SIMPLY BLUE℠ HRA GROUP BENEFITS CERTIFICATE SG

(for small, insured group customers)

This contract is between you and Blue Cross Blue Shield of Michigan. Because we are an independent corporation licensed by the Blue Cross and Blue Shield Association - an association of independent Blue Cross and Blue Shield plans - we are allowed to use the Blue Cross and Blue Shield names and service marks in the state of Michigan. However, we are not an agent of BCBSA and, by accepting this contract, you agree that you made this contract based only on what you were told by BCBSM or its agents. Only BCBSM has an obligation to provide benefits under this certificate and no other obligations are created or implied by this language.

Your coverage provides many benefits for you and your eligible dependents. These benefits are described in this book, which is your **certificate**.

Your certificate, your signed application and your BCBSM identification card are your **contract** with us.

You may also have **riders**. Riders make changes to your certificate and are an important part of your coverage. When you receive riders, keep them with this book.

This certificate will help you understand your benefits and each of our responsibilities **before** you require services. Please read it carefully. If you have any questions about your coverage, call us at one of the BCBSM Customer Service telephone numbers listed in the "How to Reach Us" section of this book.

About Your Certificate

This certificate is arranged to help you locate information easily. You will find:

- **A Table of Contents** — for quick reference
- **Information About Your Contract**
- **What You Must Pay**
- **What BCBSM Pays For**
- **How Providers Are Paid**
- **General Services That Are Not Payable**
- **General Conditions of Your Contract**
- **Definitions** — explanations of the terms used in your certificate
- **Additional Information You Need to Know**
- **How to Reach Us**
- **Index**

This certificate provides you with the information you need to get the most from your BCBSM health care coverage. Please call us if you have any questions.

Table of Contents

Section 1: Information About Your Contract

This section provides answers to general questions you may have about your contract. Topics include:

- **ELIGIBILITY**
  - Who Is Eligible to Receive Benefits
- **CHANGING YOUR COVERAGE**
- **TERMINATION**
  - How to Terminate Your Coverage
  - How We Terminate Coverage
  - Rescission
- **CONTINUATION OF BENEFITS**
  - Consolidated Omnibus Budget Reconciliation Act (COBRA)
  - Individual Coverage
- **REWARDS PROGRAM**

ELIGIBILITY

You will need to fill out an application for coverage.

We will review your application to determine if you and the people you list on it are eligible. Our decision will be based on the eligibility rules in this certificate and our underwriting policies. You and the dependents on your contract must also meet the group's eligibility requirements.

If you or anyone applying for coverage on your behalf commits fraud or intentionally lies about a material fact in your application, your coverage may be rescinded. See "Rescission" on Page 9.

Who Is Eligible to Receive Benefits

- You
- Dependents listed on your contract:
  - Your spouse
  - Your children

If you are the subscriber with surviving spouse coverage, you cannot add a spouse under this certificate.

Children are covered through the end of the calendar year when they become age 26 as long as the subscriber is covered under this certificate. The children must be related to you by:

- Birth
- Marriage
- Legal adoption
- Legal guardianship
- Becoming a dependent due to a child support order or other court order
- Foster child placement by an agency or court order

Your child's spouse is not eligible for coverage under this certificate. Your grandchildren may be covered in limited circumstances.

Newborn children, including your grandchildren, may qualify for limited benefits immediately following their birth even if they are not listed on your contract. If the member who gave birth to the newborn is covered under this contract, see Section 3 in this certificate for Maternity Care.

Your children will be removed from your contract at the end of the year in which they turn 26. They may be eligible for their own contract through the Consolidated Omnibus Budget Reconciliation Act (COBRA) or a BCBSM individual plan. To learn more about COBRA, see the Continuation of Benefits subsection.

Eligibility (continued)

Who Is Eligible to Receive Benefits (continued)

Disabled Unmarried Children

Disabled unmarried children may remain covered after they turn age 26 if all of the following apply:

- They cannot support themselves due to a diagnosis of:
  - A physical disability or
  - A developmental disability
- They depend on you for support and maintenance.

Your employer must send us a physician's certification proving the child's disability. We must receive it by 31 days after the end of the year of the child's 26th birthday. We will decide if the child meets the requirements.

You may also be eligible for group coverage if:

- You lose your Medicaid coverage (you must apply for BCBSM coverage within 60 days).
- Your dependents lose their CHIP (Children's Health Insurance Program) coverage (you must apply for BCBSM coverage within 60 days).
- You or your dependent become eligible for a premium assistance subsidy from the state you live in for employer group health care coverage. Michigan does not provide state premium assistance subsidies at this time. For additional information regarding eligibility for a state premium assistance subsidy, please contact Customer Service.

CHANGING YOUR COVERAGE

If there is a change in your family, you must notify your group. The changes include:

- Birth
- Adoption
- Gaining a dependent due to:
  - A child support order or other court order
  - Foster child placement by agency or court order
- Marriage
- Divorce
- Death of a member
- Start or end of military service

Your change takes effect as of the date it happens. Your group must notify us directly of any changes within:

- 30 days of when a dependent is removed
- 31 days of when a dependent is added

If a dependent cannot be covered by your contract anymore, they may be eligible for their own contract through COBRA or a BCBSM individual plan.

TERMINATION

How to Terminate Your Coverage

Send your written request to terminate coverage to your employer. We must receive it from your employer within 30 days of the requested termination date. Your coverage will then be terminated and all benefits under this certificate will end. However, if you are an inpatient at a hospital or facility on the date your coverage ends, please see “Services Before Coverage Begins or After Coverage Ends” in Section 6.

Termination (continued)

How We Terminate Your Coverage

We may terminate your coverage if:

- Your group does not qualify for coverage under this certificate
- Your group does not pay its bill on time

If you are responsible for paying all or a portion of the bill, you must pay it on time or your coverage will be terminated. For example, if you are a retiree or enrolled under COBRA and you pay all or part of your bill directly to BCBSM, we must receive your payment on time.

- You are serving a criminal sentence for defrauding BCBSM
- You no longer qualify to be a member of your group
- Your group changes to a non-BCBSM health plan
- We no longer offer this coverage
- You **misuse** your coverage

  Misuse includes illegal or improper use of your coverage such as:

  - Allowing an ineligible person to use your coverage
  - Requesting payment for services you did not receive

- You fail to repay BCBSM for payments we made for services that were not a benefit under this certificate, subject to your rights under the appeal process.
- You are satisfying a civil judgment in a case involving BCBSM
- You are repaying BCBSM funds you received illegally
- You no longer qualify as a dependent

Your coverage ends on the last day covered by the last premium payment we receive. However, if you are an inpatient at a hospital or facility on the date your coverage ends, please see “Services Before Coverage Begins or After Coverage Ends" in Section 6.

Rescission

We will rescind your coverage if you, your group or someone seeking coverage on your behalf has:

- Performed an act, practice, or omission that constitutes fraud, or
- Made an intentional misrepresentation of material fact to BCBSM or another party, which results in you or a dependent obtaining or retaining coverage with BCBSM or the payment of claims under this or another BCBSM certificate.

We may rescind your coverage back to the effective date of your contract. If we do, we will provide you with a 30-day notice. Once we notify you that we are rescinding your coverage, we may hold or reject claims during this 30-day period. You will have to repay BCBSM for its payment for any services you received.

CONTINUATION OF BENEFITS

Consolidated Omnibus Budget Reconciliation Act (COBRA)

COBRA is a federal law that applies to most employers with 20 or more employees. It allows you to continue your employer group coverage if you lose it due to a qualifying event; e.g., you are laid off or fired. (“Qualifying events” are listed in Section 7.) Your employer must send you a COBRA notice. You have 60 days to choose to continue your coverage. The deadline is 60 days after you lose coverage or 60 days after your employer sends you the notice, whichever is later. If you choose to keep the group coverage you must pay for it. The periods of time you may keep it are:

- 18 months of coverage for an employee who is terminated, other than for gross misconduct, or whose hours are reduced
- 29 months of coverage for all qualified beneficiaries if the Social Security Administration determined that one member was disabled at the time of the qualifying event or at some time during the first 60 days of the COBRA coverage
- 36 months of coverage for qualified beneficiaries in case of the death of the employee, divorce, legal separation, loss of dependency status, or employee entitlement to Medicare

COBRA coverage can be terminated because:

- The 18, 29 or 36 months of COBRA coverage ends
- The required premium is not paid on time
- The employer terminates its group health plan
- The qualified beneficiary becomes entitled to Medicare coverage
- The qualified beneficiary obtains coverage under a group health plan

Please contact your employer for more details about COBRA.

Individual Coverage

If you choose not to enroll in COBRA, or if your COBRA coverage period ends, coverage may be available through a BCBSM individual plan. Contact BCBSM Customer Service for information about what plan best meets your needs.

REWARDS PROGRAM

The Rewards Program will end December 31, 2026.

Covered members under this certificate can participate in the Rewards Program through December 31, 2026.

Whenever you obtain services included in our Rewardable Services List from providers recognized under the Rewards Program, you may earn rewards ranging from $25 to $500. You may earn unlimited rewards per member per calendar year. When redeeming your rewards, you have a choice of receiving a check, an electronic gift card (e-gift card) or other options available to you at the time of redemption.

If you receive rewards totaling $600 or more in a calendar year, a 1099 tax form will be issued.

How to Earn Your Reward

To earn a reward for a service on the Rewardable Services List, you must complete *all* the following steps:

- Log in to your account on BCBSM's secured member account and select Rewards
- Search a covered service to find local providers and their prices
  - Rewardable services will identify eligible providers with a "green trophy"
  - When prompted, select "yes" for Rewards and provide the requested contact information
    - This step is required for each rewardable service
- Elect to have the rewardable service performed by an eligible provider
  - After BCBSM has received and processed your claim, you may redeem your reward

Please note that the services reward amounts, and providers recognized under this program are subject to change.

Some services are listed below. For help identifying rewardable services or eligible providers, you may contact Customer Service (See Section 9) or locate them at https://member.bcbsm.com/mpa/responsive/#/Providers/Rewards.

Services	Rewards
Imaging Services (including but not limited to) - members can earn ($25-$50)	
Chest X-rays	$25
Most CT Scans	$50
Most MRIs	$50
Ultrasounds	$50
Echocardiograms	$50
Mammograms	$50
Pet Scans	$50

Rewards (continued)

Rewardable Services List (continued)

Services	Rewards
Outpatient Procedures (including but not limited to) - members can earn ($75)	
ACL Repairs	$75
Breast Biopsies and Lumpectomy	$75
Carpal Tunnel	$75
Endoscopy	$75
Cataract Surgery	$75
Colonoscopy	$75
Hammertoe Correction	$75
Hysteroscopy	$75
Knee Arthroscopy	$75
Shoulder Arthroscopy	$75
Skin Lesion Biopsy	$75
Sleep Studies	$75
Tonsillectomy (under age 12)	$75
Upper GI Endoscopy	$75

Services	Rewards
MSK Spine and Joint Care Surgical Procedures – member can earn ($500)	
Knee Replacement	$500
Hip Replacement	$500
Spinal Lumbar Fusion	$500
Spinal Cervical Fusion	$500
Spinal Decompression	$500

Exclusions

The following covered services are not eligible for a reward under the Rewards Program:

- Services not included in the Rewardable Services List
- Services that are received during a medical emergency
- Services eligible for payment by other coverage
- Services performed by non-designated providers

If your BCBSM coverage is secondary to other coverage under the Coordination of Benefits provisions in this certificate, the Rewards Program will not apply to you, even when the services are included in the Rewardable Services List.

Section 2: What You Must Pay

You have PPO coverage under this certificate. PPO coverage uses a "Preferred Provider Organization" provider network. What you must pay depends on the type of provider you choose. If you choose an "in-network" provider, you most often pay less money than if you choose an "out-of-network" provider.

The types of providers you may get services from are in the chart below.

Choosing Your Provider		
In-Network Lower Cost	**Out-of-Network Participating Provider Higher Cost**	**Out-of-Network Nonparticipating Provider Highest Cost**
BCBSM's approved amount accepted as payment in full*. Lower out-of-pocket costs: • Lower deductible, copayment and coinsurance • No deductible, copayment or coinsurance for certain preventive care benefits No claim forms to file	BCBSM's approved amount accepted as payment in full*. Higher out-of-pocket costs: • Higher deductible, copayment and coinsurance (unless noted). • No deductible, copayment or coinsurance for certain preventive care benefits No claim forms to file	BCBSM's approved amount may **not** be accepted as payment in full. Highest out-of-pocket costs: • You may be responsible for your out-of-network cost share and the difference between what the provider charges and what we pay (unless otherwise noted). You may need to file claim forms.

* The provider accepts BCBSM's approved amount minus your cost share as payment in full for covered services.

A provider can either be participating or nonparticipating. Participating providers cannot bill you for more than our payment plus what you pay in cost sharing.

Some nonparticipating providers may agree to accept our payment for certain services as payment in full. When this occurs, you only have to pay your applicable cost share. Other nonparticipating providers may **not** accept our payment as payment in full. You may be required to pay your out-of-network cost share and the difference between what the provider charges and what we pay.

This may not apply in situations where you were unable to select a participating provider or no participating provider was available. (See Surprise Billing in the General Conditions of Your Contract section for more information).

Section 4 explains more about providers: professional providers, hospitals and others. We also explain how we pay providers.

What you must pay for covered services is described in the following pages.

The deductibles, copayments and coinsurances you must pay each calendar year are illustrated in the chart below and explained in more detail in the pages that follow. These are standard amounts associated with this certificate. The amounts you have to pay may differ depending on what riders your particular plan has.

Cost-Sharing Chart

In-Network	
Deductibles	$1,500 for one member $3,000 for the family (when two or more members are covered under your contract)
Copayments	$150 per emergency room visit $30 per office visit and office consultation with a primary care physician, online visit, virtual primary care visit or visit in a retail health clinic $50 per office visit and office consultation with a specialist $30 per chiropractic spinal manipulation and osteopathic manipulative treatment, when given in a physician's office $60 per urgent care visit
Coinsurance	20% of approved amount for most covered services 50% of approved amount for bariatric surgery
Annual out-of-pocket maximums	$5,000 for one member $10,000 for the family (when two or more members are covered under your contract)
Out-of-Network	
Deductibles	$3,000 for one member $6,000 for the family (when two or more members are covered under your contract)
Copayment	$150 per emergency room visit
Coinsurance	40% of approved amount for most covered services 50% of approved amount for bariatric surgery
Annual out-of-pocket maximums	$10,000 for one member $20,000 for the family (when two or more members are covered under your contract)
Lifetime dollar maximum	None

For a list of in-network primary care physicians and specialists, visit our website at www.bcbsm.com or call our Customer Service department. The phone numbers are listed in Section 9.

Some services have different cost sharing. These are listed starting on Page 19.

In-Network Providers

Deductible Requirements
Each calendar year, you must pay a deductible for in-network covered services:

- $1,500 for one member
- $3,000 for the family (when two or more members are covered under your contract)
  - Two or more members must meet the family deductible.
  - If the one-member deductible has been met, but not the family deductible, we will pay covered services only for that member who has met the deductible.
  - Covered services for the remaining family members will be paid when the full family deductible has been met.

The approved amount that is applied to your in-network deductible for covered services received in the last three months of a calendar year will be applied toward your in-network deductible requirement for the next calendar year.

You are not required to pay a deductible for the following:

- Services subject to a copayment requirement
- Presurgical consultations
- Professional services for the initial exam and treatment of a medical emergency or an accidental injury in the outpatient department of a hospital, urgent care center or physician's office
- Hospice care benefits
- Prenatal care
- Postnatal care
- Select preventive care services

In-Network Providers (continued)

Copayment and Coinsurance Requirements

You must pay the following copayment for covered services by in-network providers:

- $150 per visit for facility services in a hospital emergency room (waived if the member is admitted)
- $30 per office visit and office consultation with a primary care physician, online visit, virtual primary care visit or visit in a retail health clinic
- $50 per office visit and office consultation with a specialist

  

  For a list of "specialists", visit our website at www.bcbsm.com or contact Customer Service (see Section 9).

- $30 per chiropractic and osteopathic manipulative treatment, when services are given in a physician's office

  

  When an office visit and manipulative treatment are billed on the same day, by the same in-network physician, you must pay only the copayment for the office visit.

- $60 per urgent care visit

In addition to your deductible, you must pay the following coinsurance for covered services by in-network providers:

- 20% of the approved amount for most covered services except:
  - Services subject to a copayment requirement
  - Presurgical consultations
  - Professional services for the initial exam and treatment of a medical emergency or an accidental injury in the outpatient department of a hospital, urgent care center or physician's office
  - Hospice care benefits
  - Prenatal care
  - Postnatal care
  - Select preventive care services
- 50% of the approved amount for bariatric surgery

In-Network Providers (continued)

Annual Out-of-Pocket Maximums

Your annual out-of-pocket maximum for covered in-network services is:

- $5,000 for one member
- $10,000 for the family (when two or more members are covered under your contract)
  - Two or more members must meet the family out-of-pocket maximum.
  - If the one-member maximum is met even if the family maximum is not, that member does not pay any more cost share for the rest of the calendar year.
  - Cost share for the remaining family members must still be paid until the annual family maximum is met.

The in-network **deductible, copayments and coinsurance** that you pay are combined to meet the annual in-network out-of-pocket maximum. This also includes what you pay for prescription drugs covered within your BCBSM prescription drug certificate. Any coupon, rebate or other credits received directly or indirectly from an assistance program or the drug manufacturer may not be applied to your annual out-of-pocket maximum. The following prescription drug expenses will NOT apply towards the annual out-of-pocket maximum:

- Payment for noncovered drugs or services
- Any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand-name drug
- The 25% member liability for covered drugs obtained from a nonparticipating pharmacy

Only payments toward your cost share are applied toward your out-of-pocket maximum. If you receive services from a nonparticipating provider and you are required to pay that provider for the difference between the charge for the services and our approved amount, your payment will not apply to your out-of-pocket maximum.

Once you meet the maximums for the year, we pay for all covered benefits at 100% of our approved amount for the rest of the calendar year.

Out-of-Network Providers

Deductible Requirements
Each calendar year, you must pay a deductible for out-of-network covered services:

- $3,000 for one member
- $6,000 for the family (when two or more members are covered under your contract)
  - Two or more members must meet the family deductible.
  - If the one-member deductible has been met, but not the family deductible, we will pay covered services only for that member who has met the deductible.
  - Covered services for the remaining family members will be paid when the full family deductible has been met.

The approved amount that is applied to your out-of-network deductible also counts toward your in-network deductible. However, the approved amount that is applied to your in-network deductible does not count toward your out-of-network deductible.

You do not have to pay an out-of-network deductible for certain covered services:

- Covered services in emergency and certain non-emergency situations as specified by state and federal law (See Surprise Billing in the General Conditions of Your Contract section for more information)
- Air ambulance
- Professional services for the initial exam and treatment of a medical emergency or accidental injury in the outpatient department of a hospital, urgent care center or physician's office
- Services from a provider for which there is no PPO network
- Services from an out-of-network provider in a geographic area of Michigan deemed a "low-access area" by BCBSM for that particular provider specialty

In limited instances, you may not have to pay an out-of-network deductible for:

- Select professional services performed by out-of-network providers in an in-network hospital, participating freestanding ambulatory surgery facility or any other location identified by BCBSM, or
- The reading and interpretation of select routine or screening services when an in-network provider performs the services, but an out-of-network provider does the analysis and interprets the results.

If one of the above applies and you do not have to pay the out-of-network deductible, you may still need to pay the in-network deductible.

You may contact BCBSM for more information about these services.

Out-of-Network Providers (continued)

Copayment and Coinsurance Requirements

You must pay the following copayment for covered services by out-of-network providers:

- $150 per visit for facility services in a hospital emergency room (waived if the member is admitted). For your requirements on services in a Michigan nonparticipating hospital, see Page 134.

In addition to your deductible, you must pay the following coinsurance for covered services by out-of-network providers:

- 40% of the approved amount for most covered services

  

  Online visits by an out-of-network professional provider will be subject to applicable out-of-network cost share requirements. Online visits and virtual primary care visits by a vendor that was not selected by BCBSM will not be covered.

  You do not have to pay the out-of-network coinsurance for certain covered services:

  - Covered services in emergency and certain non-emergency situations as specified by state and federal law (See Surprise Billing in the General Conditions of Your Contract section for more information)
  - Air ambulance
  - A prescription contraceptive device obtained from an out-of-network provider
  - Services from a provider for which there is no PPO network
  - Services from an out-of-network provider in a geographic area of Michigan deemed a “low-access area” by BCBSM for that particular provider specialty

  In limited instances, you may not have to pay out-of-network coinsurance for:

  - Select professional services performed by out-of-network providers in an in-network hospital, participating freestanding ambulatory surgery facility or any other location identified by BCBSM, or
  - The reading and interpretation of select routine or screening services when an in-network provider performs the services, but an out-of-network provider does the analysis and interprets the results.

  

  If one of the above applies and you do not have to pay the out-of-network coinsurance, you may still need to pay the in-network coinsurance.

- 50% of the approved amount for bariatric surgery

You may contact BCBSM Customer Service for more information about these services.

Out-of-Network Providers (continued)

Annual Out-of-Pocket Maximums

Your annual out-of-pocket maximum for covered out-of-network services is:

- $10,000 for one member
- $20,000 for the family (when two or more members are covered under your contract)
  - Two or more members must meet the family out-of-pocket maximum.
  - If the one-member maximum is met even if the family maximum is not, that member does not pay any more cost share for the rest of the calendar year.
  - Cost share for the remaining family members will be required until the full family annual out-of-pocket maximum has been met.

The out-of-network **deductible, copayments and coinsurance** that you pay are combined to meet the annual out-of-network out-of-pocket maximum. This also includes what you pay for prescription drugs covered within your BCBSM prescription drug certificate. Any coupon, rebate or other credits received directly or indirectly from an assistance program or the drug manufacturer may not be applied to your annual out-of-pocket maximum. The following prescription drug expenses will NOT apply towards the annual out-of-pocket maximum:

- Payment for noncovered drugs or services
- Any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand-name drug
- The 25% member liability for covered drugs obtained from a nonparticipating pharmacy

Only payments toward your cost share are applied toward your out-of-pocket maximum. If you receive services from a nonparticipating provider and you are required to pay that provider for the difference between the charge for the services and our approved amount, your payment will not apply to your out-of-pocket maximum.

Once you meet the maximums for the year, we pay for all covered benefits at 100% of our approved amount for the rest of the calendar year.

What you pay in out-of-network cost-sharing counts toward your in-network out-of-pocket maximum. However, what you pay in in-network cost sharing does not count toward your out-of-network out-of-pocket maximum.

Benefit-Specific Cost-Sharing Requirements

The benefits below differ in what you pay for them:

Collaborative Care Management
When services are received in-network, you do not pay any cost share for specific collaborative care behavioral health care.

When services are received out-of-network, you pay your out-of-network cost share.

Colonoscopy
Hospital and physician benefits for your first colonoscopy of the calendar year.

- When services are received in-network, you pay no cost share
- When services are received out-of-network, you must pay your out-of- network cost share

If you have another colonoscopy done in the same calendar year, you will have to pay your in-network or out-of-network cost share.

Contraceptive Devices
When services are received in-network, you do not pay any cost share.

When services are received out-of-network, you must pay your out-of-network deductible, but no other cost share.

Contraceptive Injections
When services are received in-network, you do not pay any cost share.

When services are received out-of-network, you must pay your out-of-network cost share.

Contraceptive Mobile App
When you purchase a yearly subscription for an FDA-approved contraceptive mobile app, log into your BCBSM member account to find and fill out a reimbursement form. Submit the form along with your receipt for reimbursement.

BCBSM will reimburse you up to charge for your yearly subscription.

Hospice Services
You do not pay any cost share for hospice services from approved physicians, facilities and other approved providers.

Benefit-Specific Cost-Sharing Requirements (continued)

Maternity Preventive Care Services
Under maternity care, we pay the following:

- Prenatal care
  - When services are received in-network, you do not pay any cost share
  - When services are received out-of-network, you pay your out-of-network cost share
- Postnatal care
  - When services are received in-network, you do not pay any cost share
  - When services are received out-of-network, you pay your out-of-network cost share

Medical Services at a Pharmacy
Covered services performed by a pharmacist, which may include certain medical evaluations and testing, when performed at a BCBSM affiliated immunization pharmacy.

An immunization pharmacy can be found through the Find Care option on your BCBSM member account. Medical evaluation by a pharmacist will apply the primary care office visit cost share as designated by your plan.

When services are received at a non-immunization pharmacy, the services are not covered.

Mental Health and Substance Use Disorder Services
You pay the same cost share for mental health and substance use disorder services that you would for many covered services, in-network or out-of-network.

Your deductible and coinsurance apply for these services, no matter the location. Your office visit or online visit copay does not apply.

Outpatient Diabetes Management Program (ODMP)
Under the ODMP, we pay to train you to manage your diabetes, when needed.

- When services are received in-network, you pay no cost share.
- When services are received out-of-network, you must pay your out-of-network cost share.

For all other services and supplies you get under the ODMP, you do pay cost sharing. You pay either in-network or out-of-network cost sharing, depending on the provider you choose.

Presurgical Consultations
When services are received in-network, you do not pay any cost share for presurgical consultations.

Specified Organ Transplants
If you need an organ transplant that we cover, you pay no cost share during the benefit period for the transplant and transplant related procedures. The benefit period begins five days before the transplant and ends one year after the transplant.

Benefit-Specific Cost-Sharing Requirements (continued)

Value Based Programs
When services are received in-network, you do not pay a deductible, copayment, or coinsurance for "care management" services (see Section 7 for the definition). These services include:

- Provider-delivered care management
  - Services obtained only in Michigan from providers designated by BCBSM
- Total care
  - Services obtained outside of Michigan from providers designated by the local Blue Cross Blue Shield plan in that state.
  - When services are received out-of-network, you are responsible for the provider's full charge.

Voluntary Sterilization of Female Reproductive Organs
We pay for voluntary sterilization of female reproductive organs.. We cover services from a physician and in a participating hospital.

- When services are received in-network, you pay no cost share.
- When services are received out-of-network, you must pay your out-of-network cost share.

Maximums for Days of Care or Visits

You might have other maximums for things like days or visits. If so, they are described elsewhere in this book.

Section 3: What BCBSM Pays For

This section describes the services we pay for and the extent to which they are covered.

- We pay for admissions and services when they are provided according to this certificate. Some admissions and services must be approved before they occur. Emergency services do not need to be preapproved.

  You should call BCBSM Customer Service or visit https://bcbsm.com/priorauth for a list of admissions and services requiring preapproval. Payment will be denied if preapproval is not obtained.

- We pay only for "medically necessary" services (see Section 7 for the definition). This includes services that may not be covered under this certificate but are part of a treatment plan approved by us. There are exceptions to this rule. Here are some examples:

  - Voluntary sterilization
  - Screening mammography
  - Preventive care services
  - Contraceptive services

  

  We will not pay for medically necessary services in an inpatient setting if they can be safely given in an outpatient location or office setting.

- We pay our approved amount (see Section 7 for the definition) for the services you receive that are covered in this certificate and any riders you may have. Riders change your certificate and are an important part of your coverage.

You must pay your cost share for many of the benefits listed, see Section 2.

We pay for services received from:

- Hospitals and Other Facilities
  We pay for covered services you receive in hospitals and other BCBSM-approved facilities. A physician must prescribe the services before we will cover them.

- Physicians and Other Professional Providers
  Covered services must be provided by BCBSM-approved providers who are legally qualified or licensed to provide them.

  

  Some physicians and other providers do not participate with BCBSM. Instead of billing BCBSM for certain services, they may bill you. The provider may bill you more than what we will pay for their services. We will pay our approved amount, but you may have to pay your cost share and the difference between what the provider charges and what we pay. (See Surprise Billing in the General Conditions of Your Contract section and "Nonparticipating Physicians and Other Providers" in Section 4 for more information).

Allergy Testing and Therapy

See Section 2 beginning on Page *12 for what you may be required to pay for these services.*

For other diagnostic services, see Page 50.

Locations: We pay for allergy testing and therapy in:

- A participating hospital
- A participating ambulatory surgery facility
- An office

We pay for:

- Allergy Testing
  - Survey, including history, physical exam, and diagnostic laboratory studies
  - Intradermal, scratch and puncture tests
  - Patch and photo tests
  - Double-blind food challenge test and bronchial challenge test
- Allergy Therapy
  - Allergy immunotherapy by injection (allergy shots)
  - Injections of antiallergen, antihistamine, bronchodilator or antispasmodic agents

We do not pay for:

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

Ambulance Services

See Section 2 beginning on Page *12 for what you may be required to pay for these services.*

For emergency treatment services, see Page 56.

Locations: We pay for ground ambulance to take a member to a covered destination. A destination may include:

- A hospital
- Other facilities
- A member's home

Locations: We pay for air ambulance to take a member to a covered destination. A destination may include:

- A hospital
- Another covered facility, with BCBSM's preapproval

In every case the following conditions must be met:

- The service must be medically necessary. Any other means of transport would endanger the member's health. Ambulance services are medically necessary for:
  - Transporting a member to a hospital
  - Transferring a member from a hospital to another treatment location such as another hospital, other facilities, a medical clinic or the patient's home. (The attending physician must order the transfer.)
  - Ambulance providers to respond and treat the patient without transport

  

  Nonemergency ambulance services are covered when medically necessary and authorized by the patient's physician.
- We only pay for the transportation of the member and whatever care is required during transport. We do not pay for other services that might be billed with it.
- The service must be provided in a vehicle licensed as a ground or air ambulance, which is part of a licensed ambulance operation.

Ambulance Services (continued)

We pay for:

- A member to be taken to the nearest approved destination capable of providing the level of care necessary to treat the member's condition

Transfer of the member between covered destinations must be prescribed by the attending physician.

We also pay for ground and air ambulance services when:

- The ambulance arrives at the scene but transport is not needed or is refused.
- The ambulance arrives at the scene but the member has expired.

Air Ambulance

We Pay for:

- Nonemergent air ambulance services between covered destinations

These services must meet the following criteria:

- The transfer must be preapproved and prescribed by the attending physician, and
- The member will be taken to the nearest approved location capable of providing the level of care necessary to treat the member's condition

The services must be approved before they occur. If they are not preapproved, they will be considered a noncovered benefit and you **may** have to pay their entire cost. It is important to make sure that your provider gets approval before you receive services.

Air Ambulance

Air ambulance services must also meet these requirements:

- No other means of transportation are available
- The member's condition requires transportation by air ambulance rather than ground ambulance
- The provider is not a commercial airline
- The member is taken to the nearest facility capable of treating the member's condition.

If your air ambulance transportation does not meet the above requirements, the services may be eligible for review under case management. They may approve the services for transportation that positively impacts clinical outcomes, but not for a member's or family's convenience.

Ambulance Services (continued)

We do not pay for:

- Services provided by fire departments, rescue squads or other emergency transport providers whose fees are in the form of donations.
- Air ambulance services when the member's condition does not require air ambulance transport.
- Air ambulance services when a hospital or air ambulance provider is required to pay for the transport under the law.

Anesthesiology Services

See Section 2 beginning on Page *12 for what you may be required to pay for these services.*

Locations: We pay for anesthesiology services in:

- A participating hospital
- A participating ambulatory surgery facility
- An office

We pay for:

- Anesthesiology during surgery

  Anesthesia services given to members undergoing covered surgery are payable to:

  - A physician other than the operating physician

    

    If the operating physician gives the anesthetics, the service is included in our payment for the surgery.

  - A physician who orders and supervises anesthesiology services
  - A certified registered nurse anesthetist (CRNA)

    CRNA services must be:

    - Directly supervised by the physician performing the surgery or procedure or
    - Under the indirect supervision of the physician responsible for anesthesiology services

    

    If a CRNA is an employee of a hospital or facility, we pay the facility directly for the anesthesia services.

- Anesthesia during infusion therapy

  We pay for local anesthesia only when needed as part of infusion therapy done in an office.

