



Confidence comes with every card.®

Blue Cross® Premier PPO Silver Saver Benefits Certificate

Blue Cross Blue Shield of Michigan 10-Day Money-Back Guarantee

Blue Cross Blue Shield of Michigan is committed to the health and satisfaction of our members. If for any reason you are unsatisfied and wish to terminate your coverage, simply notify BCBSM in writing within 10 days of the effective date of your coverage. You will receive a full refund of your premium. If you terminate your coverage after 10 days, you will receive a pro-rated refund on the unused portion of your premium. Please see the "How to Reach Us" section of this certificate for our mailing address and Customer Service telephone numbers.



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 We Do Not Pay For**
- **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 healthcare coverage. Please call us if you have any questions.

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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 for Individual Coverage
 - Who Is Eligible to Receive Benefits
- **WHEN YOU CAN ENROLL**
- **CONTRACT DATES**
- **CHANGING YOUR COVERAGE**
- **TERMINATION**
 - How to Terminate Your Coverage
 - How We Terminate Coverage
 - Rescission
- **BILLING**
 - Information About Your Bill
 - How Rates Are Classified

ELIGIBILITY

You will need to complete an application for coverage.

We will review your application to determine if you and the people you list on it are eligible for coverage. Our decision will be based on the eligibility rules in this certificate and our underwriting policies.



If you or anyone applying for coverage on your behalf commits fraud or intentionally lies about a material fact when filling out the application, your coverage may be rescinded. See “Rescission” on Page 6.

If you or anyone applying for coverage on your behalf lies about your tobacco use or state or county of residence, we have the right to get back from you the difference in premium from what you are paying and what you should have paid.

Who Is Eligible for Individual Coverage

You, your spouse and the children you have listed on your application are eligible if:

- You are a current resident of Michigan on the effective date of coverage and a U.S. citizen or legally present and must intend to live in the state except in the case of individuals living outside of Michigan temporarily (as in the case with college students or snowbirds).
- You are a minor child; you are eligible for a child-only certificate.



If more than one child is in a family, each child must have a contract and be named as the subscriber.

- You, your spouse or children do not have Medicare

Note to persons who become eligible for Medicare coverage after enrolling in this certificate:

- This certificate is not a Medicare supplemental certificate
- This certificate is not intended to fill the gaps in Medicare coverage and it may duplicate some Medicare benefits
- Review the Medicare supplemental buyer’s guide available from BCBSM and consider switching your coverage to Medicare supplemental
- Be sure you understand what this certificate covers, what it does not cover, and whether it duplicates coverage you have under Medicare

If you are enrolled in Medicare and Medicare covers a service, this same service is not payable under this contract, unless it falls in an exception, such as the ESRD coordination period.

Who Is Eligible to Receive Benefits

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

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 the subscriber by:

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



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

Your children will be removed from your contract at the end of the year in which they turn 26. If a dependent cannot be covered by your contract anymore, they may be able to get their own.

Newborn children, including your grandchildren, that are not listed on your contract may qualify for limited benefits immediately following their birth. For more information, see the *Maternity Care* section of this certificate.

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



You 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.

WHEN YOU CAN ENROLL

The only times during the year you can enroll are: during the annual open enrollment period; at any time due to a qualifying event that includes, but is not limited to, a birth, adoption, change in marital status, involuntary loss of job, or involuntary loss of group coverage, or at other times of the year as allowed by federal law.

CONTRACT DATES

All covered services and benefits are available on the effective date of your contract.

CHANGING YOUR COVERAGE

You may change your coverage only during the annual open enrollment period or at other times of the year as established by federal law.

You may change who may receive benefits under your current coverage if there is a qualifying event, including, but not limited to:

- 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

If you purchased this coverage **on** the Health Insurance Marketplace (Marketplace), you must notify the Marketplace within 60 days of the change. You generally have up to 60 days after the event to make a new plan selection. The date of this change is set by federal law.

If you purchased this coverage **off** the Marketplace, we must receive notice from you within 60 days of when a dependent or spouse is removed from coverage, and within 60 days of when a dependent or spouse is added. The date of the change and contract change effective dates are set by federal law. Not all effective dates are assigned the date of the event. The effective date depends on the type of event and options allowable by law.

You may add a member to your current coverage if you have a qualifying event. Generally, children must be added to your current coverage within 60 days of birth or adoption. Other dependents must be added to your coverage within the time allowed under federal law.

