpatient	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

Your coverage includes the following inpatient hospital services when medically necessary:

- Semi-private room and board, general nursing services and special diets
- Services provided in a special care unit, such as intensive care
- Inpatient rehabilitation
- Physician services
- Unlimited general medical care days

- Anesthesia, laboratory, oxygen, radiology and pathology services, drugs, durable medical equipment, medical and surgical supplies, prosthetic and orthotic appliances
- Chemotherapy, inhalation therapy and hemodialysis
- Diagnostic and radiology services
- Maternity care, and routine nursery care for a newborn during an eligible mother's hospital stay
- Operating and other surgical treatment rooms, delivery room and special care units
- Physical, speech and occupational therapy (Note: Not subject to the 90-visit benefit maximum)
- Pain management
- Cardiac rehabilitation services
- Whole blood, blood derivatives, blood plasma or packed red blood cells, supplies and their administration
- Hyperbaric oxygenation (therapy given in a pressure chamber)
- Organ transplants
- Other inpatient services and supplies necessary for treatment

Note: If you choose to go to a non-participating hospital when you have adequate access to a network hospital, the SHP PPO will not cover the charges.

Hospital care – outpatient	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

The services listed under "Hospital care – inpatient" are also payable when provided as outpatient care when performed in the outpatient department of a hospital or, where noted, in a freestanding facility approved by Blue Cross. See the individual benefit listing for details.

Note: If you choose to go to a non-participating hospital when you have adequate access to a network hospital, the SHP PPO will not cover the charges.

Hospital care – physician services	In-network – Covered $20 copay	Out-of-network – Covered 80% after deductible

Your benefit covers office visits when rendered in an outpatient setting outside of the main hospital campus (e.g., physician practices owned by the hospital) as well as inside the main hospital campus for the medically necessary diagnosis or treatment of an injury or sickness. Outpatient office visits rendered by your primary care physician will be covered under the State's medical plan regardless if the diagnosis is medical or behavioral health. Outpatient care rendered by a behavioral health provider will be considered for payment based on the guidelines in the Behavioral Health and Substance Use Disorder section of this benefit guide.

Human organ transplants Call HOTP at 1-800-242-3504 for more information

Human organ transplants and bone marrow	Covered 100% when pre-approved (Designated facilities)	Non-designated facilities – Not covered

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

- Combined small intestine-liver
- Heart
- Heart-lung(s)
- Liver
- Lobar lung

- Lung(s)
- Pancreas
- Partial liver
- Kidney-liver
- Simultaneous pancreas-kidney
- Small intestine (small bowel)
- Multivisceral transplants (as determined by Blue Cross)

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

When directly related to the transplant, we cover:

- Facility and professional services
- Anti-rejection drugs and other transplant-related prescription drugs, during and after the benefit period, as needed. Payment will be based on Blue Cross's approved amount
- Immunization against certain common infectious diseases during the first 24 months post-transplant (as recommended by the Advisory Committee on Immunization Practices (ACIP)
- Medically necessary services to treat a condition arising out of the organ transplant surgery if the condition:
  - Occurs **during** the benefit period and
  - Is a **direct** result of the organ transplant surgery

    Note: We will cover any service needed to treat a condition as a **direct** result of the organ transplant surgery as long as it is a benefit under any of our certificates.

When directly related to two tandem transplants, two single transplants or a single and a tandem transplant per member, per condition, the following services are covered:

- Allogeneic transplants are covered for the following services:
  - Blood tests on first degree relatives to evaluate them as donors (if the tests are not covered by their insurance)
  - Search of the National Bone Marrow Donor Program Registry for a donor. A search will begin only when the need for a donor is established and the transplant is pre-approved
  - Infusion of colony stimulating growth factors
  - Harvesting (including peripheral blood stem cell pheresis) and storage of the donor's bone marrow, peripheral blood stem cell and/or umbilical cord blood, if the donor is:
    - A first degree relative and matches at least four of the six important HLA genetic markers with the patient or
    - Not a first degree relative and matches five of the six important HLA genetic markers with the patient. (This provision does not apply to transplants for sickle cell anemia or beta thalassemia.)
    - Harvesting and storage are covered if it is not covered by the donor's insurance, but only when the recipient of harvested material is a Blue Cross member. In a case of sickle cell anemia or beta thalassemia, the donor must be an HLA-identical sibling.
- High-dose chemotherapy and/or total body irradiation
- Infusion of bone marrow, peripheral blood stem cells, and/or umbilical cord blood
- T-cell depleted infusion
- Donor lymphocyte infusion
- Hospitalization

Travel and Lodging:
We will pay up to a total of $5,000 for your travel and lodging expenses. They must be directly related to pre-approved services rendered during an approved clinical trial. The expenses must be incurred during the period that begins with the date of pre-approval and ends 180 days after the transplant. However, these expenses will not be paid if your coverage is no longer in effect.

We will pay the expenses of an adult member and another person. If the member is under the age of 18, we pay for the expenses of the member and two additional people. The following per day amounts apply to the combined expenses of the member and persons eligible to accompany the member:

- $60 per day for travel
- $50 per day for lodging

Note: These daily allowances may be adjusted from time to time. Please call Blue Cross Customer Service to find out the current maximums.

We also cover the following:

- Up to $10,000 for eligible travel and lodging during the initial transplant surgery. This includes the cost of transportation to and from the designated transplant facility for the patient and another person eligible to accompany the patient (two persons if the patient is a child under the age of 18 or if the transplant involves a living-related donor). Transportation and lodging costs for circumstances other than those related to the initial transplant surgery and hospitalization are not covered

  Note: In certain limited cases, we may consider return travel needed for an acute rejection episode to the original transplant facility. The condition must be emergent and must fall within the benefit period. The cost of the travel must still fall under the $10,000 maximum for travel and lodging.
- Reasonable and necessary costs of lodging for the person(s) eligible to accompany the patient ("lodging" refers to a hotel or motel)

Cost of acquiring the organ (the organ recipient must be a Blue Cross member. This includes, but is not limited to:

- Surgery to obtain the organ
- Storage of the organ. Storage of donor organs for the purpose of future transplants is not covered
- Transportation of the organ
- Living donor transplants such as partial liver, lobar lung, small bowel, and kidney transplants that are part of a simultaneous kidney transplant
- Payment for covered services for a donor if the donor does not have transplant services under any health care plan

Human organ transplants – cornea and kidney	**In-network – Covered 90% after deductible**	**Out-of-network – Covered 80% after deductible**

The SHP PPO will pay for services performed to obtain, test, store and transplant human tissues and organs such as cornea and kidney.

What is not covered

- Post-transplant immunizations for cornea are not covered

Human organ transplant – skin	**In-network – Covered 90% after deductible**	**Out-of-network – Covered 80% after deductible**

The SHP PPO will pay for services performed to obtain, test, store and transplant human tissues such as skin.

Injections	**In-network – Covered 90% after deductible**	**Out-of-network – Covered 80% after deductible**

Fluids that are forced into a vein or body organ or under the skin to fight disease are payable.

Laboratory and pathology (clinical)	**In-network – Covered 90% after deductible**	**Out-of-network – Covered 80% after deductible**

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

Laboratory and pathology (non-clinical)	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

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

Maternity care

You have coverage for pre- and post-natal services, including services provided by a physician attending the delivery. Maternity care benefits are also payable when provided by a certified nurse midwife. Some services may not be covered under pre-natal care but are covered under other services (e.g., laboratory, pathology, and ultrasounds).

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

Note: The baby must be eligible for coverage and must be added to your contract within 31 days of the birth.

Prenatal care	In-network – Covered 100%	Out-of-network – Covered 80% after deductible
Delivery and nursery	In-network – Covered 90% after deductible	
Postnatal care	In-network – Covered 100%	

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

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

Metabolic foods	Covered 90% after deductible (No network required)

Metabolic foods are a covered benefit and require a prescription from your provider as well as an annual letter of medical necessity. If you receive services from a nonparticipating provider, you will need to complete a Blue Cross Member Reimbursement form. The form can be found on **bcbsm.com/som/employees** under the *Forms* tab. Attach an itemized receipt that includes a description of the metabolic foods, the diagnosis, the prescription and the annual letter of medical necessity. Submit the form with this documentation to:

Blue Cross Blue Shield of Michigan
Member Reimbursement – Mail Code: 0010
600 E. Lafayette Blvd.
Detroit, MI 48226

Nutritional & health education and counseling	In-network – Covered 100%	Out-of-network – Not covered

The plan covers up to six visits per calendar year. You can seek services from certified dietitians and/or nutritionists.

Observation care	Covered 100% (No network required)

Your benefit covers hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. Because observation services often involve an overnight stay in the hospital, they may look no different than inpatient services.

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

Your benefit covers doctor office visits and doctor office consultations when rendered in an office setting for the medically necessary diagnosis or treatment of an injury or sickness. Additionally, your benefit covers office visits for behavioral health diagnoses rendered by your primary care physician.

Note: Office visits and office consultations rendered by your primary care physician will be covered under the State's medical plan regardless if the diagnosis is medical or behavioral health. Office visits and office consultations rendered by a behavioral health provider will be considered for payment based on the guidelines in the Behavioral Health and Substance Use Disorder section of this benefit guide.

Optical services – post cataract surgery	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

Your benefits include the examination and fitting of one pair of contact lenses or eyeglasses when prescribed by a physician following cataract surgery and obtained within one year of the surgery. Cataract sunglasses are not covered.

Oral surgery	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

Oral surgery is covered with limitations.

Orthognathic surgery	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

Orthognathic surgery is covered with limitations.

Osteopathic manipulation	In-network – $20 copay	Out-of-network – Covered 80% after deductible

Coverage is provided for osteopathic manipulation.

Physical, occupational, speech, and massage therapy (combined maximum of 90 visits)	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

Physical therapy, speech and language pathology services, and occupational therapy are payable when provided for rehabilitation. Therapy must be given for a condition that can be significantly improved in a reasonable and generally predictable period (usually about six months). This includes services rendered in a physician's office and an outpatient facility. Chiropractors may perform massage therapy when provided as part of a complete physical therapy plan. Massage therapy performed by a massage therapist must be supervised by a chiropractor and be part of a formal course of physical therapy. Massage therapy not part of a formal course of treatment is not a covered benefit. Developmental speech therapy is also covered. (The benefit maximum does not apply for developmental speech therapy).

Note: Physical, occupational and speech therapies are not payable when provided in a nonparticipating freestanding outpatient physical therapy facility, or any other nonparticipating facility independent of a hospital or an independent sports medicine facility.