- Other Services

  Anesthesia services may also be covered as part of electroconvulsive therapy (see Page 33) and for covered dental services (see Page 48).

Audiologist Services

See Section 2 beginning on Page *12 for what you may be required to pay for these services.*

Locations: We pay for audiology services performed by an audiologist in:

- An office
- Other approved outpatient locations.

We pay for:

- Services performed by an audiologist, if they are prescribed by a provider who is legally authorized to prescribe the services.

Autism Spectrum Disorders

See Section 2 beginning on Page 12 for what you may be required to pay for these services.

Locations: We pay for treatment of identified autism spectrum disorders in the following locations:

- An office
- A member's home
- Other approved outpatient locations.

Covered Autism Spectrum Disorders

We pay for the diagnosis and outpatient treatment of autism spectrum disorders.

Covered Services

We pay for:

- Diagnostic services provided by a qualified provider.

  These services include:

  - Assessments
  - Evaluations or tests, including the Autism Diagnostic Observation Schedule

- Treatment prescribed by a physician or licensed psychologist:

  These services include:

  - **Applied Behavior Analysis (ABA) treatment**

    - Autism spectrum disorder services including applied behavior analysis (ABA) is covered subject to the following requirements:

      - **Interdisciplinary Evaluation** – An interdisciplinary evaluation must occur before a member will be approved for ABA treatment. The interdisciplinary team must include, but is not limited to, a physician, behavioral health specialist, and a speech language specialist. A BCBSM-approved autism evaluation center can perform this evaluation and ABA treatment must be recommended for it to be covered. If BCBSM requests treatment review, BCBSM will pay for it.
      - **Prior Authorization** – Autism spectrum disorder services must be authorized by BCBSM before treatment is given. If not, you will have to pay for it. See Section 7 for the definition of autism spectrum disorder services which includes a list of service types that require prior authorization.

Autism Spectrum Disorders (continued)

We pay for: (continued)

Applied Behavior Analysis (ABA) treatment (continued)

- Treatment must be provided or supervised by one of the following:
  - A licensed behavior analyst (LBA)
    - We do not cover any other services provided by a board-certified licensed behavior analyst including, but not limited to, treatment of traumatic brain injuries.

Out-of-state behavior analysts may be board-certified or licensed.

  - A licensed psychologist
    - The psychologist must have adequate formal university training and supervised experience in ABA.

- **Behavioral Health Treatment (BHT)** – Evidence-based counseling is part of BHT. A [licensed psychologist must perform or supervise this treatment. The psychologist must have adequate formal university training and supervised experience in BHT.
- **Psychiatric care** – It includes a psychiatrist's direct or consulting services. The psychiatrist must be licensed in the state where they practice.
- **Psychological care** – It includes a psychologist's direct or consulting services. The psychologist must be licensed in the state where they practice.
- **Therapeutic care** – Evidence-based services from licensed providers. It includes:
  - Physical therapy
  - Occupational therapy
  - Speech language therapy
  - Autism spectrum disorder services (including ABA) when performed by a participating LBA or other provider acting within their scope of practice.
  - Outpatient mental health therapy
  - Nutritional therapy
  - Genetic testing

Benefits for autism spectrum disorder treatment are in addition to any other mental health or medical benefits you have under this certificate.

Autism Spectrum Disorders (continued)

Coverage Requirements

All autism services and treatment must be:

- Medically necessary and appropriate
- Comprehensive and focused on managing and improving the symptoms directly related to a member's Autism Spectrum Disorder
- Deemed safe and effective by BCBSM

Limitations and Exclusions

In addition to those listed in your certificate and riders the following limitations and exclusions apply:

- We do not pay for treatments that are not covered under the Autism Spectrum Disorders section
- We do not pay for treatment of conditions not listed within the BCBSM medical policy
- When a member receives physical therapy, occupational therapy or speech language therapy for treatment of a covered autism spectrum disorder, those services do not apply to the benefit maximums listed in this certificate.
- We only pay for autism services performed in Michigan from participating or nonparticipating providers who are registered with BCBSM.
- We only pay for autism services performed outside Michigan from providers who participate with their local Blue Cross/Blue Shield plan.

Behavioral Health Services (Mental Health and Substance Use Disorder)

See Section 2 on Page 12 for what you may be required to pay for these services.

For autism spectrum disorders, please see Page 30.
For emergency services to treat behavioral health conditions, please see Page 56.

Coverage Requirements
BCBSM covers medically necessary and medically appropriate services to evaluate, diagnose, and treat behavioral health conditions in accordance with generally accepted standards of practice.

BCBSM does not cover treatment or services that:

- Are not medically necessary or appropriate
- Are mainly for the convenience of the member or health care provider
- Are considered experimental or investigational

See Section 7 for a definition of “medically necessary” and “experimental treatment.”

When a member receives behavioral health services under a case management agreement that they, their provider and a BCBSM case manager have signed, the member will pay their in-network cost share even if the provider is out-of-network and/or does not participate with BCBSM.

See subsections on Collaborative Care Management and Value Based Programs for more information on Care Management.

Mental Health

Locations: We pay for mental health services in:

- A participating hospital
- A participating psychiatric residential treatment facility (PRTF)
- A participating outpatient psychiatric care (OPC) facility
- An office

We pay for:

- Electroconvulsive Therapy (ECT)
  - Only covered in an inpatient or outpatient hospital location
  - When administered by, or under the supervision, of a physician
  - Anesthetics for ECT when administered by, or under the supervision of, a physician other than the physician giving the ECT

Behavioral Health Services (Mental Health and Substance Use Disorder) (continued)

Mental Health (continued)

We pay for: (continued)

- Transcranial Magnetic Stimulation (TMS)
  - Must be provided by a board-certified psychiatrist in an outpatient setting.

    

    TMS services are payable as professional services only.
- Inpatient Hospital Mental Health Services

  The following services may be included:

  - Individual psychotherapeutic treatment
  - Family counseling
  - Group psychotherapeutic treatment
  - Psychological testing
  - Inpatient consultations. If a physician needs help diagnosing or treating a member's condition, we pay for inpatient consultations.

  We do not pay for:

  - Consultations required by a facility's or program's rules
  - Marital counseling
  - Services provided by a nonparticipating hospital
- Psychiatric Residential Treatment

  The following services are payable when provided by a facility that participates with BCBSM (if located in Michigan) or with its local Blue Cross/Blue Shield plan (if located outside of Michigan):

  - Psychiatric residential treatment when it has been prior authorized by BCBSM or its representative
    - If prior authorization is not obtained:
      - A participating BCBSM facility that provided the care cannot bill the member for the cost of the admission or services.
      - A nonparticipating facility that provided the care may require the member to pay for the admission and services.
  - Services provided by facility staff
  - Individual psychotherapeutic treatment
  - Family counseling
  - Group psychotherapeutic treatment
  - Prescribed drugs given by the facility

Behavioral Health Services (Mental Health and Substance Use Disorder) (continued)

Mental Health (continued)

Psychiatric Residential Treatment (continued)

We do not pay for:

- Consultations required by a facility's or program's rules
- Marital counseling
- Care provided by a non-participating psychiatric residential facility
- Services that are not focused on improving the member's functioning
- Services that are primarily for maintaining long-term gains made by the member while in another treatment program
- A residential program that is a long-term substitute for a member's lack of available supportive living environment within the community
- A residential program that serves to protect family members and other individuals in the member's living environment
- Services or treatment that are cognitive in nature or supplies related to such services or treatment
- Treatment or supplies that do not meet BCBSM requirements
- Transitional living centers such as half-way and three-quarter way houses
- Therapeutic boarding schools
- Milieu therapies, such as wilderness program, supportive houses or group homes
- Domiciliary foster care
- Custodial care
- Services to hold or confine a member under chemical influence when the member does not require medical treatment
- A private room or an apartment
- Non-medical services including, but not limited to: enrichment programs, dance therapy, art therapy, music therapy, equine therapy, yoga and other movement therapies, ropes courses, guided imagery, consciousness raising, socialization therapy, social outings or preparatory courses or classes. These services may be paid as part of a treatment program but they are not payable separately.

- Psychiatric Partial Hospitalization Program (PHP)

  The following services are payable when hospitals and outpatient psychiatric care facilities have a PHP and participate with BCBSM (if located in Michigan) or with its local Blue Cross/Blue Shield plan (if located outside of Michigan):

  - Services provided by the hospital's or facility's staff
  - Ancillary services
  - Prescribed drugs given by the hospital or facility during the member's treatment
  - Individual psychotherapeutic treatment
  - Group psychotherapeutic treatment
  - Psychological testing
  - Family counseling

Behavioral Health Services (Mental Health and Substance Use Disorder) (continued)

Mental Health (continued)

- Psychiatric Intensive Outpatient Program (IOP)

  The following services are payable when hospitals and outpatient psychiatric care facilities have a IOP and participate with BCBSM (if located in Michigan) or with its local Blue Cross/Blue Shield plan (if located outside of Michigan):

  - Services provided by the hospital's or facility's staff
  - Ancillary services
  - Individual psychotherapeutic treatment
  - Group psychotherapeutic treatment
  - Family counseling

  We do not pay for:

  - Prescribed drugs given by the hospital or facility during the member's treatment
  - Psychological testing

- Outpatient Psychiatric Care Facility and Office Setting

  The following services are payable in a participating outpatient psychiatric care facility that participates with BCBSM (if located in Michigan) or with its local Blue Cross Blue Shield plan (if located outside of Michigan) or in an office setting for mental health services. (See 30 for special rules that apply to autism spectrum disorders.):

  - Services provided by the facility's staff
  - Services provided by a qualified provider, including but not limited to a physician, fully licensed psychologist, certified nurse practitioner, clinical nurse specialist-certified, clinical licensed master's social worker, licensed professional counselor, limited licensed psychologists, or licensed marriage and family therapist, or other professional provider as determined by BCBSM in a participating outpatient psychiatric care facility or an office setting:

    - Individual psychotherapeutic treatment
    - Family counseling
    - Group psychotherapeutic treatment
    - Psychological testing

  - Prescribed drugs given by the facility in connection with treatment
  - A partial hospitalization program described in the PHP section of this document

  We do not pay for:

  - Services provided in a skilled nursing facility or through a residential or outpatient substance abuse treatment program
  - Marital counseling
  - Consultations required by a facility or program's rules
  - Services provided by a nonparticipating outpatient psychiatric care facility

Behavioral Health Services (Mental Health and Substance Use Disorder) (continued)

Substance Use Disorder Services

Locations: We pay for substance use disorder treatment services in:

- A participating hospital
- A participating residential or outpatient substance abuse treatment facility
- A participating outpatient psychiatric care (OPC) facility
- An office

We pay for:

- Inpatient Hospital
  - Acute detoxification when provided in a participating hospital

    

    Acute detoxification is covered and paid as a medical service
- Residential and Outpatient Substance Abuse Treatment Facility
  - Services must be medically necessary to treat the member's condition.
  - Services in a residential substance abuse treatment facility must be preapproved by BCBSM.
  - Services must be provided by a participating substance abuse treatment facility.

  We pay for the following services provided and billed by an approved facility:

  - Laboratory services
  - Diagnostic services
  - Supplies and equipment used for subacute detoxification or rehabilitation
  - Professional and trained staff and program services necessary for care and treatment of the member
  - Individual and group therapy or counseling
  - Therapy and counseling for family members
  - Psychological testing

  We also pay for the following services in a residential substance abuse treatment facility:

  - Room and board
  - General nursing services
  - Drugs, biologicals and solutions used in the facility

  We also pay for the following services in an outpatient substance abuse treatment facility:

  - Outpatient substance use disorder services for the treatment of tobacco dependence
  - Drugs, biologicals and solutions, including drugs taken home

Behavioral Health Services (Mental Health and Substance Use Disorder) (continued)

Substance Use Disorder (continued)

Inpatient and Outpatient Substance Abuse Treatment Facility (continued)

We do not pay for:

- Dispensing methadone or testing of urine specimens unless the member is receiving therapy, counseling or psychological testing
- Diversional therapy
- Services provided beyond the period necessary for the member's care and treatment
- Treatment, or supplies that do not meet BCBSM requirements

- Substance Use Disorder Partial Hospitalization Program (PHP)

  The following services are payable when hospitals and outpatient psychiatric care facilities have a PHP and participate with BCBSM (if located in Michigan) or with its local Blue Cross/Blue Shield plan (if located outside of Michigan):

  - Services provided by the hospital's or facility's staff
  - Ancillary services
  - Prescribed drugs given by the hospital or facility during the member's treatment
  - Individual psychotherapeutic treatment
  - Group psychotherapeutic treatment
  - Psychological testing
  - Family counseling

- Substance Use Disorder Intensive Outpatient Program (IOP)

  The following services are payable when hospitals and outpatient psychiatric care facilities have a IOP and participate with BCBSM (if located in Michigan) or with its local Blue Cross/Blue Shield plan (if located outside of Michigan):

  - Services provided by the hospital's or facility's staff
  - Ancillary services
  - Individual psychotherapeutic treatment
  - Group psychotherapeutic treatment
  - Family counseling

  We do not pay for:

  - Prescribed drugs given by the hospital or facility during the member's treatment
  - Psychological testing

Behavioral Health Services (Mental Health and Substance Use Disorder) (continued)

Substance Use Disorder (continued)

- Outpatient Psychiatric Care Facility and Office Setting

  We pay for the following services in a participating outpatient psychiatric care (OPC) facility and office setting:

  - Services provided by the facility's staff
  - Services provided by a qualified provider, including but not limited to a physician, fully licensed psychologist, certified nurse practitioner, clinical nurse specialist-certified, clinical licensed master's social worker, licensed professional counselor, limited licensed psychologists, or licensed marriage and family therapist, or other professional provider as determined by BCBSM
  - Prescribed drugs given by the facility in connection with treatment

  We do not pay for:

  - Services provided in a skilled nursing facility or through a residential or outpatient substance abuse treatment program
  - Marital counseling
  - Consultations required by a facility or program's rule
  - Services provided by a nonparticipating outpatient psychiatric care facility

Cardiac Rehabilitation

See Section 2 beginning on Page *12 for what you may be required to pay for these services.*

For pulmonary rehabilitation, see Page 99.

Locations: We pay for cardiac rehabilitation in the following locations:

- A participating hospital

We pay for:

- Services that began during a hospital admission for an invasive cardiovascular procedure (e.g., heart surgery) or an acute cardiovascular event (e.g., heart attack)
- Services given when intensive monitoring and/or supervision during exercise is required.

We do not pay for:

- Services that require less than intensive monitoring or supervision because the member's endurance while exercising and management of risk factors are stable
- More than 30 visits a year for combined outpatient cardiac or pulmonary rehabilitation services

Chemotherapy

See Section 2 beginning on Page 12 for what you may be required to pay for these services.

For high dose chemotherapy used in bone marrow transplants, see Pages 117 – 119.

We pay for chemotherapeutic drugs. Since specialty pharmaceuticals may be used in chemotherapy treatment, please see the prior authorization requirement for Chemotherapy Specialty Pharmaceuticals described on Page 89.

To be payable, the drugs must be:

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

If the FDA has not approved the drug for the specific disease being treated, BCBSM's Medical Policy department determines the appropriateness of the drug for that disease by using the following criteria:

  - Current medical literature must confirm that the drug is effective for the disease being treated
  - Recognized oncology organizations must generally accept the drug as treatment for the specific disease
  - The physician must obtain informed consent from the member for the treatment.

We also pay for:

- Physician services for the administration of 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

Infusion pumps used for the administration of chemotherapy are considered durable medical equipment and are subject to the durable medical equipment guidelines described on Pages 54 to 55.

We pay for the outpatient treatment of breast cancer.

Chiropractic Services and Osteopathic Manipulative Therapy

See Section 2 beginning on Page *12 for what you may be required to pay for these services.*

When received with physical therapy see Page 85.

Locations: We pay for chiropractic services and osteopathic manipulative therapy in:

- An office
- A participating outpatient facility

We pay for:

- Osteopathic manipulation therapy (OMT) on any location of the body
- Chiropractic spinal manipulation (CSM) to treat misaligned or displaced vertebrae of the spine and chiropractic manipulations (CM) to treat other areas of the body allowed by BCBSM

  

  OMT, CSM, and CM are always considered rehabilitative. You have a combined 30-visit benefit limit per member, per year for **rehabilitative** physical therapy, occupational therapy, physical medicine, chiropractic manipulations and osteopathic manipulations (in-network and out-of-network providers combined).

- Chiropractic office visits:
  - For new patients, we pay for one office visit every 36 months. A new patient is one who has not received chiropractic services within the past 36 months.
  - For established patients, we pay for office visits. An established patient is one who has received chiropractic services within the past 36 months.
- Physical medicine that is part of a treatment plan prepared by your chiropractor. The plan must be signed by your M.D. or D.O. **before** you receive physical medicine services for those services to be covered. If a treatment plan is not signed by your M.D. or D.O. before services are rendered, the services will not be covered and you may have to pay for them.
  - A signed treatment plan is not required for the first physical medicine service your chiropractor performs on you.

  

  You have a combined 30-visit benefit limit per member, per year for **rehabilitative** physical therapy, occupational therapy, physical medicine, chiropractic manipulations and osteopathic manipulations (in-network and out-of-network providers combined).

  You have a separate combined 30-visit benefit limit per member, per year for **habilitative** physical therapy and occupational therapy (in-network and out-of-network providers combined).
- Mechanical traction once per day when it is given with CSM or CM. These visits are applied toward your combined 30-visit limit for **rehabilitative** physical medicine, physical and occupational therapy services.
- X-rays when medically necessary.

Chronic Disease Management

See Section 2 beginning on Page 12 *for what you may be required to pay for these services.*

Locations: We pay for services to manage chronic diseases in:

- A participating hospital
- An office
- A participating facility
- A member's home

We pay for:

- Chronic disease management services provided by:
  - Participating hospitals
  - Physicians
  - Participating facilities
  - Certified nurse practitioners
  - Clinical nurse specialists-certified
  - Certified licensed social workers
  - Psychologists
  - Physical therapists
  - Athletic trainers

Clinical Trials (Routine Patient Costs)

See Section 2 beginning on Page 12 for what you may be required to pay for these services.

For oncology clinical trial services, see Page 77.

We pay the routine costs of items and services related to clinical trials. The trials may be Phase I, II, III or IV. The purpose of the trial must be to prevent, detect or treat cancer or another life-threatening disease or condition. The member receiving the items or services must be a qualified individual according to the terms of this certificate.

Cancer drugs required by Michigan law are covered.

We pay for:

- All routine services, covered under this certificate and related riders, that would be covered even if the member were not enrolled in an approved clinical trial

You can find the following definitions in Section 7:

  - Approved clinical trial
  - Life-threatening condition
  - Routine patient costs
  - Qualified individual

We do not pay for:

- The experimental or investigational item, device or service
- Use of transition technologies as a routine service in an approved clinical trial such as cellular or gene therapies that have not been FDA approved for those indications.
- Routine patient costs for Phase I clinical trials whose primary purpose is not for therapeutic intent (eg. prolongation of life, shrinkage of tumor, or improved quality of life, even in absence of cure or dramatic improvement of a condition)
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the trial participant, or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

BCBSM may require you to go to a BCBSM-contracted provider who is already part of an approved clinical trial. The provider may be participating or in-network. An exception would be if the trial is conducted outside of Michigan.

Collaborative Care Management

Collaborative Care Management also known as CoCare operates through a care team centered around the patient to manage medical and behavioral health conditions. The care team includes a primary care physician (PCP), behavioral health care manager (BHCM) and a consulting psychiatrist.

CoCare services are covered when they are performed by designated providers. Under CoCare, a care manager will coordinate your care.

Locations: We pay for professional services for CoCare in the following locations, subject to the conditions described below:

- An office
- A participating outpatient hospital
- A participating facility
- A member's home
- Other locations designated by BCBSM

We pay for:

- Telephone or face-to-face contact and group interventions
- Medication assessments to identify:
  - The appropriateness of a drug for your condition
  - The correct drug dosage
  - The right time to take the drug
  - The drug Interactions

Covered services are subject to change.

Eligibility

You are eligible to receive Collaborative Care Management if you have:

- Active BCBSM coverage
- A chronic medical condition along with a behavioral health condition
- Agreed to actively participate with CoCare
- A referral for care management services from your physician

Collaborative Care Management (continued)

Eligibility (continued)

Your physician will determine your eligibility and refer you to care managers based on factors, such as your:

- Diagnosis
- Admission status
- Clinical status

Termination of Collaborative Care Management

You may opt-out of CoCare at any time. BCBSM may also terminate CoCare services based on:

- Termination or cancellation of your BCBSM coverage
- Other factors

We do not pay for:

- Services performed by providers who are not designated as CoCare providers

For more information on CoCare services, contact BCBSM Customer Service.

Contraceptive Services

See Section 2 beginning on Page *12 for what you may be required to pay for these services.*

We pay for contraceptive services as part of your preventive care benefit. Please see the preventive care benefit description of contraceptive services on Page 93 for more details.

Dental Services

See Section 2 beginning on Page *12 for what you may be required to pay for these services.*

For dental surgery, see Page 108.

Locations: We pay for emergency dental care given in:

- A hospital
- An ambulatory surgery facility
- A dentist's office (accidental injuries only)

We pay for other dental services in a participating hospital or a provider's office as described below.

We pay for:

- Emergency Dental Care

  Emergency dental care is the treatment of accidental injuries within 24 hours of the injury. This is to relieve pain and discomfort. We also pay for follow-up treatment completed within six months of the injury.

  

  A dental accidental injury is when an external force to the lower half of the face or jaw damages or breaks sound natural teeth, gums or bone.

- Dental Services in a Participating Hospital
  - We will pay for dental treatment for a member in a participating hospital if the treatment helps improve the medical condition that put the member in the hospital. The dental condition must be hindering improvement of the medical condition.
  - We may pay for facility and anesthesia services for a member in a participating hospital if dental treatment would be unsafe in an office setting.

  

  In these cases, we do not pay for the services of the dentist. We only pay for the facility and anesthesia services.

- Examples of such medical conditions are:
  - Bleeding or clotting abnormalities
  - Unstable angina
  - Severe respiratory disease
  - Known reaction to analgesics, anesthetics, etc.

  Medical records must confirm the need for the dental services above.

  Procedures that are payable in the circumstances explained above include:

  - Alveoplasty
  - Diagnostic X-rays
  - Multiple extractions or removal of unerupted teeth

Dental Services (continued)

We pay for: (continued)

- Other Dental Services
  - Services to treat temporomandibular joint dysfunction (TMJ) limited to those described below:
    - Surgery directly to the temporomandibular joint (jaw joint) and related anesthesia services
    - Arthrocentesis performed for the treatment of temporomandibular joint (jaw joint) dysfunction
    - Diagnostic X-rays
    - Physical therapy (see Page 85 for physical therapy services)
    - Reversible appliance therapy (mandibular orthotic repositioning device such as a bite splint)

We do not pay for:

- Routine dental services
- Treatment that was previously paid as a result of an accident
- Dental implants and related services, including repair and maintenance of implants and surrounding tissue
- Dental conditions existing before an accident requiring emergency dental treatment
- Services to treat temporomandibular joint dysfunction (except as described above.)

Diagnostic Services

See Section 2 beginning on Page 12 for what you may be required to pay for these services.

For allergy testing services, see Page 24.
For diagnostic radiology services, see Page 100.
For mental health diagnostic services, such as psychological testing, see Page 33.

Locations: We pay for diagnostic services in:

- A participating hospital
- Other approved facilities
- An office

We pay for:

Diagnostic Testing
We pay for the tests a physician uses to diagnose disease, illness, pregnancy or injury.

- Physician services are payable for tests such as:
  - Thyroid function
  - Electrocardiogram (EKG)
  - Electroencephalogram (EEG)
  - Pulmonary function studies
- Physician and independent physical therapist services are payable for the following tests:
  - Electromyogram (EMG)
  - Nerve conduction

The test must be prescribed by a physician if performed by an independent physical therapist.

Diagnostic Laboratory and Pathology Services
We pay for the lab and pathology tests a physician uses to diagnose disease, illness, pregnancy or injury. Services must be provided:

- In a participating hospital (under the direction of a pathologist employed by the hospital) or
- By your in-network physician, or
- By another physician, if your in-network physician refers you to one, or
- By an in-network lab at your in-network physician's direction.
  - We pay for standard office lab tests in your in-network physician's office. Other lab tests must be sent to an in-network laboratory.
  - You will need to pay the out-of-network cost share if tests are done by an out-of-network lab or in an out-of-network hospital.

Dialysis Services

See Section 2 beginning on Page *12 for what you may be required to pay for these services.*

Locations: We pay for dialysis services in:

- A participating hospital
- A participating freestanding end stage renal disease (ESRD) facility
- A member's home

We pay for:

Dialysis services (including physician services), supplies and equipment to treat:

- Acute renal (kidney) failure
- Chronic, irreversible kidney failure End Stage Renal Disease (ESRD)

BCBSM shares the cost of treating ESRD with Medicare. It is important that you apply for Medicare coverage if you have ESRD and if you meet the Medicare eligibility requirements. This is done through the Social Security Administration. (Please see Page 151 for a detailed explanation.)

Services Provided in a Freestanding ESRD Facility

We pay for:

- Ultrafiltration
- Equipment
- Solutions
- Routine laboratory tests
- Drugs
- Supplies
- Other medically necessary services related to dialysis treatment

Dialysis Services (continued)

Services Provided in a Freestanding ESRD Facility (continued)

We do not pay for:

- Services provided by a nonparticipating end stage renal disease facility.
- Services not provided by the employees of the ESRD facility.
- Services not related to the dialysis process.

Services Provided in the Home
Dialysis services (hemodialysis and peritoneal dialysis) must be billed by a hospital or freestanding ESRD facility participating with BCBSM and must meet the following conditions:

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

We pay for:

- Home hemodialysis
  - Continuous ambulatory peritoneal dialysis and self-dialysis training with the number of training sessions limited according to Medicare guidelines
  - Continuous cycling peritoneal dialysis (limited to 14 dialysis treatments per month) and self-dialysis training with the number of training sessions limited according to Medicare guidelines
- Placement and maintenance of a dialysis machine in the member's home
- Expenses to train the member and one other person who will assist the member 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

Dialysis Services (continued)

Services Provided in the Home (continued)

We do not pay for:

- Services provided by persons under contract with the hospital, agencies or organizations assisting in the dialysis or acting as "backups" including hospital personnel sent to the member'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 member’s home
- Physician services not paid by the hospital

Durable Medical Equipment

See Section 2 beginning on Page *12 for what you may be required to pay for these services.*

Locations: We pay for durable medical equipment in:

- A participating hospital
- A participating skilled nursing facility
- An office
- A member's home

We pay for:

- The use of durable medical equipment while you are in the hospital
- The rental or purchase of durable medical equipment, if prescribed by a physician or other provider licensed to prescribe it. You may obtain it from:
  - A participating hospital (when you are discharged)
  - A DME supplier
    - To avoid out-of-network cost share, obtain your prescribed durable medical equipment, prosthetics, orthotics, and medical supplies from an in-network provider. Contact Customer Service to locate a provider in your network.

In many instances, we cover the same items covered by Medicare Part B as of the date of purchase or rental. In some instances, however, BCBSM guidelines may differ from Medicare. Please call your local Customer Service center for specific coverage information.

DME items must meet the following guidelines:

- The prescription includes a description of the equipment, the reason for the need, and the diagnosis.
- The physician or other provider licensed to prescribe it writes a new prescription when the current prescription expires; otherwise, we will stop payment on the current expiration date, or 30 days after the date of the member's death, whichever is earlier.

If the equipment is:

- Rented, we will not pay for the charges that exceed the BCBSM purchase price. Participating providers cannot bill the member when the total of the rental payments exceeds the BCBSM purchase price.
- Bought, we will pay to have the equipment repaired and restored to use, but not for routine periodic maintenance.

Durable Medical Equipment (continued)

We pay for: (continued)

Continuous Positive Airway Pressure (CPAP)
When prescribed by a physician or other provider licensed to prescribe it, the CPAP device, humidifier (if needed) and related supplies and accessories are covered as follows:

- We will cover the rental fee only for the CPAP device. Our total rental payments will not exceed our approved amount to purchase the device. Once our rental payments equal the approved purchase price, you will own this equipment and no additional payments will be made by BCBSM for the device.
  - We will pay for the rental or purchase of a humidifier for the CPAP device, if needed.
  - We will pay for the purchase of any related supplies and accessories.
- After the first 90 days of rental, you are required to show that you have complied with treatment requirements for BCBSM to continue to cover the equipment and the purchasing of supplies and accessories. The CPAP device supplier or your prescriber must document your compliance.

If you fail to comply with treatment requirements, you must return the rented device to the supplier or you may be held liable by the supplier for the cost of continuing to rent the equipment. We will also no longer cover the purchase of supplies and accessories.

Enteral and Supplemental Feeding Supplies
We will pay for formulas that are administered via tube. We will pay for the supplies, equipment and accessories needed to administer this type of nutrition therapy.

We also pay for nutrients, supplies and equipment needed for feedings via an IV. (This is referred to as parenteral nutrition.)

Blood Pressure Monitors
A blood pressure monitor is covered when a member has an elevated blood pressure reading regardless of hypertension diagnosis.

We do not pay for:

- Exercise and hygienic equipment, such as exercycles, Moore Wheel, bidet toilet seats and bathtub seats
- Deluxe equipment, such as motorized wheelchairs and beds, unless medically necessary and required so that members can operate the equipment themselves
- Comfort and convenience items, such as bed boards, bathtub lifts, overbed tables, adjust-a-beds, telephone arms or air conditioners
- Provider's equipment, such as stethoscopes
- Self-help devices not primarily medical in nature, such as sauna baths and elevators
- Experimental equipment

Emergency Treatment

See Section 2 beginning on Page *12 for what you may be required to pay for these services.*

For urgent care services, please see Page 123.

Locations: We pay for services to treat medical emergencies and accidental injuries (see Section 7 for the definitions) subject to the conditions described below, in:

- A hospital
- An independent freestanding emergency department
- An urgent care center
- An office
- Other approved outpatient locations

We pay for:

- Facility and professional services to examine and treat a medical emergency or accidental injury.

Fertility Preservation

See Section 2 beginning on Page 12 for what you may be required to pay for these services.

We pay for:

Fertility preservation services are covered **only** for members with malignant cancer diagnosis when undergoing fertility-threatening medical or radiation therapies and treatments.

Fertility preservation treatment and services include, but not limited to:

- Collection of mature eggs and sperm
- Cryopreservation of embryos, mature eggs and sperm
- Storage of embryos, mature eggs and sperm for up to one year
- Thawing of embryos, mature eggs and sperm within one year of procurement
- Culture of eggs
- Ovarian transposition
- Embryo transfer to member within one year from cryopreservation

We do not pay for:

- Storage of sperm, eggs or embryos for longer than one year
- Co-culture of embryo(s)
- Post-menopausal members
- Members who have undergone elective sterilization (vasectomy, tubal sterilization), with or without reversal

Gender Affirming Services

See Section 2 beginning on Page *12 for what you may be required to pay for these services.*

We pay for:

- Medically necessary professional and facility services for the treatment of gender dysphoria.

  Covered services include, but not limited to, the following:

  - Behavioral health services
  - Gender affirming surgery and related services

We do not pay for:

- Gender affirming services that are not medically necessary, considered to be cosmetic, experimental, or investigational by BCBSM.

Home Health Care Services

See Section 2 beginning on Page *12 for what you may be required to pay for these services.*

Locations: We pay for care and services provided in a member's home.

Home health care provides an alternative to long-term hospital care by offering coverage for care and services in the member's home. Home health care must be:

- Prescribed by the attending physician
- Provided and billed by a participating home health care agency
- Medically necessary (See Section 7 for a definition)

The following criteria for home health care must be met:

- The attending physician certifies that the member is confined to the home because of illness.
  - This means that transporting the member to a health care facility, an office or hospital for care and services would be difficult due to the nature or degree of the illness.
- The attending physician prescribes home health care services and submits a detailed treatment plan to the home health care agency.
- The agency accepts the member into its program.