Changing Your Coverage (continued)

You must remove a member from your plan, as in the case of a divorce, within 60 days of the date of divorce. You may not change your coverage when you remove a member from your current plan, except as established by federal law. The member may qualify for their own coverage due to the qualifying event.

If a member on your contract dies, please notify us, and your rate will be adjusted as of the date of death. If the subscriber dies, the contract must be rewritten to reflect a new subscriber and the rate will be adjusted. In either event, you may not change your coverage until the next open enrollment period, except as established by federal law.

If you are changing your coverage in any of these ways, you must provide supporting proof of your qualifying event. For a list of supporting proof by event, please visit <https://www.bcbsm.com/documents.html>.

Once you receive your new ID card, do not use your old one. However, keep your old card until all claims incurred under your former contract have been processed.

TERMINATION

How to Terminate Your Coverage

Call or send us your written request to terminate coverage at the phone number or address listed in Section 9, "How to Reach Us." You may also call the phone number on your BCBSM identification card. We will accept termination of your coverage only from you. Your coverage will then be terminated as of the requested future date. All benefits under this certificate will end. A refund or credit will be given for the pro-rated share of any premiums that were prepaid.

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.

If you voluntarily terminate your coverage and premium is due, BCBSM reserves the right to collect this premium from you.

If you purchased this coverage **on** the Marketplace, you may terminate it only if you contact the Marketplace with proper notice. Once you provide this notice, the Marketplace will notify us of the date the termination takes effect, which is usually 14 days from the date of notification.

If you purchased this coverage **off** the Marketplace, call or send us your written request to terminate coverage at the phone number or address listed in Section 9. You may also call the phone number on your BCBSM identification card.



If you decide to terminate your coverage within 10 days after the date that it is effective, you will be given a full refund of the premium that you paid. If you decide to terminate your coverage after it has been effective for 10 days, you will be given a pro-rated refund of any unused portion of the premium that you paid.

Termination (continued)***How We Terminate Your Coverage***

We may terminate your coverage if:

- You no longer qualify for coverage under this certificate
- You do not pay your bill on time
- You are serving a criminal sentence for defrauding BCBSM
- You cannot provide proof you are a Michigan resident
- 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.

If we terminate your coverage, we will provide you with 30 days’ notice, along with the reason for the termination.

Rescission

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

- Performed an act, practice, or omission that constitutes fraud, or
- Intentionally lied about a 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 must repay BCBSM for its payment for any services you received.

BILLING

Information About Your Bill

Each bill for a regular billing cycle covers a one-month period.

If you bought this coverage on the Health Insurance Marketplace (Marketplace) and the Marketplace determines you are eligible for a premium tax credit (subsidy):

- You are responsible only for your portion of the premium, not any applicable amount covered by the subsidy.
- You must pay your premium by the due date printed on your bill. When we receive your payment, we will continue your coverage through the period for which you have paid.
- You may get subsidies if:
 - This coverage is available on the Marketplace and
 - You buy this coverage on the Marketplace

If you are receiving an advance payment of a federal premium tax credit and have paid at least one full month of premium during the current benefit year, you will be given a three-month grace period before we will terminate or cancel your coverage for not paying your premium when due. If you receive healthcare services at any time during the second or third months of the grace period, we will hold payment for claims for these services beginning on the first day of the second month of the grace period. We will notify your providers that we are not paying these claims during this time.

If we do not receive your payment in full for all premiums due before the grace period ends, your coverage will be terminated or cancelled. Your last day of coverage will be the last day of the first month of the three-month grace period. All claims for any health services that were provided after that last day of coverage will be denied.

If you bought this coverage either off the Marketplace or on the Marketplace and are not eligible for a subsidy:

- You are responsible for the entire premium amount
- You must pay your premium by the due date printed on your bill. When we receive your payment, we will continue your coverage through the period for which you have paid.
- The three-month grace period does not apply if you do not receive a premium tax credit. If we do not receive your premium by the due date, we will allow you a grace period of 31 days, during which we will send you a final bill. If we do not receive your premium payment during the grace period, your coverage will be terminated or cancelled as of the last day of paid coverage.



We will accept payment of your health insurance premium only from you, your spouse, or when appropriate, from a parent, blood relative, legal guardian or other person or entity that is allowed by law to pay your premium on your behalf, including: The Ryan White HIV/AIDS Program; tribes, tribal organizations, or urban Indian organizations; and local, State, or Federal government programs, including grantees directed by a government program to make payments on its behalf. We otherwise reserve the right to decline premium payments made directly or indirectly, by any other person or entity from which we are not required to accept payment.