Benefit maximum

These services have a combined benefit maximum of 90 visits per member, per calendar year, for services rendered in an outpatient location (hospital outpatient, independent therapist offices, freestanding outpatient physical therapy facility or physician's office) whether obtained from an in-network or out-of-network provider.

Physical, occupational and speech therapy services related to autism treatment are not subject to the combined benefit maximum of 90 visits.

Mechanical traction performed by a chiropractor **is** applied toward this maximum.

The physical therapy, speech and language pathology services and occupational therapy benefit maximum renews each calendar year.

Visit count

Each treatment date counts as one visit even if two or more therapies are provided and two or more conditions are treated. For example, if a facility provides you with physical therapy and occupational therapy on the same day, the services are counted as one visit.

An initial evaluation is not counted as a visit. If approved, it will be paid separately from the visit and will not be applied towards the maximum benefit limit.

Physical therapy must be:

- Given by a(n):
  - Doctor of medicine, osteopathy or podiatry
  - Dentist for the oral-facial complex
  - Chiropractor rendering mechanical traction
  - Optometrist for services which he or she is licensed
  - Certified nurse practitioner in an independent practice
  - Physical therapist
  - Physical therapist in a physician's or independent physical therapist's office
  - Independent physical therapist in his or her office
  - Physical therapy assistant and athletic trainer under the direct supervision of a physical therapist
  - Physician assistant or certified nurse practitioner employed by a physician
  - Physical therapy assistant or athletic trainer under the direct supervision of an independent physical therapist in the therapist's office

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Speech and language pathology services must be:

- Given by a speech-language pathologist certified by the American Speech-Language-Hearing Association or by one fulfilling the clinical fellowship year under the supervision of a certified speech-language pathologist

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Occupational therapy must be:

- Given by a(n):
  - Occupational therapist
  - Occupational therapy assistant under the direct supervision of an occupational therapist
  - Athletic trainer under the direct supervision of an occupational therapist

  Note: Both the occupational therapist and the occupational therapy assistant must be certified by the National Board of Occupational Therapy Certification and registered or licensed in the state where the care is provided.

What is not covered:

- Health club membership or spa membership
- Massage therapy (Unless it is part of the overall treatment plan)
- Services provided by speech-language pathology assistants or therapy aides
- Inpatient hospital admissions principally for speech or language therapy
- Treatment solely to improve cognition (e.g., memory or perception), concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought

  Note: We may pay for treatment to improve cognition when part of a comprehensive rehabilitation plan of care.
- Recreational therapy
- Therapy to treat long-standing, chronic conditions such as arthritis that have not responded to or are unlikely to respond to therapy
- Tests to measure physical capacities such as strength, dexterity, coordination or stamina, unless part of a complete physical therapy treatment program
- Patient education and home programs (such as home exercise programs)
- Sports medicine for purposes such as prevention of injuries or for conditioning

Pre-admission testing	**In-network – Covered 90% after deductible**	**Out-of-network – Covered 80% after deductible**

Testing must be performed within seven days before a scheduled hospital admission or surgery. These tests must be medically appropriate, valid at the time of admission and must not be duplicated during the hospital stay.

Preventive services	**Covered 100%**

Preventive services may include tests or services recommended by your doctor when they are used to first detect or screen for a disease or condition. Examples of preventive services are those included in annual exams, such as health maintenance exams (physicals) or OB-GYN visits.

For a complete list of preventive services covered under the SHP PPO, visit the benefits tab of the State of Michigan Employees page at: **www.bcbsm.com/som**.

Private duty nursing (requires prior authorization)	**In-network – Covered 90% after deductible**	**Out-of-network – Covered 80% after deductible**

Your benefits provide for in-home private duty nursing services when your medical condition requires these services. Services must be prescribed by a physician and provided by a registered or licensed practical nurse. The State Health Plan does not cover private duty nursing services provided by medical assistants, nurse's aides, home health aides, or other non-nurse level caregivers.

Rural health clinic	**In-network – $20 copay**	**Out-of-network – Covered 80% after deductible**

Your benefit covers doctor visits when rendered in a rural health clinic setting for the medically necessary diagnosis or treatment of an injury or sickness.

Note: Services rendered at a rural health clinic relating to behavioral health will be considered for payment based on the guidelines in the Behavioral Health and Substance Use Disorder section of this benefit guide.

Rural health clinic – facility services	In-network – Covered 100%	Out-of-network – Covered 80% after deductible

Your benefit covers facility services when rendered in a rural health clinic setting for the medically necessary diagnosis or treatment of an injury or sickness.

Self-administered drugs	Covered 100%

Your benefits provide for self-administered drugs provided in the hospital outpatient setting.

Skilled nursing care	In-network – Covered 90% after deductible (in a Blue Cross-approved facility)	Out-of-network – Not covered

Your benefits provide for skilled care and related physician services in a skilled nursing facility (SNF). Admission is covered when:

- Care is received in a Blue Cross-approved SNF
- The admission is ordered by the patient's attending physician
- The patient is suffering from or gradually recovering from an illness or injury and is expected to improve

We require written confirmation of the need for skilled care from the patient's attending physician.

Benefit period

Maximum of up to 120 days per confinement.

Note: Nursing services are covered under the State's medical plan regardless if the diagnosis is medical or behavioral health. Nursing service rendered by a behavioral health provider will be considered for payment based on the guidelines in the Behavioral Health and Substance Use Disorder section of this benefit guide.

The following services are covered:

- Semiprivate room, general nursing services, meals and special diets
- Special treatment rooms
- Laboratory examinations
- Oxygen and other gas therapy
- Drugs, biologicals and solutions used while in the SNF
- Gauze, cotton, fabrics, solutions, plaster, and other materials used in dressings and casts
- Durable medical equipment used in the SNF or for use outside of the facility when rented or purchased from the facility upon discharge
- Physical therapy, occupational therapy, and speech and language pathology services

  Note: PT, OT and ST services must not be the principal reason for an admission or provided in conjunction with a noncovered admission. The physical and occupational therapy or speech-language pathology services that are done in a skilled nursing facility are inpatient benefits. The 90 visit benefit maximums apply only when these services are provided on an outpatient basis.

What is not covered

- Care for long-term mental illness
- Care for senility or intellectual disability
- Care for substance use disorder
- Custodial care

Sleep studies	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

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

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

Sleep studies are not covered for the following:

- Bruxism
- Drug dependency
- Enuresis
- Hypersomnia
- Impotence
- Night terrors or dream anxiety attacks
- Nocturnal myoclonus
- Restless leg syndrome
- Shift work and schedule disturbances

Surgery	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

Surgery is covered inpatient and outpatient, in the physician's office and in ambulatory surgical facilities.

Multiple surgeries (two or more surgical procedures performed by the same physician during one operative session) are also covered, but are subject to the following payment limitations:

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

Coverage also includes the administration of anesthesia, performed in connection with a covered service by a physician, other professional provider or certified registered nurse anesthetist who is not the surgeon or the assistant at surgery or by the surgeon in connection with covered oral surgical procedures.

A technical surgical assistant is covered for certain major surgeries that require surgical assistance by another physician.

What is not covered

- Cosmetic surgery and related services solely for improving appearance, except as specified in this booklet
- Dental surgery other than for the removal of impacted teeth or multiple extractions when the patient must be hospitalized for the surgery because a concurrent medical condition exists
- Reverse sterilization

Telehealth - Blue Cross online tool (online visits)	In-network – $0 copay	Out-of-network – Not covered

You have access to online health care powered by Virtual Care, available 24 hours a day, seven days a week from any mobile device or computer.

Telehealth services offered using your provider's online tool	In-network – $20 copay	Out-of-network – Covered 80% after deductible

You have access to online health care using your provider's online tool.

Temporomandibular Joint Syndrome (TMJ)	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

Benefits for TMJ or jaw-joint disorder are limited to:

- Surgery directly to the jaw joint
- X-rays (including MRIs)
- Trigger point injections
- Arthrocentesis (injection procedures)

What is not covered

- Irreversible TMJ services with the exception of surgery directly related to the jaw joint
- Treatment of TMJ and related jaw-joint problems by any method other than as specified in this benefit booklet

Urgent care visits	In-network – $20 copay	Out-of-network – Covered 80% after deductible

Non-emergency treatments are covered at independent urgent care facilities.

Vision screening	In-network – Covered 100%	Out-of-network – Not covered

One vision screening exam is covered per calendar year, must be performed in a physician's office.

Weight loss	Covered 100% (up to $300 lifetime maximum)

When preauthorized by Blue Cross, benefits are available for non-medical weight reduction up to a lifetime maximum of $300.

Wigs	Covered 100% (up to $300 lifetime maximum)

Up to a lifetime maximum of $300 for wigs, wig stands and supplies, such as adhesives. This benefit is for those who need wigs for hair loss due to a medical condition or the treatment of a medical condition. Additional replacements for children due to growth are not limited to the lifetime maximum.

Benefit summary

	In network	Out of network
Cost share		
Out-of-pocket dollar maximums	$2,000 per member $4,000 per family	$3,000 per member $6,000 per family
Deductible	$400 per member $800 per family	$800 per member $1,600 per family
Coinsurance	10% for most services 20% for acupuncture	20% for most services
Fixed dollar copays	$20 copay for office and urgent care visits, medical eye exam, medical hearing exam, osteopathic, chiropractic manipulation $0 copay for telehealth (Blue Cross online tool)	N/A
Preventive services **For a complete list, visit www.bcbsm.com/som**		
Annual gynecological exam	Covered 100%	Not covered
Annual physical		
Adult vaccinations		
Childhood immunizations (through age 16)		Covered 80%
Colonoscopy		Covered 80% after deductible
Mammography		
Prostate screening		Not covered
Well-child visits		
Emergency medical care		
Ambulance services	Covered 90% after deductible	
Emergency room	$200 copay (waived if admitted as inpatient)	
Observation care	Covered 100% (No network required)	
Diagnostic tests and radiation services		
Diagnostic mammography	Covered 90% after deductible	Covered 80% after deductible
Diagnostic tests		
Lab and pathology tests		
Position Emission Tomography (PET) scans		
Radiation therapy		
X-rays, ultrasound, MRI and CAT scans		

This benefit chart is intended as an easy-to-read summary. It is not a contract. Additional limitations and exclusions may apply to covered services. Every effort has been made to ensure the accuracy of this information. However, if statements in this description differ from the applicable coverage documents, then the terms and conditions of those documents will prevail. Payment amounts are based on the Blue Cross-approved amount, less any applicable deductible and/or copay amount required by the SHP PPO. This coverage is provided pursuant to a contract entered into with the State of Michigan and shall be construed under the jurisdiction and according to the laws of the state of Michigan.