We pay for:

Services provided by health care professionals employed by the home health care agency or by providers who participate with the agency in this program. The agency must bill BCBSM for the services. They are:

- 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 member's attending physician
- The following when provided for rehabilitation:
  - Occupational therapy, Page 72
  - Physical therapy, Page 85
  - Speech language therapy services, Page 104

  If services in a member's home are billed by a home health care agency, then these services will **not** count toward the combined visit maximums.

Home Health Care Services (continued)

We pay for: (continued)

- If physical therapy, occupational therapy, or speech language therapy services cannot be done in the home, we will pay for outpatient therapy. It may be in an outpatient department of a hospital or a physical therapy facility. Benefits are subject to the combined 30-visit maximums for occupational therapy and physical therapy and the 30-visit maximum for speech language therapy service described on Pages 72, 85 and 104.

  If services in a member's home are billed by a professional provider or independent therapist, they will count toward the visit maximums

- Part-time health aide services, including preparing meals, laundering, bathing and feeding if:

  - The member is receiving skilled nursing care or physical therapy or speech language therapy services
  - The member's family cannot provide the services **and** the home health care agency has identified a need for these services for the member to participate in the program
  - The services are provided by a home health aide and supervised by a registered nurse employed by the agency

We pay the following covered services when the home health care is provided by a **participating** hospital:

- Lab services, prescription drugs, biologicals and solutions related to the condition for which the member is participating in the program

- Medical and surgical supplies such as catheters, colostomy supplies, hypodermic needles and oxygen needed to effectively administer the medical treatment plan ordered by the physician

We do not pay for:

- General housekeeping services

- Transportation to and from a hospital or other facility

- Private duty nursing

- Elastic stockings, sheepskin or comfort items (lotion, mouthwash, body powder, etc.)

- Durable medical equipment

- Physician services (when billed by the home health care agency)

- Custodial or nonskilled care

- Services performed by a nonparticipating home health care provider

Hospice Care Services

See Section 2 beginning on Page 12 *for what you may be required to pay for these services.*

Locations: We pay for hospice care services in:

- A participating hospice facility
- A participating hospital
- A participating skilled nursing facility
- A member's home

We pay for services to care for the terminally ill. Services must be provided through a participating hospice program. Hospice care services are payable for as long as medically necessary to treat the patient's condition. To be payable, the following criteria must be met:

- The member or their representative elects hospice care services in writing. This written statement is filed with a participating hospice program.
- A written certification stating the member is terminally ill, that is signed by the hospice program's medical director or a physician of the hospice interdisciplinary group and the attending physician (if the member has one), is kept on file in the patient's medical record.
- The hospice program's medical director or a physician of the hospice interdisciplinary group evaluates and recertifies the treatment plan every 90 days.
- The member or their representative signs a "Waiver of Benefits" form acknowledging that hospice care has been fully explained to them. The waiver explains that BCBSM does not pay for treatment of the terminal illness itself or related conditions during hospice care.

BCBSM benefits for conditions not related to the terminal illness remain in effect.

We pay for:

Counseling, evaluation, education and support services for the member and their family from the hospice staff before the member elects to use hospice services. These services are limited to a 28-visit maximum.

When a member elects to use hospice care services, regular BCBSM coverage for services in connection with the terminal illness and related conditions are replaced by the following:

Hospice Care Services (continued)

We pay for: (continued)

Home Care Services

- Up to eight hours of routine home care per day
- Continuous home care for up to 24 hours per day during periods of crisis
- Home health aide services provided by qualified aides. These services must be rendered under the general supervision of a registered nurse.

Facility Services

- Inpatient care provided by:
  - A participating hospice inpatient unit
  - A participating hospital contracting with the hospice program or
  - A participating skilled nursing facility contracting with the hospice program
- Short-term general inpatient care when the member is admitted for pain control or to manage symptoms. (These services are payable if they meet the plan of care established for the member.)
- Five days of occasional respite care during a 30-day period

Hospice Services

- 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 member and to caregivers, when care is provided at home
- BCBSM-approved medical appliances and supplies (these include drugs and biologicals to provide comfort to the member)
- BCBSM-approved durable medical equipment furnished by the hospice program for use in a member’s home
- Physical therapy, speech language therapy and occupational therapy when provided to control symptoms and maintain the member’s daily activities and basic functional skills
- Bereavement counseling for the family after the member 's death

Hospice services are limited to a maximum amount. That amount is reviewed and adjusted from time to time. Once you reach the maximum, hospice benefits will still be covered under the case management program. Please call us for information about the current maximum amount.

Hospice Care Services (continued)

We pay for: (continued)

Professional Services

- Provided by the attending physician to make the member comfortable and to manage the terminal illness and related conditions

We do not pay for physician services from a member of the hospice interdisciplinary team.

Professional services for hospice care are limited to a maximum amount. This amount is determined by BCBSM and reviewed at times. Once you reach the maximum, professional services will still be covered under the case management program. Please call us for information about the current maximum amount. This amount is separate from, and not included in, the limit for the hospice program services described above.

How to Cancel Hospice Care Services
Hospice care services may be canceled at any time by the member or their representative. Simply submit a written statement to the hospice. When the services are canceled, regular Blue Cross Blue Shield coverage will be reinstated.

How to Reinstate Hospice Care Services
Hospice care services may be reinstated at any time. The member is reinstated for any remaining period for which they are eligible.

We do not pay for services:

- Other than those furnished by the hospice program.
- Of a hospice program other than the one designated by the member. (If the designated program arranges for the member to receive the services of another hospice program, the services are covered.)
- That are not part of the plan of care established by the hospice program for the member.

Hospital Services

See Section 2 beginning on Page *12 for what you may be required to pay for these services.*

For services in a long-term acute care hospital (LTACH), see Page 67.

The services in this section are in addition to all other services listed in this certificate that are payable in a participating hospital. An example would be surgery (see Page 107).

Locations: The following services are payable in:

- A participating hospital

We pay for:

- Inpatient Hospital Services:
  - Medical care by hospital personnel while you are receiving inpatient services.
  - Semiprivate room
  - Nursing services
  - Meals, including special diets
  - Services provided in a special care unit, such as intensive care
  - Oxygen and other therapeutic gases and their administration
  - Inhalation therapy
  - Electroconvulsive Treatment (ECT)
  - Pulmonary function evaluation
  - Whole blood, blood derivatives, blood plasma or packed red blood cells, supplies and their administration
  - Hyperbaric oxygenation (therapy given in a pressure chamber)

- Outpatient Hospital Services:

  If a service is payable as an inpatient service, it is also payable as an outpatient service. (Exceptions are services related to inpatient room, board, and inhalation therapy).

- Temporary Benefits for Hospital Services:

  If you are receiving services from a hospital that ends its contract with BCBSM, you still have benefits. These benefits are for continuity of care, designated services, emergency care, and travel and lodging. Benefits for continuity of care are available for up to **six months** from the date the hospital ends its participating contract with BCBSM. Benefits for designated services and emergency care are available for as long as medically necessary. Benefits for travel and lodging are available for the period of time approved by BCBSM. See Page 110 for more information.

Infertility Treatment

See Section 2 beginning on Page 12 for what you may be required to pay for these services.

We pay for professional, hospital and facility services to treat the underlying causes of infertility.

Locations: We pay for treatment in:

- A participating hospital
- A participating freestanding ambulatory surgery facility
- An office

We pay for:

Treatment of the underlying cause of infertility. Services include:

- Medically necessary diagnostic services
- Counseling services
- Planning services

We do not pay for:

Services that treat infertility or that are intended to help a member to become pregnant.

They include but are not limited to:

- Artificial insemination
- Sperm washing
- Post-coital test
- Monitoring of ovarian response to ovulatory stimulants
- In vitro fertilization
- Ovarian wedge resection or ovarian drilling
- Reconstructive surgery of one or both fallopian tubes to open the blockage that causes infertility
- Diagnostic studies done for the sole purpose of infertility assessment
- Any procedure done to enhance reproductive capacity or fertility

You or your physician can call us to determine if other proposed services are a covered benefit under your certificate.

Infusion Therapy

See Section 2 beginning on Page 12 for what you may be required to pay for these services.

BCBSM considers services from a participating infusion provider to be in-network. You will need to pay in-network cost-sharing for these services. What you pay may vary depending on where you receive these services.

BCBSM may require approval for these services. Your in-network provider is responsible for obtaining approval. For a more detailed explanation, see *Prior Authorization for Specialty Pharmaceuticals* in the *Prescription Drugs* subsection.

Locations: We pay for infusion therapy services in:

- A participating ambulatory infusion center
- A member's home
- An office
- A participating hospital

To be eligible for infusion therapy services, your condition must be such that infusion therapy is:

- Prescribed by a physician to manage an incurable or chronic condition or treat a condition that requires acute care. (For home infusion therapy, the condition must be able to be safely managed in the home.)
- Medically necessary
- Given by a participating infusion therapy provider

We pay for:

- Drugs required for infusion therapy. Since specialty pharmaceuticals may be used in infusion therapy, please see the *Prior Authorization for Specialty Pharmaceuticals* requirement described on Page 89
- Nursing services needed to administer infusion therapy and treat infusion therapy-related wound care

  

  Nursing services must meet our guidelines to be covered.
- Durable medical equipment, medical supplies and solutions needed for infusion therapy

We do not pay for services rendered by **nonparticipating** infusion therapy providers.

Long-Term Acute Care Hospital Services

See Section 2 beginning on Page *12 for what you may be required to pay for these services.*

Locations: We pay for services provided in a participating long-term acute care hospital (LTACH).

We pay for:

- Services in a participating LTACH that we would pay for in a participating hospital.
  - The provider must request and receive preapproval for inpatient services

The LTACH is liable for the care if the inpatient services are not preapproved.

We do not pay for:

- Services in a nonparticipating LTACH, including emergency services, unless BCBSM determines there are extenuating circumstances
- Inpatient admissions that BCBSM has not preapproved
- LTACH services primarily for a diagnosis of a mental health or substance use disorder condition

Maternity Care

See Section 2 beginning on Page *12 for what you may be required to pay for these services.*

Locations: We pay for facility and professional services for maternity care and related services in:

- A participating inpatient hospital setting
- A participating birthing center
- An office

Under federal law, we generally may not restrict benefits for any hospital length of stay in connection with childbirth for the birth parent to less than:

- 48 hours following a vaginal delivery
- 96 hours following a delivery by cesarean section

However, we may pay for a shorter stay if the attending physician or certified nurse midwife discharges the birth parent earlier, after consulting them.

Federal law requires that we cover the same benefits with the same cost-sharing levels during the 48 or 96 hours.

In addition, we may not require that a physician or other provider get approval for a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain preapproval to use certain providers or to reduce your out-of-pocket costs. For information on preapproval, contact BCBSM Customer Service (see Section 9).

We pay for:

- Obstetrics

  Covered services provided by a physician or certified nurse midwife attending the delivery. These covered services include but are not limited to:

  - Prenatal care, including maternity education provided in a physician's office as part of a prenatal visit
  - Medically necessary genetic testing
  - Vaginal delivery or cesarean section when provided in:

    - An A participating hospital setting
    - A hospital-affiliated birthing center that is owned and operated by a participating state-licensed and accredited hospital, as defined by BCBSM

  - Postnatal care, including a Papanicolaou (PAP) smear during the six-week visit
  - Lactation education and alternative fertility awareness counseling

Maternity Care (continued)

We pay for: (continued)

- Newborn services provided **during the first 48 or 96 hours if** the newborn has not been added to a BCBSM contract of the birth parent. These services include

  - Newborn examination given by a physician other than the anesthesiologist or the attending physician of the birth parent.
  - Routine care during the newborn's eligible hospital stay.
  - Services to treat a newborn's injury, sickness, congenital defects or birth abnormalities.

We do not pay for:

- Lamaze, parenting or other similar classes

- Services provided to the newborn if one of the following apply:

  - The birth parent is not covered under this certificate on the newborn's date of birth
  - The newborn is eligible for coverage as a dependent under a BCBSM or other health care benefit plan and has been added as a dependent to that plan.
  - The subscriber directs BCBSM not to cover the newborn's services
  - Services provided to the newborn occur after the 48 or 96 hours

Medical Supplies

See Section 2 beginning on Page *12 for what you may be required to pay for these services.*

For medical supplies for outpatient diabetes treatment, see Page 83.
For medical supplies for infusion therapy, see Page 66.

Locations: We pay for medical supplies in:

- A participating hospital
- A participating hospice
- A participating outpatient facility
- A participating skilled nursing facility
- An office
- A member's home

To avoid out-of-network cost share, obtain your prescribed durable medical equipment, prosthetics, orthotics, and medical supplies from an in-network provider. Contact Customer Service to locate a provider in your network.

We pay for:

Medical supplies and dressings used for the treatment of a specific medical condition. The quantity of medical supplies and dressings must be medically necessary. They include but are not limited to:

- Gauze, cotton, fabrics, plaster and other materials used in dressings and casts
- Ostomy sets and accessories
- Catheterization equipment and urinary sets

See Section 7 for the definition of "medically necessary."

Newborn Care

See Section 2 beginning on Page 12 *for what you may be required to pay for these services.*

For maternity care, see Page 68.

If the newborn is not covered under a BCBSM contract, they may qualify for coverage under the maternity care benefit of the birth parent.

Locations: We pay for facility and professional services for routine newborn care during an eligible hospital stay in:

- A participating hospital setting
- A participating birthing center

Under federal law, we generally may not restrict benefits for any hospital length of stay in connection with childbirth for a newborn child to less than:

- 48 hours following a vaginal delivery
- 96 hours following a delivery by cesarean section

However, we may pay for a shorter stay if the attending physician or certified nurse midwife discharges the newborn earlier, after consulting the birth parent.

Federal law requires that we cover the same benefits with the same cost-sharing levels during the 48 or 96 hours.

In addition, we may not require that a physician or other provider get approval for a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain preapproval to use certain providers or to reduce your out-of-pocket costs. For information on preapproval, contact BCBSM Customer Service (see Section 9).

We pay for:

- Newborn examination
  - The exam must be given by a physician other than the anesthesiologist or the birth parent's attending physician.
- Routine care
  - Routine care during the newborn's eligible hospital stay.

We do not pay for:

- Parenting or other similar classes

Occupational Therapy

See Section 2 beginning on Page *12 for what you may be required to pay for these services.*

Special rules apply when services are provided to treat autism (see Page 30).
For physical therapy services, see Page 85.
For speech language therapy services, see Page 104.

Locations: We pay for facility and professional occupational therapy services in:

- A participating hospital

  

  Inpatient therapy must be used to treat the condition for which the member is hospitalized.
- Other approved facilities
- An office
- A member's home
- A nursing home, if it's the member's primary residence

We pay for:

- A combined maximum of 30 habilitative and a combined maximum of 30 rehabilitative outpatient visits per member per calendar year.

Important: **See Note below about treatment dates and initial evaluations. The combined 30-visit habilitative and combined 30-visit rehabilitative maximums renew each calendar year. They include all in-network and out-of-network outpatient visits, regardless of location (hospital, facility, office or home), for:**

- **Occupational therapy**
- **Physical therapy**
- **Physical Medicine**
- **Chiropractic manipulations (rehabilitative only)**
- **Osteopathic manipulative therapy (rehabilitative only)**

If services performed in a member's home are billed by a professional provider, they will count toward the combined visit maximum.

If services performed in a member's home are billed by a home health care agency, they will not count toward the combined visit maximum.

Each **treatment date** counts as one visit even when two or more therapies are provided and when 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 (described above).

Occupational Therapy (continued)

Occupational therapy must be:

- Prescribed by a professional provider licensed to prescribe occupational therapy services
- Given for a condition that can be significantly improved in a reasonable and generally predictable period of time (usually about six months), or to optimize the developmental potential of the member and/or maintain the member's level of functioning
- Given by:
  - An M.D. or D.O. in an outpatient setting
  - An occupational therapist
  - An occupational therapy assistant under the indirect supervision of an occupational therapist, who cosigns all assessments and member s' progress notes

    

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

  - An athletic trainer in an outpatient setting

We do not pay for:

- More than combined 30 habilitative and combined 30 rehabilitative outpatient visits per member per calendar year, whether obtained from an in-network or out-of-network provider
- Therapy billed as a rehabilitative service when it does not meet the definition of rehabilitative service in this certificate
- Therapy billed as a habilitative service when it does not meet the definition of habilitative in this certificate
- Therapy that is performed without an occupational therapy treatment plan
- Services provided by a freestanding facility in a home, hospital, skilled nursing facility, psychiatric residential treatment facility or residential substance abuse treatment facility
- Services received from a nonparticipating hospital or nonparticipating facility
- Services received from an independent sports medicine clinic

Occupational Therapy (continued)

We do not pay for: (continued)

- 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 without an occupational therapy treatment plan that guides and helps to monitor the provided therapy

  

  We may pay for treatment to improve cognition if it is:

  – Part of a comprehensive rehabilitation plan
  – Medically necessary to treat severe deficits in members who have certain conditions that are identified by BCBSM

- Recreational therapy

- Member education and home programs

Office, Outpatient and Home Medical Care Visits

See Section 2 beginning on Page 12 for what you may be required to pay for these services.

We pay for the following when provided by a physician or eligible professional provider when medically necessary:

- Behavioral health and medical office visits

  They include:

  - Urgent care visits
  - Office consultations
  - Online visits
  - Virtual primary care visits
  - Retail health clinic visits

- Outpatient visits

- Home medical care visits

Online Visits

We pay for online visits by a professional provider or an online vendor selected by BCBSM.

Online visits by an online vendor not selected by BCBSM will not be covered.

We pay for:

- The diagnosis of a condition

- Treatment and consultation recommendations

The online visit must allow the member to interact with the professional provider or an online visit vendor in real time. Treatment and consultation recommendations made online, including issuing a prescription, are to be held to the same standards of appropriate practice as those in traditional settings.

Not all services delivered via the internet are considered an online visit, but may be considered telemedicine. Telemedicine services will be subject to the same cost share as services rendered in an office setting (see Section 7 for the definition of “telemedicine”).

The online visit provider must be licensed in the state where the member is located during the online visit.

Online visits must meet BCBSM’s standards for an Evaluation and Management visit.

Office, Outpatient and Home Medical Care Visits (continued)

Online Visits (continued)

Online visits do not include:

- Reporting of normal test results
- Provision of educational materials
- Handling of administrative issues, such as registration, scheduling of appointments, or updating billing information

Virtual Primary Care
We pay for virtual primary care visits for members 18 years of age or older when provided by a vendor selected by BCBSM.

Virtual primary care visits by a vendor not selected by BCBSM will not be covered.

Virtual primary care visits include a broad range of primary care provider services including managing and coordinating your health care for chronic and non-urgent conditions.

The in-network cost share for a virtual primary care visit is the same as the in-network cost share you pay for an in-person primary care provider visit.

Oncology Clinical Trials

See Section 2 beginning on Page *12 for what you may be required to pay for these services.*

For general surgery services, see Page 107.
For transplant services, see Page 116.

Locations: We pay for services performed in a designated cancer center (see Section 7 for the definition of a designated cancer center).

Benefits for specified oncology clinical trials provide coverage for:

- Preapproved, specified bone marrow and peripheral blood stem cell transplants and their related services
- FDA-approved antineoplastic drugs to treat stages II, III and IV breast cancer
- All stages of ovarian cancer when they are provided pursuant to an approved phase II or III clinical trial

Benefits are not limited or precluded for antineoplastic drugs when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.

Mandatory Preapproval

All services, admissions or lengths of stay for the services below must be **preapproved** by BCBSM.

Preapproval ensures that you and your physician know ahead of time that services are covered. If preapproval is not obtained, services will **not** be covered. This includes:

- Hospital admission
- Length of stay
- All payable medical care and treatment services.

Our decision to preapprove hospital and medical services is based on the information your physician submits to us. We reserve the right to request more information if needed.

If your condition or proposed treatment plan changes after preapproval is granted, your provider must submit a new request for preapproval. Failure to do so will result in the transplant, related services, admissions and length of stay not being covered.

Preapproval is good only for one year after it is issued. However, preapproved services, admissions or a length of stay will not be paid if you no longer have coverage at the time they occur.

Oncology Clinical Trials (continued)

Mandatory Preapproval (continued)

The designated cancer center must submit its written request for preapproval to:

Blue Cross Blue Shield of Michigan
Human Organ Transplant Program
Mail Code 1519
600 Lafayette East
Detroit, MI 48226

Fax: (866) 752-5769

Preapproval will be granted to a BCBSM member if:

- The member has BCBSM hospital-medical-surgical coverage.
- The proposed services will be rendered in a designated cancer center or in an affiliate of a designated center.
- The proposed services are medically necessary.
- An inpatient stay at a cancer center is medically necessary (in those cases requiring inpatient treatment). We must preapprove the admission before it occurs.
- The length of stay at a designated cancer center is medically necessary. We must preapprove the length of stay before it begins.

We pay for:

- Antineoplastic drugs

  If Michigan law requires it, we cover these drugs and the reasonable cost of giving them.

- Immunizations

  We pay for vaccines against infection during the first 24 months after a transplant as recommended by the Advisory Committee on Immunization Practices (ACIP).

- Autologous Transplants

  - Infusion of colony stimulating growth factors
  - Harvesting (including peripheral blood stem cell pheresis) and storage of bone marrow and/or peripheral blood stem cells
  - Purging or positive stem cell selection of bone marrow or peripheral blood stem cells
  - High-dose chemotherapy and/or total body irradiation
  - Infusion of bone marrow and/or peripheral blood stem cells
  - Hospitalization

Oncology Clinical Trials (continued)

We pay for: (continued)

- Allogeneic Transplants
  - Blood tests to evaluate donors (if not covered by the potential donor's insurance)
  - Search of the National Bone Marrow Donor Program Registry for a donor. A search will begin only when the need for a donor is established and the transplant is preapproved.
  - Infusion of colony stimulating growth factors
  - Harvesting and storage (both covered even if it is not covered by the donor's insurance) of the donor's:
    - Bone marrow
    - Peripheral blood stem cell (including peripheral blood stem cell pheresis)
    - Umbilical cord blood

    

    The recipient of harvested material must be a BCBSM member.
  - 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 preapproved services rendered during an approved clinical trial. The expenses must be incurred during the period that begins with the date of preapproval 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

  

  These daily allowances may be adjusted from time to time. Please call us to find out the current maximums.

Oncology Clinical Trials (continued)

We do not pay for:

- An admission to a designated center or a length of stay at a designated center that has not been preapproved
- Services that have not been preapproved
- Services that are not medically necessary (see Section 7 for the definition of “medically necessary”)
- Services rendered at a nondesignated cancer center
- Services provided by persons or entities that are not legally qualified or licensed to provide such services
- Donor services for a transplant recipient who is not a BCBSM member
- Services rendered to a donor when the donor’s health care coverage will pay for such services
- The routine harvesting and storage costs of bone marrow, peripheral blood stem cells or a newborn’s umbilical cord blood if not intended for transplant within one year
- More than two single transplants per member for the same condition
- Non-health care related services and/or research management (such as administrative costs)
- Transplants performed at a center that is not a designated cancer center or its affiliate
- Search of an international donor registry
- Experimental treatment not included in this certificate
- Items or services that are normally covered by other funding sources (e.g., investigational drugs funded by a drug company)

Oncology Clinical Trials (continued)

We do not pay for: (continued)

- Items that are not considered by BCBSM to be directly related to travel and lodging. Examples include, but are not limited to:

Alcoholic beverages	Flowers, toys, gifts, greeting cards, stationery, stamps, mail/UPS services	Internet connection, and entertainment (such as cable television, books, magazines and movie rentals)	Mortgage or rent payments	Tips
Car maintenance	Furniture rental	Kennel fees	Reimbursement of food stamps	
Clothing, toiletries	Household products	Lost wages	Security deposits, cash advances	
Dry cleaning, laundry services	Household utilities (including cellular telephones)	Maids, babysitters or day care services	Services provided by family members	

- Any other services, admissions or length of stay related to any of the above exclusions

The limitations and exclusions listed elsewhere in your certificate and/or riders, also apply to this benefit.

Optometrist Services

See Section 2 beginning on Page *12 for what you may be required to pay for these services.*

We pay for:

Medically necessary optometrist services when:

- Covered services are provided within the state of Michigan.
- The optometrist is:
  - Licensed in the state of Michigan
  - Certified by the Michigan Board of Optometry to administer and prescribe therapeutic pharmaceutical agents
- If you get services from an optometrist who does not participate in BCBSM's vision program, they will be treated as services of a nonparticipating provider.

Outpatient Diabetes Management Program (ODMP)

See Section 2 beginning on Page *12 for what you may be required to pay for these services.*

Locations: We pay for ODMP services in:

- A participating hospital
- An office
- A member's home

We pay for:

- Services and medical supplies to treat and control diabetes when prescribed by a physician or other professional provider licensed to prescribe it. Services and supplies include:
  - Blood glucose monitors
  - Blood glucose monitors for the legally blind
  - Insulin pumps
  - Test strips for glucose monitors
  - Visual reading and urine test strips
  - Lancets
  - Spring-powered lancet devices
  - Syringes
  - Insulin
  - Medical supplies required for the use of an insulin pump
  - Nonexperimental drugs to control blood sugar
  - Medication prescribed by a doctor of podiatric medicine, M.D. or D.O. that is used to treat foot ailments, infections and other medical conditions of the foot, ankle or nails associated with diabetes
  - Diabetes self-management training conducted in a group setting, whenever practicable, if:
    - Self-management training is considered medically necessary upon diagnosis by an M.D. or D.O. who is managing your diabetic condition and when needed under a comprehensive plan of care to ensure therapy compliance or to provide necessary skills and knowledge
    - Your M.D. or D.O. diagnoses a significant change with long-term implications in your symptoms or conditions that necessitate changes in your self-management or a significant change in medical protocol or treatment
    - The provider of self-management training must be:
      - Certified to receive Medicare or Medicaid reimbursement **or**
      - Certified by the Michigan Department of Community Health

If you receive diabetic supplies and devices paid by your BCBSM prescription drug plan, your BCBSM medical plan will not pay for the same diabetic supplies and devices.

Pain Management

See Section 2 beginning on Page *12 for what you may be required to pay for these services.*

For infusion therapy services, see Page 66.

Locations: We pay for services to manage pain in:

- A participating hospital
- A participating outpatient facility
- An office

We pay for:

- Covered services and devices for pain management

We do not pay for:

- Services and devices for pain management provided by a nonparticipating hospital or facility.

Physical Therapy

See Section 2 beginning on Page *12 for what you may be required to pay for these services.*

Special rules apply when services are provided to treat autism, see Page 30.
For chiropractic services and osteopathic manipulative therapy, see Page 42.
For occupational therapy services, see Page 72.
For speech language therapy services, see Page 104.

Locations: We pay for physical therapy services in:

- A participating hospital

Inpatient therapy must be used to treat the condition for which the member is hospitalized.

- Other approved facilities
- An office
- A member's home
- A nursing home, if it is the member's primary residence

We pay for:

- A combined maximum of 30 habilitative and a combined maximum of 30 rehabilitative outpatient visits per member per calendar year.

Important: **See Note below about treatment dates and initial evaluations. The combined 30-visit habilitative and combined 30-visit rehabilitative maximums renew each calendar year. They include all in-network and out-of-network outpatient visits, regardless of location (hospital, facility, office or home), for:**

- **Occupational therapy**
- **Physical therapy**
- **Physical Medicine**
- **Chiropractic manipulations (rehabilitative only)**
- **Osteopathic manipulative therapy (rehabilitative only)**

If services performed in a member's home are billed by a professional provider, they will count toward the combined visit maximum.

If services performed in a member's home are billed by a home health care agency, they will not count toward the combined visit maximum.

Each **treatment date** counts as one visit even when two or more therapies are provided and when 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 (described above).

Physical Therapy (continued)

We pay for: (continued)

Physical therapy must be:

- Prescribed by a professional provider licensed to prescribe it, unless it is performed by a chiropractor (see Page 42)
- Given for a neuromuscular condition that can be significantly improved in a reasonable and generally predictable period of time (usually about six months), or to optimize the developmental potential of the member and/or maintain the member's level of functioning
- Given by:
  - A professional provider (M.D., D.O. or podiatric physician)
  - A dentist or optometrist
  - A chiropractor
  - A physical therapist or physical therapist assistant
  - Athletic trainer
  - A physician assistant

Not all of the providers listed above can perform physical therapy in all locations. Some of these providers must be supervised by other types of providers for their services to be covered. Please call Customer Service if you have questions about where physical therapy can be provided or who can provide it.

We do not pay for:

- More than combined 30 habilitative and combined 30 rehabilitative outpatient visits per member per calendar year, whether obtained from an in-network or out-of-network provider
- Services received from a nonparticipating hospital or nonparticipating facility
- Services rendered in an independent sports medicine clinic
- Services provided by a freestanding facility in a home, hospital, skilled nursing facility, psychiatric residential treatment facility or residential substance abuse treatment facility
- Therapy billed as a rehabilitative service when it does not meet the definition of rehabilitative service in this certificate
- Therapy billed as an habilitative service when it does not meet the definition of habilitative service in this certificate
- Therapy that is performed without a physical therapy treatment plan
- Tests to measure physical capacities such as strength, dexterity, coordination or stamina, unless part of a complete physical therapy treatment program

Physical Therapy (continued)

We do not pay for: (continued)

- 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 without a physical therapy treatment plan that guides and help monitor the provided therapy

We may pay for treatment to improve cognition if it is:

  - Part of a comprehensive rehabilitation plan, and
  - Medically necessary to treat severe deficits in members who have certain conditions that are identified by BCBSM

- Member education and home programs
- Sports medicine for purposes such as prevention of injuries or for conditioning
- Recreational therapy

Prescription Drugs

For chemotherapy services, see Page 41.
For contraceptive services, see Page 93.

Prescription drugs obtained from a pharmacy are not covered under this certificate. They may be covered if you have a prescription drug certificate.

Locations: We pay for medically necessary prescription drugs in:

- A participating hospital
- Other approved locations

Prescription Drugs Provided by a Medical Provider
BCBSM pays for select prescription drugs that are provided by hospitals, facilities, and professional providers.

We pay for:

- Drugs Received in a Hospital

  We pay for prescription drugs, biologicals and solutions (such as irrigation and I.V. solutions) administered as part of the treatment for the disease, condition or injury that are:

  - Labeled FDA-approved as defined under the amended Federal Food, Drug and Cosmetic Act
  - Used during an inpatient hospital stay or dispensed when part of covered outpatient services

- Drugs Received in Other Locations

  - In a participating freestanding ambulatory surgery facility when directly related to surgery (see Page 108)
  - In a participating freestanding ESRD facility in conjunction with dialysis services (see Page 51)
  - In a participating skilled nursing facility (see Page 101)
  - As part of home health services when services are provided by a participating hospital (see Page 56)
  - When required for infusion therapy (see Page 66)
  - In a participating hospice for the comfort of the member (see Page 60)
  - In a participating residential or outpatient substance abuse treatment facility (see Page 37).

Prescription Drugs (continued)

- Drugs Administered by a Physician

  

  Self-injected drugs are not covered unless approved by BCBSM

  – **Injectable Drugs:** We pay for, injectable drugs or biologicals, and their administration. The drugs or biologicals must be:

    - FDA approved,
    - Ordered or furnished by a physician, and
    - Administered by the physician or under the physician's supervision.

  – **Specialty Pharmaceuticals:** We pay for approved specialty drugs when:

    - They are administered and billed by a physician, or
    - They are billed by the contracted specialty pharmacy and administered by a physician

- Prior Authorization for Specialty Pharmaceuticals

  Prior authorization is required for select specialty drugs that will be administered in select locations identified by BCBSM. These locations include, but not limited to:

  – Office
  – Clinic
  – Home
  – Outpatient facilities

  BCBSM requires prior authorization for specialty drugs for in-state and out-of-state services (See Section 6 for Prior Authorization). Your physician should contact us and follow our utilization management processes to get prior authorization for your specialty drug. We will notify your physician if the request is approved. Only FDA-approved drugs can be preauthorized. Of those drugs, we will preauthorize only the specialty drugs that meet our medical policy standards for the treatment of your condition.