Billing (continued)***How Rates Are Classified***

Your rate will be based upon certain rating factors such as age, tobacco use and where you live, in accordance with federal law.

Your rate will be:

- The sum of the rates for each member on the contract (subscriber, spouse and adult children 21 years up to 26 years of age) as of the effective date of the contract

PLUS

- The sum of the rates for each child under 21 years of age on the effective date of the contract. You will be charged for a maximum of three children under 21 years of age, even if there are more than three children under 21 covered on this contract.



If the subscriber or spouse is under the age of 21, they are not included in the three-child maximum.

Section 2: What You Must Pay

You have BCBSM PPO coverage under this certificate. BCBSM PPO coverage uses a “Preferred Provider Organization” provider network.

What you must pay depends on the type of provider you choose and whether your services are performed in Michigan or outside of Michigan. If you choose a BCBSM PPO “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 Michigan Provider		
BCBSM PPO 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 otherwise 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. • 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.

* Provider accepts BCBSM’s approved amount minus your cost share as payment in full for the covered services.

Choosing Your Provider Outside the State of Michigan
Generally, <u>all services performed outside the state of Michigan</u> will be subject to your out-of-network cost share. <u>Exceptions:</u> • Your urgent care, medical emergency and accidental injury services are subject to your in-network cost share • Your provider is in BCBSM’s PPO network and has a Michigan Provider ID.

What You Must Pay (continued)**Choosing Your Provider** (continued)

Whether you pay a provider's charge depends if the provider is participating or nonparticipating with Blue Cross Blue Shield (BCBS):

- **Participating providers** have signed agreements with BCBS and cannot bill you for more than our approved amount minus your cost share.
- **Nonparticipating providers** have not signed agreements with BCBS. 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).

What you must pay for covered services is described in the following pages. Section 4 on Page 139 explains more about providers such as professional providers, hospitals and others. That section explains how we pay providers.

The deductibles, copayments and coinsurances you must pay each calendar year are shown in the charts 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. Deductible, copayment **AND** coinsurance apply to some services.

BCBSM PPO In-Network Cost-Sharing Chart	
Deductibles	\$5,000 for one member \$10,000 for the family (when two or more members are covered under your contract)
Copayments	\$0 for 24/7 virtual visits only when performed through the Blue Cross selected vendor app before your deductible \$30 for diagnostic laboratory and pathology services in an outpatient hospital, independent laboratory or physician's office before your deductible \$60 per primary care office, home, online, virtual and outpatient visit, retail health clinic visit, mental health and substance use disorder visits (office, virtual or online visit), applied behavior analysis (ABA) treatment, medical evaluation at an affiliated immunization pharmacy, office consultation and pre-surgical consultation in a primary care office before your deductible \$110 per specialist office, home, virtual and outpatient visit; office consultation; and pre-surgical consultation in a specialist office after deductible has been met. \$75 per urgent care visit in freestanding urgent care center, office or outpatient urgent care center in a hospital before your deductible \$450 for <i>outpatient professional surgical services</i> rendered by a physician or other licensed healthcare professional when received in a hospital outpatient department or ambulatory surgical center after your deductible has been met. \$450 for <i>outpatient facility surgical services</i> when received in a hospital outpatient department or ambulatory surgical center after deductible has been met. \$750 per visit for facility services in a hospital emergency room (in-network or out-of-network) after deductible has been met <i>See Section 3 for Prescription Drug Copayments</i>
Coinsurance	40% of the approved amount for most covered services including diabetes and medical supplies, after in-network deductible has been met. 50% of the approved amount for bariatric surgery, temporomandibular surgery, infertility testing and treatment, prosthetics and orthotics, and durable medical equipment, after in-network deductible has been met.
Annual Out-of-Pocket Maximums	\$9,000 for one member \$18,000 for the family (when two or more members are covered under your contract)
Lifetime Dollar Maximum	None

What You Must Pay (continued)