	In network	Out of network
Maternity services provided by a physician or certified nurse midwife		
Delivery and nursery care	Covered 90% after deductible	Covered 80% after deductible
Prenatal care	Covered 100%	
Postnatal care		
Hospital care		
Chemotherapy	Covered 90% after deductible	Covered 80% after deductible
Consultations – inpatient and outpatient		
Inpatient care – unlimited days		
Alternatives to hospital care		
Home health care (unlimited visits)	Covered 90% after deductible (participating provider only)	Not covered
Hospice care	Covered 100% (limited to the lifetime dollar maximum that is adjusted annually by the State; participating provider only)	
Private duty nursing (requires prior authorization)	Covered 90% after deductible	Covered 80% after deductible
Skilled nursing care (up to 120 skilled days per confinement)	Covered 90% after deductible (in a Blue Cross–approved facility)	Not covered
Urgent care visit	$20 copay	Covered 80% after deductible
Human organ transplants – Contact HOTP at 1-800-242-3504 for additional criteria and information		
Bone marrow	Covered 100% (in designated facilities)	Not covered
Kidney, cornea and skin	Covered 90% after deductible	Covered 80% after deductible
Liver, heart, lung, pancreas and other specified organs	Covered 100% (in designated facilities)	Not covered
Surgical services		
Surgery	Covered 90% after deductible	Covered 80% after deductible
Voluntary female sterilization	Covered 100%	
Voluntary male sterilization		
Hearing care		
Audiometric exam	Covered 100%	Not covered
Hearing aid evaluation and conformity test		
Hearing aid (ordering and fitting)		
Hearing aids (standard only)		
Medical hearing clearance exam	$20 copay	Covered 80% after deductible

	In network	Out of network
Other services		
Acupuncture	Covered 80% after deductible (if performed by a participating acupuncturist or under the supervision of a M.D. or D.O.)	
Allergy testing and therapy	Covered 90% after deductible	Covered 80% after deductible
Anesthesia	Covered 90% after deductible	
Cardiac rehabilitation (Phase 1 and Phase 2)	Covered 90% after deductible	Covered 80% after deductible
Chiropractic / spinal manipulation 24 visits per calendar year	$20 copay	
Durable medical equipment; prosthetic and orthotic appliances and medical supplies	Covered 100%	Covered 80% of Blue Cross-approved amount (member responsible for difference)
Home visits	Covered 90% after deductible	Covered 80% after deductible
Injections		
Office consultations	$20 copay	
Office and outpatient hospital visits		
Osteopathic manipulation therapy		
Outpatient physical, speech and occupational combined 90 visit maximum per calendar year	Covered 90% after deductible	
Telehealth (Online visits – Blue Cross Online Tool)	$0 copay	Not covered
Telehealth (Online visits – Provider's Tool)	$20 copay	Covered 80% after deductible
Weight loss	Covered ($300 lifetime maximum)	
Wig, wig stand, adhesives	Covered ($300 lifetime maximum; additional wigs covered for children due to growth)	

What is not covered

The following general services are not covered under the SHP PPO:

- Care and services received under another certificate offered by Blue Cross or another Blue Cross Blue Shield Plan
- Infertility treatments
- Items for the personal comfort or convenience of the patient
- Medical services or supplies provided or furnished before the effective date of coverage or after the coverage termination date
- Medically necessary services that can be provided safely in an outpatient or office location are not payable when provided in an inpatient setting
- Premarital or pre-employment exams
- Services and supplies that are not medically necessary according to accepted standards of medical practice
- Services, care, devices or supplies considered experimental or investigative
- Services for which a charge is not customarily made
- Services for which the patient is not obligated to pay or services without cost
- Services that are not included in your plan coverage documents
- Services are not covered for incarcerated members
- Transportation and travel except as specified in this benefit booklet
- Treatment of occupational injury or disease that the State of Michigan is obligated to furnish or otherwise fund

Selecting providers when using your State Health Plan PPO

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

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

- Network providers
- Out of network but participating providers
- Non-participating providers

Network providers

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

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

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

If your PPO physician leaves the network

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

Out of network participating providers

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

Participating providers

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

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

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

Referrals to out of network providers

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

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

Out of network hospitals and facilities

If you choose to go to an out of network hospital or facility when you have adequate access to a network hospital, the SHP PPO will pay 80 percent after your out-of-network deductible.

Nonparticipating providers

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

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

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

Nonparticipating hospitals and facilities

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

Exceptions to the rule

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

The SHP PPO access standards are:

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

Virtual Care

You can visit a board-certified doctor on your smart phone, tablet or computer, for a $0 copay when your regular doctor isn't available. This online virtual doctor's visit available through Teladoc Health® makes it easy for you to get a quick consultation, whether you're away on vacation or at home in bed. The doctor can write prescriptions and will provide a summary of the virtual visit. The best part: Online visits are available to you 24 hours a day, 7 days a week — and the entire appointment takes approximately 10 minutes.

To get started, you can choose from the following:

- Visit **bcbsm.com/virtualcare** for a link to download the Teladoc Health app
- Call **1-800-835-2362**. TTY users, call **1-855-636-1578**.

Teladoc Health® is an independent company that provides Virtual Care Solutions for Blue Cross Blue Shield of Michigan and Blue Care Network.

TruHearing®

State Health Plan members have access to TruHearing®, a national Blue Cross Blue Shield participating provider.

Your State Health Plan covers standard hearing aids at 100 percent of the Blue Cross-approved amount. However, for deluxe hearing aids, you're responsible for the difference between the approved amount and the provider's charge. TruHearing provides exclusive savings of 30 to 50 percent off the retail price of deluxe hearing aids—an average savings of $1,780 per pair.

Combining your hearing aid coverage with TruHearing discounts will help to reduce your out-of-pocket costs.

How it works

Sample Models (per pair)	Retail Price	TruHearing Discounted Charge Price	Blue Cross Approved Amount	You Pay
ReSound Alera 5W	$3,720	$1,790	$2,500	$0
Phonak Audeo Q50	$3,920	$2,190	$2,500	$0
Oticon Nera Pro	$5,900	$3,100	$2,500	$600

Your hearing benefit has not changed. You can choose to see your current hearing aid provider, or any participating provider in our network. However, **you can only access these savings through a Blue Cross participating TruHearing provider.**

For questions about TruHearing, or to schedule an appointment, call TruHearing Customer Care at 844-330-4420. TTY users should call 1-800-975-2674.

Care when you travel

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

If you ever need medical assistance while traveling, follow these steps below.

If you experience an emergency, go to the nearest hospital.

Within the United States

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

1. Go to **bcbs.com** and select 'Find a doctor' to search for the nearest PPO doctors and hospitals.
   - You can also call **1-800-810-BLUE (2583)** any day of the week to speak with an assistance coordinator. The coordinator, in conjunction with a medical professional, will arrange a physician appointment or hospitalization, if necessary.
2. Show your Blue Cross ID card to the provider. Remind your provider to include the alphabetical prefix on all of your claims.
3. Pay the applicable in-network deductibles, coinsurance and copayments required by the SHP PPO. After you receive care, you should:
   - Not have to complete any claim forms
   - Not have to pay upfront for medical services, except for the usual out-of-pocket expenses (noncovered services, deductible, coinsurance and copayment)
   - Receive an Explanation of Benefits (EOB) from Blue Cross

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

Around the world

The SHP PPO only pays for emergency services and unexpected illnesses for residents of the United States traveling in foreign countries. Services are payable if:

- The hospital is accredited
- The physician is licensed

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

If you receive services from a non-participating provider, you will need to pay up front, then complete a claim form and send it with the bill(s) to Blue Cross Blue Shield Global Core. The claim form and instructions are available online at **bcbsglobalcore.com**.

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

Value-added resources at no cost to you

As an employee enrolled in the SHP PPO, you and your eligible dependents can participate in several wellness and discount programs. While these programs are designed to improve health and complement traditional health care, some also could save you money. For more information on these value-added programs, visit **bcbsm.com**.

Blue365℠

With Blue365, you can score big savings and special offers on health products and services from both Michigan and national companies just by showing your Blue Cross ID card. This discount savings program is offered through an easy-to-use online tool updated daily for your convenience. Check out **blue365deals.com** to get started.

Blue Cross® Coordinated Care

Case Management

A serious illness can be overwhelming. We're here to help you. Case management offers comprehensive care management services for high-risk, medically complex cases. They will work with the member, providers and caregivers to ensure a clear understanding of the member's condition, prognosis and treatment options.

Through the Case Management program, our registered nurses will work with you, your family and your regular doctor to:

- Coordinate your care
- Inform you about treatment options
- Help with community resources
- Find specialty medical devices and equipment

To learn more about this program, call **1-800-775-BLUE (2583)**, Monday through Friday 8 a.m. to 6 p.m. Eastern time. TTY users, please call **1-800-240-3050.**

Blue Cross Well-Being℠ – Online well-being resources

The Blue Cross Well-Being website offers you a variety of resources to help you live a healthier lifestyle. Just log in to your member account on **bcbsm.com**, then click on the *Programs & Services* tab. Select *Blue Cross Well-Being* under *Quick Links*. We're working with Personify Health™ to offer:

- An interactive, easy-to-complete health assessment that provides you with a list of your health risks and ways to improve your health
- New well-being courses called Journeys® that offer more than 60 lifestyle and health-related self-guided courses
- Blue Cross Blue Shield of Michigan's Tobacco Cessation Coaching program. It provides you with the support and resources you need to establish and embrace a tobacco-free life
- Fitness tracking that lets you sync data from your fitness app or tracker to Blue Cross Well-Being
- Daily tips to help you live well
- Healthy Habits that provide bite-sized ways to build a healthy routine and improve your well-being
- My Care Checklist, a handy health care tracker that assists you in managing your health by keeping track of well visits, screenings and vaccinations — all in one place
- Sleep and Nutrition Guides

The Engagement Center

The Engagement Center is a central hub of resources where you can learn more about how to make the most of Blue Cross's services and tools. For example, with the 24-Hour Nurse Line, you can contact our team of nurses with any health-related questions you have. To contact the Engagement Center, call **1-800-775-BLUE** from 8 a.m. to 6 p.m. EST Monday through Friday.

Personify Health is an independent company that provides health and well-being services on behalf of Blue Cross Blue Shield of Michigan and Blue Care Network.