  

  If Medicare is your primary payer, your physician does not have to get prior authorization.

Prescription Drugs (continued)

- Requests for Drugs Not on BCBSM's Drug List

  If your prescription drug coverage is limited to an approved drug list, BCBSM must approve coverage of a prescription drug not on the list ***before*** it is dispensed. If you or your prescriber do not obtain approval before the drug is dispensed, the drug will not be covered.

  To request BCBSM's approval, you, your designee, or the prescriber or the prescriber's designee should contact us and follow our exception request process.

  For expedited requests due to exigent circumstances:
  We will notify the person making the request of our decision (either approval or denial) within 24 hours after we get all of the information we need to make our determination.

  For requests that are not due to exigent circumstances:
  If your request is not an exigent circumstance, we will notify you of our decision within 72 hours after we get all of the information we need to make our determination.

  If we approve the exception request, you will have to pay your cost share.

  

  Only FDA-approved drugs are eligible for an exception. Of those drugs, BCBSM will only approve the drugs that meet our clinical criteria and are effective in treating your condition.

  To learn more about this process call BCBSM Customer Service (See Section 9).

Preventive Care Services

See Section 2 beginning on Page *12 for what you may be required to pay for these services.*

We pay for all preventive and immunization services required under the Patient Protection and Affordable Care Act (PPACA). Because the services required under PPACA change from time- to-time, we have mentioned only some of them in this certificate. To see a complete list, go to the https://www.healthcare.gov/coverage/preventive-care-benefits/ website. You may also contact BCBSM Customer Service.

Most preventive care services are covered only when performed by an in-network provider. But, colonoscopies, mammograms, and contraceptive services are covered whether they are done by an in-network or an out-of-network provider. This section describes what we cover for preventive care services.

Locations: We pay for facility and professional services for preventive care in:

- A participating hospital
- A participating independent laboratory
- A participating facility (e.g., an ambulatory surgery center)
- An office

We pay for:

- Related reading and interpretation of your test results
- Health Maintenance Examination

  One exam per member, per calendar year.
- Routine Flexible Sigmoidoscopy Examination

  One per member, per calendar year.
- Routine Gynecological Examination

  Two per member, per calendar year.
- Routine Pap Smear

  One per member, per calendar year, when prescribed by a physician.

Preventive Care Services (continued)

We pay for: (continued)

- Screening Mammography

  One per member per calendar year to screen for breast cancer.

  

  We follow PPACA guidelines consistent with the HRSA-Supported Women's Preventive Services Guidelines. Additional breast cancer screening services, such as an ultrasound, may be required to address findings from the initial screening mammography. Each of the additional services are covered as preventive if received within 12 months of a screening mammography but not more than one per year.

- Fecal Occult Blood Screening

  One per member, per calendar year to detect blood in the feces or stool.

- Routine Well-Baby and Well-Child Visits

  - Eight visits for children from birth through 12 months
  - Six visits for children 13 months through 23 months
  - Six visits for children 24 months through 35 months
  - Two visits for children 36 months through 47 months
  - Well-child visits after 47 months are limited to one per member, per calendar year under your health maintenance exam benefit.

- Routine Immunizations

  We follow the recommendations of the Advisory Committee on Immunization Practices. We may also follow other sources as known to BCBSM.

  We pay for all other immunizations and preventive care benefits ordered by PPACA at the time the services are performed.

- Prostate Specific Antigen Screening

  One per member, per calendar year.

- Routine Laboratory and Radiology Services

  The following services are paid once per member, per calendar year, when performed as routine screening:

  - Chemical profile
  - Complete blood count or any of its components
  - Urinalysis
  - Chest X-ray
  - EKG
  - Cholesterol testing

Preventive Care Services (continued)

We pay for: (continued)

- Routine Colonoscopy

  One per member per calendar year, for cancer screening

- Morbid Obesity Weight Management

  For a member with a BMI of 30 or above, we pay for 26 visits per member per calendar year. Visits can include nutritional counseling, such as dietician services, billed by a professional provider recognized by BCBSM.

- Tobacco Cessation Programs

  Screening counseling and select prescription drugs to help you stop smoking.

- Contraceptive Services

  We pay for all FDA-approved contraceptive methods for women as required by PPACA and consistent with the HRSA-Supported Women's Preventive Services Guidelines. Including contraceptive counseling, office visits, inpatient and outpatient facility, laboratory and physician's services.

  – Voluntary sterilization of female reproductive organs including tubal ligation and related charges associated with the procedure (anesthesia, labs, etc.)

  – Contraceptive counseling

    Provided during a preventive exam or counseling session

  – Contraceptive devices, injections and implants

    This may also include payment for the insertion and removal of devices and contraceptive medication (if supplied by the professional provider). If you obtain the contraceptive medication from a pharmacy, we only pay the provider for the administration.

  – Contraceptive Mobile App

    One yearly subscription per member per 12 consecutive months

    

    This mobile app must be FDA approved. Please call Customer Service for specific coverage information.

Preventive Care Services (continued)

We pay for: (continued)

- Additional counseling and screening services, including but not limited to:

  – Genetic counselling and breast cancer genetic testing (BRCA)
  – Rh(D) incompatibility screening
  – Cervical cancer screening
  – Sexually transmitted infection screening
  – HIV counseling and screening
  – HPV screening

We do not pay for:

- Screening and preventive care services that are:

  – Not listed in this certificate or
  – Not required to be covered under PPACA.

  To see a complete list of the services and immunizations that must be covered under PPACA go to the https://www.healthcare.gov/coverage/preventive-care-benefits/ website.

  You may also contact BCBSM Customer Service.

Professional Services

See Section 2 beginning on Page 12 for what you may be required to pay for these services.

The services listed in this section are in addition to all of the other services listed in this certificate. The services in this section are also payable to a professional provider.

We pay for:

- Inpatient and Outpatient Consultations: If a physician needs help diagnosing or treating a member's condition, we pay for inpatient and outpatient consultations. They must be provided by a physician or professional provider who has the skills or knowledge needed for the consultations.

  We do not pay for staff consultations required by a facility's or program's rules.

- Therapeutic injections

Prosthetic and Orthotic Devices

See Section 2 beginning on Page *12 for what you may be required to pay for these services.*

For durable medical equipment services, see Page 54.

Locations: We pay for prosthetic and orthotic devices in:

- A participating hospital
- A participating skilled nursing facility
- An office
- A member's home

We pay for:

- The cost of purchasing or replacing a device

  We will pay for the cost to replace a prosthetic device due to:

  – A change in the patient's condition
  – Damage to the device so that it cannot be restored
  – Loss of the device

- The cost of developing and fitting a basic device
- Any medically necessary special features
- Repairs, limited to the cost of a new device

BCBSM covers most external prosthetic and orthotic devices that are payable by Medicare Part B. In some cases, BCBSM guidelines may be different from those of Medicare Part B. Please call your local Customer Service center for specific coverage information.

Prosthetic and orthotic devices must meet the following guidelines:

- Be prescribed by a physician or other provider licensed to prescribe it, and:

  – Permanently implanted in the body, or
  – Used externally, such as an artificial eye, leg or arm.

- The prescription must contain complete details including the following information:

  – Diagnosis related to the services or items provided
  – Description and quantity of all items ordered

Prosthetic and Orthotic Devices (continued)

Provider Limitations

To avoid out-of-network cost share, obtain your prescribed durable medical equipment, prosthetics, orthotics, and medical supplies from an in-network provider. Contact Customer Service to locate a provider in your network.

- Custom-made devices must be furnished:
  - By a provider, accredited by a Medicare-deemed accrediting organization

  You may call Customer Service to confirm a provider's status.

- A participating provider with BCBSM, who is not accredited by a Medicare-deemed accrediting organization, may only provide the following devices:
  - External breast prostheses following a mastectomy which include:
    - Two post-surgical brassieres and
    - Two brassieres in any 12-month period thereafter

    Additional brassieres are covered if they are required:
    - Because of significant change in body weight
    - For hygienic reasons
  - Prefabricated custom-fitted orthotic devices
  - Artificial eyes, ears, noses and larynxes
  - Prescription eyeglasses or contacts lenses after cataract surgery; the surgery can be for any disease of the eye or to replace a missing organic lens. Optometrists may provide these lenses.
  - External cardiac pacemakers
  - Therapeutic shoes, shoe modifications and inserts for persons with diabetes
  - Maxillofacial prostheses (as defined in Section 7) that have been approved by BCBSM. Dentists may provide you with these devices.
  - If you have an urgent need for an item that is not custom-made (e.g., wrist braces, ankle braces, or shoulder immobilizers), we will pay for the item to be provided by a M.D., D.O., or podiatric physician. Please call Customer Service for information on which devices are covered.

Prosthetic and Orthotic Devices (continued)

We do not pay for:

- Hair prostheses such as wigs, hair pieces, hair implants, etc.
- Spare prosthetic devices
- Routine maintenance of a prosthetic device
- Experimental prosthetic devices
- Devices ordered or purchased prior to the certificate's effective date
- Nonrigid devices and supplies such as elastic stockings, garter belts, arch supports, and corsets
- Hearing aids

Pulmonary Rehabilitation

See Section 2 beginning on Page 12 for what you may be required to pay for these services.

For cardiac rehabilitation, see Page 33.

Locations: We pay for pulmonary rehabilitation in the following location:

- A participating hospital

We pay for:

- Services given when intensive monitoring and/or supervision during exercise is required.

We do not pay for:

- Services that require less than intensive monitoring or supervision because the member's endurance while exercising and management of risk factors are stable
- More than 30 visits per calendar year for combined outpatient cardiac or pulmonary rehabilitation services

Radiology Services

See Section 2 beginning on Page *12 for what you may be required to pay for these services.*

For radiology services in an ambulatory surgical facility, see Page 108.

Locations: We pay for diagnostic and therapeutic radiology services in:

- A participating hospital
- A participating facility
- An office

We pay for:

- Diagnostic Radiology Services

  These services include facility and physician radiology services used to diagnose disease, illness, pregnancy or injury. The services must be prescribed by a professional provider. Examples of these services are:

  - X-rays
  - Radioactive isotope studies and use of radium
  - Ultrasound
  - Computerized axial tomography (CAT) scans
  - Magnetic resonance imaging (MRI)
  - Positron emission tomography (PET) scans
  - Medically necessary mammography

Therapeutic Radiology Services
These services include facility and physician services to treat medical conditions by X-ray, radon, radium, external radiation or radioactive isotopes. The services must be prescribed by a professional provider.

We do not pay for:

- Procedures not directly related and necessary to diagnose a disease, illness, pregnancy or injury (such as an ultrasound solely to determine the sex of the fetus).

Skilled Nursing Facility Services

See Section 2 beginning on Page *12 for what you may be required to pay for these services.*

Locations: We pay for facility and professional services in a participating skilled nursing facility.

Requirements:

We pay for an admission to a participating skilled nursing facility when:

- The member's physician provides a written confirmation indicating that skilled care is needed.

Length of Stay

We pay only for the period that is necessary for the proper care and treatment of the member. The maximum length of stay is 120 days per member, per calendar year.

We pay for:

- A semiprivate room, including general nursing service, meals and special diets
- Special treatment rooms
- Laboratory examinations
- Oxygen and other gas therapy
- Drugs, biologicals and solutions
- Gauze, cotton, fabrics, solutions, plaster, and other materials used in dressings and casts
- Durable medical equipment used in the facility or outside the facility when rented or bought from the skilled nursing facility
- Physician services (up to two visits per week)
- Physical therapy (Page 85), speech language therapy services (Page 104) or occupational therapy (Page 72) when medically necessary

The physical therapy, occupational therapy, or speech language therapy services that are done in a skilled nursing facility are inpatient benefits. The combined 30-visit maximums for occupational therapy and physical therapy and the 30-visit maximum for speech language therapy service apply only when these services are provided on an outpatient basis.

Skilled Nursing Facility Services (continued)

We do not pay for:

- Acute care
- Custodial care
- Care for senility or developmental disability
- Care primarily for substance use disorder
- Care primarily for mental illness (other than for short-term nervous and mental conditions to which the 120-day maximum applies)
- Care provided by a nonparticipating skilled nursing facility

Special Medical Foods for Inborn Errors of Metabolism

See Page 8 *for what you may be required to pay for these services.*

We pay for:

Special medical foods for the dietary treatment of inborn errors of metabolism. These foods must be prescribed by professional provider.

The following criteria must be met:

- The cost of special medical foods must be higher than the cost of foods or items that are not special medical foods
- Medical documentation must support the diagnosis of a covered condition that requires special medical foods

BCBSM determines which conditions are payable

To be paid, you must submit the prescription from the treating professional provider along with receipts for your special medical food purchases to BCBSM. Mail your receipts along with a "Member Application for Payment Consideration" to:

Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd
Imaging & Support Services, MC 0010
Detroit, MI 48226-2998

You can get the above-mentioned form by visiting our website at www.bcbsm.com. **C**lick on "Forms" under the "Member Secured Services" tab. If you can't access the website or you have trouble finding what you need, please contact Customer Service at one of the telephone numbers listed in Section 9.

We do not pay for:

- Nutritional products, supplements, medical foods or any other items provided to treat medical conditions that are not related to the treatment of inborn errors of metabolism

BCBSM determines what conditions are related to inborn errors of metabolism. Diabetes mellitus is excluded as a payable diagnosis for this benefit.

- Foods used by members with inborn errors of metabolism that are not special medical foods, as defined by this certificate
- Nutritional products, supplements or foods used for the member's convenience or for weight reduction programs

Speech Language Therapy

See Section 2 beginning on Page *12 for what you may be required to pay for these services.*

Special rules apply when services are provided to treat autism, see Page 30.
For occupational therapy services, see Page 72.
For physical therapy services, see Page 85.

Locations: We pay for facility and professional speech language therapy services in:

- A participating hospital

  

  Inpatient therapy given in a hospital must be used to treat the condition for which the member is hospitalized.

- Other approved facilities
- An office
- A member's home
- A nursing home, if it's the member's primary residence

We pay for:

- A maximum of 30 habilitative and 30 rehabilitative outpatient visits per member per calendar year

Important: **See Note below about treatment dates and initial evaluations. The 30-visit habilitative and 30-visit rehabilitative maximums renew each calendar year. They include all in-network and out-of-network outpatient visits, regardless of location (hospital, facility, office or home).**

If services performed in a member's home are billed by a professional provider, they will count toward the visit maximum.

If services performed in a member's home are billed by a home health care agency, they will not count toward the visit maximum.)

These visit maximums are separate from the maximums that apply to physical or occupational therapy. Please see the information about those therapies on the pages above.

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

Speech Language Therapy (continued)

Speech language therapy services must be:

- Prescribed by a professional provider licensed to prescribe speech language therapy services
- Given for a condition that can be significantly improved in a reasonable and generally predictable period of time (usually about six months), or to optimize the developmental potential of the member and/or maintain the member's level of functioning
- 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 and language pathologist

When a speech language pathologist has completed the work for their master's degree, they begin a clinical fellowship for a year. In that year their work is supervised by a certified speech language pathologist.

We do not pay for:

- Treatment **solely** to improve cognition (e.g., memory or perception), concentration and/or attentiveness, organizational or problem-solving skills, academic skills, impulse control or other behaviors for which behavior modification is sought without a speech language therapy treatment plan that guides and helps to monitor the provided therapy

We may pay for treatment to improve cognition if the treatment is part of a comprehensive rehabilitation plan. The treatment must be necessary to treat severe speech deficits language and/or voice deficits. This treatment is for members with certain conditions that have been identified by BCBSM.

- Recreational therapy
- Member education and home programs
- Therapy billed as a rehabilitative service when it does not meet the definition of rehabilitative service in this certificate.
- Therapy billed as an habilitative service when it does not meet the definition of habilitative service in this certificate.

Speech Language Therapy (continued)

We do not pay for: (continued)

- Treatment of chronic, developmental or congenital conditions, learning disabilities or inherited speech abnormalities

A BCBSM medical consultant may decide that speech language therapy services can be used to treat chronic, developmental or congenital conditions for some children with severe developmental speech disabilities.

- Therapy that is performed without a speech language therapy treatment plan
- Services provided by speech language therapy assistants or therapy aides.
- Services received from a nonparticipating hospital or nonparticipating facility.
- More than 30 habilitative and 30 rehabilitative outpatient visits per member per calendar year.
- Services provided by a freestanding facility in a home, hospital, skilled nursing facility, psychiatric residential treatment facility or residential substance abuse treatment facility

Surgery

See Section 2 beginning on Page *12 for what you may need to pay for these services.*

For transplant services, see Page 116.

Locations: We pay for hospital, facility and professional services for surgery in:

- A participating hospital
- A participating freestanding ambulatory surgery facility
- An office

We pay for:

Presurgical Consultations
If your physician tells you that you need surgery, you may choose to have a presurgical consultation with another physician. The consulting physician must be a MD, DO, podiatric physician or an oral surgeon.

The consultation will be paid if the surgery you plan to have is covered under this certificate and will be done in a covered location (see above).

- You are limited to three presurgical 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

Surgery:

- Physician's surgical fee
- Medical care provided by the surgeon before and after surgery while the member is in the hospital
- Visits to the attending physician for the usual care before and after surgery
- Operating room services, including delivery and surgical treatment rooms
- Sterilization procedures of female reproductive organs and male reproductive organs (whether or not medically necessary)

  

  As part of your preventive care services, we cover voluntary sterilization of female reproductive organs (see Page 93).

- Whole blood, blood derivatives, blood plasma or packed red blood cells, supplies and their administration related to surgery

Surgery (continued)

We pay for: (continued)

- Cosmetic surgery is only payable when medically necessary 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
  - Blepharoplasty of upper lids
  - Breast reduction
  - Surgical treatment of male gynecomastia
  - Panniculectomy
  - Sleep apnea treatments:
    - Rhinoplasty
    - Septorhinoplasty

  

  We will not pay for cosmetic surgery and related services that are only to improve your personal appearance.

- Dental Surgery is only payable for:
  - Multiple extractions or removal of unerupted teeth or alveoloplasty when:
    - A hospitalized member 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 and treatment related to the treatment of temporomandibular joint (TMJ) dysfunction.
- Bariatric surgery - one surgery during each member's lifetime.
- Technical surgical assistance (TSA): In some cases, a surgeon will need another physician to give them technical assistance. We pay the approved amount for TSA, according to our guidelines. The surgery can be done in a:
  - Participating hospital (inpatient or outpatient)
  - Participating ambulatory surgery facility

  A list of TSA surgeries that we cover is available from Customer Service.

  We do not pay for TSA:
  - When services of interns, residents or other physicians employed by the hospital are available at the time of surgery or
  - When services are provided in a location other than a hospital or ambulatory surgery facility

Surgery (continued)

Freestanding Ambulatory Surgery Facility Services
We pay for facility services in a participating ambulatory surgery center. You must be under the care of a licensed doctor of medicine, osteopathy, podiatry or oral surgery. The services must be directly related to the covered surgery.

The following services are payable:

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

We do not pay for:

- Services by a nonparticipating ambulatory surgery facility

Temporary Benefits

We pay temporary benefits for some services when a participating professional provider, hospital or facility ends its contract with BCBSM.

Professional Provider Services
We pay temporary benefits for continuity of care services from a professional provider. These services are available for up to **90 days** from the date the professional provider ends its participating contract with BCBSM.

Payable Services

- Continuity of Care

  Coverage Requirements
  We will pay for your continued treatment after a professional provider ends its participating contract with BCBSM as required by law. These benefits are available for **up to 90 days** from the date the professional provider ends its contract with BCBSM if one of the following is true:

  - You were undergoing a continued and regular course of treatment for a serious and complex condition by the provider;
  - You are undergoing a course of institutional or inpatient care from the provider or facility;
  - You are scheduled to undergo nonelective surgery from the provider or facility, including receiving postoperative care related to a surgery;
  - You are pregnant and undergoing a course of treatment for the pregnancy from a provider; or
  - You are terminally ill and receiving treatment for such illness from the provider.

  Additionally, for continuity of care to apply, the following conditions must also be true:

  - BCBSM paid your claims for treatment of that condition before the professional provider ended the participating contract with BCBSM, and
  - The services are medically necessary and would be covered if the professional provider was a BCBSM in-network or participating provider.

  Payment for Continuity of Care Services
  We will pay our approved amount for covered services, less your in-network cost-share requirements under this certificate for **up to 90 days** to allow for a transition of care to an in-network provider. During this period, our paid amount less any required in-network cost share is considered as payment in full for continuity of care services.

Hospital or Facility Services
Hospitals and/or facilities are sometimes referred to as “noncontracted” hospitals or facilities. We pay temporary benefits for some services of noncontracted hospitals and facilities. These benefits are for continuity of care, designated services, emergency care, and travel and lodging. Benefits for continuity of care are available for up to **six months** from the date the hospital or facility ends its participating contract with BCBSM. Benefits for designated services and emergency care are available for as long as they are medically necessary. Benefits for travel and lodging are available for the period of time approved by BCBSM.

Temporary Benefits (continued)

Hospital and/or Facility (continued)

Mandatory Preapproval

You must obtain preapproval from BCBSM for any travel and lodging expenses before they occur. If you do not obtain preapproval, travel and lodging will not be covered and you will be responsible for these costs. Please call BCBSM to obtain preapproval (see Section 9 “How to Reach Us”).

Our Customer Service representatives can provide you with the telephone number to call for preapproval (see Section 9). If your request for preapproval of travel and lodging is related to a bone marrow or organ transplant, ask your Customer Service representative for the telephone number of the Human Organ Transplant Program. For more information on transplants, see Page 116.

Payable Services

- Continuity of Care

  Coverage Requirements

  We will pay for your continued treatment in a hospital or facility after it ends its participating contract with BCBSM as required by law. These benefits are available for **up to six (6) months** from the date the hospital or facility ends its contract with BCBSM if one of the following is true:

  - You were undergoing a continued and regular course of treatment for a serious and complex condition by the provider or facility;
  - You are undergoing a course of institutional or inpatient care from the provider or facility;
  - You are scheduled to undergo nonelective surgery from the provider or facility, including receiving postoperative care related to a surgery;
  - You are pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
  - You are terminally ill and receiving treatment for such illness from the provider or facility.

  Additionally, for continuity of care to apply, the following conditions must also be true:

  - BCBSM paid your claims for treatment of the same condition at the hospital or facility before it ended its participating contract with BCBSM, and
  - The services are medically necessary and would be covered if the hospital or facility were a BCBSM in-network or participating hospital or facility.

  Payment for Continuity of Care Services

  We will pay our approved amount for covered services, less your in-network cost-share requirements under this certificate for up to six months to allow for a transition of care to a participating hospital or facility. During this period, our paid amount less any required in-network cost share is considered as payment in full for continuity of care services.

Temporary Benefits (continued)

Hospital and/or Facility (continued)

Payable Services (continued)

- Designated Services and Emergency Care

  Coverage Requirements
  We will pay for designated services and emergency care that you receive from a hospital or facility that ends its contract with BCBSM when the following criteria are met:

  – The services are medically necessary and would be covered if the hospital or facility were a BCBSM in-network or participating hospital or facility, **and**
  – The hospital or facility that ends its contract with BCBSM is within 75 miles of your primary residence (this applies only to designated services)

  Payment for Designated Services and Emergency Care
  When the above coverage requirements are met, we will pay you as follows:

  – Designated Services

    We will pay our approved amount, less your cost sharing required under this certificate. Our approved amount may be less than the bill. You may be required to pay the difference.

  – Emergency Care

    The below method is used to determine what we pay for accidental injuries and emergency services:

    - We pay a rate based on the requirements of state or federal law

    - The rate we pay for emergency care may be less than the bill; you will not be required to pay the difference between what the provider charges and what we pay (See Surprise Billing in the General Conditions of Your Contract section for more information).

You will not have to pay any out-of-network cost sharing that applies to these services. However, you must pay any in-network cost sharing that applies, which is calculated based on Michigan or federal law. The cost share you pay will apply to your in-network deductible and in-network out-of-pocket maximum. In some cases, cost sharing may be waived see Section 2 for information about what cost sharing you must pay for accidental injuries and emergency services.

Temporary Benefits (continued)

Hospital and/or Facility (continued)

Payable Services (continued)

Designated Services and Emergency Care (continued)

Transport From a Noncontracted Area Hospital or Facility
If you are receiving designated services or emergency care in a hospital or facility that ended its contract with BCBSM, and your physician says that you are medically stable, you may choose to be transferred to the nearest participating hospital or facility that can treat your condition. We will pay our approved amount to transport you by ambulance to that hospital or facility.

If you use a nonparticipating ground ambulance service to transport you, the bill may be more than our approved amount. You may be required to pay the difference.

If you transfer to a participating out-of-network hospital or facility, you do not have to pay any out-of-network cost sharing. But, you will still have to pay for any in-network cost sharing.

BCBSM certificates will provide coverage for emergency services at nonparticipating hospitals or facilities until you are admitted and sign a form waiving your surprise billing protections. They provide you with no coverage if you are admitted on a nonemergency basis. If you decide to stay in a noncontracted hospital or facility and sign the form, we will pay you at the nonparticipating rate. Our rate may be less than the hospital or facility charges. You will have to pay the difference.

Limitations and Exclusions

- If you get services from a hospital or facility that ends its contract with BCBSM that are not designated services, we will pay only the amount we pay for nonparticipating hospital or facility services. These amounts are described in Section 2. You will have to pay the difference between what we pay and the hospital's or facility's charge. This difference may be substantial since we do not pay for nonemergency services in a nonparticipating hospital or facility.
- We will pay for ambulance transport services only if they are for an admission that is covered under this certificate. If your certificate covers nonemergency transports, you will have to pay for your cost share.

- Travel and Lodging

  If you need to get services at an out-of-area hospital or facility, we will pay for the cost of travel and lodging if all the following are met:

  - You live within 75 miles of the noncontracted area hospital or facility
  - The travel and lodging are preapproved, as previously described
  - You cannot reasonably get covered services from:

    - A contracted hospital or facility in your area or other participating provider within 75 miles of the noncontracted area hospital or facility, and
    - Your physician directs you to an out-of-area hospital or facility.

Temporary Benefits (continued)

Hospital and/or Facility (continued)

Payable Services (continued)

Travel and Lodging (continued)

- Payment will be subject to the following provisions:

  Inpatient Services
  If you need inpatient services from an out-of-area hospital or facility, we will pay a maximum of $250 per day for the reasonable and necessary cost of travel and lodging. We will pay up to a total of $5,000 for travel and lodging costs for each admission. Both of these maximum payment amounts will cover the combined expenses for you and the person(s) eligible to accompany you. If you spend less than $250 per day or a total of $5,000 for all of your travel and lodging, we will pay you the amount you actually spent. If you spend more than $250 per day or a total of $5,000, we will only pay you the maximum of $250 per day or $5,000 total for your travel and lodging expenses.

  Coverage will begin on the day before your admission and end on your date of discharge. We will pay for the following:

  - Travel for you and another person (two persons if the member is a child under the age of 18) to and from the out-of-area hospital or facility
  - Lodging for the person(s) eligible to accompany you

  Outpatient Services
  If you need outpatient services from an out-of-area hospital or physician, we will pay up to $125 for travel and lodging each time you need these services.

Temporary Benefits (continued)

Hospital and/or Facility (continued)

Payable Services (continued)

Travel and Lodging (continued)

Limitations and Exclusions

- We do not pay for travel and lodging that were not preapproved, as previously described.
- Travel and lodging will be paid only after you submit your original receipts to us.
- Travel does not include an ambulance transport to an out-of-area hospital or facility.
- We will not pay for travel and lodging beyond the maximums stated above.
- We will not pay for items that are not directly related to travel and lodging, such as:

Alcoholic beverages	Charges for hospital or facility services not covered, e.g., private room	Household products	Movie rentals Private room
Babysitters or daycare services	Clothing	Household utilities (including cell phones)	Security deposits
Books or magazines	Dry cleaning	Kennel fees	Stamps or stationery
Cable television	Flowers	Laundry services	Telephone Television Toiletries
Car maintenance	Greeting cards	Maids	Toys

- Any other services, admissions or length of stay related to any of the above exclusions
- The deductible, copayment or coinsurance requirements in this certificate do not apply to travel and lodging.

Transplant Services

See Section 2 beginning on Page *12 for what you may be required to pay for these services.*

For general surgery services, see Page 107.
For oncology clinical trials, see Page 77.

Locations: Cornea, skin and bone marrow transplants are payable when performed in a:

- Participating hospital
- Participating ambulatory surgery facility

We cover transplants of specified organs such as kidney, heart or liver **only** if they are done in a "designated facility". (See Section 7 for the definition of a designated facility.)

Transplant Time Frames
We cover services for transplants, bone marrow transplants and specified human organ transplants as long as they are medically necessary and related to the preapproved transplant. Certain services have specific time frames.

We pay for:

Organ transplants and bone marrow transplants if the transplant recipient is a BCBSM member. Living donor and recipient transplant services are paid under the recipient's coverage.

Organ Transplants
We pay for services performed to obtain, test, store and transplant the following human tissues and organs:

- Cornea
- Skin
- Bone marrow (described below)

We cover immunizations against common infectious diseases during the first 24 months after your transplant. We follow the guidelines of the Advisory Committee on Immunization Practices (ACIP).

The immunization benefit does **not** apply to cornea and skin transplants.

Transplant Services (continued)

Bone Marrow Transplants

Bone marrow transplants require preapproval. Once a transplant is preapproved, we cover any services you receive that are medically necessary and related to the preapproved transplant. If your transplant is not approved before you receive it, neither it nor any related services will be covered and you will have to pay all costs.

We pay for covered services when they are directly related to:

- Two tandem transplants
- Two single transplants
- A single and a tandem transplant

For each member and for each condition, we pay the following services:

- Allogeneic Transplants
  - Blood tests on first degree relatives to evaluate them as donors
  - Search of the National Bone Marrow Donor Program Registry for a donor. A search will begin only when the need for a donor is established and the transplant is preapproved
  - Infusion of colony stimulating growth factors
  - Harvesting (including peripheral blood stem cell pheresis) and storage of the donor's bone marrow, peripheral blood stem cell and/or umbilical cord blood, if the donor is:
    - A first degree relative and matches at least four of the six important HLA genetic markers with the member or
    - Not a first degree relative and matches five of the six important HLA genetic markers with the member. (This provision does not apply to transplants for Sickle Cell Anemia (ss or sc) or Beta Thalassemia.)

    

    In a case of Sickle Cell Anemia (ss or sc) or Beta Thalassemia, the donor must meet BCBSM HLA genetic marker matching requirements.
  - 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

Transplant Services (continued)

Bone Marrow Transplants (continued)

We pay for: (continued)

- Autologous Transplants
  - Infusion of colony stimulating growth factors
  - Harvesting (including peripheral blood stem cell pheresis) and storage of bone marrow and/or peripheral blood stem cells
  - Purging and/or positive stem cell selection of bone marrow or peripheral blood stem cells
  - High-dose chemotherapy and/or total body irradiation
  - Infusion of bone marrow and/or peripheral blood stem cells
  - Hospitalization

A tandem autologous transplant is covered only when it treats germ cell tumors of the testes, multiple myeloma, or other conditions identified by BCBSM. We pay for up to two tandem transplants or a single and a tandem transplant per member for this condition. (See Section 7 for the definition of “Tandem Transplant”.)

- Allogeneic transplants and autologous transplants covered to treat only certain conditions. Please call Customer Service for a list of these conditions.

Additional services for bone marrow transplants:

In addition to the conditions listed above, we will pay for services related to, or for:

- High-dose chemotherapy
- Total body irradiation
- Allogeneic or autologous transplants to treat conditions that are not experimental

This does not limit or prevent coverage of antineoplastic drugs when Michigan law requires that these drugs be covered. The coverage includes the cost of administering the drugs.