Out-of-Network Cost-Sharing Chart (Not in the BCBSM PPO Network)	
 Your cost share may be higher for out-of-network and out-of-state services. You may be responsible for the difference between what BCBSM pays and what your provider charges for services you receive in or outside the state of Michigan. <u>ALL</u> services performed outside the state of Michigan are subject to your out-of-network cost share, unless your provider is in the BCBSM PPO network and has a Michigan provider ID number. <u>Exception:</u> • Urgent care, treatment of an accidental injury or medical emergency services are subject to your in-network cost share.	
Deductibles	\$10,000 for one member \$20,000 for the family (when two or more members are covered under your contract)
Copayments	None
Coinsurance	60% of the approved amount for most covered services including diabetes and medical supplies, after out-of-network deductible has been met. 70% of the approved amount for bariatric surgery, temporomandibular surgery, infertility testing and treatment, prosthetics and orthotics, and durable medical equipment after out-of-network deductible has been met.
Annual Out-of-Pocket Maximums	\$18,000 for one member \$36,000 for the family (when two or more members are covered under your contract)
Lifetime Dollar Maximum	None

BCBSM PPO In-Network Providers

Deductible Requirements

This plan has an integrated medical and prescription drug deductible. “Integrated” means that all the payments you make for covered medical and prescription drug expenses are combined to meet this deductible.

What you must pay:

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

- \$5,000 for one member
- \$10,000 for the family (when two or more members are covered under your contract)

For a family contract, two or more members must meet the family deductible.

However:

- If one family member meets the one-member deductible, that member does not pay any more deductible cost sharing for the rest of the calendar year
- The other members must pay their cost share until the annual family deductible maximum is met

We will begin paying for covered services after your integrated deductible has been met.

- Deductibles paid in one calendar year are not applied to the deductible you must pay the following year.
- In-network and out-of-network deductibles may not be combined to satisfy this certificate’s in-network deductible requirements.



We base your deductible on the amount defined annually by the federal government. Since changes in the federal government amounts will affect your deductible in future years, please call our BCBSM Customer Service center for an annual update.

Payments for the following will not be applied to your deductible:

- Non-covered services or charges that exceed our approved amount or
- Copayments and coinsurances

BCBSM PPO In-Network Providers (continued)
Deductible Requirements (continued)**Benefits for the following are not subject to the in-network deductible:**

- Preventive benefits
- Prenatal Care Visits
- Postnatal Care Visit
- Tier 1 Prescription Drugs
- A primary care physician office, home, online, virtual or outpatient visit
- A retail health clinic visit
- A virtual primary care visit through the Blue Cross selected vendor app
- An office consultation
- A pre-surgical consultation
- An Applied Behavior Analysis (ABA) treatment
- A medical evaluation at an affiliated immunization pharmacy
- A mental health or substance use disorder visit (office, virtual or online visit)
- An urgent care visit
- Diagnostic laboratory and pathology services in an outpatient hospital, independent laboratory or physician's office
- Provider-delivered care management services performed by designated in-network providers as identified by BCBSM rendered in Michigan.
- You pay no cost share for Enhanced Condition Management Program benefits provided by a BCBSM selected vendor. For all other diabetic services and supplies you receive outside of this program, you may have to pay cost share. See the Outpatient Diabetes Management Program and What You Must Pay sections in your certificate.

BCBSM PPO In-Network Providers (continued)**Copayment Requirements**

See “Prescription Drugs” in Section 3 for what you must pay for prescribed drugs obtained from a pharmacy.

What you must pay:

Your copayment for the following covered services **before your in-network deductible** is met is:

- \$0 for 24/7 virtual visits only when performed through the Blue Cross selected vendor app
- \$30 for diagnostic laboratory and pathology services in an outpatient hospital, independent laboratory or physician’s office

NOTE

Your copayment is applied per day, not per diagnostic laboratory and pathology service. However, when an office visit and diagnostic laboratory and pathology service are billed on the same day, you will also pay your applicable office visit copayment.

If you are admitted to the hospital, your deductible and coinsurance will apply to diagnostic laboratory and pathology services billed by the hospital during your inpatient stay.

- \$60 for:
 - A primary care physician office, home, online, virtual or outpatient visit
 - A retail health clinic visit
 - A virtual primary care visit through the Blue Cross selected vendor app
 - An office consultation
 - A pre-surgical consultation
 - An Applied Behavior Analysis (ABA) treatment
 - A medical evaluation at an affiliated immunization pharmacy
 - A mental health or substance use disorder visit (office, virtual or online visit)

NOTE

Diagnostic laboratory and pathology services performed in an office are subject to your diagnostic laboratory and pathology copayment requirements. All other diagnostic services are subject to your deductible and coinsurance.