Coordination of benefits

Coordination of benefits (COB) is the process group health care plans and insurance carriers use to manage benefits when members are covered by more than one plan. Under COB, group health care plans and insurance carriers work together to make sure members receive the maximum benefits available under their plans. Your SHP PPO requires that your benefit payments are coordinated with those from any other group plan for services that may be payable under both plans.

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

How COB works

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

These are the guidelines used to determine which plan pays first:

- If a group health plan does not have a coordination of benefits provision, that plan is primary.
- If husband and wife have their own coverage, the husband's health coverage is primary when he receives services and the wife's coverage is primary when she receives services.
- If a child is covered under both the mother's and the father's plan, the plan of the parent (or legal guardian) whose birthday is earlier in the year is primary. If the child's parents are divorced, benefits will be paid according to any court decree. If no such decree exists, benefits are determined in the following order unless a court order places financial responsibility on one parent:
  - Custodial parent
  - Custodial stepparent (if the custodial parent has remarried)
  - Noncustodial parent
  - Noncustodial stepparent (if the noncustodial parent has remarried)

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

Processing your COB claims

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

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

Be sure to include the EOB you received from your primary plan. **Please make copies of all forms and receipts for your files.**

Keeping your COB information updated

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

Subrogation

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

- Your right to recover payment from them is transferred to Blue Cross.
- You are required to do whatever is necessary to help Blue Cross enforce their right of recovery.

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

Auto No-Fault Insurance

Beginning July 2, 2020, the State's Automobile No Fault Insurance Law changed. Under the new legislation, eligible members may select different levels of PIP coverage in certain circumstances. These changes apply to policies issued or renewed after July 1, 2020.

Personal Injury Protection (PIP) pays for services that health insurance may or may not pay for such as:

- Transportation to and from medical appointments
- Vehicle modifications
- Long-term and custodial care
- Household services

Your Blue Cross coverage does not change because of this legislation. However, the way your auto insurance coverage coordinates with your health benefits could change depending on what level of PIP coverage you choose. Contact your auto insurance carrier/agent for specific questions regarding PIP coverage.

Explanation of Benefits

You will receive an EOB form every month we process a claim under your contract number. The EOB is not a bill. It is a statement that helps you understand how your benefits were paid. It tells you:

- The family member who received services
- Who provided the service, the payments made and any amount saved by using a network or participating provider
- Helpful information about Blue Cross programs
- Service dates, charges, payments and any balance you may owe

You may access your EOB online by visiting **bcbsm.com** and signing in at the Members Secured Services site. You may also receive your EOBs by mail.

Please check your EOBs carefully. If you see an error, please contact your provider first. If they cannot correct the error, call the Blue Cross Customer Service Center.

If you think your provider is intentionally billing us for services you did not receive, or that someone is using your Blue Cross ID card illegally, contact our anti-fraud toll-free hotline at 1-800-482-3787. Your call will be kept strictly confidential.

Filing claims

When you use your benefits, a claim must be filed before payment can be made. PPO network providers and Blue Cross participating providers should automatically file all claims for you. All you need to do is show your Blue Cross ID card. However, if you receive services from nonparticipating providers, they may or may not file a claim for you.

To file your own claim, follow these steps:

- Ask your provider for an itemized statement with the following information:
  - Patient's name and birth date
  - Enrollee's name, address, phone number and enrollee number (from your Blue Cross ID card)
  - Provider's name, address, phone number and federal tax ID number
  - Date and description of services
  - Diagnosis (nature of illness or injury) and procedure code
  - Admission and discharge dates for hospitalization
  - Charge for each service
- Make a copy of all items for your files. You will also need to complete a claim form. To obtain a form, visit **bcbsm.com/som** or call the Blue Cross Customer Service Center.
- Mail the claim form and itemized statement to the Blue Cross Customer Service Center at:
  Blue Cross Blue Shield of Michigan
  Member Claims
  600 E. Lafayette Blvd., MC0010
  Detroit, MI 48226-2998

You will receive payment directly from Blue Cross. The check will be in the enrollee's name, not the patient's name.

Medicare coverage

The SHP PPO is primary, which means it pays first, for actively working employees and their enrolled dependents. Medicare enrollment is not required while you are covered under the active employee SHP PPO, but you will want to consult with Medicare to confirm your enrollment requirements while enrolled in active employee group coverage. If you or your dependent is eligible to enroll in Medicare because of End Stage Renal Disease, the SHP PPO will pay first for 30 months, whether or not you are enrolled in Medicare. During this time, Medicare is the secondary payer. At the end of the 30 months, Medicare enrollment is required and becomes the primary payer.

Enrolling in Medicare

Enrollment in Medicare is handled in two ways: 1) you are enrolled automatically, or 2) you must apply.

Here is how it works:

Automatic enrollment for those already receiving Social Security benefits

If you're not 65 yet but receive Social Security, you don't have to apply for Medicare. You'll be automatically enrolled in Medicare Part A and Part B, and it will begin the month you turn 65. Your Medicare card will be mailed to you about three months before your 65th birthday.

If you are disabled and have been receiving disability benefits under Social Security for 24 months, you'll be automatically enrolled in Medicare Part A and Part B beginning the 25th month of your disability benefits. Your card will be mailed to you about three months before your Medicare benefits begin.

If you choose to enroll in Medicare Part A and/or Part B

You can enroll in Medicare during your Initial Enrollment Period (IEP) even if you do not plan to retire at age 65. When you apply through Social Security, there is an option to apply for Medicare only. You can sign up to receive Social Security retirement benefits later.

If you miss your Initial Enrollment Period for whatever reason, you can sign up for Medicare Part A and/or Part B during the General Enrollment Period that runs from January 1 through March 31 of every year, but your coverage will start July 1. You may have to pay a late enrollment penalty for both Part A and Part B if you did not sign up when you first became eligible. You can also make changes to your coverage during general enrollment.

If you sign up for Medicare Part A and/or Part B during your initial enrollment, the start of your coverage will depend on which month of Initial Enrollment Period you signed up. The following chart shows when your Medicare coverage becomes effective if you enroll during your Initial Enrollment Period:

For more information on Medicare's enrollment period log on to the Social Security – Medicare website at **http://www.socialsecurity.gov/pubs/10043.html.**

If you enroll in this month of your initial enrollment period:	**Then your Medicare coverage starts:**
One to three months before you turn 65 years old	The month you turn 65 years old
The month of your 65th birthday	One month after your 65th birthday
Two or three months after you turn 65 years old	Three months after you enroll in Medicare

If you are covered under a group health plan based on current employment, you qualify for a Special Enrollment Period during which you may sign up for Medicare Part A and/or Part B. The Special Enrollment Period provides two options for enrollment:

- You may enroll in Medicare Part A and/or Part B anytime, if you or your spouse (or family member if you are disabled) are working and covered by a group health plan.
- You may enroll during the eight-month period that begins the month after the employment ends or the group health plan coverage ends, whichever happens first.

REMEMBER: Medicare enrollment is not required by the SHP PPO while you are actively working. The SHP PPO is your primary coverage. Upon retirement, if you are Medicare eligible and do not enroll in Medicare Part A and Part B at the appropriate time, you will not be eligible for health and prescription drug insurance under the State of Michigan Employee Retirement System.

For more information on Medicare, log on to the Medicare website at **www.medicare.gov**. For more information on retirement insurance eligibility contact the Office of Retirement Services at 1-800-381-5111, Monday through Friday, 8:30 a.m. to 5 p.m.

State Health Plan PPO

Behavioral Health/Substance Use Disorder Benefits

Behavioral health/substance use disorder benefits

Your plan offers comprehensive benefits for behavioral health services. Behavioral health services treat mental health and substance use disorder conditions. This behavioral health coverage is a network-based benefit, so your out of pocket costs depend on whether you choose a provider in the Blue Cross network.

Whether it's your own journey or that of someone you love, everyone has a time in life where mental health becomes a priority. In those times, it's important to know where to go for help. Blue Cross Behavioral Health provides behavioral health services to help you get the care you need.

- To get care for a behavioral health crisis, care managers are available 24 hours a day, seven days a week for emergencies at **1-866-503-3158**. TTY users call **711**.
- To get answers to questions about your behavioral health coverage or help finding a provider, Blue Cross Customer Service is available Monday through Friday from 7 a.m. to 7 p.m. (excluding holidays) at **1-800-843-4876**. TTY users call **711**.

Guide to getting behavioral health services		
Type of care	**Description**	**What you need to do**
Routine care		
Get care: • Within 10 days for first visits • Within 30 business days for follow up visits	Where no danger is detected and your ability to cope is not at risk.	Tell the behavioral care manager of any special needs to ensure appropriate referral.
Urgent care		
Get care within 48 hours	Conditions that are not life-threatening, but face-to-face contact is necessary within a short period of time. Example: severe depression	Contact Blue Cross Behavioral Health 1-866-503-3158
Non-life-threatening emergency care		
Get care within 6 hours	Conditions that require rapid intervention to prevent deterioration of your state of mind, which left untreated, could jeopardize your safety.	Contact Blue Cross Behavioral Health 1-866-503-3158
Life-threatening emergency care		
Get care immediately	A condition that requires immediate intervention to prevent death or serious harm to you or others.	Seek help at the nearest emergency room or call 911. After the emergency, contact your PCP within 24 hours.

Getting preapproval for behavioral health services

Some behavioral health services require authorization. Authorization confirms that the service you're going to have is both eligible and is provided at the medically necessary level of care. By getting a service authorized, you ensure that the behavioral health services you get are covered under the Plan.

Services that require authorization

Mental health

- Applied Behavioral Analysis for Autism Spectrum Disorders
- Inpatient treatment
- Partial hospital treatment
- Intensive outpatient therapy

Substance use disorder

- Residential treatment
- Partial hospital treatment
- Intensive outpatient treatment

If you or your provider do not notify Blue Cross Behavioral Health about a service that requires authorization, your benefits may be reduced, or not paid at all. If you need an authorization for care, call Blue Cross Behavioral Health 24 hours a day, seven days a week at **1-866-503-3158**.

Your behavioral health/substance use disorder benefits, A–Z

Your plan offers comprehensive benefits for behavioral health services. Behavioral health services treat mental health and substance use disorder conditions. Mental health and substance use disorder treatment provided by nonparticipating providers are covered. Members seeking services from these providers are responsible for the out-of-network deductible and coinsurance, plus the difference between the charge and the Blue Cross approved amount.