Transplant Services (continued)

Bone Marrow Transplants (continued)

We do not pay the following for bone marrow transplants:

- Services that are not medically necessary (see Section 7 for the definition of “medically necessary”)
- Services provided in a facility that does not participate with BCBSM
- Services provided by persons or groups that are not legally qualified or licensed to provide such services
- Services provided to a transplant recipient who is not a BCBSM member
- Services provided to a donor when the transplant recipient is not a BCBSM member
- Any services related to, or for, allogeneic transplants when the donor does not meet the HLA genetic marker matching requirements
- Expenses related to travel, meals and lodging for donor or recipient
- Search of an international donor registry
- An allogeneic tandem transplant
- The routine harvesting and storage costs of bone marrow, peripheral blood stem cells or a newborn’s umbilical cord blood if not intended for transplant within one year
- Experimental treatment
- Any other services or admissions related to any of the above-named exclusions

Transplant Services (continued)

Specified Human Organ Transplants
Specified Human Organ Transplants require preapproval. If you do not get preapproval before you receive these services, they will not be covered, and you will have to pay for them. Once the transplant is preapproved, any services that you receive during the benefit period will be covered as long as those services are medically necessary and related to the preapproved transplant.

These services have a specific benefit period. The benefit period begins five days before the transplant and ends one year after the transplant.

When performed in a designated facility (see Section 7 for the definition of designated facility), **we pay for** transplant of the following organs:

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

We also pay for the cost of getting, preserving and storing human skin, bone, blood, and bone marrow that will be used for medically necessary covered services.

All specified human organ transplant services must be provided during the benefit period if they are going to be paid by BCBSM. The only exceptions are anti-rejection drugs and other transplant-related prescription drugs.

Transplant Services (continued)

Specified Human Organ Transplants (continued)

When directly related to the transplant, we pay for:

- Facility and professional services
- Anti-rejection drugs and other transplant-related prescription drugs, during and after the benefit period, as needed; the payment for these drugs will be based on BCBSM's approved amount.
- During the first 24 months after the transplant, immunizations against certain common infectious diseases are covered. Immunizations that are recommended by the Advisory Committee on Immunization Practices (ACIP) are covered by BCBSM.
- Medically necessary services needed 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

Services to treat the condition must be a benefit under your certificates.

We also pay for the following:

- Up to $10,000 for eligible travel and lodging during the initial transplant surgery, including:
  - Cost of transportation to and from the designated transplant facility for the member and another person eligible to accompany the member (two persons if the member is a child under the age of 18 or if the transplant involves a living-related donor)

In some cases, we may pay for return travel to the original transplant facility if you have an acute rejection episode. The episode 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 member ("lodging" refers to a hotel or motel)
  - Cost of acquiring the organ (the organ recipient must be a BCBSM member.) This includes, but is not limited to:
    - Surgery to obtain the organ
    - Storage of the organ
    - Transportation of the organ
    - Living donor transplants such as kidney, 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

We will pay the BCBSM-approved amount for the cost of acquiring the organ.

Transplant Services (continued)

Specified Human Organ Transplants (continued)

Limitations and Exclusions

We do not pay for the following for specified human organ transplants:

- Services that are not BCBSM benefits
- Services provided to a recipient who is not a BCBSM member
- Living donor transplants not listed in this certificate
- Anti-rejection drugs that do not have Food and Drug Administration approval
- Transplant surgery and related services performed in a nondesignated facility

You have to pay for the transplant surgery and related services if you receive them in a nondesignated facility. If the surgery is medically necessary *and* approved by the BCBSM medical director, we will pay for it.

- Transportation and lodging costs for circumstances other than those related to the initial transplant surgery and hospitalization
- Items that are not considered by BCBSM to be directly related to travel and lodging. Examples include, but are not limited to:

Alcoholic beverages	Flowers, toys, gifts, greeting cards, stationery, stamps, mail/UPS services	Internet connection, and entertainment (such as cable television, books, magazines and movie rentals)	Mortgage or rent payments	Tips
Car maintenance	Furniture rental	Kennel fees	Reimbursement of food stamps	
Clothing, toiletries	Household products	Lost wages	Security deposits, cash advances	
Dry cleaning or laundry services	Household utilities (including cellular telephones)	Maids, babysitters or day care services	Services provided by family members	

- Routine storage cost of donor organs for the future purpose of transplantation
- Services prior to your organ transplant surgery, such as expenses for evaluation and testing, unless covered elsewhere under this certificate
- Experimental transplant procedures. See Section 5 for guidelines related to experimental treatment.

Urgent Care Services

See Section 2 beginning on Page *12 for what you may be required to pay for these services.*

We pay for physician services provided at an urgent care facility.

Value Based Programs

See Section 2 beginning on Page 12 *for what you may need to pay for these services.*

See Section 7 for the definitions of Provider-Delivered Care Management (PDCM) and Total Care (TC).

Provider-Delivered Care Management (PDCM)
PDCM services are covered only when they are performed in Michigan by BCBSM designated providers. Under PDCM, a care manager will coordinate your care.

This section describes what we cover under PDCM.

Locations: We pay for professional services for PDCM in the following locations, subject to the conditions described below:

- An office
- A participating outpatient hospital
- A participating facility
- A member's home
- Other locations as designated by BCBSM

We pay for:

Care management services identified by BCBSM only when performed by BCBSM-designated providers in Michigan:

PDCM services may include:

- Telephone, individual face-to-face, and group interventions
- Medication assessments to identify:
  - The appropriateness of the drug for your condition
  - The correct dosage
  - When to take the drug
  - Drug Interactions
- Setting goals by your primary care physician (PCP), your care manager, and yourself to help you manage your health better

Covered services are subject to change.

Value Based Programs (continued)

Provider-Delivered Care Management (PDCM) (continued)

We pay for: (continued)

Most PDCM services include support for setting goals and ensuring member participation. We encourage in-person contact between you and your care managers.

Eligibility

You are eligible to receive PDCM services if you have:

- Active BCBSM coverage
- Agreed to actively participate with PDCM
- A referral for care management services from your physician

Your physician will determine your eligibility and refer you for care management services based on factors, such as your:

- Diagnosis
- Admission status
- Clinical status

Termination of Provider-Delivered Care Management

You may opt-out of PDCM at any time. BCBSM may also terminate PDCM services based on:

- Your nonparticipation in PDCM
- Termination or cancellation of your BCBSM coverage
- Other factors

We do not pay for:

- Services performed by providers who are not designated as PDCM providers
- Services performed by providers outside the state of Michigan

For more information on PDCM services, contact BCBSM Customer Service.

Value Based Programs (continued)

Total Care (TC)
TC services are covered only when they are performed by designated providers outside the state of Michigan and the member has an established relationship with the designated provider. Designated providers are identified by the local Blue Cross/Blue Shield plan in that the where the BDTC services are performed.

This section describes what we cover under TC.

Locations: We pay for professional services for TC in the following locations, subject to the conditions described below:

- An office
- A participating outpatient hospital
- A participating facility
- A member's home
- Other locations as designated by the local Blue Cross/Blue Shield plan in the state where the services are provided

We pay for:

- Services of out-of-state, providers who are designated by their local Blue Cross/Blue Shield plan to provide care management services

TC services may include:

- Telephone, individual face-to-face, and group interventions
- Medication assessments to identify:
  - The appropriateness of the drug for your condition
  - The correct dosage
  - When to take the drug
  - Drug Interactions
- Setting goals by your primary care physician (PCP), your care manager, and yourself to help you manage your health better

Covered services are subject to change.

Most TC services include support for setting goals and ensuring member participation. We encourage in-person contact between you and your care managers.

Value Based Programs (continued)

Total Care (TC) (continued)

Eligibility

You are eligible to receive TC services if you have:

- Active BCBSM coverage

Your physician will determine your eligibility and refer you for care management services based on factors, such as your:

- Diagnosis
- Admission status
- Clinical status

Termination of Total Care

You may opt-out of TC at any time. The local Blue Cross/Blue Shield plan may also terminate TC services based on:

- Your nonparticipation in TC
- Termination or cancellation of your BCBSM coverage
- Other factors

We do not pay for:

- Services performed by providers who are not designated by the local Blue Cross/Blue Shield plan as TC providers
- Services performed in Michigan

For more information on TC services, contact BCBSM Customer Service.

Section 4: How Providers Are Paid

This section explains how BCBSM pays its providers and the people or facilities that provide services or supplies related to your medical care. They include, but are not limited to, hospitals, facilities, physicians, licensed labs, and health care professionals. Facilities include providers such as outpatient physical therapy facilities, clinics, ambulatory surgical centers, residential and outpatient substance use disorder facilities. Health care professionals include providers that are not physicians, such as certified nurse midwives, physical therapists, audiologists, labs, home health care and home infusion care providers.

Our PPO payment policy is shown in the chart below.

PPO In-network Providers	In-network PPO providers have an agreement with BCBSM to provide services through the BCBSM PPO program. They have agreed to accept BCBSM's approved amount as payment in full for the covered services they provide. BCBSM sends payment directly to in-network providers.
Out-of-Network Providers	Out-of-network providers do not have an agreement with BCBSM to provide services through the BCBSM PPO program. If you get services from an out-of-network provider, BCBSM will treat those services as out-of-network. Not all services are covered out-of-network. 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 BCBSM. *Here's why:* • **Participating providers** — BCBSM sends payment of its approved amount directly to participating providers. They accept this payment amount as payment in full. • **Nonparticipating physicians and other health care professionals** — BCBSM may send payment directly to you, and you may need to pay the provider. (See Surprise Billing in the General Conditions of Your Contract section for more information). • **Nonparticipating hospitals** — BCBSM does not pay for services from nonparticipating hospitals unless it's to treat accidental injuries or medical emergencies. Otherwise, you will need to pay most of the hospital's charges yourself. • **Nonparticipating facilities** — BCBSM does not pay for services from nonparticipating facilities

BCBSM has agreements with different types of providers. Each type of provider has separate payment practices. In this section we describe payment practices for:

- PPO In-Network Providers
- Out-of-Network Providers
- BlueCard® PPO Program
- Negotiated (non-BlueCard Program) National Account Arrangements
- Blue Cross Blue Shield Global Core Program

PPO In-Network Providers (Hospitals, Facilities, Physicians and Health Care Professionals)

How They Are Paid

Step 1	Step 2	Step 3
Services	**Approved amount**	**Provider Payment**
You receive covered services from a PPO in-network provider.	The provider accepts BCBSM's approved amount minus your in-network cost share as payment in full for the covered services.	BCBSM sends payment (the approved amount minus your in-network cost share) directly to the in-network provider.

What We Pay and What You Pay

We pay:	You pay for:	You do not pay for:
• The approved amount minus what you must pay	• In-network deductibles, coinsurances and copayments • Services not covered by your contract • Services that we determine are not medically necessary or that are experimental You may be billed only if: – You acknowledge in writing before you receive the service that we will not cover it because it is not medically necessary or it is experimental, and you agree to pay for the service, and – The provider gives you an estimate of what the services will cost you. • Services when you do not give your provider the claim information in a timely manner. See General Conditions for timely filing.	• Services that are not covered because we determined that the provider did not have the required credentials or privileges to perform the services, or the provider did not comply with our policies when providing the services • An overpayment we make to the provider • The difference between what we pay and what the provider charges

Out-of-Network Participating Providers (Hospitals, Facilities, Physicians and Health Care Professionals Not in the PPO Network)

How They Are Paid

Step 1	Step 2	Step 3
Services	**Approved amount**	**Provider Payment**
You receive covered services from an out-of-network participating provider.	The provider accepts BCBSM's approved amount minus your out-of-network cost share as payment in full for the covered services.	BCBSM sends payment (the approved amount minus your out-of-network cost share) directly to the provider.

What We Pay and What You Pay

We pay:	You pay for:	You do not pay for:
• The approved amount minus what you must pay	• Out-of-network deductibles, coinsurances and copayments • Services not covered by your contract • Services that we determine are not medically necessary or that are experimental You may be billed only if: – You acknowledge in writing before you receive the service that we will not cover it because it is not medically necessary or it is experimental, and you agree to pay for the service, and – The provider gives you an estimate of what the service will cost you • Services when you do not give your provider the claim information in a timely manner. See General Conditions for timely filing.	• Services that are not covered because we determined that the provider did not have the required credentials or privileges to perform the services, or the provider did not comply with our policies when providing the services • An overpayment we make to the provider • The difference between what we pay and what the provider charges • Out-of-network cost-sharing requirements for the following services: – Exam and treatment for a *medical emergency or accidental injury* in the outpatient department of a hospital, urgent care center or physician's office – Treatment from a provider for which there is no PPO network. – Services from an out-of-net*work* provider in an area of Michigan that we consider a "low-access area" for the provider's specialty. You are responsible for your in-network cost share for these services.

Out-of-Network Participating Providers (Hospitals, Facilities, Physicians and Health Care Professionals Not in the PPO Network) (continued)

In limited instances, you may not have to pay your out-of-network deductible, coinsurance or copayment for:

- Select professional services performed by out-of-network providers in an in-network hospital, participating freestanding ambulatory surgery facility or any other location identified by BCBSM, or
- The reading and interpretation of select routine or screening services when an in-network provider performs the service, but an out-of-network provider does the analysis and interprets the results.

If one of the above applies and you do not have to pay the out-of-network cost share, you may still need to pay the in-network cost share.

If you need to know when you will not have to pay your out-of-network cost share, you may contact BCBSM (see Section 9).

Out-of-Network Nonparticipating Providers (Physicians and Health Care Professionals Not in the PPO Network)

If the out-of-network provider is nonparticipating, you may need to pay most of the charges yourself. Your bill could be substantial. After paying your provider, you may need to submit a claim to us.

How They Are Paid

Step 1	Step 2	Step 3
Services	**Approved Amount**	**Provider Payment**
You receive covered services from an out-of-network nonparticipating professional provider.	The provider does not agree to accept BCBSM's approved amount and your out-of-network cost share as payment in full for covered services.	BCBSM sends payment (the approved amount minus your out-of-network cost share) directly to you. You pay the provider.

What We Pay and What You Pay

We pay:	You pay for*:*	You do not pay for:
• The approved amount minus what you must pay	• Out-of-network deductibles, coinsurances and copayments, unless otherwise noted in Surprise Billing and • *The difference between what the provider charges and what we pay, unless otherwise noted in Surprise Billing (This amount is not applied toward your out-of-network cost-sharing requirements). • Services not covered by your contract • Services that we determine are not medically necessary or that are experimental	• Out-of-network cost-sharing requirements for the following services: – Covered services in emergency and certain non-emergency situations as specified by state and federal law (see Surprise Billing in the General Conditions of Your Contract section for more information) – Treatment from a provider for which there is no PPO network – Services from an out-of-network provider in an area of Michigan that we consider a "low-access area" for the provider's specialty *You are responsible for your in-network cost share for these services.

Out-of-Network Nonparticipating Providers (Physicians and Health Care Professionals Not in the PPO Network) (continued)

To receive payment for certain covered services provided by a nonparticipating provider, you may need to send us a claim. Call Customer Service (see Section 9) for information on filing claims.

Some nonparticipating professional providers may agree to provide specific services on a claim-by-claim basis. This means that they will accept our payment, after your deductibles and coinsurances have been met, as payment in full for a service they have provided. The provider may submit a claim to us and we will send the payment to the nonparticipating provider.

The out-of-network nonparticipating providers listed below do not participate with BCBSM on a per claim basis:

- Independent physical therapists
- Certified nurse practitioners
- Clinical nurse specialists-certified
- Independent occupational therapists
- Independent speech-language pathologists
- Audiologists
- Athletic trainers
- Genetic counselors

If you receive services that require preapproval from a provider who does not participate with us, and the provider does not get the preapproval before those services are received, you may have to pay the bill yourself. We will not pay for it. It is important to make sure that the nonparticipating provider gets that preapproval before you receive the services.

Providers who do not participate with us" and "nonparticipating provider" can include out-of-state providers; regardless of their participation with the plan where your services are being rendered.

Out-of-Network Nonparticipating Hospitals and Facilities Performing Non-Emergency Services

How They Are Paid

Step 1	Step 2	Step 3
Services	**Approved Amount**	**Provider Payment**
You receive covered services from a nonparticipating hospital or facility for treatment that is **not** for an urgent care, accidental injury or medical emergency.	BCBSM **does not** pay for this type of service.	BCBSM **does not pay** out-of-network nonparticipating hospitals or facilities for their services; you pay these providers their total charge.

Out-of-Network Nonparticipating Hospitals and Facilities Performing Emergency Services

How They Are Paid

Step 1	Step 2	Step 3
Services	**Approved Amount**	**Provider Payment**
You receive covered services from a nonparticipating hospital or facility for urgent care, treatment of an accidental injury or medical emergency.	*The provider accepts BCBSM's payment as payment in full	*BCBSM sends payment minus your in-network cost share to the provider.

What We Pay and What You Pay

We pay for:	You pay:	You do not pay for:
• The approved amount minus your in-network cost share for the treatment of an urgent care, emergency services or accidental injury.	• In-network deductible, coinsurances and copayments	• Out-of-network cost-sharing requirements for the following services: – *Covered services necessary to treat your condition as specified by state and federal law – The difference between what the provider charges and what we pay

*See Surprise Billing in the General Conditions of Your Contract section for more information.

Nonparticipating Hospitals and Facilities

BCBSM does not pay for nonemergency services at nonparticipating:

- Hospitals
- Residential substance abuse treatment facilities
- Outpatient physical therapy facilities
- Outpatient psychiatric care facilities
- Outpatient substance abuse treatment facilities
- Psychiatric residential treatment facilities
- Freestanding ambulatory surgery facilities
- Freestanding ESRD facilities
- Home health care agencies
- Hospice programs
- Long-term acute care hospitals
- Skilled nursing facilities, or
- Ambulatory infusion centers or home infusion providers

If you need to know if a provider participates, ask your provider, the provider's admitting staff, or call us. (See Section 9).

BlueCard® PPO Program

We participate in inter-plan programs with other Blue Cross and/or Blue Shield Plans. These programs operate under rules and procedures issued by the Blue Cross Blue Shield Association. This program offers medical benefits to Blue Cross and/or Blue Shield members when they are out of their local service area, such as out of state. The Blue Cross and/or Blue Shield Plan that pays for those covered services for you is your Host Plan. BCBSM will pay the Host Plan for the covered services it covered. However, the Host Plan is responsible for contracting with its participating providers and making sure they receive payment.

All types of claims can be processed through these inter-plan programs, except for the following:

- Dental care claims that are not paid as medical claims/benefits.
- Prescription drug benefits or vision care benefits that are administered by a third party contracted by BCBSM to provide those specific service or services.

BlueCard PPO Network Providers
If you receive covered services from a Host Plan PPO network provider:

- The provider will file your claim with the Host Plan
- The Host Plan will pay the provider according to its contract with the provider

The Plan will **not** reduce its payment to the amount specific to this certificate for services provided by an out-of-network provider.

Network status is not based on provider participation with BCBSM but with the plan where the services are rendered.

When you receive covered services outside our service area and the claim is processed through the BlueCard Program, your deductible, copayment and coinsurance and will be based on the lower of:

- The amount the provider charged for your services or
- The actual price. The actual price is a negotiated rate that the Host Plan has made available to us.

This “negotiated price” will be one of the following:

- A simple discount that reflects an actual price that the Host Plan pays to your provider.
- Average price. An average price is a percentage of billed charges for covered services.
- Estimated price. An estimated price that takes into account special arrangements with your provider or provider group that may include settlements, incentive payments, and/or other credits or charges.

BlueCard PPO Program (continued)

The Host Plan will apply the actual, average or estimated price method consistent with its specific provider contracts. The Host Plan can negotiate with the provider to determine the price for each service. However, under the terms of the BlueCard Program, the price the Host Plan uses will be the final price that you are responsible for. There will be no pricing adjustment once that price has been determined.

The average or estimated pricing also include adjustments we may need to make to estimates of past pricing for transaction changes noted above. These adjustments will not affect the price we pay for your claim because they are not applied to claims already paid.

Laws in other states may require the Host Plan to add a surcharge to your claim. If you receive services in a state that imposes such a fee, we will calculate what you need to pay according to the applicable laws of that state.

BCBSM may process claims for covered services through a negotiated account arrangement with one or more Host Plans as an alternative to BlueCard. In those instances, the negotiated terms will determine the payment amount. Your cost share will be calculated based on the negotiated price or the lower of either the billed amount or the negotiated price.

We have included a factor for bulk distributions from Host Plans in your premium for Value-Based Programs when applicable under this agreement.

If your coverage contains reference-based benefits, special rules apply. Reference-based benefits are those that have dollar limits for specific procedures. These limits are based on a Host Plan's local market rates. You will be responsible for paying the amount the provider bills above the specific reference benefit limit for a given procedure. For a participating provider, that amount will be the difference between the negotiated price and the reference benefit limit. For a nonparticipating provider, that amount will be the difference between the provider's billed charge and the reference benefit limit. Where a reference benefit limit exceeds either a negotiated price or a provider's billed charge, you will incur no additional liability, other than any applicable cost sharing required in your certificate or riders.

BlueCard PPO Out-of-Network Providers

If the provider is not a Host Plan PPO network provider and does not participate with the Host Plan, we may only pay our out-of-network provider amount, and you may be responsible for the difference, depending on applicable state and federal law.

BlueCard PPO providers may not be available in some areas. In areas where they are not available, you can still receive BlueCard PPO benefits if you receive services from a BlueCard participating provider. The Host Plan must notify BCBSM of the provider's status.

BlueCard PPO Program (continued)

Nonparticipating Providers Outside Our Service Area
An out-of-area provider that does not participate with the Host Plan may require you to pay for services at the time they are provided. If they do:

- Call your customer service representative at one of the numbers listed in Section 9: "How to Reach Us" for information on filing claims.
- Submit an itemized statement to us for the services.
- We will pay you the amount stated in this certificate for covered services provided by a nonparticipating provider. We do not pay for services of the nonparticipating facility providers listed within this certificate. We provide very limited coverage for the services of nonparticipating hospitals.

In certain situations, you are responsible for the out-of-network deductible, copayment and/or coinsurance payments that are covered in this certificate and/or riders.

To find out if an out of area provider is a BlueCard or BCBSM PPO provider please call 1-800-810-BLUE (2583).

You may also visit the BlueCard Doctor and Hospital Finder website at www.bcbs.com for a listing of participating providers.

Member Liability Calculation
When you receive covered services outside of our service area from nonparticipating providers, the amount you pay for these services will generally be based on either:

- What the Host Plan pays its nonparticipating providers or
- The price required by applicable state or federal law

In these cases, you may have to pay the difference between the amount the nonparticipating provider bills and the amount that BCBSM paid for the service.

Exceptions:
In some situations, we may use other payment methods to determine the amount we will pay for services rendered by nonparticipating providers.

These methods may include:

- Billed covered charges
- The payment we would make if the services were provided in our service area
- A special negotiated payment

In these cases, you may have to pay the difference between the amounts the nonparticipating provider bills and the amount we will pay for the covered services.

BlueCard PPO Program (continued)

Specialty Providers in the BlueCard Program

The Host Plan can pay for you to get medical care from providers who offer special services (e.g., allergist, chiropractor, podiatric physician) within the Host Plan's area, even if the provider offers a specialty that BCBSM does not cover. As long as the Host Plan contracts with the specialty provider, the services they provide to you will be paid.

BlueCard PPO Program Exceptions

The BlueCard PPO Program will not apply if:

- The services are not a benefit under this certificate
- This certificate excludes coverage for services performed outside of Michigan
- The provider specialty is not covered by BCBSM or the Host Plan
- The Blue Cross and/or Blue Shield plan does not participate in the BlueCard PPO Program
- You require the services of a provider whose specialty is not part of the BlueCard PPO Program or
- The services are performed by a vendor or provider who does not have a contract with BCBSM for those services.

Negotiated (non-BlueCard Program) Programs

As an alternative to the BlueCard Program, we may process your claims for covered services through an arrangement that we have negotiated with a Host Plan.

The amount you pay for covered services under this arrangement will be calculated based on the:

- Negotiated price or
- Lower of either the billed charges or the negotiated price that the Host Plan has made available to us

Blue Cross Blue Shield Global Core Program

If you are living or traveling outside of the United States, the Blue Cross Blue Shield Global Core Program will assist you in getting covered health care services. This program provides access to a worldwide network of inpatient, outpatient and professional providers and it also includes claims support services.

The Blue Cross Blue Shield Global Core Program is different from the BlueCard PPO Program in certain ways. For example, although the Blue Cross Blue Shield Global Core Program assists you with accessing a network of health care providers, the network does not have Host Plans.

A PPO network is not available outside the United States.

In this section, references to participating or nonparticipating providers mean they participate or do not participate in the Blue Cross Blue Shield Global Core Program.

Medical Assistance Services

If you need medical services while traveling or living outside of the United States, contact the service center at:

- 1-800-810-BLUE (2583) or
- Call 804-673-1177 collect, if you are calling from outside the United States

The center's staff will help you get the information about participating hospitals, physicians and medical assistance services. If you do not contact the service center, you may have to pay for all of the services that you receive.

Coverage for Blue Cross Blue Shield Global Core Participating Hospitals

Inpatient Hospital Services

If you need to be admitted to a hospital as an inpatient, call the service center to arrange for cashless access with a participating hospital. Cashless access means that you will only have to pay the in-network deductible(s) and copayment(s) for all covered services when you are admitted to the hospital. The hospital will file the claim with the service center for you.

You are responsible for:

- In-network deductible(s), copayment(s) and coinsurances
- The payment of noncovered services
- If you do not contact the service center to get cashless access and an approval from BCBSM, you may be responsible for paying all of the cost for all of the services that you receive.
- Submitting the international claim form(s), if you did not get cashless access
  - Forms are available from BCBSM, the service center or online at www.bcbsglobalcore.com.

It is your responsibility to contact BCBSM and get preapproval for the services you will receive.

Blue Cross Blue Shield Global Core Program (continued)

Coverage for Blue Cross Blue Shield Global Core Participating Hospitals (continued)

Outpatient Hospital Services
You are responsible for:

- Paying for all of the outpatient services at the time they are provided
- Submitting the international claim form(s)
  - Forms are available from BCBSM, the service center or online at www.bcbsglobalcore.com.
- Providing copies of the medical record, itemized bill, and proof of payment with the claim form. BCBSM will only pay for covered services.

Coverage for Blue Cross Blue Shield Global Core Nonparticipating Hospitals

Inpatient Hospital Services
If you need to be admitted to a nonparticipating hospital as an inpatient, call the service center to get a referral for cashless access. Cashless access means that you will only have to pay the out-of-network deductible(s) and copayment(s) for all covered services you receive when you are admitted to the hospital. The hospital will file the claim with the service center for you.

You are responsible for:

- Out-of-network deductible(s), copayment(s) and coinsurances
- The payment of noncovered services
- If you set up cashless access, you will be responsible for the out-of-network deductible(s) and copayment(s) and non-covered services.
- If you do not contact the service center to get cashless access and an approval from BCBSM, you may be responsible for paying all of the cost for all of the services that you receive.
- Submitting the international claim form(s), if you did not get cashless access
  - Forms are available from BCBSM, the service center or online at www.bcbsglobalcore.com.
- Providing copies of the medical record, itemized bill, and proof of payment with the claim form. BCBSM will only pay for covered services.

It is your responsibility to contact BCBSM and get preapproval for the services you will receive.

Blue Cross Blue Shield Global Core Program (continued)

Coverage for Blue Cross Blue Shield Global Core Nonparticipating Hospitals (continued)

Outpatient Hospital Services

You are responsible for:

- Paying for all outpatient services at the time they are provided
- Submitting the international claim form(s)
  - Forms are available from BCBSM, the service center or online at www.bcbsglobalcore.com.
- Providing copies of the medical record, itemized bill, and proof of payment with the claim form. BCBSM will only pay for covered services.

Emergency Services at Participating or Nonparticipating Hospitals

- In the case of an emergency, you should go to the nearest hospital. If you are admitted, follow the process for inpatient hospital services.
- If you are not admitted to the hospital, you must pay for all professional and outpatient services at the time they are provided.
- You are responsible for submitting the international claim form(s).
  - Forms are available from BCBSM, the service center or online at www.bcbsglobalcore.com.
- You must provide copies of your medical record, the itemized bill, and proof of payment along with the claim form. BCBSM will only pay for covered services.

Blue Cross Blue Shield Global Core Professional Services
You are responsible for payment of all professional services at the time they are provided.

- You are also responsible for submitting the international claim form(s).
  - Forms are available from BCBSM, the service center or online at www.bcbsglobalcore.com
- You must provide copies of your medical record, itemized bill, and proof of payment with the claim form. BCBSM will only pay for covered services.

Section 5: General Services We Do Not Pay For

The services listed in this section are in addition to all other **nonpayable** services stated in this certificate.

We do not pay for:

- Noncontractual services that are described in your case management treatment plan, if the services have not been approved by BCBSM.
- Services performed in Michigan from participating or nonparticipating providers who are not registered with BCBSM.
- Non-emergency and non-urgent care services for members traveling outside of the United States. Coverage for members traveling outside of the United States is limited to medical emergencies and urgent care services.
- Claims or coordinate benefits for services with incomplete member benefit coverage information.

It is your responsibility to provide complete and accurate information when requested by us to coordinate benefits. Failure to provide the requested information, including information about other coverage, may result in denial of claims. If claims are not covered due to your failure to update this information, you may be responsible for the full amount of your provider's charge.

- Treatment programs that have predetermined or fixed lengths of care
- Programs associated with disorders of consciousness for individuals in any of the following states of consciousness including, but not limited to, coma, cognitive motor disassociation, vegetative/unresponsive wakefulness or minimally conscious state using therapies such as arousal program therapy, sensory stimulation, coma-responsiveness, neuromodulation, and multi-sensory stimulation
- Self-injectable drugs unless approved by BCBSM
- Gender affirming services that are considered by BCBSM to be cosmetic, or treatment that is experimental or investigational.
- Elective abortion (also known as termination of pregnancy) - Services, devices, drugs or other substances for which federal funding is not available, no matter the location.
- Radial keratotomy surgery
- Private duty nursing services
- Court ordered services
- Routine eye exams or hearing tests (unless they are related to illness, injury, or pregnancy)
- Reversal of voluntary sterilization of male reproductive organs

We do not pay for (continued)

- Hospital admissions for services that are not acute. Non-acute services include but are not limited to:

  - Basal metabolism tests
  - Cobalt or ultrasound studies
  - Convalescence or rest care
  - Convenience items
  - Dental treatment, including extraction of teeth, except as otherwise noted in this certificate
  - Diagnostic evaluations
  - Electrocardiography
  - Lab exams
  - Observation
  - Weight reduction
  - X-ray, exams or therapy
  - Those mainly for physical therapy, speech language therapy services or occupational therapy

  

  Your plan does not allow hospital admissions solely to receive a service listed above. However, the service itself may be a covered benefit. Please review your certificate/riders for covered services and appropriate locations.

- Hospital services that we do not pay for:

  - Services that may be medically necessary but can be provided safely in an outpatient or office location
  - Custodial care or rest therapy
  - Psychological tests if used as part of, or in connection with, vocational guidance training or counseling
  - Outpatient inhalation therapy
  - Sports medicine, member education or home exercise programs

- Facility services that we do not pay for:

  - Facility services you receive in a convalescent and long-term illness care facility, nursing home, rest home or similar nonhospital institution

  

  If a nursing home is your primary residence, then we will treat that location as your home. Under those circumstances, services that are payable in your home will also be covered when provided in a nursing home when performed by health care providers other than the nursing home staff.