- \$75 per urgent care visit in:
 - A freestanding urgent care center
 - An office, or
 - An outpatient urgent care center in a hospital

NOTE

Diagnostic laboratory and pathology services performed in an office are subject to your diagnostic laboratory and pathology copayment requirements. All other diagnostic services are subject to your deductible and coinsurance.

BCBSM PPO In-Network Providers (continued)
Copayment Requirements (continued)

Your copayment for the following covered services **after your in-network deductible** is met is:

- \$110 for:
 - A specialist office, home, virtual or outpatient visit
 - An office consultation with a specialist
 - A pre-surgical consultation with a specialist
-  **NOTE** Diagnostic laboratory and pathology services performed in an office are subject to your diagnostic laboratory and pathology copayment requirements. All other diagnostic services are subject to your deductible and coinsurance.
- Surgical services in an outpatient department of a hospital or ambulatory surgical center:
 - \$450 for *surgical services* rendered by a physician or other licensed healthcare professional
- AND**
- \$450 for *outpatient facility surgical services*
-  **NOTE** Non-surgical services performed in an outpatient hospital setting remain subject to the cost-share requirements explained in this section.
- \$750 per visit for facility services in a hospital emergency room (in-network or out-of-network)

If the approved amount of your service is less than your copayment, you pay only the approved amount of the service.

You do not pay an in-network copayment for certain provider-delivered care management services (see Section 7: Definitions). These services must be obtained from Michigan providers approved by BCBSM

You pay no cost share for Enhanced Condition Management Program benefits provided by a BCBSM selected vendor. For all other diabetic services and supplies you receive outside of this program, you may have to pay cost share. See the Outpatient Diabetes Management Program and What You Must Pay sections in your certificate.

BCBSM PPO In-Network Providers (continued)**Coinsurance Requirements**

See “Prescription Drugs” in Section 3 for what you must pay for prescribed drugs obtained from a pharmacy.

Unless we state otherwise, you must pay a coinsurance for most covered services **after your in-network deductible is met**.

What you must pay:

Your coinsurance for the following covered services:

- 40% of the approved amount for most covered services, including diabetes and medical supplies
- 50% of the approved amount for:
 - Bariatric surgery
 - Temporomandibular surgery
 - Infertility testing and treatment
 - Prosthetics and orthotics
 - Durable medical equipment

The following services are **not** subject to in-network coinsurance:

- Preventive services
- Hospice care
- Prenatal Care Visits
- Postnatal Care Visit
- Primary care physician office, home, online, virtual or outpatient visits
- Specialist office, home, virtual or outpatient visits
- Virtual primary care visit through the Blue Cross selected vendor app
- Consultation office visits
- 24/7 virtual visit through the Blue Cross selected vendor app
- Retail health clinic visits
- Urgent care visits
- Diagnostic laboratory and pathology services in an outpatient hospital, independent laboratory or physician’s office
- Facility services for outpatient surgery in an ambulatory surgical facility or outpatient hospital
- Facility services in a hospital emergency room (in-network or out-of-network).
- Applied Behavior Analysis (ABA) treatment
- A medical evaluation at an affiliated immunization pharmacy
- Mental health or substance use disorder visits (office, virtual or online visits)
- Provider-delivered care management services (see Section 7: Definitions). These services must be obtained from providers approved by BCBSM in Michigan.
- Enhanced Condition Management Program provided by a BCBSM selected vendor

BCBSM PPO In-Network Providers (continued)**Annual Out-of-Pocket Maximums**

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

- \$9,000 for one member
- \$18,800 for the family (when two or more members are covered under your contract)

For a family contract, two or more members must meet the family out-of-pocket maximum. However:

- If one family member meets the one-member maximum, that member does not pay any more cost sharing for the rest of the calendar year
- The other members must pay their cost share until the annual family out-of-pocket maximum is met

We base your out-of-pocket maximum on the amount defined annually by the federal government. Since changes in the federal government amounts will affect your out-of-pocket maximum in future years, please call your BCBSM Customer Service center for an annual update.

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 those services and our approved amount, your payment will not apply to your out-of-pocket maximum.

The in-network **deductible, copayments and coinsurance** that you pay are combined to meet the annual in-network out-of-pocket maximum. This includes those for prescription drugs. 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.