Autism spectrum disorders Applied Behavioral Analysis (ABA) (requires authorization)	**In-network – Covered 90% after deductible**	**Out-of-network – Covered 80% after deductible**

You are covered for ABA services administered by a licensed clinician, such as a board-certified behavior analyst, working in association with a paraprofessional. To be eligible for benefits, the paraprofessional must be supervised by the licensed clinician. Your benefit covers autism spectrum disorders to treat ABA.

Consultations – hospital (inpatient)	**In-network – Covered 90% after deductible**	**Out-of-network – Covered 80% after deductible**

Medical consultations are payable when a physician requires assistance in diagnosing or treating a condition relating to behavioral health or substance use disorder. Hospital outpatient consultations rendered by your primary care physician will be covered under the State's medical plan regardless if the diagnosis is medical or behavioral health.

Electroconvulsive Therapy (ECT)	**In-network – Covered 90% after deductible**	**Out-of-network – Covered 80% after deductible**

You are covered for medically necessary ECT treatment including anesthesia services for this benefit. Anesthesia services for ECT are covered at 90% after deductible.

Emergency care	**$200 copay for emergency room (waived if admitted to the same hospital)**

Your benefit plan covers emergency care for behavioral health and substance use disorder diagnoses. Emergency care not resulting in a hospital admission is covered under the State's medical plan regardless if the diagnosis is medical or behavioral health or substance use disorder.

Halfway house	**In-network – Covered 90% after deductible**	**Out-of-network – Covered 80% after deductible**

Halfway houses provide substance-free residences for those in recovery from alcohol and substance use. Prior authorization is required.

Hospital care – inpatient behavioral health (requires authorization)	**In-network – Covered 90% after deductible**	**Out-of-network – Covered 80% after deductible**

You are covered for behavioral health care services that require a hospital stay. Your benefit allows for 365 days per year.

Hospital care – inpatient substance use disorder (requires authorization)	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

You are covered for inpatient substance use disorder services as well as sub-acute detoxification services.

Hospital care – outpatient office visit (physician services)	In-network – $20 copay	Out-of-network – Covered 80% after deductible

Your benefit covers office visits rendered in an outpatient hospital setting for the medically necessary behavioral health and substance use disorder diagnoses from behavioral health providers. Outpatient office visits rendered by your primary care physician will be covered under the State's medical plan regardless if the diagnosis is medical or behavioral health.

Intensive Outpatient Program (IOP) – behavioral health	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

You are covered for IOP mental health services provided on an outpatient basis. These services involve frequent visits (usually three to five days per week) and may include, but are not limited to individual, group and family counseling, medical testing, diagnostic evaluation and referral to other services in a treatment plan. Two IOP days equal one inpatient day.

Intensive Outpatient Program (IOP) – substance use disorder	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

You are covered for IOP substance use disorder services provided on an outpatient basis. These services involve frequent visits (usually three to five days per week) and may include individual, group and family counseling, medical testing, diagnostic evaluation and referral to other services in a treatment plan. Two IOP days equal one inpatient day.

Neuropsychological and psychological testing – inpatient	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

Your benefit covers medically necessary neuropsychological and psychological testing for behavioral health diagnoses.

Neuropsychological and psychological testing – office setting	In-network – Covered $20 copay	Out-of-network – Covered 80% after deductible

Your benefit covers medically necessary neuropsychological and psychological testing for behavioral health diagnoses.

Neuropsychological and psychological testing – outpatient	Covered 90% after deductible

Your benefit covers medically necessary neuropsychological and psychological testing for behavioral health diagnoses.

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

Your benefit covers office visits and office consultations when rendered in an office setting for the medically necessary behavioral health and substance use disorder diagnoses from behavioral health providers. Office visits and office consultations rendered by your primary care physician will be covered under the State's medical plan regardless if the diagnosis is medical or behavioral health.

Outpatient care – behavioral health (no authorization required)	In-network – Covered $20 copay	Out-of-network – Covered 80% after deductible

You are covered for individual, conjoint, family or group psychotherapy and crisis intervention services. Hospital outpatient visits rendered by your primary care physician will be covered under the State's medical plan regardless if the diagnosis is medical or behavioral health.

Outpatient care – substance use disorder (no authorization required)	In-network – Covered $20 copay	Out-of-network – Covered 80% after deductible

Services include office based opioid treatment and methadone maintenance. Outpatient visits rendered by your primary care physician will be covered under the State's medical plan regardless if the diagnosis is medical or behavioral health.

Partial Hospitalization Program (PHP) – behavioral health (requires authorization)	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

PHP is a comprehensive care given for a minimum of 6 hours per day, 5 days a week. Treatment may include counseling, medical testing, diagnostic evaluations and referral to other services in a treatment plan. PHP services are often provided in lieu of inpatient behavioral health for non-acute conditions. Two PHP days equal one inpatient day.

Partial Hospitalization Program (PHP) – substance use disorder (requires authorization)	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

Program offered at least five hours of therapy a day, up to seven days a week. Two PHP days equal one inpatient day.

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

Physical therapy, speech and language pathology services, and occupational therapy are payable when provided for behavioral health and substance use disorder treatment.

Residential mental health treatment (requires authorization)	In-network – Covered 90% after deductible	Out-of-network – Not covered

A specialized form of inpatient care. It includes supervision and monitoring within a non-hospital setting.

Residential substance use disorder treatment (requires authorization)	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

Acute care services provided in a structured full day setting when patient is ambulatory and does not require medical hospitalization. Residential services may include 24-hour supervision, counseling, detox, medical testing, diagnostic evaluation and referral or other services specified in a treatment plan.

Rural health clinic	In-network – Covered $20 copay	Out-of-network – Covered 80% after deductible

Your benefit covers visits rendered at a rural health clinic relating to behavioral health. Services rendered at a rural health clinic relating to a medical are covered under the State's medical plan.

Telehealth – Blue Cross online tool (online visits)	In-network – $0 copay	Out-of-network – Not covered

You have access to online behavioral health and substance use disorder powered by Virtual Care, available 24 hours a day, seven days a week from any mobile device or computer.

Telehealth services offered using your provider's online tool	In-network – $20 copay	Out-of-network – Covered 80% after deductible

You have access to online behavioral health and substance use disorder using your provider's online tool.

Transcranial magnetic stimulation (TMS) (Requires authorization)	In-network – Covered 90% after deductible	Out-of-network – Covered 80% after deductible

TMS is a treatment technique that uses a magnetic field to influence brain activity. It can treat depression, obsessive-compulsive disorder and other brain-related conditions. A prior authorization is required for in-network, out-of-network and non-participating providers.

Benefit summary

	In network	Out of network
Cost share		
Out-of-pocket dollar maximums	$2,000 per member $4,000 per family	$3,000 per member $6,000 per family
Deductible	$400 per member $800 per family	$800 per member $1,600 per family
Coinsurance	10% (where applicable)	80% for most services
Fixed dollar copay	$20 copay for outpatient behavioral health/substance use disorder care $0 copay for online telehealth visits (Blue Cross online tool), $20 copay for online telehealth visits (Provider's tool)	Note: Fixed dollar copays do not apply out of network. See appropriate section below for out of network coverage.
Emergency Care		
Emergency room	$200 copay (waived if admitted to the same hospital)	
Hospital care (Inpatient)		
Hospital care – behavioral health (requires authorization)	Covered 90% after deductible	Covered 80% after deductible
Hospital care – substance use disorder (requires authorization)		
Consultations		
Neuropsychological and psychological testing		
Behavioral health		
Autism spectrum disorders – ABA (requires authorization)	Covered 90% after deductible	Covered 80% after deductible
Electro-Convulsive Therapy (ECT)		
Intensive outpatient program (IOP)		
Neuropsychological and psychological testing – outpatient	Covered 90% after deductible	

<table>
<tr><th></th><th>In network</th><th>Out of network</th></tr>
<tr><td>Outpatient behavioral health</td><td>$20 copay</td><td rowspan="2">Covered 80%
after deductible</td></tr>
<tr><td>Partial Hospitalization Program (PHP)
(requires authorization)</td><td rowspan="2">Covered 90%
after deductible</td></tr>
<tr><td>Residential Mental Health treatment
(requires authorization)</td><td rowspan="2">Not covered</td></tr>
<tr><td>Telehealth (Online visits) – Blue Cross Online Tool</td><td>$0 copay</td></tr>
<tr><td>Telehealth (Online visits) – Provider’s Tool</td><td>$20 copay</td><td>Covered 80%
after deductible</td></tr>
<tr><td colspan="3">Substance use disorder</td></tr>
<tr><td>Intensive Outpatient Program (IOP)</td><td>Covered 90%
after deductible</td><td rowspan="4">Covered 80%
after deductible</td></tr>
<tr><td>Outpatient care – substance use disorder (includes office based opioid treatment and methadone maintenance)</td><td>$20 copay</td></tr>
<tr><td>Partial Hospitalization Program (PHP)
(requires authorization)</td><td rowspan="2">Covered 90%
after deductible</td></tr>
<tr><td>Residential Substance Use Disorder treatment
(requires authorization)</td></tr>
</table>

What is not covered

The following behavioral health services aren't covered under the State Health Plan:

- Art therapy
- Biofeedback
- Claims deemed fraudulent which, through the exercise of due diligence by contractor, could have been prevented
- Completion on any insurance form
- Counseling for vocational, academic, or education purposes
- Court-ordered psychotherapy, including substance use disorder
- Hypnotherapy
- Medical services or drugs not administered for BH/SU treatment
- Music therapy
- Phone consultations or therapeutic phone questions
- Psychodrama
- Recreation therapy
- Services provided by practitioners not designated as eligible providers including those the health professional or facility is not licensed to provide
- Services received at private residences (except for autism spectrum disorder to treat ABA)
- Services provided or covered by any state or governmental agency, by Workers' Compensation or similar occupational law, or for which no charge is made to the member
- Services provided while the member is not covered for this benefit
- Services which are not medically necessary or are experimental or research in nature, according to accepted standards of practice
- Wilderness Therapy (including health resorts, recreational programs, outdoor skills programs, relaxation or lifestyle programs, residential treatment centers and services provided in conjunction with or as part of these programs)