We do not pay for (continued)

- Professional provider services that we do not pay for:
  - Services, care, supplies or devices not prescribed by a physician
  - Self-treatment by a professional provider and services given by the provider to parents, siblings, spouse or children
  - Services for cosmetic surgery when performed primarily to improve appearance, except for those conditions listed on Page 108.
  - Weight loss programs (unless covered elsewhere in this certificate or otherwise required by law)
  - Services provided during nonemergency medical transport
  - Experimental treatment
  - Hearing aids or services to examine, prepare, fit or obtain hearing aids
  - Prescription drug compounding kits or services provided to you related to the kits
  - Services provided by persons who are not eligible for payment or not appropriately credentialed or privileged. Providers who are not legally authorized or licensed to order or provide such services.

If a participating BCBSM PPO in-network provider has not been credentialed or privileged by BCBSM to perform a service, they will be financially responsible for the entire cost of the service. They cannot bill you for their services. They also cannot bill you for any deductibles, copayments, or coinsurance amounts.

If you decide to get medical services from a nonparticipating out-of-network provider, who is not credentialed or privileged to perform those services, you will have to pay for the entire cost of the service.

  - Services to examine, prepare, fit or obtain eyeglasses or other corrective eye appliances, unless you lack a natural lens
  - Services for eye surgeries such as, but not limited to, LASIK, PRK, or RK performed to correct visual acuity
  - Alternative medicines or therapies (such as acupuncture, herbal medicines and massage therapy)
  - Sports medicine, member education (except as otherwise specified) or home exercise programs
  - Screening services (except as otherwise stated)
  - Rest therapy or services provided to you while you are in a convalescent home, long-term care facility, nursing home, rest home or similar nonhospital institution

If a nursing home is your primary residence, then we will treat that location as your home. Under those circumstances, services that are payable in your home will also be covered when provided in a nursing home when performed by health care providers other than the nursing home staff.

  - Non-contractual services described in your case management treatment plan when such services have not been approved by BCBSM.

Section 6: General Conditions of Your Contract

This section explains the conditions that apply to your certificate. They may make a difference in how, where and when benefits are available to you.

Assignment

Benefits covered under this certificate are for your use only. They cannot be transferred or assigned. Any attempt to assign them will automatically terminate all your rights under this certificate. You cannot assign your right to any payment from us, or for any claim or cause of action against us, to any person, provider, or other insurance company.

We will not pay a provider except under the terms of this certificate.

Changes in Your Address

Your employer or group must notify us of any changes in your address. An enrollment/change of status form should be completed when you change your address.

Changes in Your Family

Your employer or group must notify us of any changes in your family. Changes include marriage, divorce, birth, death, adoption, gaining a dependent due to court order, child support order, or foster care placement or the start or end of military service.

You must complete an enrollment/change of status form and give it to your employer or group. We must receive notice from your employer or group within 30 days of when a dependent or spouse is removed from your coverage and within 31 days of when a dependent or spouse is added. Any coverage changes take effect on the date of the event.

Changes to Your Certificate

BCBSM employees, agents or representatives cannot agree to change or add to the benefits described in this certificate.

- Any changes must be approved by BCBSM and the Michigan Department of Insurance and Financial Services.
- We may add, limit, delete or clarify benefits in a rider that amends this certificate. If you have riders, keep them with this certificate.

Coordination of Benefits

We coordinate benefits payable under this certificate per Michigan's Coordination of Benefits Act.

It is your responsibility to provide complete and accurate information when requested by us to coordinate benefits. Failure to provide the requested information, including information about other coverage, may result in denial of claims. If claims are not covered due to your failure to update this information, you may be responsible for the full amount of your provider's charge.

Coordination of Benefits (continued)

Provisions per Michigan's Coordination of Benefits Act (MCL 550.253)

Guidelines to Determine Primary Coverage If You Are Covered by Two or More Plans

(1) If an individual is covered by 2 or more plans, the rules for determining the order of benefit payments are as follows:

(a) The insurer that issues the primary plan shall pay or provide benefits as if a secondary plan does not exist.
(b) If the individual is covered by more than 1 secondary plan, the order of benefit determination rules under this act determine the order under which secondary plan benefits are determined in relation to each other. An insurer that issues a secondary plan shall take into consideration the benefits of the primary plan and the benefits of any other plan that are, under this act, determined to be payable before those of the secondary plan.
(c) Subject to subdivision (d), a plan that does not contain order of benefit determination provisions that are consistent with this act is always the primary plan unless the provisions of both plans, regardless of this subdivision, state that the complying plan is primary.
(d) If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the insurer that issues the secondary plan shall pay or provide benefits as if it were the primary plan if a covered person uses a nonpanel provider, except for emergency services or authorized referrals that are paid or provided by the insurer that issued the primary plan.

Order of Benefit Payments

(2) The order in which benefits are payable by insurers that issue plans are determined by using the first of the following rules that applies:

(a) The nondependent/dependent rule. If the individual is not a dependent but is an employee, member, subscriber, policyholder, or retiree under 1 plan and is a dependent under another plan, the order of payment of benefits under the plans is determined as follows:

(i) Except as otherwise provided in subparagraph (ii), the plan that covers the individual other than as a dependent is the primary plan and the plan that covers the individual as a dependent is the secondary plan.
(ii) If the individual is a Medicare beneficiary and, as a result of the provisions of title XVIII of the social security act, 42 USC 1395 to 1395lll, Medicare is secondary to the plan covering the individual as a dependent and primary to the plan covering the individual as other than a dependent, then the order of benefits is reversed and the plan covering the individual as other than a dependent is the secondary plan and the plan covering the individual as a dependent is the primary plan.

(b) The dependent covered under more than 1 plan rule. If the individual is a dependent child, unless there is a court order or judgment stating otherwise, the order of payment of benefits under the plans covering the dependent child is determined as follows:

(i) If the child's parents are married or are living together, whether or not they have ever been married, as follows:

(A) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan.
(B) If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.

Coordination of Benefits (continued)

(ii) If the child's parents are divorced, separated, or not living together, whether or not they have ever been married, as follows:

(A) If a court order or judgment states that 1 of the parents is responsible for the dependent child's health care expenses or health care coverage and the insurer that issued the plan of the parent with responsibility has actual knowledge of the terms of the order or judgment, that plan is the primary plan. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This sub-subparagraph does not apply with respect to a plan year during which benefits are paid or provided before the insurer has actual knowledge of the terms of the court order or judgment.

(B) If a court order or judgment states that both parents are responsible for the dependent child's health care expenses or health care coverage, the order of benefits is determined in the manner prescribed in subparagraph (i).

(C) If a court order or judgment states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the order of benefits is determined in the manner prescribed in subparagraph (i).

(D) If there is no court order or judgment allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows, in the following order of priority:

(i) The plan covering the custodial parent.
(ii) The plan covering the custodial parent's spouse.
(iii) The plan covering the noncustodial parent.
(iv) The plan covering the noncustodial parent's spouse.

(iii) If the child is covered under more than 1 plan of individuals who are not the parents of the child, the order of benefits is determined in the manner prescribed in subparagraph (i) or (ii), as applicable, as if those individuals were parents of the child.

(iv) If the child is covered under either or both parents' plans and is also covered as a dependent under his or her spouse's plan, the order of benefits is determined in the manner prescribed in subdivision (e). If the dependent child's coverage under his or her spouse's plan began on the same date as his or her coverage under either or both parents' plans, the order of benefits is determined by applying the birthday rule prescribed in subparagraph (i) to the dependent child's parents, as applicable, and his or her spouse.

Coordination of Benefits (continued)

(c) The active, retired, or laid-off employee rule. If the individual is an active employee, laid-off employee, or retired employee, or is a dependent of an active employee, laid-off employee, or retired employee, the order of payment of benefits under the plans covering the individual is determined as follows:

(i) The plan that covers the individual as an active employee or as a dependent of an active employee is the primary plan. The plan that covers the individual as a laid-off employee or retired employee or as a dependent of a laid-off employee or retired employee is the secondary plan.
(ii) Subparagraph (i) does not apply if the other plan that covers the individual does not have the rule described in subparagraph (i) and, as a result, the plans do not agree on the order of benefits.
(iii) This rule does not apply if the plan that covers the member, subscriber, enrollee, or retiree or the individual as a dependent of an employee, member, subscriber, enrollee, or retiree is the primary plan.

(d) The continuation coverage rule. If the individual has coverage under a right of continuation pursuant to federal or state law, the order of payment of benefits under the plans covering the individual is determined as follows:

(i) The plan that covers the individual as an employee, member, subscriber, enrollee, or retiree or as a dependent of an employee, member, subscriber, enrollee, or retiree is the primary plan. The plan that covers the individual under the continuation coverage is the secondary plan.
(ii) Subparagraph (i) does not apply if the other plan that covers the individual does not have the rule described in subparagraph (i) and, as a result, the plans do not agree on the order of benefits.
(iii) This rule does not apply if the order of benefits can be determined by the rule in subdivision (a).

(e) The longer or shorter length of coverage rule. If the rules in subdivisions (a) to (d) do not determine the order of benefits, the plan that has covered the individual for the longer period of time is the primary plan and the plan that has covered the individual for the shorter period of time is the secondary plan. To determine the length of time an individual has been covered under a plan, 2 successive plans are treated as 1 if the covered individual was eligible under the second plan within 24 hours after coverage under the first plan ended. Any of the following changes do not constitute the start of a new plan:

(i) A change in the amount or scope of a plan's benefits.
(ii) A change in the entity that pays, provides, or administers the plan's benefits.
(iii) A change from 1 type of plan to another, such as from a single-employer plan to a multiple-employer plan.

Coordination of Benefits (continued)

Length of Time Covered under a Plan

(3) A person's length of time covered under a plan is measured from the person's first date of coverage under the plan. If that date is not readily available for a group plan, the date the person first became a member of the group must be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

Plan Inability to Agree on Order of Benefits

(4) If the insurers that issued plans cannot agree on the order of benefits within 30 calendar days after the insurers have received all of the information needed to pay the claim, the insurers shall immediately pay the claim in equal shares and determine their relative liabilities following payment. An insurer is not required to pay more than it would have paid had the plan it issued been the primary plan.

Amount to be Paid by the Secondary Plan

(5) Except as provided in subsection (6), in determining the amount to be paid on a claim by the insurer that issued a secondary plan, if the insurer wishes to coordinate benefits, the insurer shall calculate the benefits it would have paid on the claim in the absence of other health care coverage and apply the calculated amount to any allowable expense under its plan that is unpaid under the primary plan. The insurer that issued a secondary plan may reduce its payment by the calculated amount so that, when combined with the amount paid under the primary plan, the total benefits paid or provided under all plans for the claim do not exceed 100% of the total allowable expense for the claim.

Amount to be Paid by the Secondary Plan

(6) In determining the amount to be paid on a dental plan claim by the insurer that issued a secondary plan, if the insurer wishes to coordinate benefits, it may do so in accordance with subsection (5) or, for not more than 2 years after the effective date of the amendatory act that added this subsection, it may do so under a nonduplication of benefits method. Under a nonduplication of benefits method, the primary plan payment is subtracted from the secondary plan's allowable benefit amount. If there is a positive balance, the insurer that issued the secondary plan shall make a payment equal to the difference. If there is a negative or zero balance, the insurer that issued the secondary plan shall make no payment. If an insurer that issues a plan is advised by a covered person that all plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account established in accordance with section 223 of the internal revenue code of 1986, 26 USC 223, the primary high-deductible health plan's deductible is not an allowable expense, except for any health care expense incurred that may not be subject to the deductible as described in section 223(c)(2)(C) of the internal revenue code of 1986, 26 USC 223.

Payment of Claims or Coordination of Benefits not Provided or Authorized by Health Maintenance Organization

(7) A health maintenance organization is not required to pay claims or coordinate benefits for services that are not provided or authorized by the health maintenance organization and that are not benefits under the health maintenance contract.

Coordination of Coverage for End Stage Renal Disease (ESRD)

If you have ESRD, you may be eligible to receive Medicare benefits prior to age 65. However, you need to have worked long enough to qualify for social security benefits. If you are eligible for Medicare because you have ESRD, we coordinate with Medicare to pay for your ESRD treatment.
It is important for you to apply for Medicare coverage if you have ESRD and you satisfy Medicare eligibility requirements; otherwise, you will be responsible for paying the cost of your ESRD treatment. (See Section 6 for "Services That are Not Payable".) You can apply for Medicare through the Social Security Administration. To read more about signing up for Medicare, visit: End-Stage Renal Disease (ESRD) | Medicare.

When Medicare Coverage Begins

The Medicare waiting period affects when your Medicare coverage begins. The **Medicare waiting period** is three months after you begin dialysis. Your Medicare coverage will start on the first day of the fourth month of your dialysis treatment.

Dialysis begins February 12. Medicare coverage begins May 1.

Medicare Waiting Period Exceptions

All or part of the Medicare waiting period is waived if one of the following occurs:

- If you participate in self-dialysis training during the first three months of your regular course of dialysis, and your doctor expects you to be able to do your own dialysis treatments upon the completion of training, then Medicare coverage may begin the first day of the month you begin a regular course of dialysis; or

- If you are admitted to the hospital for a kidney transplant or services related to the kidney transplant, then Medicare coverage begins the first day of the month you are admitted. However, you must receive your transplant within the following two months of being admitted to the hospital and the hospital must be approved by Medicare.

If your transplant is delayed more than two months after you are admitted to the hospital, then Medicare coverage begins two months before the month of your transplant.

When BCBSM Coverage is the Primary or Secondary Plan

This is an overview of how BCBSM coverage works as a primary or secondary plan for members with ESRD and BCBSM group coverage. To read more about how Medicare works with other health coverage visit: https://www.medicare.gov/supplements-other-insurance/how-medicare-works-with-other-insurance.

If you are enrolled in Medicare because you have ESRD, BCBSM coverage will pay primary during the Medicare coordination period. The **coordination period** is the period of time defined by Medicare, that begins in the first month of ESRD Medicare entitlement (see Section 7 for the definition). and may last up to 30 months. Once the coordination period is over, Medicare will be the primary payor.

Coordination of Coverage for End Stage Renal Disease (continued)

When ESRD Medicare Coverage Ends

- A member is no longer eligible for Medicare due to ESRD if they have a successful transplant or regain kidney function.
- Medicare coverage due to ESRD will end 36 months after a successful kidney transplant or 12 months after the month dialysis treatment ends.
- BCBSM becomes primary when Medicare coverage due to ESRD ends.
- If the member is also eligible for Medicare due to age or disability, Medicare Secondary Payer (MSP) rules must be considered to determine which coverage is primary.

Coverage for Drugs and Devices

We do not pay for a drug or device prescribed for uses or in dosages other than those approved by the Food and Drug Administration. (This is called the off-label use of a drug or device.) However, we will pay for them and the reasonable cost of supplies needed to administer them, if the prescriber proves that the drug or device is recognized for treatment of the condition it is prescribed for by:

- The American Hospital Formulary Service Drug Information
- The United States Pharmacopoeia Dispensing Information, Volume 1, “Drug Information for the Health Care Professional”
- Two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.

Chemotherapeutic drugs are not subject to this general condition.

If a prescription is for a contraceptive drug or device, the prescriber must show why all other contraceptives covered under the member’s benefits cannot be used by the member.

Deductibles, Copayments and Coinsurances Paid Under Other Certificates

We do not pay any cost sharing you must pay under any other certificate. An exception is when we must pay them under coordination of benefits requirements.

Enforceability of Various Provisions

Failure of BCBSM to enforce any of the provisions contained in this contract will not be considered a waiver of those provisions.

Entire Contract; Changes

This certificate, including your riders, if any, is the entire contract of your coverage. No change to this certificate is valid until approved by a BCBSM executive officer. No agent has authority to change this certificate or to waive any of its provisions.

Experimental Treatment

Services That Are Not Payable

We do not pay for:

- Experimental treatment. This includes experimental drugs and devices
- Services and administrative costs related to experimental treatment
- Costs of research management.

See Section 3 for "Clinical Trials (Routine Patient Costs)", "Oncology Clinical Trials" and "Services That Are Payable" below for exceptions.

This certificate does not limit coverage for antineoplastic or off-label drugs when Michigan law requires that they, and the reasonable cost of their administration, be covered.

How BCBSM Determines If a Treatment Is Experimental

If a treatment is not covered under this certificate, BCBSM's medical director will determine if it is experimental. The director may decide it is experimental if:

- Medical literature or clinical experience cannot say whether it is safe or effective for treatment of any condition, or
- It is shown to be safe and effective treatment for some conditions. However, there is inadequate medical literature or clinical experience to support its use in treating the member's condition, or
- Medical literature or clinical experience shows the treatment to be unsafe or ineffective for treatment of any condition, or
- There is a written experimental or investigational plan by the attending provider or another provider studying the same treatment, or
- It is being studied in an on-going clinical trial, or
- The treating provider uses a written informed consent that refers to the treatment as:
  - Experimental or investigational, or
  - Other than conventional or standard treatment.

The medical director may consider other factors.

Experimental Treatment (continued)

How BCBSM Determines If a Drug Is Experimental

BCBSM's Pharmacy and Therapeutics (P&T) Committee determines whether a drug is experimental. The committee may decide a drug is experimental if there is insufficient evidence of a clinical benefit for the indication(s) in question. A drug may be deemed experimental if any of the following apply:

- The drug does not have unrestricted market approval from the FDA for the requested use
- There is insufficient medical and scientific evidence to evaluate the therapeutic value of the drug for the requested use
- There is inconclusive medical and scientific evidence in peer-reviewed medical literature that the drug has a beneficial effect on health outcomes; for example, when a drug does not meet its primary endpoint in a pivotal or confirmatory trial
- The drug is not as beneficial as established alternatives or there is insufficient information or inconclusive scientific evidence that, when used in a non-investigational setting, the drug is as beneficial as established alternatives.

When available, these sources are considered in deciding if a treatment or drug is experimental under the above criteria:

- Scientific data (e.g., controlled studies in peer-reviewed journals or medical literature)
- Information from the Blue Cross and Blue Shield Association or other local or national bodies
- Information from independent, nongovernmental, technology assessment and medical review organizations
- Information from local and national medical societies, other appropriate societies, organizations, committees or governmental bodies
- Approval, when applicable, by the FDA, the Office of Health Technology Assessment (OHTA) and other government agencies
- Accepted national standards of practice in the medical profession
- Approval by the hospital's or medical center's Institutional Review Board

The medical director may consider other sources.

Experimental Treatment (continued)

Services That Are Payable

We do pay for experimental treatment and its related services, including drugs, when **all** of the following are met:

- BCBSM considers the experimental treatment to be conventional treatment when used to treat another condition (i.e., a condition other than what you are currently being treated for).
- The services related to the experimental treatment are covered under your certificate when they are related to conventional treatment.
- The experimental treatment and related services are provided during a BCBSM-approved oncology clinical trial (check with your provider to determine whether a clinical trial is approved by BCBSM), or the related services are routine patient costs that are covered under "Clinical Trials (Routine Patient Costs)" in Section 3.

This certificate does not limit coverage for antineoplastic or off-label drugs when Michigan law requires that they, and the reasonable cost of their administration, be covered.

Limitations and Exclusions

- This general condition does not add coverage for services not otherwise covered under your certificate.
- Drugs or devices given to you during a BCBSM-approved oncology clinical trial will be covered only if they have been approved by the FDA. The approval does not need to be for treatment of the member's condition. However, we will not pay for them if they are normally provided or paid for by the sponsor of the trial or the manufacturer, distributor or provider of the drug or device.

Fraud, Waste and Abuse

We do not pay for the following:

- Services that are not medically necessary; may cause significant member harm; or are not appropriate for the member's documented medical condition;
- Services that are performed by a provider who is sanctioned at the time the service is performed.

Sanctioned providers have been sanctioned by BCBSM, the Office of the Inspector General, the Government Services Agency, the Centers for Medicare and Medicaid Services, or state licensing boards.

BCBSM will notify you if any provider you have received services from during the previous 12 months has been sanctioned. You will have 30 days from the date you are notified to submit claims for services you received prior to the provider being sanctioned. After that 30 days has passed, we will not process claims from that provider.

Genetic Testing
We will not:

- Adjust premiums for this coverage on genetic information related to you, your spouse or your dependents
- Require genetic testing of anyone covered under this certificate
- Collect genetic information from anyone covered under this certificate at any time for underwriting purposes
- Limit coverage based on genetic information related to you, your spouse or your dependents

Grace Period
A grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period the coverage shall continue in force.

Guaranteed Renewability
Coverage under this certificate is guaranteed renewable.

Improper Use of Contract
If you let an ineligible person receive benefits (or try to receive benefits) under this certificate, we may:

- Refuse to pay benefits
- Cancel your coverage
- Begin legal action against you
- Refuse to cover your health care services at a later date

Individual Coverage
If you choose not to enroll in COBRA, or if your COBRA coverage period ends, coverage may be available through a BCBSM individual plan. Contact BCBSM Customer Service for information about what plan best meets your needs.

Notification
When we need to notify you, we mail it to your employer or your remitting agent. This fulfills our obligation to notify you.

Payment of Covered Services
The services covered under this certificate may be combined and paid according to BCBSM's payment policies. Examples include multiple surgeries or a series of lab tests.

Personal Costs

We will not pay for:

- Transportation and travel, even if recommended by a licensed practitioner, except as provided in this certificate
- Care, services, supplies or devices that are personal or convenience items
- Charges to complete claim forms
- Domestic help

Pharmacy Fraud, Waste and Abuse

We do not pay for the following:

- Prescription drugs that are not medically necessary; may cause significant member harm; or are not appropriate for the member's documented medical condition;
- Drugs prescribed by a prescriber who is sanctioned at the time the prescription is dispensed.

Sanctioned prescribers have been sanctioned by BCBSM, the Office of the Inspector General, the Government Services Agency, the Centers for Medicare and Medicaid Services, or state licensing boards.

BCBSM will notify you if any prescriber you have received services from during the previous 12 months has been sanctioned. You will be given 30 days' notice, after which we will not pay for drugs prescribed by the sanctioned prescriber.

Physician of Choice

You may continue to get services from the physician you choose. However, be sure to get services from an in-network physician to avoid out-of-network costs.

Preapproval

Some admissions and services must be approved before they occur. If they are not preapproved, you **may** have to pay their entire cost. It is important to make sure that your provider gets approval before you receive services or are admitted to a hospital or facility that require preapproval. Preapproval can also sometimes be referred to as prior authorization.

If preapproval is not obtained:

- In-state participating providers cannot bill you for the cost of the services.
- Out-of-state or nonparticipating providers may require you to pay for the cost of the services.

In addition to preapproval requirements identified within this certificate, there may be other services or admissions that require preapproval. They are subject to change. For information on preapproval, contact your BCBSM Customer Service representative (see Section 9).

Prior Authorization

Some admissions and services require prior authorization before you receive them. If you receive those services without first obtaining prior authorization, you may have to pay the bill yourself. We may not pay for it. It is important to make sure that your provider gets the prior authorization before you receive these services.

Release of Information

You agree to let providers release information to us. This can include medical records and claims information related to services you may receive or have received.

We agree to keep this information confidential. Consistent with our Notice of Privacy Practices, this information will be used and disclosed only as authorized by law.

Reliance on Verbal Communications

If we tell you a member is eligible for coverage, or benefits are available, this does not guarantee that claims will be paid. Claims are paid only after:

- The reported diagnosis is reviewed
- Medical necessity is verified
- Benefits are available when the claim is processed

Right to Interpret Contract

During claims processing and internal grievances, BCBSM reserves the right to interpret and administer the terms of this certificate and any riders that amend it. BCBSM's final adverse decisions regarding claims processing and grievances may be appealed under applicable law.

Semiprivate Room Availability

If a semiprivate room is not available when you are admitted to a participating hospital, you may be placed in a room with more than two beds. When a semiprivate room is available, you will be placed in it. You may select a private room; however, you must pay for any additional cost. BCBSM will not pay the difference between the cost of hospital rooms covered by your certificate and more expensive rooms.

Services Before Coverage Begins or After Coverage Ends

Unless this certificate states otherwise, we do not pay for any services, treatment, care or supplies provided before your coverage under this certificate begins or after it ends. If your coverage begins or ends while you are an inpatient in an acute care hospital, our payment will be based on our contract with the hospital. It may cover:

- The services, treatment, care or supplies you receive during the entire admission, **or**
- Only the services, treatment, care or supplies you receive while your coverage is in effect.

We pay for only the services, treatment, care or supplies you receive while your coverage is in effect if it begins or ends while you are:

- An inpatient in a facility such as a hospice, long-term acute care facility, rehabilitation hospital, psychiatric hospital, skilled nursing facility or other facility identified by BCBSM, **or**
- Being treated for an episode of illness by a home health agency, ESRD facility or outpatient hospital rehabilitation unit or other facility identified by BCBSM.

If you have other coverage when a facility admits or discharges you, it may have to pay for the care you receive before your BCBSM coverage begins or after it ends.

Services That Are Not Payable

We do not pay for services that:

- You legally do not have to pay for or for which you would not have been charged if you did not have coverage under this certificate
- Are available in a hospital maintained by the state or federal government, unless payment is required by law
- Can be paid by government-sponsored health care programs, such as Medicare, for which a member is eligible. We do not pay for these services even if you have not signed up to receive the benefits from these programs. However, services are payable if federal laws require the government-sponsored program to be secondary to this coverage.
- Are more costly than an alternate service or sequence of services that are at least as likely to produce equivalent results
- Are not listed in this certificate as being payable

Special Programs

BCBSM has special programs where you may receive enhanced benefits, wellness program incentives or financial assistance in meeting the cost-share requirements of your coverage based on your eligibility, participation and adherence with select medical services/prescription drugs and/or taking part in a case management program. These programs may be provided by a BCBSM approved vendor or directly through us.

When special programs are available, you must enroll in and use the program when required by BCBSM or the approved vendor. For example, you may be required to enroll in and use programs provided by drug manufacturers or affiliates to receive coupons or assistance for select medications.

Special programs may lower the cost typically associated with medical services and medications. Participation in certain special programs may result in you paying less than your standard cost share. If you choose not to participate or are not eligible to participate in the program, you will pay the applicable cost share for the service as defined in the certificate and associated riders.

Only the amount you pay out of pocket will apply towards your annual out-of-pocket maximum.

We may terminate any special program based on:

- Your nonparticipation in the program
- Termination or cancellation of your BCBSM coverage
- Termination of the program
- Other factors

You may access information on these programs by contacting BCBSM Customer Service.

Subrogation: When Others Are Responsible for Illness or Injury

If BCBSM paid claims for an illness or injury, and:

- Another person caused the illness or injury, or
- You are entitled to receive money for the illness or injury, then BCBSM is entitled to recover the amount of benefits it paid on your behalf.

Then BCBSM is entitled to recover the amount of benefits it paid on your behalf.

Subrogation is BCBSM's right of recovery. BCBSM is entitled to its right of recovery even if you are not "made whole" for all of your damages in the money you receive. BCBSM's right of recovery is not subject to reduction of attorney's fees, costs, or other state law doctrines such as common fund.

Subrogation: When Others Are Responsible for Illness or Injury (continued)

Whether you are represented by an attorney or not, this provision applies to:

- You
- Your covered dependents

You agree to:

- Cooperate and do what is reasonably necessary to assist BCBSM in the pursuit of its right of recovery.
- Not take action that may prejudice BCBSM's right of recovery.
- Permit BCBSM to initiate recovery on your behalf if you do not seek recovery for illness or injury.
- Contact BCBSM promptly if you seek damages, file a lawsuit, file an insurance claim or demand, or initiate any other type of collection for your illness or injury.

BCBSM may:

- Seek first priority lien on proceeds of your claim in order to fulfill BCBSM's right of recovery.
- Request you to sign a reimbursement agreement.
- Delay processing of your claims until you provide a signed copy of the reimbursement agreement.
- Offset future benefits to enforce BCBSM's right of recovery.

BCBSM will:

- Pay the costs of any covered services you receive that are in excess of any recoveries made.

  Examples where BCBSM may utilize the subrogation rule listed below:

  BCBSM can recover money it paid on your behalf if another person or insurance company is responsible:

  - When a third party injures you, for example, through medical malpractice;
  - When you are injured on premises owned by a third party; or
  - When you are injured and benefits are available to you or your dependent, under any law or under any type of insurance, including, but not limited to medical reimbursement coverage.

Subscriber Liability

At the discretion of your provider, certain technical enhancements may be employed to complement a medical procedure. These enhancements may involve additional costs above and beyond the approved maximum payment level for the basic procedure. The costs of these enhancements are not covered by this certificate. Your provider must inform you of these costs. You then have the option of choosing any enhancements and assuming the liability for these additional charges.

Surprise Billing

Federal and Michigan state law require us to pay nonparticipating providers certain rates for covered services and prohibit those providers from billing you the difference between what we pay and what the provider charges. When the surprise billing laws apply, we will pay the provider directly, and you will only pay the cost share applicable to that service as defined in federal or Michigan law. The cost share you pay for these services will apply to your in-network deductible and in-network out-of-pocket maximum. The following situations are covered by the surprise billing laws:

- Covered emergency services at a participating or a nonparticipating facility
  - Emergency services are covered regardless of whether the facility is participating or nonparticipating.
  - If you receive emergency services rendered by a nonparticipating facility or provider, administrative requirements will be the same, regardless of the facility's participating status.
- Covered non-emergency services provided by nonparticipating providers in the following participating facilities: hospitals, critical access hospitals, hospital outpatient departments, and ambulatory surgical centers.
  - You can waive surprise billing protections if you sign a notice and consent form.
  - Certain "ancillary" providers are not allowed to ask you to waive your surprise billing protections. These include anesthesiologists, pathologists, emergency medicine providers, radiologists, neonatologists, hospitalists, and surgical assistants.
- Covered air ambulance services

Termination of Coverage

You must provide the required notification if you want to terminate your coverage under this certificate.

Send your written request to terminate coverage to your employer. Your employer must notify BCBSM within 30 days of the requested termination date. Your coverage will then be terminated on the requested date and all benefits under this certificate will end.

Time Limit for Filing Pay-Provider Medical Claims

These claims are professional and facility claims for medical services. They do not include claims for prescription drugs received from pharmacies or for dental or vision services that are not covered under this certificate.

For participating provider claims:

- We will not pay medical claims filed after the timeframe set out in your treating provider's participation agreement with BCBSM.
  - 180 days (for professional claims)
  - 12 months (for hospital and facility claims)
  - 15 months (for home infusion therapy claims)
  - Or after the service because you did not furnish the provider with information needed to file a claim

For nonparticipating provider claims:

- For nonparticipating providers, the claims must be submitted within 24 months from the date of service.

Time Limit for Filing Pay-Subscriber Medical Claims

These claims are professional and facility claims for medical services. They do not include claims for prescription drugs received from pharmacies or for dental or vision services that are not covered under this certificate.

The time limit for filing claims is 24 months from the date of service. We will not pay claims filed after that date.

Time Limit for Legal Action

You may not begin legal action against us later than three years after the date of service of your claim. If you are bringing legal action about more than one claim, this time limit runs independently for each claim.

You must first exhaust the grievance and appeals procedures, as explained in this certificate, before you begin legal action. You cannot begin legal action or file a lawsuit until 60 days after you notify us that our decision under the grievance and appeals procedure is unacceptable.

Unlicensed and Unauthorized Providers

We do not for pay services provided by persons who are not:

- Appropriately credentialed or privileged (as determined by BCBSM), or
- Legally authorized or licensed to order or provide such services.

What Laws Apply

This certificate will be interpreted under the laws of the state of Michigan and federal law where applicable.

Workers' Compensation

We do not pay for treatment of work-related injuries covered by workers' compensation laws. We do not pay for work-related services you get at an employer's medical clinic or other facility.

Section 7: Definitions

This section explains the terms used in your certificate. The terms are listed in alphabetical order.

Accidental Injury
Any physical damage caused by an action, object or substance outside the body. This may include:

- Strains, sprains, cuts and bruises
- Allergic reactions caused by an outside force such as bee stings or another insect bite
- Extreme frostbite, sunburn, sunstroke
- Poisoning
- Drug overdosing
- Inhaling smoke, carbon monoxide or fumes
- Attempted suicide
- A dental accidental injury occurring when an external force to the lower half of the face or jaw damages or breaks sound natural teeth, periodontal structures (gums) or bone.

Accredited Hospital
A facility that has been endorsed by one of the following organizations: Joint Commission on the Accreditation of Health Care Organizations, the American Osteopathic Association or the Commission on Accreditation of Rehabilitation Facilities. (Also see the definition of “Hospital" in this section.)

Acute Care
Medical care that requires a wide range of medical, surgical, obstetrical and/or pediatric services. It generally requires a hospital stay of less than 30 days.

Acute Care Facility
A facility that provides acute care. This facility primarily treats members with conditions that require a hospital stay of less than 30 days. The facility is not used primarily for:

- Custodial, convalescent, tuberculosis or rest care
- Care of the aged or those with substance use disorder
- Skilled nursing or other nursing care

Administrative Costs
Costs incurred by the organization sponsoring an approved oncology clinical trial. They may include, but are not limited to, the costs of gathering data, conducting statistical studies, meeting regulatory or contractual requirements, attending meetings or travel.

Adverse Benefit Decision
A decision to deny, reduce or refuse to pay all or part of a benefit. It also includes a decision to terminate coverage.

Affiliate Cancer Center
A health care provider that has contracted with an NCI-approved cancer center to provide treatment.

Allogeneic (Allogenic) Transplant
A procedure using another person's bone marrow, peripheral blood stem cells or umbilical cord to transplant into the member. This includes syngeneic transplants.

Ambulatory Infusion Center
A freestanding outpatient facility that provides infusion therapy and select injections that can be safely performed in this setting.

Ambulatory Surgery
Elective surgery that does not require the use of extensive hospital facilities and support systems, but is not usually performed in a physician’s office. Only surgical procedures identified by BCBSM as ambulatory surgery are covered.

Ambulatory Surgery Facility
A freestanding outpatient surgical facility offering surgery and related care that can be safely performed without the need for overnight inpatient hospital care. It is not an office of a physician or other private practice office.

Ancillary Services
Services such as drugs, dressings, laboratory services, physical therapy or other care that supplements the primary care the member receives. They do not include room, board and nursing care.

Approved Amount
The lower of the billed charge or our maximum payment level for the covered service. Copayments and/or coinsurance and deductibles, which may be required of you, are subtracted from the approved amount before we make our payment.

Approved Clinical Trial
Phase I, II, III or IV clinical trial that is conducted for the prevention, detection or treatment of cancer or other life-threatening disease or condition, and includes any of the following:

- A federally-funded trial, as described in the Patient Protection and Affordable Care Act
- A trial conducted under an investigational new drug application reviewed by the Food and Drug Administration
- A drug trial that is exempt from having an investigational new drug application
- A study or investigation conducted by a federal department that meets the requirements of Section 2709 of the Patient Protection and Affordable Care Act

Arthrocentesis
Surgical puncture of a joint to inject and/or withdraw fluid. When performed for temporomandibular joint (jaw joint) dysfunction, this surgery may be performed for reversible, irreversible or diagnostic purposes.

Athletic Trainer
A health care professional who specializes in the practice of athletic training, clinical evaluation, injury and illness assessment, risk management, injury prevention, rehabilitation and reconditioning. Must be licensed by the state of Michigan and meet Blue Cross Blue Shield of Michigan qualification requirements. When outside the state of Michigan, is legally qualified to perform services in the state where services are performed.

Attending Physician
The physician in charge of a case who exercises overall responsibility for the member's care:

- Within a facility (such as a hospital and other inpatient facility)
- As part of a treatment program
- In a clinic or private office setting

The attending physician may be responsible for coordination of care delivery by other physicians and/or ancillary staff.

Audiologist
A professional who is licensed or legally qualified in the state in which services are provided to perform audiometric and other procedures to assist in the diagnosis, treatment and management of individuals with hearing loss or balance problems.

Autism Diagnostic Observation Schedule
The protocol available through western psychological services for diagnosing and assessing autism spectrum disorders or any other standardized diagnostic measure for autism spectrum disorders that is approved by the director of the Michigan Department of Insurance and Financial Services, if the director determines that the diagnostic measure is recognized by the health care industry and is an evidence-based diagnostic tool.

Autism Evaluation Center
An academic and/or hospital-based, interdisciplinary center experienced in the assessment, work-up, evaluation and diagnosis of the autism spectrum disorders. The autism evaluation center must be approved by BCBSM to:

- Evaluate and diagnose the member as having one of the covered autism spectrum disorders and
- Determine whether ABA therapy is medically necessary and appropriate for members with autism spectrum disorders.

Autism Spectrum Disorders
A developmental disability caused by differences in the brain**.** Autism spectrum disorder (ASD) is characterized by impaired social function, problems with verbal and nonverbal communication and imagination, and unusual or severely limited activities and interests. The treatment of ASD may be behavior modification.

Autism Spectrum Disorder Services
Services that require a prior authorization for assessment, reassessment, and supervision of applied behavior analysis (ABA), line therapy, skills training, and caregiver training.

Autologous Transplant
A procedure using the member's own bone marrow or peripheral blood stem cells to transplant back into the member.

BCBSM
Blue Cross Blue Shield of Michigan or another entity or person Blue Cross Blue Shield of Michigan authorizes to act on its behalf.

Behavioral Health Treatment for Autism
Evidence-based counseling and treatment programs, including applied behavior analysis, that meet both of the following requirements:

- Are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.
- Are provided or supervised by a licensed behavior analyst or a licensed psychologist so long as the services performed are commensurate with the psychologist's formal university training and supervised experience.

Benefit Period
The period of time that begins five days before, and ends one year after, the organ transplant. All payable human organ transplant services, except anti-rejection drugs and other transplant–related prescription drugs, must be provided during this period of time.

Biological
A virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, allergenic product, or similar product, used for the prevention, treatment, or cure of a disease or condition of human beings. FDA regulations and policies have established that biological products include blood-derived products, vaccines in vivo diagnostic allergenic products, immunoglobulin products, products containing cells or microorganisms, and most protein products.

Birth Year
A 12-month period of time beginning with a child's month and day of birth.

BlueCard® PPO Program
A program that allows Blue Cross Blue Shield PPO members to receive health care services in other states and have claims processed by the Host Plan, subject to Blue Cross and Blue Shield Association policies.

Blue Cross Blue Shield Global Core Program
A program that provides access to a network of inpatient facilities and medical assistance services worldwide including referrals to professional providers for all Blue Cross Blue Shield of Michigan members whose claims are eligible for processing through the BlueCard Program.

Blue Cross Plan
Any hospital service plan approved by the Blue Cross and Blue Shield Association at the time the hospital service is furnished.

Blue Shield Plan
Any medical service plan approved by the Blue Cross and Blue Shield Association at the time the medical service is furnished.

Calendar Year
A period of time beginning January 1 and ending December 31 of the same year.

Cancellation
An action that ends a member's coverage dating back to the effective date of the member's contract. This results in the member's contract never having been in effect.

Carrier
An insurance company providing a health care plan for its members.

Case Management
A program that is designed to help manage the health care of members with acute or chronic conditions. It is up to BCBSM to decide whether you qualify for this program.

In certain circumstances, BCBSM may find it necessary to pay for services that are generally not covered by your contract but that are medically necessary to treat your condition. When this occurs, a case management contract must be signed by you (or your representative), your provider and the BCBSM case manager. This contract will define the services that will be covered under the case management program.

If BCBSM has contracted with a vendor to manage the case management program, then that vendor will make decisions regarding case management and sign any necessary case management documents on behalf of BCBSM.

Certificate
This book, which describes your benefit plan, **and** any riders that amend it.

Certified Nurse Midwife
A nurse who provides some maternity, contraceptive, and other services and who:

- Is licensed as a registered nurse by the state of Michigan
- Has a specialty certification as a nurse midwife by the Michigan Board of Nursing
- Has current national certification as a midwife by an organization recognized by the Michigan Board of Nursing

Certified Nurse Practitioner
A nurse who provides some medical and/or psychiatric services and who:

- Is licensed as a registered nurse by the state of Michigan
- Has a specialty certification as a certified nurse practitioner by the Michigan Board of Nursing
- Meets BCBSM qualification standards
- When outside the state of Michigan, is legally qualified to perform services in the state where services are performed

Certified Registered Nurse Anesthetist
A nurse who provides anesthesiology services and who:

- Is licensed as a registered nurse by the state of Michigan
- Has a specialty certification as a certified registered nurse anesthetist by the Michigan Board of Nursing
- Meets BCBSM qualification standards
- When outside of the state of Michigan, is legally qualified to perform anesthesiology services in the state where the services are performed

Chronic Condition
A condition that recurs frequently or one that may or may not have been present at birth but will last a long time, perhaps throughout the member's life. Therapy may not help and the chronic condition may eventually result in significant disability and/or death. Arthritis and heart disease are examples of chronic diseases.

Claim for Damages
A lawsuit against, or demand to, another person or organization for compensation for an injury to a person.

Clinical Licensed Master's Social Worker
A clinical licensed master's social worker who provides some mental health services and who:

- Is licensed as a clinical social worker by the state of Michigan.
- Meets BCBSM qualification standards.
- When outside of the state of Michigan, is legally qualified to perform services in the state where services are performed.

Clinical Nurse Specialist-Certified
A nurse who provides some medical, psychiatric services, prescribes drugs, physical therapy, occupational therapy, durable medical equipment and who:

- Is licensed as a registered nurse by the state of Michigan
- Has a specialty certification as a clinical nurse specialist-certified by the Michigan Board of Nursing
- Meets BCBSM qualification standards
- When outside the state of Michigan, is legally qualified to perform services in the state where services are performed

Clinical Trial
A study conducted on a group of patients to determine the effect of a treatment. For purposes of this certificate, clinical trials include:

- Phase II - a study conducted on a number of patients to determine whether the treatment has a positive effect on the disease or condition as compared to the side effects of the treatment.

- Phase III - a study conducted on a much larger group of patients to compare the results of a new treatment of a condition to the results of conventional treatment. Phase III gives an indication as to whether the new treatment leads to better, worse or no change in outcome.

Coinsurance
A portion of the approved amount that you must pay for a covered drug or service. This amount is determined based on the approved amount at the time the claims are processed or reprocessed. Your coinsurance is not altered by an audit or recovery and are not reduced by any coupon, rebate or other credits received directly or indirectly from an assistance program. However, you may be able to take advantage of BCBSM-approved special coupon programs to help you pay some or all of your coinsurance. For prescription drugs, your coinsurance is not reduced by any rebate or other credit received directly or indirectly from an assistance program or the drug manufacturer, but you may be able to take advantage of BCBSM-approved special coupon programs to help you pay some or all of your coinsurance.

Collaborative Care Management
An integration of medical and behavioral health treatment that allows a primary care physician team and a consulting psychiatrist to care for members' medical and behavioral health conditions using an outcomes-based model to control costs.

Colonoscopy
A colonoscopy is a procedure for viewing the interior lining of the large intestine (colon) using a small camera called a colonoscope.

Colony Stimulating Growth Factors
Factors that stimulate the multiplication of very young blood cells.

Congenital Condition
A condition that exists at birth.

Consolidated Omnibus Budget Reconciliation Act (COBRA)
A federal law that may allow you to temporarily keep your health coverage after:

- Your employment ends,

- You lose coverage as a dependent of the covered employee, or

- Another qualifying event.

If you elect COBRA coverage, you pay 100% of the premiums, including the share the employer used to pay for you, plus a small administrative fee.

Continuity of Care
Seamless, continuous care rendered by a specific provider that if interrupted, could have negative impacts on the specific condition or disorder for which the member is being treated. Continuity of care also includes ongoing coordination of care in high risk members that have multiple medical conditions. If a provider changes network status, patients with complex care needs have at least a 90-day period of continued coverage at in-network cost-sharing rates to allow for a transition of care to an in-network provider.

Contraceptive Counseling
A preventive care service that helps you choose a contraceptive method.

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

Contraceptive Medication
Any drug used for the express purpose of preventing pregnancy at the time of its administration.

Contract
This certificate and any related riders, your signed application for coverage and your BCBSM ID card.

Contracted Area Hospital
A BCBSM participating or in-network hospital located in the same area as a noncontracted area hospital.

Conventional Treatment
Treatment that has been scientifically proven to be safe and effective for treatment of the member's condition.

Coordination Period
A period of time, defined by Medicare, that begins in the first month of Medicare entitlement due to ESRD and lasts for 30 months.

Copayment
The dollar amount that you must pay for a covered drug or service. Your copayment is not altered by an audit or recovery. For prescription drugs, your copayment is not reduced by any coupon, rebate or other credit received directly or indirectly from an assistance program or the drug manufacturer, but you may be able to take advantage of BCBSM-approved special coupon programs to help you pay some or all of your copayment.

Cost Sharing
Copayments, coinsurances, and deductibles you must pay under this certificate.

Covered Services
A health care service that is identified as payable in this certificate. Such services must be medically necessary, as defined in this certificate, and ordered or performed by a provider that is legally authorized or licensed to order or perform the service. The provider must also be appropriately credentialed or privileged, as determined by BCBSM, to order or perform the service.

Custodial Care
Care primarily used in helping the member with activities of daily living or meeting personal needs. Such care includes help in walking, getting in and out of bed, and bathing, dressing and taking medicine. Custodial care can be provided safely and reasonably by people without professional skills or training.

Deductible
The amount that you must pay for covered services, under any certificate, before benefits are payable. Payments made toward your deductible are based on the approved amount at the time claims are processed reprocessed. Payments made toward your deductible are not altered by an audit or recovery and are not reduced by any coupon, rebate or other credits received directly or indirectly from an assistance program. However, you may be able to take advantage of BCBSM-approved special coupon programs to help you pay some or all of your deductible. For prescription drugs, your deductible is not reduced by any rebate or other credit received directly or indirectly from an assistance program or the drug manufacturer, but you may be able to take advantage of BCBSM-approved special coupon programs to help you pay some or all of your deductible.

Dental Care
Care given to diagnose, treat, restore, fill, remove or replace teeth or the structures supporting the teeth, including changing the bite or position of the teeth.

Department of Insurance and Financial Services (DIFS)
The department that regulates insurers in the state of Michigan.

Designated Cancer Center
A site approved by the National Cancer Institute as a cancer center, comprehensive cancer center, clinical cancer center or an affiliate of one of these centers. The names of the approved centers and their affiliates are available to you and your physician upon request.

Designated Facility
To be a covered benefit, human organ transplants must take place in a “BCBSM-designated” facility. A **designated facility** is one that BCBSM determines to be qualified to perform a specific organ transplant. We have a list of designated facilities and will make it available to you and your physician upon request.

Designated Services
Services that BCBSM determines only a noncontracted area hospital is equipped to provide.

Detoxification
The medical process of removing an intoxicating or addictive substance from the body of a person who is dependent on that substance.

Developmental Condition
A condition that can delay or completely stop the normal progression of speech development. Speech language therapy services may not help these conditions.

Diagnostic Agents
Substances used to diagnose rather than treat a condition or disease.

Diagnostic Radiology
Tests used to determine the anatomic or functional state of a particular area or part of the body for the diagnosis or treatment or both of illness, disease, injury or pregnancy.

Dialysis
The process of cleaning wastes from the blood artificially. This job is normally done by the kidneys. If the kidneys fail, the blood must be cleaned artificially with special equipment. The two major forms of dialysis are hemodialysis and peritoneal dialysis.

Direct Supervision
The type of supervision that requires the supervising personnel to be in the same physical structure where the service is being performed.

Diversional Therapy
Planned recreational activities, such as hobbies, arts and crafts, etc., not directly related to functional therapy for a medical condition.

Dual Entitlement
When an individual is entitled to Medicare on the basis of both ESRD and age or disability.

Durable Medical Equipment
Equipment that can withstand repeated use and that is used for a medical purpose by a member who is ill or injured. It may be used in the home.

Effective Date
The date your coverage begins under this contract. This date is established by BCBSM.

Elective Abortion
The intentional use of an instrument, or other substance or device to terminate a pregnancy that doesn't meet the definition of non-elective abortion.

Eligibility
As used in Section 1 of this certificate under **End Stage Renal Disease**, eligibility means the member's right to Medicare coverage under Title XVIII of the Social Security Act, as amended. Otherwise, eligibility means the member's right to coverage under this certificate.

Emergency Care
Care to treat an accidental injury or medical emergency.

Emergency Medical Condition
Whether a condition is an emergency medical condition does not depend on a particular diagnosis. Instead, it is a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) which could cause a prudent layperson with average knowledge of health and medicine to reasonably expect that the absence of immediate medical attention would result in:

- The health of the member (or during a pregnancy, the health of an unborn child) to be in serious jeopardy, or
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part (or with respect to a pregnant member who is having contractions, there is inadequate time for a safe transfer to another hospital before delivery or the transfer may pose a threat to the health and safety of the member or unborn child)

Emergency Services
Emergency Services include medical screening exams (as required under Section 1167 of the Social Security Act) that are within the capability of an emergency room department of a hospital or independent freestanding emergency departments and include ancillary services routinely available in a hospital's emergency room to evaluate an emergency medical condition. They also include, within the capabilities of the staff and facilities available at the hospital, additional medical exams and treatment (as required under Section 1867 of the Social Security Act) to stabilize the member. In nonparticipating hospitals and independent freestanding emergency departments, services rendered after the member is stabilized will continue to be emergency services until the member receives and signs a notice and consent form as required under the No Surprises Act.

End Stage Renal Disease (ESRD)
Chronic, irreversible kidney failure that requires a regular course of dialysis or a kidney transplant as verified by a medical evidence report (defined in this section) or a provider bill that contains a diagnosis of chronic renal (kidney) failure.

Enrollment Date
The first date of coverage or, if there is a new hire waiting period, the first day of the waiting period.

Entitlement (or Entitled)
The member's right to receive Medicare benefits once the member has met the eligibility requirements to qualify for Medicare coverage, has filed a valid application for benefits, and has met any applicable waiting period requirements.

Evaluation
An evaluation must include a review of the member's clinical history and examination of the member. Based on the member's needs, as determined by the BCBSM-approved treatment center, an evaluation may also include cognitive assessment, audiologic evaluation, a communication assessment, assessment by an occupational or physical therapist and lead screening.

Exclusions
Situations, conditions, or services that are not covered by the subscriber's contract.

Exigent Circumstance
An exigent circumstance exists when you suffer from a health condition that may seriously jeopardize your life, health or ability to regain maximum function, or when you are undergoing a current course of treatment using a drug that is not on our approved drug list.

Experimental Treatment
Treatment that has not been scientifically proven to be as safe and effective for treatment of the member's conditions as conventional treatment. Sometimes it is referred to as “investigational” or “experimental services.”

Facility
A hospital or facility that offers acute care or specialized treatment, including, but not limited to, substance use disorder treatment, skilled nursing care or physical therapy.

Fecal Occult Blood Screening
A laboratory test to detect blood in feces or stool.

First Degree Relative
An immediate family member who is directly related to the member: either a parent, sibling or child.

First Priority Security Interest
The right to be paid before any other person from any money or other valuable consideration recovered by:

- Judgment or settlement of a legal action
- Settlement not due to legal action
- Undisputed payment

This right may be invoked without regard for:

- Whether plaintiff’s recovery is partial or complete
- Who holds the recovery
- Where the recovery is held

Flexible Sigmoidoscopy
A visual examination of the lower portion of the colon through the rectum, using a flexible instrument called a sigmoidoscope.

Food and Drug Administration (FDA)
An agency of the U.S. Department of Health and Human Services that is responsible for protecting the public health by assuring the safety, efficacy and security of human drugs.

Freestanding Outpatient Physical Therapy Facility
An independently owned and operated facility, separate from a hospital, which provides outpatient physical therapy services and occupational therapy or speech language therapy services.

Gender Affirming Services
A collection of services that are used to treat the clinical diagnosis of gender dysphoria. These services may include hormone treatment and/or gender affirming surgery, as well as counseling and behavioral health services. These services must be medically necessary to be payable by BCBSM. BCBSM will not pay for services that it considers to be cosmetic. BCBSM also will not pay for services that are experimental or investigational.

Gender Dysphoria
A *condition* classified as emotional discomfort or distress caused by a discrepancy between a person's gender identity and that person's sex assigned at birth.

Genetic Counselor
Obtains and evaluates individual, family, and medical histories to determine the genetic risk for genetic or medical conditions or diseases in a client, the client's descendants, or other family members of the client. Explanation to the client provides the clinical implications of genetic laboratory tests and other diagnostic studies and their results.

Group
A collection of members under one contract. Generally, all members of a group are employed by the same employer. One employer, however, may have different segments or categories of employees working for the same employer. A group can also include participants of a trust fund that has been established to purchase health care coverage pursuant to collective bargaining agreements.

Gynecological Examination
A history and physical examination of the female genital tract.

Habilitative/Habilitation Services
Health care services that help you keep, learn, or improve skills and functioning for daily living.

Hazardous Medical Condition
The dangerous state of health of a member who is at risk for loss, harm, injury or death.

Health Maintenance Examination
A comprehensive history and physical examination including blood pressure measurement, skin examination for malignancy, breast examination, testicular examination, rectal examination and health counseling regarding potential risk factors.

Hematopoietic Transplant
A transplant of bone marrow, peripheral blood stem cells or umbilical cord blood.

Hemodialysis
The use of a machine to clean wastes from the blood after the kidneys have failed.

High-Dose Chemotherapy
A procedure in which members are given cell destroying drugs in doses higher than those used in conventional therapy. Stem cell replacement is required after high-dose chemotherapy is given.

High-Risk Member
An individual who has an increased risk of mortality or morbidity according to standard criteria recognized by the oncology community.

HLA Genetic Markers
Specific chemical groupings that are part of many body cells, including white blood cells. Called human leukocyte antigens, these chemical groupings are inherited from each parent and are used to detect the constitutional similarity of one person to another. Close (or the degree of) identity is determined by tests using serologic (test tube) methods and/or molecular (DNA fingerprinting) techniques. An HLA identical match occurs when the six clinically important markers of the donor are identical to those of the member.

Home Health Care Agency
An organization that is primarily engaged in providing skilled nursing services and other therapeutic services in the member's home.

Hospice
A public agency, private organization or subdivision of either, which primarily provides care for terminally ill persons.

Hospital
A facility that:

- Provides inpatient or outpatient diagnostic, therapeutic, and surgical services for injured or acutely ill persons, **and**
- Is fully licensed and certified as a hospital, as required by all applicable laws, **and**
- Complies with all applicable national certification and accreditation standards

Hospital services must be provided by or under the supervision of a professional staff of licensed physicians, surgeons and registered nurses.

A facility that provides specialized services that does not meet all of the above requirements does not qualify as a hospital under this certificate, regardless of its affiliation with any hospital that does meet the above requirements. Such facilities include but are not limited to the following:

- Facilities that provide custodial, convalescent, pulmonary tuberculosis, rest or domiciliary care
- Facilities that serve as institutions for exceptional children or for the treatment of the aged or those with substance use disorder
- Skilled nursing facilities or other nursing care facilities

Hospital Privileges
Permission granted by a hospital to allow accredited professional providers on the hospital's medical staff to perform certain services at that hospital.

Host Plan
A Blue Cross and/or Blue Shield plan outside of Michigan that participates in the BlueCard PPO Program and processes claims for services that you receive in that state.

Independent Occupational Therapist
An occupational therapist who provides some occupational therapy services and who:

- Is licensed as an occupational therapist by the state of Michigan
- Meets BCBSM qualification standards
- When outside the state of Michigan, is legally qualified to perform services in the state where services are performed.

Independent Physical Therapist
A physical therapist who provides some physical therapy services and who:

- Is licensed as a physical therapist by the state of Michigan
- Meets BCBSM qualification standards
- When outside the state of Michigan, is legally qualified to perform services in the state where services are performed.

Independent Speech-Language Pathologist
A speech language pathologist who provides some speech language therapy services and who:

- Is licensed as a speech language pathologist by the state of Michigan. If the state of Michigan has not released license applications or has not issued licenses, then a Certificate of Clinical Competence from the American Speech-Language-Hearing Association is an acceptable alternative until the state issues licenses.
- Meets BCBSM qualification standards
- When outside the state of Michigan, is legally qualified to perform services in the state where services are performed.

Infusion Therapy
The continuous, slow administration of a controlled drug, nutrient, antibiotic or other fluid into a vein or other tissue on a daily, weekly or monthly basis, depending on the condition being treated and type of therapy.

Injectable Drugs
Payable drugs that are ordered or furnished by a physician and administered by the physician or under the physician’s supervision.

In-Network Providers
Hospitals, physicians and other licensed facilities or health care professionals who provide services through this PPO program. In-network providers have agreed to accept BCBSM's approved amount as payment in full for covered services provided under this PPO program.

Irreversible Treatment
Refers to medical and/or dental treatment of temporomandibular joint (jaw joint) dysfunction.

- The treatment is to the mouth, teeth, jaw, jaw joint, skull, and the complex of muscles and nerves, including blood vessels and tissues related to the jaw joint.
- The treatment is intended to cause permanent change to a person's bite or position of the jaws.
- The treatment includes, but is not limited to:
  - Crowns, inlays, caps, restorations and grinding
  - Orthodontics, such as braces, orthopedic repositioning and traction
  - Installation of removable or fixed appliances such as dentures, partial dentures or bridges
  - Surgery directly to the jaw joint and related anesthesia services
  - Arthrocentesis

Intensive Outpatient Program (IOP)
Treatment for mental, emotional and substance use disorders for a minimum of three hours per day, at least three days a week provided by a hospital or an outpatient psychiatric care facility (OPC) to a member who lives at home and goes to a hospital or OPC.

Jaw Joint Disorders
These include, but are not limited to:

- Skeletal defects of the jaws or problems with the bite that cause pain and inability to move the jaw properly
- Muscle tension, muscle spasms, or problems with the nerves, blood vessels or tissues related to the jaw joint that cause pain and inability to move the jaw properly
- Defects within the temporomandibular joint (jaw joint) that cause pain and an inability to move the jaw properly

Licensed Behavior Analyst
An analyst licensed by the State of Michigan at the time services are rendered.

Licensed behavior analysts will be paid only for applied behavior analysis services. Any other treatment performed by a licensed behavior analyst including, but not limited to, treatment of traumatic brain injuries will not be paid.

Out-of-state behavior analysts may be board-certified or licensed.

Licensed Professional Counselor (LPC)
A licensed professional counselor who provides some mental health services and who:

- Is licensed as a professional counselor by the state of Michigan;
- Meets BCBSM qualification standards;
- When outside the state of Michigan, is legally qualified to perform services in the state where services are performed.

Lien
A first priority security interest in any money or other thing of value obtained by judgment, settlement or otherwise up to the amount of benefits, costs and legal fees BCBSM paid because of the plaintiff's injuries.

Life-threatening Condition
Any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Lobar Lung
A portion of a lung from a cadaver or living donor.

Long-Term Acute Care Hospital
A specialty hospital that focuses on treating members requiring extended intensive care; meets BCBSM qualification standards and is certified by Medicare as an LTACH.

Mammogram
An imaging study of the breast using X-rays. It may consist of two or more x-ray views of each breast. The radiation machine must be state-authorized and specifically designed and used to perform mammography.

There are two types of mammograms:

- Screening mammograms assess members without any signs or symptoms to assist in the early identification of breast disease
- Diagnostic mammograms assess members in whom signs and symptoms of breast disease are present

Mandibular Orthotic Reposition Device
An appliance used in the treatment of temporomandibular joint dysfunction.

Maternity Care
Hospital and professional services for any condition due to pregnancy except ectopic (tubal) pregnancy.

Maxillofacial Prosthesis
A custom-made replacement of a missing part of the face or mouth such as an artificial eye, ear, nose or an obturator to close a cleft. Excludes replacement of teeth or appliances to support teeth.

Maximum Payment Level
The most BCBSM will pay for a covered service. For participating or in-network providers, it is the amount BCBSM pays the provider under the provider's contract with BCBSM. For services provided by nonparticipating or out-of-network providers, it is the amount BCBSM pays for the service to its participating or in-network providers or the amount BCBSM negotiates with the nonparticipating or out-of-network provider. Maximum payment level is not a "Medicare-like rate" described in 42 C.F.R. §136.30, et. seq.

Medical Emergency
A condition that occurs suddenly and unexpectedly. This condition could result in serious bodily harm or threaten life unless treated immediately. This is not a condition caused by an accidental injury. Emergency services treat medical emergencies.

Medical Evidence Report
A form required by the Centers for Medicare and Medicaid Services that a physician must complete and submit for each ESRD member beginning dialysis.

Medical Supplies
Medically necessary quantities of medical supplies and dressings used for the treatment of a specific medical condition. Medical supplies include but are not limited to gauze, cotton, fabrics, plaster and other materials used in dressings and casts.

Medically Appropriate
Services that are consistent with how providers generally treat their patients. The services can be those used to diagnose or for treatment. They are based on standard practices of care and are supported by evidence of their effectiveness.

Medically Necessary
Medically necessary means that according to evidence-based clinical practice guidelines (proven to be safe and effective based on current research), a health care service or procedure is considered necessary to treat, prevent or manage a disease. To meet medical necessity criteria, the following must be true:

- The services must be in accordance with generally accepted standards of medical practice

  

  "Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician or provider society recommendations and the views of physicians or providers practicing in relevant clinical areas and any other relevant factors.

- The service, treatment, or supply is clinically **appropriate** for the symptoms and is consistent with the diagnosis

  

  "Clinically appropriate" means the type, frequency, extent, site and duration are considered effective for the member's illness, injury or disease.

- The service is not mainly for the convenience of the member or health care provider.

- The treatment is not generally regarded as experimental by BCBSM.

Medically Necessary (continued)

There are two circumstances where this definition applies: payment to professional providers (M.D.s, D.O.s, podiatric physician, chiropractors, fully licensed psychologists and oral surgeons) and other providers services; and acute inpatient admissions and post-acute care admissions.

There are additional criteria for these two circumstances:

- Medical necessity for payment of professional providers and other providers services:
  - Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that member's illness, injury or disease.
- Medical necessity for payment of acute inpatient admissions and post-acute care admissions
  - For inpatient hospital stays, the member 's condition must necessitate acute care because safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.
  - The treatment is not determined to be medically inappropriate by the Utilization Quality and Health Management Programs (applies only to hospitals, not to LTACHs).

Medically Necessary Drug
A drug must be medically necessary to be covered, as determined by pharmacists and physicians acting for BCBSM, based on criteria and guidelines developed by pharmacists and physicians for BCBSM. The covered drug must be accepted as necessary and appropriate for the member's condition and not mainly for the convenience of the member or prescriber.

In the absence of established criteria, medical necessity will be determined by pharmacists and physicians according to accepted standards and practices.

Medicare
The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Member
Any person eligible for health care services under this certificate on the date the services are rendered. This means the subscriber and any eligible dependent listed on the application. The member is the "patient" when receiving covered services.

Network Providers
Also called "in-network providers" See the definition of "In-network Providers" on Page 181.

Newborn Care
Hospital and professional services that are provided to newborns during the initial stay following birth. This care includes the newborn examination, which must be given by a physician other than the anesthesiologist or the attending physician of the birth parent and routine care during the newborn's inpatient stay.

Non-Elective Abortion
Services that meet federal funding guidelines:

- In the case of a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, in the treating physician's opinion, place the member in danger of death unless an abortion is performed

- In the case of rape or incest when the abortion is legal in the location where the service is rendered

Abortion does not include:

- Prescription drugs or devices intended to prevent a pregnancy.
- Treatment upon a pregnant member who is experiencing a miscarriage or has been diagnosed with an ectopic pregnancy.
- Treatment to preserve the life and health of the child after birth.

Noncontracted Area Hospital
A BCBSM nonparticipating and out-of-network hospital located in an area defined by BCBSM.

Nonparticipating Hospital
A hospital that has not signed a participation agreement with BCBSM to accept our approved amount as payment in full.