Other behavioral health resources

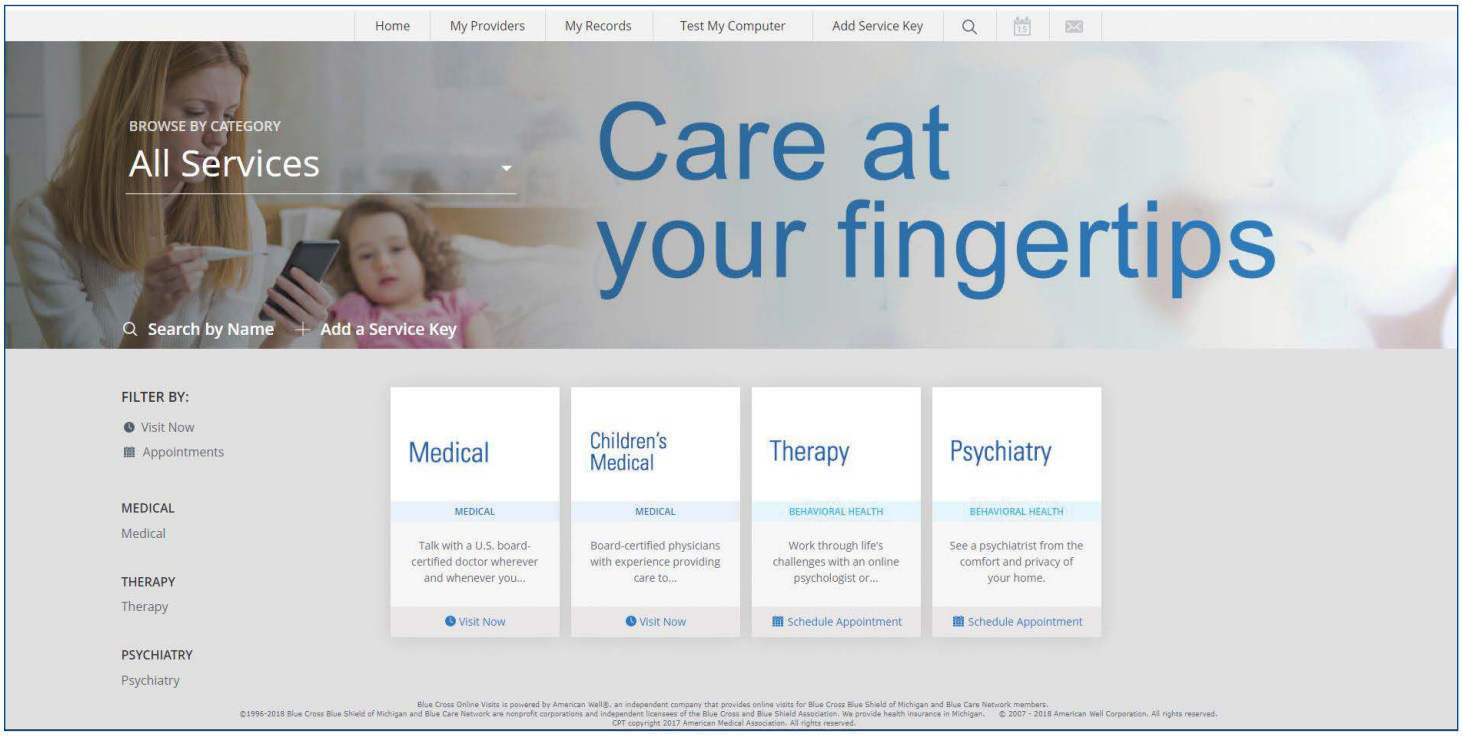
Telehealth (Online visits)

Behavioral health visits online through Virtual Care

You can use Virtual Care to see and talk to a behavioral health specialist to help work through challenges like anxiety, depression and grief. These visits are available by appointment only.

Costs for behavioral health services vary depending on the type of provider and services received. You'll be charged the appropriate cost share for the service using your existing outpatient behavioral health benefits. Before your online visit, you'll be prompted to enter your payment information.

For more information and to sign up, you can call **1-800-835-2362** or visit **bcbsm.com/virtualcare.**



Case management

Behavioral health case management helps you or a family member with your mental health or substance use disorder needs. The goal of the program is to help you get the most out of treatment. The program is free, and participation is optional.

What case managers do:

- Help organize care around your doctors, nurses, and social workers
- Give you information about mental health and substance use disorder services and other community services
- Help you in getting the mental health and substance use disorder services that work best for you
- Work with you to get help from local programs
- Help you with a plan to remember to take your medication
- With your permission, keep your primary care provider and psychiatrist updated on your progress

Case management can help if you:

- Have been in the hospital for mental health or substance use disorder reasons
- Have trouble getting the care that works best for you
- Have mental health or substance use disorder issues and medical issues
- Need support to help you follow your doctor, nurse, or social workers advice
- Are pregnant or recently were pregnant and needed mental health or substance use disorder services

Behavioral health case managers are experienced and licensed nurses, social workers, and mental health experts. To find out more about behavioral health care management, call Blue Cross Behavioral Health at **1-866-503-3158**.

Specialty services offered through Blue Cross Behavioral Health

Care management – Work with a licensed behavioral health clinician who can help you identify your needs, create a treatment plan and coordinate with your doctors.

Autism resources – Care managers specially trained in treating Autism Spectrum Disorder can assist you through the process of obtaining a diagnosis and authorizing treatment.

Clinical Response Unit (for substance use disorders) – Licensed clinicians can assess your needs, teach you about evidence-based treatment options and ensure you are connected with the right care.

Employee Service Program

The State of Michigan Employee Service Program (ESP) provides confidential employee assistance to State employees and their eligible family members. ESP's licensed master social workers (LMSW) are available to provide expert, confidential services to you and your family members to help you identify strategies for resolving concerns that are affecting your personal or work life.

ESP services are provided free of charge. If a referral is made for additional counseling services,ESP counselors refer clients to professionals covered by the State Health Plan. The ESP counselor can also discuss basic information about the counseling benefit and provide telephone numbers for further information about coverage.

For confidential assistance contact ESP toll-free at **1-800-521-1377**, Monday through Friday from 8 a.m. to 5 p.m.

Selecting Behavioral Health and Substance Use Disorder Providers

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

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

- Network providers
- Out-of-network but participating providers
- Nonparticipating

Network providers

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

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

Out-of-network participating providers

When you receive care from a provider that is not part of the PPO network, your care is considered out-of-network. For most out-of-network services, you have a 20 percent coinsurance and a higher deductible. You may also be responsible for any charge above Blue Cross's approved amount.

Nonparticipating providers

Nonparticipating providers are providers who are not in the PPO network and do not participate in Blue Cross's Traditional plan. If you receive services from a nonparticipating provider, in addition to the out-of-network deductible and coinsurance, you may also be responsible for any charge above Blue Cross's approved amount.

Tips for selecting providers or referrals:

- Find in-network doctors and hospitals across the country at **bcbsm.com**. Simply log in and search by name, treatment or service for a list of behavioral health and substance use disorder providers who are near you and accept your plan.
- Contact Blue Cross Behavioral Health at 1-866-503-3158 to assist you with selecting a provider or to receive a referral to a behavioral health or substance use disorder provider.

State Health Plan PPO

Medical and Behavioral Health/ Substance Use Disorder Benefits

Appeals and Grievances

Your right to file an appeal or grievance

Most questions or concerns about how we processed your claim or request for benefits can be resolved through a phone call to the Blue Cross Customer Service Center. The number for Customer Service is on page 2 of this guide. You have 180 days from the date of the notice of an adverse decision to file an appeal or grievance with Blue Cross.

An **appeal and/or grievance** is a member's written request for review of an adverse determination, which reduced or denied benefits or services in whole or in part, including the availability, delivery, or quality of health care services, including an adverse determination arising from a complaint.

Internal appeals and grievances

Standard appeal and grievance process

Under the standard appeal and grievance process, we must provide you with our final written determination within 30 calendar days of receipt of your pre-service appeal or grievance and within 60 calendar days of our receipt of your written post-service appeal or grievance.

The standard appeal or grievance process is as follows:

- You or your authorized representative must send us a written statement explaining why you disagree with our determination on your request for benefits or payment.
  - **Mail your written appeal or grievance to:**
    Appeals Unit – Mail code 1620
    Blue Cross Blue Shield of Michigan
    600 East Lafayette Blvd.
    Detroit, MI 48226
  - You may submit written materials or testimony to help us in our review at any step of the appeal or grievance process. You can use the **Member Appeal Form (PDF)** to submit your appeal or grievance. The form is optional. You can use it by itself or with a formal letter of appeal or grievance.
- Upon receipt of your appeal or grievance, we'll contact you to schedule a conference if applicable. During your conference, you can provide us with any other information you want us to consider in reviewing your appeal or grievance. You can choose to have the conference in person or over the phone. If in-person, the conference will be held at our office in Detroit during regular business hours. Following the conference, we'll respond to your appeal or grievance in writing. If you agree with our response, it becomes our final determination and the appeal or grievance ends.
- If you disagree with our final decision, or you do not receive our decision on your pre-service appeal or grievance within 30 days, or your post-service appeal or grievance within 60 days, you may request an external review through the Michigan Department of Insurance and Financial Services (DIFS).
- You must make your request for an external review within 127 days of the date you receive or should have received our final decision.
  - **Send your written request for an external review to:**
    DIFS – Office of Appeals and Market Regulation
    Appeals Section
    P.O. Box 30220
    Lansing, MI 48909-7720
    Fax: 517-284-8838

- In addition to the information found above, you should also know:
  - You may authorize another person including, but not limited to, a physician to act on your behalf at any stage in the standard appeal or grievance process. If you authorize someone else, including your physician, to act on your behalf at any stage in the standard review process, we'll need your authorization in writing on the **Designation of Authorized Representative for Appeal Form (PDF)**. You can download the form or call Blue Cross Customer Service to request a copy be mailed to you. Complete the form, sign it and send it with your appeal or grievance.
- Although we have 30 days for a pre-service appeal or grievance and 60 days for a post-service appeal or grievance, you have the right to allow us additional time if you wish.
- You may obtain copies of information relating to our denial, reduction or termination of coverage for a health care service at no charge.

Expedited appeal or grievance process

If a physician substantiates orally or in writing that adhering to the time frame for the standard appeal or grievance would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, you may file a request for an expedited appeal or grievance.

You may file a request for an expedited appeal or grievance only when you think we've wrongfully denied, terminated or reduced coverage for a health care service prior to your having received that health care service or if you believe we've failed to respond in a timely manner to a request for benefits or payment.

The process to submit an expedited appeal or grievance is as follows:

- Call **1-313-225-6800** to ask for an expedited appeal or grievance. Your physician should also call this number to confirm that you qualify for an expedited appeal or grievance.
  - We must provide you with our decision within 72 hours of receiving both your appeal or grievance **and** the physician's substantiation.
  - If you do not agree with our appeal or grievance decision, you may, within 10 days of receiving it, request an expedited external review of your appeal or grievance.
- In addition to the information found above, you should also know:
  - You may authorize in writing another person including, but not limited to, a physician to act on your behalf at any stage in the expedited appeal or grievance process.
  - If our decision is communicated to you orally, we must provide you with written confirmation within three calendar days.