Nonparticipating Providers
Physicians and other health care professionals, or hospitals and other facilities or programs that have not signed a participation agreement with BCBSM to accept our payment as payment in full. Some nonparticipating providers, however, may agree to accept our payment on a per claim basis.

Occupational Therapy
A rehabilitative service that uses specific activities and methods. The therapist is responsible for involving the member in specific therapeutic tasks and activities to:

- Develop, improve, retain or restore the performance of necessary neuromusculoskeletal functions affected by an illness or injury or following surgery

- Help the member learn to apply the newly restored or improved function to meet the demands of daily living, or

- Design and use splints, ortheses (such as universal cuffs and braces) and adaptive devices (such as door openers, shower chairs, large-handle eating utensils, lap trays and raised toilet seats)

Off-Label
The use of a drug or device for clinical indications other than those stated in the labeling approved by the Food and Drug Administration.

Online Visit
A structured real-time online health consultation using secure audio-visual technology to connect with a BCBSM professional provider or BCBSM select on-demand virtual care vendor. The online visit is for the purpose of diagnosing and providing medical or behavioral health treatment for low-complexity non-emergent conditions. Contact is initiated by the member and must be within the provider's scope of practice.

Orthopedic Shoes
Orthopedic shoes are prescribed by a physician, certified nurse practitioner, or clinical nurse specialist-certified to support or correct the bones, joints, muscles, tendons and ligaments of a weak or deformed foot.

Orthotic Device
An appliance worn outside the body to correct a body defect of form or function.

Out-of-Area Hospital
A BCBSM in-network or participating hospital that is more than 75 miles from a noncontracted area hospital. It is not in the same area as a contracted or noncontracted area hospital.

Out-of-Area Services
Services available to members living or traveling outside a health plan's service area.

Out-of-Network Providers
Hospitals, physicians and other licensed facilities or health care professionals who have not signed an agreement to provide services under this PPO program.

Out-of-Pocket Maximum
The most you have to pay for covered services during a calendar year. The out-of-pocket maximum includes your medical and pharmacy deductible, copayment and coinsurance. This limit does not include your premium, balance billed charges or services that we do not cover. Any coupon, rebate or other credits received directly or indirectly from an assistance program or the drug manufacturer may not be applied to your out-of-pocket maximum.

Outpatient Mental Health Facility
A facility that provides outpatient mental health services. It must have a participating agreement with BCBSM. Sometimes referred to as an outpatient psychiatric care facility (OPC), it may include centers for mental health care such as clinics and community mental health centers, as defined in the Federal Community Mental Health Centers Act of 1963, as amended. The facility may or may not be affiliated with a hospital.

Outpatient Substance Abuse Treatment Facility
A facility that provides medical and other services on an outpatient basis specifically for those with substance use disorder.

Pap Smear
A method used to detect abnormal conditions, including cancer of the female genital tract.

Partial Hospitalization Program (PHP)
Treatment for mental, emotional and substance use disorders for a minimum of four hours per day, at least five days a week provided by a hospital or an outpatient psychiatric care facility (OPC) to a member who lives at home and goes to a hospital or OPC. The American Association of Behavioral Health (AABH) recommends five to six hours a day for five to six days a week.

Partial Liver
A portion of the liver taken from a cadaver or living donor.

Participating Hospital
A hospital that has signed a participation agreement with BCBSM to accept our approved amount as payment-in-full. Your cost share, which may be required of you, is subtracted from the approved amount before we make our payment.

Participating PPO Provider
A provider who participates with the Host Plan's PPO.

Participating Providers
Physicians and other health care professionals, or hospitals and other facilities or programs that have signed a participation agreement with BCBSM to accept the approved amount as payment in full. Any cost-share, which may be required of you, is subtracted from the approved amount before we make our payment.

Patient
The subscriber or eligible dependent that is awaiting or receiving medical care and treatment.

Pay-Provider Claim
This is a type of claim where Blue Cross pays your provider directly according to the terms of your coverage.

Pay-Subscriber Claim
This is a type of claim where Blue Cross will reimburse you, the subscriber, according to the terms of your coverage. Either you or your provider may submit this type of claim.

Per Claim Participation
Available to some nonparticipating providers when they elect to accept our payment for specific covered services as payment in full.

Period of Crisis
A period during which a member requires continuous care (primarily nursing care) to alleviate or manage acute medical symptoms.

Peripheral Blood Stem Cell Transplant
A procedure in which blood stem cells are obtained by pheresis and infused into the member's circulation.

Peritoneal Dialysis
Removal of wastes from the body by perfusion of a chemical solution through the abdomen.

Pheresis
Removal of blood from the donor or member in order to separate and retain specific components of the blood (red cells, white cells, platelets and stem cells).

Physical Medicine
A branch of medicine that specializes in the diagnosis, treatment, and management of patients who have been disabled from a disease, condition, disorder, or injury. Services include by not limited to:

- Manipulation
- Traction
- Massage
- Exercise
- Heat

Physical Therapist
A physical therapist who provides some physical therapy services and who is licensed as a physical therapist by the state of Michigan.

Physical Therapy
The use of specific activities or methods to treat disability when there is a loss of neuromusculoskeletal functions due to an illness or injury, or following surgery. Treatments include exercise and therapy of the member's specific muscles or joints to keep, learn, retain or improve:

- Muscle strength
- Joint motion
- Coordination
- General mobility

Physician
A doctor of medicine, osteopathy, podiatry, chiropractic or an oral surgeon. Physicians may also be referred to as "practitioners." The term physician or practitioner may also include other types of professional providers when they perform services they are licensed or legally qualified to perform in the state where the services are provided.

Physician Assistant
A physician assistant is licensed by the state of Michigan to engage in the practice of medicine, osteopathic medicine and surgery, or podiatric medicine and surgery with a participating physician under a practice agreement.

Plaintiff
The person who brings the lawsuit or claim for damages. The plaintiff may be the injured party or a representative of the injured party.

Post-Service Grievance
A post-service grievance is an appeal that you file when you disagree with our payment decision or our denial for a service that you have already received.

Practitioner
A physician (a doctor of medicine, osteopathy, podiatry, or chiropractic) or a professional provider (a doctor of medicine, osteopathy, podiatric physician, chiropractor, fully licensed psychologist, clinical licensed master's social worker, licensed professional counselor genetic counselor, athletic trainer, or oral surgeon) or other professional provider who participates with BCBSM or who is in a BCBSM PPO network. Practitioner may also be referred to as "participating" or "in-network" provider.

Preapproval
A process that allows you or your provider to know if we will cover proposed services before you receive them. If preapproval is not obtained **before** you receive certain services described in this certificate, they will not be covered. Preapproval can also sometimes be referred to as prior authorization.

Preferred Provider Organization (PPO)
A limited group of health care providers who have agreed to provide services to BCBSM members enrolled in the PPO program. These providers accept the approved amount as payment in full for covered services.

Pre-Service Grievance
A pre-service grievance is an appeal that you can file when you disagree with our decision not to pre-approve a service you have not yet received.

Presurgical Consultation
A consultation that allows a member to get an additional opinion from a physician who is a **doctor of medicine, osteopathy, podiatry or an oral surgeon** when surgery is recommended.

Preventive Care
Care designed to maintain health and prevent diseases or conditions at an early stage when treatment is likely to work best. Examples of preventive care include health screenings, mammograms, and colonoscopies.

Primary Care Physician (PCP)
The physician you choose to provide or coordinate all of your medical care, including specialty and hospital care. A primary care physician is appropriately licensed in one of the following medical fields:

- Family Practice
- General Practice
- Internal Medicine
- Pediatrics

Primary Payer
The health care coverage plan that pays first when you are provided benefits by more than one carrier. (For example, you may have BCBSM group coverage and Medicare.)

Primary Plan
The health care plan obligated to pay for services before any other health care plan that covers the member.

Prior Authorization
Some prescription drug Some admissions and services require prior authorization before you receive them. If you receive them without first obtaining prior authorization, you may have to pay the bill yourself. We may not pay for it. It is important to make sure that your provider gets the prior authorization before you receive these drugs.

Professional Provider
One of the following:

- Doctor of Medicine (M.D.)
- Doctor of Osteopathy (D.O.)
- Podiatric physician
- Chiropractor
- Physician assistant (PA)
- Fully licensed psychologist
- Limited licensed psychologist (LLP)
- Clinical licensed master's social worker (CLMSW)
- Licensed marriage and family therapist (LMFT)
- Licensed professional counselor (LPC)
- Oral surgeon
- Licensed behavior analyst
- Independent physical therapist (IPT)
- Independent speech therapist (IST)
- Independent Occupational therapist (IOT)
- Certified nurse practitioner (CNP)
- Certified nurse midwife (CNM)
- Certified registered nurse anesthetist (CRNA)
- Clinical nurse specialist-certified (CNS-C)
- Athletic trainer
- Genetic counselor
- Other providers as identified by BCBSM

Professional providers may also be referred to as "practitioners."

Prosthetic Device
An artificial appliance that:

- Replaces all or part of a body part or
- Replaces all or part of the functions of a permanently disabled or poorly functioning body organ

Protocol
A detailed plan of a medical experiment or treatment.

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

Provider-Delivered Care Management (PDCM)
A program that allows you to receive care management services in Michigan from a trained clinical care manager in a team effort with, and directed by, your primary care physician.

Psychiatric Residential Treatment Facility
A facility that provides residents with 24-hour mental health care and treatment, seven days a week. The facility must participate with BCBSM (if located in Michigan) or with its local Blue Cross/Blue Shield plan (if located outside of Michigan).

Therapeutic boarding schools, milieu therapies, such as wilderness programs, supportive houses or group homes are not considered psychiatric residential treatment facilities.

Psychologist
A practitioner of clinical psychology, counseling or guidance, who is fully licensed and certified by the state of Michigan or by the state where you receive services. Where there are no certification or licensure requirements, the psychologist must be recognized by the appropriate professional society.

Purging
A process that attempts to remove abnormal cells from a blood or bone marrow sample so that a clean sample with only normal blood producing cells is obtained.

Qualified Beneficiary
Persons eligible for continued group coverage under COBRA. This includes the employee, spouse and children (including those born to, or placed for adoption with, the employee during the period of COBRA coverage).

Qualified Individual
A member eligible for coverage under this certificate who participates in an approved clinical trial according to the trial protocol for treatment of cancer or other life-threatening disease or condition and either:

- The referring provider participates in the trial and has concluded that the individual's participation in it would be appropriate because the individual meets the trial's protocol, or
- The member provides medical and scientific information that establishes their eligibility to participate in the trial.

Qualifying Event
One of the following events that allows you to enroll in different health care coverage, change your current coverage or allows a beneficiary to receive coverage under COBRA:

- Termination of employment, other than for gross misconduct, or reduction of hours
- Start or end of military service. Members must perform military duty for more than 30 days.
- Death of the employee
- Divorce
- Loss of dependent status due to age, marriage, change in student status, etc.
- The employee becomes entitled to coverage under Medicare

The examples in this definition are not exhaustive and may change. Please call Customer Service for more information about qualifying events.

Radiology Services
These include X-ray exams, radium, radon, cobalt therapy, ultrasound testing, radioisotopes, computerized axial tomography scans, magnetic resonance imaging scans and positron emission tomography scans.

Referral
The process in which the PCP sends a member to another provider for a specified service or treatment plan.

Refractory Member
An individual who does not achieve clinical disappearance of the disease after standard therapy.

Registered Provider
A participating or nonparticipating provider (or in-network or out-of-network PPO provider) that has the qualifications to meet BCBSM's provider enrollment and credentialing standards.

Rehabilitative/Rehabilitation Services
Health care services that help you keep, get back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled.

Relapse
When a disease recurs after a period of time following therapy. This period of time is defined by evidence-based literature pertaining to the member's condition.

Remitting Agent
Any individual or organization that has agreed, on behalf of the subscriber, to:

- Collect or deduct premiums from wages or other sums owed to the subscriber and
- Pay the subscriber's BCBSM bill

Rescission
The cancellation of coverage that dates back to the effective date of the member's contract and voids coverage during this time.

Research Management
Services, such as diagnostic tests, which are performed solely to support the sponsoring organization's research. They are not necessary for treating the member's condition.

Residential Substance Abuse Treatment Facility
A facility that provides residents with 24-hour substance use disorder care and treatment, seven days a week. The facility must participate with BCBSM (if located in Michigan) or with its local Blue Cross/Blue Shield plan (if located outside of Michigan). The services are sometimes referred to or considered as "intermediate care."

This residential substance abuse treatment facility is not considered inpatient acute medical/surgical care in a hospital.

Respite Care
Relief to family members or other persons caring for terminally ill persons at home.

Retail Health Clinic
A medical clinic located inside a retail store. It offers "walk-in" care for minor conditions, provided by a professional provider.

Reversible Treatment
Refers to medical and/or dental treatment of temporomandibular joint (jaw joint) dysfunction.

- The treatment is to the mouth, teeth, jaw, jaw joint, skull, and the complex of muscles and nerves, including blood vessels and tissues related to the jaw joint.
- This treatment is **not** intended to cause permanent change to a person's bite or position of the jaws.
- This treatment is designed to manage the member's symptoms. It can include, but is not limited to, the following services:
  - Arthrocentesis
  - Physical therapy (see Page 85 for physical therapy services)
  - Reversible appliance therapy (mandibular orthotic repositioning)

Rider
A document that changes a certificate by adding, limiting, deleting or clarifying benefits.

Right of Recovery
The right of BCBSM to make a claim against you, your dependents or representatives if you or they have received funds from another party responsible for benefits paid by BCBSM.

Routine Patient Costs
All items and services related to an approved clinical trial if they are covered under this certificate (or any riders that amend it) for members who are not participants in an approved clinical trial. They do not include:

- The investigational item, device, or service itself
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the member, or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Sanctioned Prescriber
Any provider who has been disciplined under Section 1128 and Section 1902(a)(39) of the Social Security Act; excluded or suspended from participation in Medicare or Medicaid; whose license to issue prescriptions has been revoked or suspended by any state licensing board; or whose prescribing habits have been determined by BCBSM to deviate significantly from established standards of medical necessity.

Screening Services
Procedures or tests ordered for a member (or for almost all member s of a particular class or group) that are not directly related to the diagnosis or treatment of a specific disease or injury. For example, tests routinely performed as part of a physical are considered screening services.

Secondary Plan
The health care plan obligated to pay for services after the primary plan has paid for services.

Self-Dialysis Training
Teaching members to conduct dialysis on themselves.

Semiprivate Room
A hospital room with two beds.

Service Area
The geographic area in which BCBSM is authorized to use the Blue Cross and Blue Shield name and service marks.

BCBSM may contract with providers in areas contiguous with the state of Michigan. These providers' claims will not be subject to BlueCard rules.

Services
Surgery, care, treatment, supplies, devices, drugs or equipment given by a health care provider to diagnose or treat a disease, injury, condition or pregnancy.

Skilled Care
A level of care that can be given only by a licensed nurse to ensure the medical safety of the member and the desired medical result. Such care must be:

- Ordered by the attending physician
- Medically necessary according to generally accepted standards of medical practice
- Provided by a registered nurse or a licensed practical nurse supervised by a registered nurse or physician

Skilled Nursing Facility
An inpatient subacute facility that provides continuous skilled nursing and other health care services by or under the supervision of a physician and a registered nurse.

Small Bowel Transplant
A procedure in which the member's small intestine is removed and replaced with the small intestine of a cadaver.

Special Medical Foods
Special foods that are formulated for the dietary treatment of inborn errors of metabolism. The nutritional requirements of the member are established by a physician's medical evaluation of the member. The diet must be administered under the supervision of a physician.

Specialist
A provider with a specific skill or expertise in the treatment of a particular condition or disease.

Specialty Hospitals
Hospitals that treat specific diseases, such as mental illness.

Specialty Pharmaceuticals
Biotech drugs, including high-cost infused, injectable, oral and other drugs related to specialty disease categories or other categories. BCBSM determines which specific drugs are payable. This may include vaccines and chemotherapy drugs used in the treatment of cancer, but excludes injectable insulin. **Select specialty pharmaceuticals require prior authorization from BCBSM.**

Examples of specialty pharmaceuticals include, but are not limited to, the following:

- Drugs administered by infusion therapy providers
- Drugs administered in the office by health care practitioners
- Certain drugs to treat highly complex disorders, such as multiple sclerosis, lupus and immune deficiency
- Chemotherapy specialty pharmaceuticals dispensed at the pharmacy and self-administered, or administered by a health care practitioner at an approved facility or a physician's office

BCBSM will cover these drugs under the certificate that applies to the benefit. For example, drugs administered in the office by a health care practitioner are covered under the certificate that applies to your medical benefits.

Specialty Pharmacy
Companies that specialize in specialty pharmaceuticals and the associated clinical management support.

Speech Language Therapy Services
Rehabilitative services that use specific activities or methods to treat speech, language or voice impairment due to an illness, injury or following surgery.

Spouse
An individual who is legally married to the subscriber and meets the group's eligibility requirements.

Stabilize
Stabilize, with respect to an emergency medical condition, means that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the member from a facility (or with respect to a pregnant member who is having contractions, to deliver the child (including the placenta)).

Stem Cells
Primitive blood cells originating in the marrow, but also found in small quantities in the blood. These cells develop into mature blood components including red cells, white cells and platelets.

Subrogation
Subrogation occurs when BCBSM assumes the right to make a claim against or to receive money or other thing of value from another person, insurance company or organization. This right can be your right or the right of your dependents or representatives.

Subscriber
The person who signed and submitted the application for coverage.

Substance Use Disorder
Taking alcohol or other drugs in amounts that can:

- Harm a person's physical, mental, social and economic well-being
- Cause a person to lose self-control as reflected by alterations of thought, mood, cognition, or behavior
- Endanger the safety or welfare of self or others because of the substance's habitual influence on the person.

Substance use disorder is alcohol or drug abuse or dependence as classified in the most current edition of the “International Classification of Diseases.”

Tobacco addictions are included in this definition.

Surprise Billing
Instances where a member unknowingly receives care from a nonparticipating provider or receives care from a nonparticipating provider because a participating provider is unavailable and later receives an unexpected bill for the difference between what the provider charges and what we pay. (See Surprise Billing in the General Conditions of Your Contract section for more about laws that protect you from surprise billing).

Syngeneic Transplant
A procedure using bone marrow, peripheral blood stem cells or umbilical cord blood from a member’s identical twin to transplant into the member.

Tandem Transplant
A procedure in which the member is given chemotherapy followed by a blood stem cell (peripheral or umbilical cord blood) transplant or bone marrow transplant, and if the member’s cancer has not progressed, a second round of chemotherapy followed by a blood stem cell or bone marrow transplant. The second round of chemotherapy and transplant is usually performed within six months of the first transplant and if not, it must be approved by BCBSM. Tandem transplants are also referred to as dual transplants or sequential transplants. A tandem transplant is considered to be one transplant.

T-Cell Depleted Infusion
A procedure in which T-Cells (immunocompetent lymphocytes) are eliminated from peripheral blood stem cells, bone marrow or umbilical cord blood.

Technical Surgical Assistance
Professional active assistance given to the operating physician during surgery by another physician not in charge of the case.

Professional active assistance requires direct physical contact with the member.

Telemedicine
Real-time health care services, delivered via telephone, internet, or other electronic technology when you're not in your provider's presence. Telemedicine visits are for the purpose of treating an ongoing condition that is expected to result in multiple visits before the condition is resolved or stabilized. Contact for these services can be initiated by the member or provider and must be within your provider's scope of practice for both medical and behavioral health services.

Terminally Ill
A state of illness causing a person's life expectancy to be 12 months or less according to a medically justified opinion.

Termination
An action that ends a member's coverage after the member's contract takes effect. This results in the member's contract being in effect up until the date it is terminated.

Therapeutic Radiology
The treatment of neoplastic conditions with radiant energy.

Therapeutic Shoes
Therapeutic or diabetic shoes are prescribed by a physician certified nurse practitioner, or clinical nurse specialist-certified and are either "off-the-shelf" or custom-molded shoes which assist in protecting the diabetic foot.

Total Body Irradiation
A procedure that exposes most of the body to ionizing radiation to produce an anti-tumor effect that helps prevent rejection of a bone marrow, peripheral blood stem cell or umbilical cord blood transplant.

Total Care (TC)
A program that allows you to receive care management services outside the state of Michigan from a trained clinical care provider in a team effort with, and directed by, your primary care physician.

Treatment Plan
A written plan that describes the goals, expected outcomes, type and limited duration of services to be provided to the member under the case management program. The treatment plan may include medically necessary services that BCBSM determines should be covered because of the member's condition as specified in the plan, even if those services are not covered under the member's hospital and professional certificates. (Such services are referred to as non-contractual services.) All services described in the treatment plan must be ordered by the member's physician. Because plans that include non-contractual services are a binding contract between the member and BCBSM, they must be signed by the member (or representative) and the BCBSM case manager.

Urgent Care
Walk-in care needed for an unexpected illness or injury that requires immediate treatment to prevent long-term harm. Urgent care centers are not the same as emergency rooms or professional providers' offices.

Valid Application
An application for Medicare benefits filed by a member with ESRD according to the rules established by Medicare.

Virtual Primary Care
The ability for members 18 and over to access a virtual primary care provider by a secure HIPAA-compliant digital platform including messages, telephone and video calls. Virtual primary care is a convenient, virtual visit that provides a broad range of primary care services including management and coordination of a member's health care. BCBSM partners with a Virtual Primary Care vendor to provide access to a Virtual PCP.

Voluntary Sterilization
Sterilization that is not medically necessary according to generally accepted standards of medical practice and is performed strictly at the request of the member.

Waiting Period
Defined by Medicare as the period of time (up to three months) before a member with ESRD, who has begun a regular course of dialysis, becomes entitled to Medicare. Entitlement begins on the first day of the fourth month of dialysis, provided the member files a valid application for Medicare.

Ward
A hospital room with three or more beds.

We, Us, Our
Used when referring to Blue Cross Blue Shield of Michigan or another entity or person Blue Cross Blue Shield of Michigan authorizes to act on its behalf.

Well-Baby Care
Services provided in a physician's office to monitor the health and growth of a healthy child.

Working Aged
Employed individuals age 65 or over, and individuals age 65 or over with employed spouses of any age, who have group health plan coverage by reason of their own or their spouse's current employment.

Working Disabled
Disabled individuals under age 65 who have successfully returned to work but continue to have a disabling impairment.

You and Your
Used when referring to any person covered under the subscriber's contract.

Section 8: Additional Information You Need to Know

We want you to be satisfied with how we administer your coverage. If you have a question or concern about how we processed your claim or request for benefits, we encourage you to contact Customer Service. The telephone number is on the back of your ID card and in the top right hand corner of your Explanation of Benefit (EOB) Payments statements.

Grievance and Appeals Process

We have a formal grievance and appeals process that allows you to dispute an adverse benefit decision or rescission of your coverage.

An adverse benefit decision includes a:

- Denial of a request for benefits
- Reduction in benefits
- A determination that surprise billing protections are not applicable or the improper application of those protections
- Failure to pay for a service or part of a service
- Rescission of coverage
  - A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, such as a cancellation that treats a policy as void from the time of enrollment.

You may file a grievance or appeal about any adverse benefit decision or rescission within 180 days after you receive the claim denial. The dollar amount involved does not matter.

If you file a grievance or appeal:

- You will not have to pay any filing charges
- You may submit materials or testimony at any step of the process to help us in our review
- You may authorize another person, including your physician, to act on your behalf at any stage in the standard review process. Your authorization must be in writing. Please call the Customer Service number on the back of your ID card and ask for a *Designation of Authorized Representative and Release of Information* form. Complete it and send it with your appeal.
- Although we have 60 days to give you our final determination for post-service appeals, you have the right to allow us additional time if you wish.
- You do not have to pay for copies of information relating to BCBSM's decision to deny, reduce or terminate your coverage.

Grievance and Appeal Process (continued)

The grievance and appeals process begins with an internal review by BCBSM. Once you have exhausted your internal options, you have the right to a review by the Michigan Department of Insurance and Financial Services.

You do not have to exhaust our internal grievance process before requesting an external review in certain circumstances:

- We waive the requirement
- We fail to comply with our internal grievance process
  - Our failure to comply must be for more than minor violations of the internal grievance process.
    - Minor violations are those that do not cause and are not likely to cause you prejudice or harm.

Standard Internal Review Process

Step 1: You or your authorized representative send us a written statement explaining why you disagree with our decision.

Mail your written grievance to:
Appeals Unit
Blue Cross Blue Shield of Michigan
600 East Lafayette Blvd.
M.C. 1620
Detroit, MI 48226

Step 2: We will contact you to schedule a conference once we receive your grievance. During your conference, you can provide us with any other information you want us to consider in reviewing your grievance. You can choose to have the conference in person or over the telephone. If in person, the conference will be held at our office in Detroit during regular business hours. The written decision we give you after the conference is our final decision.

Step 3: If you disagree with our final decision, or you do not receive our decision within 60 days after we received your original grievance, you may request an external review. See below for how to request an external review.

Grievance and Appeal Process (continued)

Standard External Review Process

Once you have gone through our standard internal review 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 Department 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 Department 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 will have to authorize the release of medical records that may be required to reach a decision during the external review. The Michigan Department of Insurance & Financial Services 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 Department 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 BCBSM if the Department decides to accept the group's recommendation. The Department 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.

Grievance and Appeal Process (continued)

Reviews of Medical Issues

Step 1: The Department will assign an independent review group to review your request if it concerns a medical issue that is appropriate for an external review.

- You can give the Department additional information within seven days of requesting an external review. We must give the independent review group all of the information we considered when we made a final decision, within seven days of getting notice of your request from the Department.

Step 2: The review group will recommend within 14 days whether the Department should uphold or reverse our decision. The Department must decide within seven business days whether to accept the recommendation and then notify you of its decision. The decision is your final administrative remedy under the Patient's Right to Independent Review Act of 2000.

Reviews of Nonmedical Issues

Step 1: Department's staff will review your request if it involves nonmedical issues and is appropriate for external review.

Step 2: They will recommend if the Department should uphold or reverse our decision. The Department will notify you of the decision. This is your final administrative remedy under the Patient's Right to Independent Review Act of 2000.

Expedited Internal Review Process

- Your physician shows (verbally or in writing) that following the timeframes of the standard internal process will seriously jeopardize:
  - Your life or health, or
  - Your ability to regain maximum function

You may request an expedited internal review if you believe:

- We wrongly denied, terminated, cancelled or reduced your coverage for a service before you receive it, or
- We failed to respond in a timely manner to a request for benefits or payment

The process to submit an expedited internal review is as follows:

Step 1: Call 1-313-225-6800 to request an expedited review. Your physician should also call this number to verify that you qualify for an expedited review.

Step 2: We must provide you with our decision within 72 hours of receiving both your grievance and the physician's substantiation.

Step 3: If you do not agree with our decision, you may, within 10 days of receiving it, request an expedited external review.

Grievance and Appeal Process (continued)

Expedited External Review Process

If you have filed a request for an expedited internal review, you or your authorized representative may ask for an expedited external review from the Department of Insurance and Financial services.

You may request an expedited external review if you believe:

- We wrongly denied, terminated, cancelled or reduced your coverage for a service before you receive it, or
- We failed to respond in a timely manner to a request for benefits or payment

The process is as follows:

Step 1: A request for external review form will be sent to you or your representative with our final adverse determination

Step 2: Complete this form and mail it 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 Department 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 will have to authorize the release of medical records that may be required to reach a decision during the external review.

Step 3: The Department will decide if your request qualifies for an expedited review. If it does, the Department will assign an independent review group to conduct the review. The group will recommend within 36 hours if the Department should uphold or reverse our decision.

Step 4: The Department must decide whether to accept the recommendation within 24 hours. You will be told of the Department's decision. This decision is the final administrative decision under the Patient's Right to Independent Review Act of 2000.

Pre-Service Appeals

For members who must get approval before obtaining certain health services.
Your plan may require preapproval of certain health services. If pre-approval is denied, you can appeal this decision.

Please follow the steps below to request a review. If you have questions or need help with the appeal process, please call the Customer Service number on the back of your ID card.

All appeals must be requested in writing. We must receive your written request within 180 days of the date you received notice that the service was not approved.

Requesting a Standard Pre-Service Review
You may make the request yourself, or your professional provider or someone else acting on your behalf may make the request for you. If another person will represent you, that person must obtain written authorization to do so. Please call the Customer Service number on the back of your ID and ask for a Designation of Authorized Representative and Release of Information form. Complete it and send it with your appeal.

Your request for a review must include:

- Your contract and group numbers, found on your ID card
- A daytime phone number for both you and your representative
- The member's name, if different from your name
- A statement explaining why you disagree with our decision and any additional supporting information

Once we receive your appeal, we will provide you with our final decision within 30 days.

Requesting an Urgent Pre-Service Review
If your situation meets the definition of urgent under the law, your request will be reviewed as soon as possible; generally within 72 hours. An urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician; you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an urgent review or a simultaneous expedited external review.

See above for the steps to follow to request an expedited external review.

For more information on how to ask for an urgent review or simultaneous expedited external review, call the Customer Service number listed on the back of your ID card.

Pre-service Appeals (continued)

Need More Information?
At your request and without charge, we will send you information details from your health care plan if our decision was based on your benefits. If our decision was based on medical guidelines, we will provide you with the appropriate protocols and treatment criteria. If we involved a medical expert in making this decision, we will provide that person's credentials.

To request information about your plan or the medical guidelines used, or if you need help with the appeal process, call the Customer Service number on the back of your ID card.

Other Resources to Help You
For questions about your rights, this certificate, or for assistance, call the Employee Benefits Security Administration at 1-866-444-EBSA (3272). You can also contact the Director of the Michigan Department of Insurance and Financial Services for assistance.

To contact the Director:

- Call toll-free at 1-877-999-6442; or
- Fax at 1-517-284-8837; or
- Go online at https://difs.state.mi.us/Complaints/ExternalReview.aspx; or
- Mail to:

  Department of Insurance and Financial Services
  P.O. Box 30220
  Lansing, MI 48909-7720

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 711 :877-469-2583 TTY 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。

ܙܘܗܪܐ: ܐܢ ܐܢܬ ܡܗܡܙܡܢܬ ܐܬܘܪܝܐ، ܦܠܚܢܘܬܐ ܕܗܝܪܬܐ ܕܠܫܢܐ ܒܕ ܗܘܝܐ ܦܬܝܚܐ ܩܕܡܝܟ ܕܠܐ ܐܓܪܐ. ܐܦ ܦܠܚܢܘܬܐ
ܦܘܪܢܣܝܬܐ ܠܣܝܥܬܐ ܠܡܘܬܒܬܐ ܕܡܘܕܥܢܘܬܐ ܒܛܘܦܣܐ ܡܬܡܛܝܢܐ ܐܝܬܝܗ̇ ܦܬܝܚܐ ܕܠܐ ܐܓܪܐ. ܡܩܪܐ ܥܠ ܡܢܝܢܐ 711 :877-469-2583 TTY ܐܘ
ܡܡܠܠ ܥܡ ܡܦܪܢܣܢܟ.

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

Discrimination Is Against The Law (continued)

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 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

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/

Section 9: How to Reach Us

This section lists phone numbers and addresses to help you get information quickly. You may call our BCBSM Customer Service centers.

To Call

Most of our BCBSM Customer Service lines are open for calls 8:00 a.m. to 8:00 p.m., Monday through Friday. Please have your ID card ready when you call.

Area code 248, 313, 586, 734, 810 or 947
Southeast Michigan toll-free 1-877-790-2583

Area code 231, 269 or 616
West Michigan toll-free 1-877-671-2583

Area code 517 or 989
Mid-Michigan toll-free 1-877-354-2583

Area code 906
Upper Peninsula toll-free..... 1-877-457-2583

For when you are out-of-state, call BlueCard..... 1-800-810-2583

For when you are out of the country, call Blue Cross Blue Shield Global Core
…….....1-804-673-1177 (call collect)

Index

A

B

C

D

E

F

G

H

I

J

L

M

N

O

P

Q

R

S

T

U

V

W

X

Y

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