Disclosure required by the Patient Protection Act

Upon enrollment, we must provide subscribers, in plain English, a written description of the terms and conditions of Blue Cross Blue Shield of Michigan's certificate. The form must list all information that's available to the member upon request.

The following information is available to you by calling or writing Blue Cross Customer Service at the number or address listed on page 2 of this guide. You can request:

- A description of the current provider network in your service area
- A description of the professional credentials of participating health professionals
- The licensing verification phone number for the Michigan Department of Consumer and Industry Services
- A description of any prior authorization requirements and any limitations, restrictions or exclusions
- A description of the financial relationships between the Blue Cross managed care areas and any closed provider network

We require that your request for information be submitted to Blue Cross in writing.

External review

Standard external review

Once you have gone through our standard process, you or your authorized representative may request an external review. The standard external review process is as follows:

Within 127 days of the date you receive or should have received our final decision, send a written request for an external review to the DIFS as listed below.

You may mail your request and the required forms that we give you to:

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

You may have your request delivered by courier or delivery to:

Department of Insurance and Financial Services
530 W. Allegan Street, 7th Floor
Lansing, MI 48933

You may also contact the DIFS with your request by phone, fax, email or online:

Phone: 1-877-999-6442
Fax: 517-284-8838
Email: DIFS-HealthAppeal@michigan.gov
Online: **https://difs.state.mi.us/Complaints/ExternalReview.aspx**

When you file a request for an external review, you'll have to authorize the release of medical records that may be required to reach a decision during the external review. The DIFS will independently review the adverse benefit determination, including determinations related to the application of surprise billing protections under the No Surprises Act.

If you ask for an external review about a medical issue or a surprise billing issue and the issue is found to be appropriate for external review, the DIFS will assign an independent review group to conduct the external review. The group will consist of independent clinical peer reviewers. The recommendation of the independent review group will only be binding on you and Blue Cross if the DIFS decides to accept the group's recommendation. The DIFS will make sure that this independent review group does not have a conflict of interest with you, with us, or with any other relevant party.

Expedited external review

Once you have filed a request for an expedited appeal or grievance, you may also request an expedited external review from the commissioner before you receive our determination. A physician must substantiate orally or in writing that you have a medical condition for which the time frame for completion of an expedited appeal or grievance would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function.

You may file a request for an expedited external review only when you think that we have wrongfully denied, terminated or reduced coverage for a health care service prior to your having received that health care service. You must make your request within 10 days of your receipt of our adverse determination, and you may do so in writing or by phone.

A request for external review form will be sent to you or your representative with our final adverse determination.

Mail the completed form and your written request for external review to:

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

You may have your request delivered by courier or delivery to:

Department of Insurance and Financial Services
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You may also contact the DIFS with your request by phone, fax, email or online:

Phone: 1-877-999-6442
Fax: 517-284-8838
Email: DIFS-HealthAppeal@michigan.gov
Online: **https://difs.state.mi.us/Complaints/ExternalReview.aspx**

When you file a request for an external review, you'll have to authorize the release of medical records that may be required to reach a decision during the external review.

The DIFS will decide if your request qualifies for an expedited review. If it does, the DIFS will assign an independent review group to conduct the review. The group will recommend within 36 hours if the DIFS should uphold or reverse our decision.

The DIFS must decide whether to accept the recommendation within 24 hours. You'll be told of the DIFS decision. This decision is the final administrative decision under the Patient's Right to Independent Review Act of 2000.

State Health Plan PPO

Medical and Behavioral Health/ Substance Use Disorder Benefits

Glossary of terms

Glossary

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

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

Acute care facility is a facility that offers a wide range of medical, surgical, obstetric and pediatric services. These facilities primarily treat patients with conditions that require a hospital stay of less than 30 days.

The facility is not primarily for:

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

Adequate access is defined by how far you live from PPO providers and hospitals. The SHP PPO access standards are:

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

Affordable Care Act (ACA), also known as the Patient Protection and Affordable Care Act (PPACA), is the health reform legislation that includes health-related provisions intended to extend coverage to uninsured Americans, to implement measures that will lower health care costs and improve system efficiency.

Allowed amount is the maximum amount on which payment is based for covered health care services. This may be called “eligible expense,” “payment allowance” or “negotiated rate.” If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance billing.)

Ambulatory Detoxification is non-residential service to which a person may be admitted for a systematic reduction of physical dependence upon a substance. This service utilizes prescribed chemicals and provides an assessment of the client’s needs and motivation toward continuing participation in the treatment process.

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

Appeal and/or grievance is a member’s written request for review of an adverse determination, which reduced or denied benefits or services in whole or in part, including the availability, delivery, or quality of health care services, including an adverse determination arising from a complaint.

Applied Behavioral Analysis (ABA) is the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences to produce significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Approved amount is the Blue Cross maximum payment level or the provider's billed charge for the covered service, whichever is lower. Deductibles and copays are deducted from the approved amount.

Approved Autism Evaluation Center (AAEC) is an academic and/or hospital-based, multidisciplinary center experienced in the assessment, work-up, evaluation and diagnosis of the Autism Spectrum Disorders (ASD). AAEC evaluation is necessary for Applied Behavioral Analysis (ABA).

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

Approved hospital is a facility that meets all applicable local and state licensure and certification requirements, is accredited as a hospital by state or national medical or hospital authorities or associations and has been approved as a provider by Blue Cross or an affiliate of Blue Cross.

Autism Spectrum Disorders (ASD) are disorders that are defined by the most recent edition of the Diagnostic and Statistical Manual published by the American Psychiatric Association.

Balance billing means that a provider will bill you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the Blue Cross allowed amount is $70, the provider may bill you for the remaining $30. A Blue Cross PPO network provider may not balance bill you.

Benefit is coverage for health care services available according to the terms of your health care plan.

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

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

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

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

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

Coinsurance is a member's out-of-pocket percentage of the Blue Cross allowed amount for covered services.

Complications of pregnancy are conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a nonemergency caesarean section are not considered complications of pregnancy.

Confinement is a medically necessary inpatient stay that is due to injury or illness.

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

Copayment (or copay) is the designated portion of the approved amount you are required to pay for covered services.

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

Crisis Stabilization Bed (CARES Unit) is an inpatient crisis intervention service that provides intensive short-term rapid assessment, stabilization, and disposition management for children under the age of 18 experiencing an acute behavioral health crisis who can be stabilized or discharged within 72 hours. The CARES Unit is designed to provide diversion from inpatient care for those children/adolescents who are in psychiatric crisis and who can be rapidly stabilized. Referrals will come primarily from local Emergency Mobile Psychiatric Services (EMPS) and affiliated Hospital Emergency Departments.

Custodial care is care mainly for helping a person with activities of daily living, such as walking, getting in and out of bed, bathing, dressing, eating or taking medicine. Custodial care can be provided safely and reasonably by people without professional skills or training to help patients with daily activities or personal needs, such as walking, getting in and out of bed, bathing, dressing and taking medicine. It also includes medical services, such as respiratory care, that a dedicated lay person can learn to perform. Custodial care is not covered by the SHP PPO.

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

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

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

Detoxification is an immediate and short-term clinical support to individuals who are withdrawing from alcohol and other drugs.

Diabetes - Self management See the document entitled, 'State Health Plan PPO - Preventive services for active employees' located at bcbsm.com/som for benefit details.

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

Electro Convulsive Therapy (ECT) is brain stimulation techniques such as electroconvulsive therapy (ECT) can be used to treat major depression that hasn't responded to standard treatments.

Emergency first aid is the initial exam and treatment of conditions resulting from accidental injury. First aid may include the following conditions which may require first aid treatment:

- Allergic reactions to bee stings or insect bites
- Attempted suicide
- Food poisoning
- Ingestion of poisons (accidental or intentional)
- Inhalation of smoke, carbon monoxide or fumes
- Sprains, strains
- Rape, attempted rape, questionable rape
- Cuts, abrasions, bruises
- Contusions
- Epitasis (nose bleed) if no packing or cautery is performed
- Sunburn or frostbite if no dressing is applied

- Application of butterfly suture
- Splinting or strapping billed along with traumatic diagnosis or as initial treatment of fracture
- Gastric lavage

Emergency medical condition is an illness, injury, symptom or condition so serious that you must seek care right away to avoid severe harm.

Emergency medical transportation is an ambulance that is used for an emergency medical condition.

Emergency room care provides emergency services in an emergency room.

Emergency services provide an evaluation of an emergency medical condition and treatment to keep the condition from getting worse. Emergency services include medical screening exams that are within the capability of an emergency room department of a hospital or independent freestanding emergency department and includes ancillary services routinely available in a hospital's emergency room to evaluate an emergency medical condition. Services also include, within the capabilities of the staff and facilities available at the hospital, additional medical exams and treatment to stabilize the member.

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

Excluded services are health care services for which your health plan does not pay or cover.

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

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

Extended Day Treatment (EDT) is a community-based program for children and their families that offers a structured, intensive, therapeutic milieu with group, family and individual therapy services. Services are typically after school for several days per week and the program can last up to six months. EDT provides a broad range of treatment services and psycho-social interventions.

Facility is a hospital that offers medical care or specialized treatment, such as rehabilitation treatment, skilled nursing care or physical therapy.

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

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

Health insurance is a contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home health care is a range of health care services that can be given in the home. Home health care is usually less expensive, more convenient, but as effective as care in a hospital or skilled nursing facility. The goal of home health care is to treat an illness or injury.

Hospice services provide comfort and support for persons in the last stages (usually six months or less) of a terminal illness and their families.

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

Hospital outpatient care is care in a hospital that usually does not require an overnight stay.

Hospitalization is care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

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

In-network copayment is the fixed amount you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are usually less than out-of-network copayments.

In-network providers are providers who have met PPO standards and signed agreements to participate in the Community Blue network and to accept our approved amount as payment in full for covered services.

Intensive Outpatient Services (IOP) is an integrated program of outpatient psychiatric services that are designed for more intensive treatment than routine outpatient psychiatric services and are provided at a psychiatric outpatient clinic for adults, an outpatient treatment service for substance use disorder, or an outpatient psychiatric clinic for children.

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

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

- The covered service is for the treatment, diagnosis of the symptoms of an injury, condition or disease.
- The service, treatment or supply is appropriate for the symptoms and is consistent with the diagnosis.
  - *Appropriate* means the type, level and length of care, treatment or supply and setting are needed to provide safe and adequate care and treatment.

For inpatient hospital stays, acute care as an inpatient must be necessitated by the patient's condition because safe and adequate care cannot be received as an outpatient or in a less intense medical setting. This means that:

- The services are not mainly for the convenience of the member or health care provider.
- The treatment is not generally regarded as experimental or investigational by Blue Cross.
- The treatment is not determined to be medically inappropriate by the Utilization Management and Quality Assessment programs.

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

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

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

- Generally accepted as necessary and appropriate for the patient's condition, considering the symptoms. The covered service is consistent with the diagnosis.

- Essential or relevant to the evaluation or treatment of the disease, injury, condition or illness. It is not mainly for the convenience of the member or physician.
- Reasonably expected to improve the patient's condition or level of functioning. In the case of diagnostic testing, the results are used in the diagnosis and management of the patient's care.

Medically necessary are health care services or supplies needed to prevent, diagnose or treat an illness, injury, disease or its symptoms and that meet accepted standards of medicine.

Medication Assisted Treatment (MAT) is an approach to treating both opioid and alcohol substance use disorders. The FDA has approved several different medications to treat Opioid Use and Alcohol Use

Disorders. These medications relieve withdrawal symptoms and psychological cravings that cause chemical imbalances in the body. MAT programs provide a safe and controlled level of medication to overcome the use of an abused substance. Research has shown that when provided at the proper dose, MAT medications used have no negative effects on a person's intelligence, mental capability, physical functioning, or employability.

Member is any person covered under the SHP PPO plan. This includes the subscriber and any eligible dependents listed in Blue Cross membership records.

Methadone Maintenance is treatment where the goal is to stabilize a member on methadone or other federally approved medication for as long as is needed to avoid return to previous patterns of substance use disorder.

Network is a group of doctors, hospitals, DME and other health care providers contracted with Blue Cross to provide services to members. Members typically pay less for using a network provider.

Nonparticipating providers are providers that have not signed participation agreements with Blue Cross agreeing to accept the Blue Cross payment as payment in full. However, nonparticipating professional (non-facility) providers may agree to accept the Blue Cross-approved amount as payment in full on a per claim basis.

Observation consists of services up to 48 hours at a hospital to assess whether further inpatient services or community-based services might be needed; usually following a visit to the Emergency Room.

Occupational therapy is treatment consisting of specifically designed therapeutic tasks or activities that:

- Improve or restore a patient's functional level when illness or injury has affected muscles or joints
- Help the patient apply the restored or improved function to daily living

Out-of-network refers to services not rendered by a Blue Cross PPO network provider.

Out-of-network costs are increased copayment and deductible amounts members may incur if they receive services from a provider that does not belong to the Blue Cross PPO network without a referral. These costs could also include charges from a nonparticipating provider that are above the approved Blue Cross amount.

Outpatient Services (for behavioral health and substance use disorder) includes behavioral health evaluation and treatment services such as individual, group, family therapy, medication management, Autism Spectrum Disorder services, psychological and developmental testing, consultation, and case management that are provided to people who have a primary behavioral health diagnosis. Services may be provided in a freestanding clinic, hospital outpatient clinic, or by a group practice or solo practitioner who is a licensed behavioral health professional.

Out-of-pocket maximum is the dollar amount you pay in deductibles, copayments, and coinsurance during the calendar year. Once you satisfy your out-of-pocket maximum, the plan will cover 100% of the allowed amount for covered services. Certain coinsurance, deductibles and other charges cannot be used to meet your out-of-pocket maximum, such as out-of-network coinsurance, out-of-network deductible and charges for non-covered services.

Partial Hospitalization Program (PHP) is a program used to treat mental health and/or substance use disorders. In partial hospitalization, the member continues to live at home, but commutes to a hospital-based or clinic-based program several days per week.

Participating providers are providers who have signed agreements with Blue Cross to accept the Blue Cross-approved amount for covered services as payment in full.

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

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

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

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

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

Psychiatric Hospitalization consists of services where a member stays overnight at a hospital (inpatient) either at a general hospital, psychiatric hospital, or freestanding detox service in the case of a substance use disorder.

Reconstructive surgery is surgery or follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Referral process is the formal process members must follow when referred to a non-Blue Cross PPO network provider by a network provider. The referring network provider must provide a completed Preferred Provider Organization Program Referral form to the member and the physician before the referred services are provided. A verbal referral is not acceptable.

Residential Mental Health Treatment Program is a specialized form of inpatient care in a participating psychiatric residential treatment facility (PRTF) that typically includes 24-hour supervision and monitoring within a non-hospital setting, often aimed at providing an intensive therapeutic environment and treatment for members with mental health issues.

Residential Substance Use Disorder Treatment Program is a community based (non-hospital) facility that provides medical and other services specifically for substance use disorder in a facility that operates 24 hours a day, seven days a week. Treatment in this type of a program is sometimes called intermediate care and may include subacute detoxification early in the treatment course.

Skilled nursing care is furnished or supervised by a licensed nurse under the general direction of a physician to ensure the patient's safety and to achieve a medically desired result. Eligible members are eligible for services when they require care that is at a lower level than provided in a hospital but is at a higher level than is generally available on an outpatient basis, in the home or basic nursing home.

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

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

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

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

Subscriber is the person who signed and submitted the application for SHP PPO Drug plan coverage.

Urgent care covers an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

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

You and Your are used when referring to any person covered under the SHP PPO.

We Speak Your Language

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 877-469-2583 TTY: 711 or speak to your provider.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También se ofrecen, sin costo alguno, ayuda y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 877-469-2583 TTY: 711 o hable con su proveedor.

تنبيه: إذا كنت تتحدث الإنجليزية، فإن خدمات المساعدة اللغوية المجانية متوفرة لك. تتوفر أيضًا المساعدات والخدمات المساعدة المناسبة لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجانًا. اتصل برقم 877-469-2583 TTY: 711 أو تحدث إلى مزود الخدمة الخاص بك.

注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。请致电 877-469-2583 (TTY: 711) 或咨询您的服务提供商。

ܬܘܡܪܐ: ܐܢ ܐܢܬܘܢ ܡܫܡܠܝܢ ܠܫܢܐ ܐܪܡܝܬܐ، ܫܪܘܬܐ ܕܬܪܓܡܢܘܬܐ ܕܠܫܢܐ ܕܡܬܐ ܡܬܝܠܐ ܠܟܘܢ ܒܚܢܡ. ܐܦ ܫܪܘܬܐ ܕܬܪܓܡܢܘܬܐ ܕܡܬܐܡܢܐ ܘܡܬܐܡܢܐ ܕܡܬܚܘܝܢ ܠܡܬܩܢܐ ܕܡܬܩܝܡܝܢ ܒܦܪܡܛܐ ܕܡܬܩܝܡܐ ܠܫܡܝܫܐ ܠܟܘܢ ܒܚܢܡ. ܡܬܨܠܬܘ ܠܒܪ 877-469-2583 TTY: 711 ܐܘ ܡܬܝܠܘ ܥܡ ܡܦܩܚܢܘܬܟܘܢ.

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ và dịch vụ phù hợp để cung cấp thông tin bằng các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi số 877-469-2583 TTY: 711 hoặc trao đổi với người cung cấp dịch vụ của bạn.

VËMENDJE: Nëse flisni shqip, shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Ndihma të përshtatshme dhe shërbime shtesë për të siguruar informacion në formate të përdorshme janë gjithashtu në dispozicion falas. Telefononi 877-469-2583 TTY: 711 ose bisedoni me ofruesin tuaj të shërbimit.

알림: 한국어를 사용하는 경우 언어 지원 서비스를 무료로 이용할 수 있습니다. 정보를 접근 가능한 형식으로 제공받을 수 있는 적절한 보조 기구와 서비스도 무료로 이용할 수 있습니다. 877-469-2583 TTY: 711 번으로 전화하거나 담당 기관에 문의하십시오.

মনোযোগ দিন: যদি আপনি বাংলা বলেন তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবাদি উপলব্ধ রয়েছে। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহযোগিতা এবং পরিষেবাদিও বিনামূল্যে উপলব্ধ রয়েছে। 877-469-2583 TTY: 711 নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।

UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 877-469-2583 TTY: 711 lub porozmawiaj ze swoim usługodawcą.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 877-469-2583 TTY: 711 an oder sprechen Sie mit Ihrem Provider.

ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'877-469-2583 TTY: 711 o parla con il tuo fornitore.

注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。情報をアクセスしやすい形式で提供するための適切な補助器具やサービスも無料でご利用いただけます。877-469-2583 TTY: 711 までお電話いただくか、ご利用の事業者にご相談ください.

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 877-469-2583 TTY: 711 или обратитесь к своему поставщику услуг.

PAŽNJA: Ako govorite srpsko-hrvatski, dostupne su vam besplatne usluge jezične pomoći. Odgovarajuća pomoćna pomagala i usluge za pružanje informacija u pristupačnim formatima također su dostupni besplatno. Nazovite 877-469-2583 TTY: 711 ili razgovarajte sa svojim pružateljem usluga.

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na karagdagang tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 877-469-2583 TTY: 711 o makipag-usap sa iyong provider.

Discrimination is against the law

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes). Blue Cross Blue Shield of Michigan and Blue Care Network does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Blue Cross Blue Shield of Michigan and Blue Care Network:

- Provide people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as: qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provide free language services to people whose primary language is not English, which may include qualified interpreters and information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call the Customer Service number on the back of your card. If you aren't already a member, call 877-469-2583 or, if you're 65 or older, call 888-563-3307, TTY: 711.

Here's how you can file a civil right complaint if you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with:

Office of Civil Rights Coordinator
600 E. Lafayette Blvd., MC 1302
Detroit, MI 48226
Phone: 888-605-6461, TTY: 711
Fax: 866-559-0578
Email: CivilRights@bcbsm.com

If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal website https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, or by mail, phone, or email at:

U.S. Department of Health & Human Services
200 Independence Ave, SW
Room 509, HHH Building
Washington, D.C. 20201
Phone: 800-368-1019, TTD: 800-537-7697
Email: OCRComplaint@hhs.gov

Complaint forms are available on the U.S. Department of Health & Human Services Office for Civil Rights website https://www.hhs.gov/ocr/complaints/index.html.

This notice is available at Blue Cross Blue Shield of Michigan and Blue Care Network's website: https://www.bcbsm.com/important-information/policies-practices/nondiscrimination-notice/

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