In addition, the following prescription drug expenses will NOT apply towards the annual out-of-pocket maximum:

- Payment for non-covered drugs or services
- Any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand-name drug
- Amounts that exceed our approved amount for covered drugs or out-of-network retail penalty amounts

In-network and out-of-network cost share may not be combined to satisfy your annual out-of-pocket maximum for in-network services.

Once your out-of-pocket maximum is met, no more deductible, copayments or coinsurance will be required for the remainder of the calendar year.

BCBSM PPO Out-of-Network Providers

Your cost share may be higher for out-of-network and out-of-state services.

You may be responsible for the difference between what BCBS pays and what your provider charges for services you receive from out-of-network providers.

Deductible Requirements

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

- \$10,000 for one member
- \$20,000 for the family (when two or more members are covered under your contract)

For a family contract, two or more members must meet the family deductible.
However:

- If one family member meets the one-member deductible, that member does not pay any more deductible cost sharing for the rest of the calendar year
- The other members must pay their cost share until the annual family deductible is met



Your out-of-network deductible requirement includes payments you make for services you receive outside the state of Michigan and from Michigan out-of-network providers. Deductible payments made to in-network providers do not apply to your out-of-network deductible requirement.

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

- An in-network provider refers you to an out-of-network provider in Michigan.



You must obtain the approved individual out-of-state exception form, or the service will be subject to the out-of-network cost share requirements.

- You receive 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).
- You receive services for air ambulance
- You receive services from a provider for which there is no PPO network.
- You receive 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.

BCBSM PPO Out-of-Network Providers (continued)**Deductible Requirements** (continued)

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.
- The reading and interpretation of select routine or screening services when an in-network provider performs the service, but an out-of-network Michigan provider does the analysis and interprets the results.

NOTE

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

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

Copayment Requirements

- None

NOTE

Out-of-network services are subject to your out-of-network deductible and coinsurance.

Coinsurance Requirements**What you must pay:**

Your coinsurance for the following covered services **after your out-of-network deductible is met** is:

- 60% of the approved amount for most covered services, including diabetes and medical supplies.

NOTE

Online visits by an out-of-network professional provider will be subject to applicable out-of-network cost-sharing requirements. 24/7 virtual visits and virtual primary care visits through a vendor that was not selected by BCBSM will not be covered.

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

- An in-network provider refers you to an out-of-network provider in Michigan
- You receive 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).
- You receive services for air ambulance

NOTE

You must obtain the approved individual out-of-state exception form, or the service will be subject to the out-of-network cost share requirements.

- You receive services from a provider for which there is no PPO network.
- You receive 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.

BCBSM PPO Out-of-Network Providers (continued)**Coinsurance Requirements** (continued)

- 70% of the approved amount for:
 - Bariatric surgery
 - Temporomandibular surgery
 - Infertility testing and treatment
 - Durable medical equipment
 - Prosthetics and orthotics

Annual Out-of-Pocket Maximums

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

- \$18,000 for one member
- \$36,000 for the family (when two or more members are covered under your contract)

For a family contract, two or more members must meet the family out-of-pocket maximum. However:

- If one family member meets the one-member maximum, that member does not pay any more cost sharing for the rest of the calendar year
- The other members must pay their cost share until the annual family out-of-pocket maximum is met

We base your out-of-pocket maximum on the amount defined annually by the federal government. Since changes in the federal government amounts will affect your out-of-pocket maximum in future years, please call your BCBSM Customer Service center for an annual update.

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 those services and our approved amount, your payment will not apply to your out-of-pocket maximum.

The out-of-network **deductible, copayments and coinsurance** that you pay are combined to meet the annual out-of-network maximum. This includes those for prescription drugs. 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.

In addition, the following prescription drug expenses will NOT apply towards the annual out-of-pocket maximum:

- Payment for non-covered drugs or services.
- Any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand-name drug.
- Amounts that exceed our approved amount for covered drugs or out-of-network retail penalty amounts.

In-network and out-of-network cost share may not be combined to satisfy your annual out-of-pocket maximum for out-of-network services.

Once your out-of-pocket maximum is met, no more deductible, coinsurance or copayments will be required for the remainder of the calendar year.

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 9 for what you may be required to pay for these services.

For other diagnostic services, see Page 51.

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 9 for what you may be required to pay for these services.

For emergency treatment services, see Page 57.

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.



Non-emergency 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:**

- Non-emergent 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 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.

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 9 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

NOTE

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

NOTE

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 electroshock therapy electroconvulsive therapy (ECT) (see Page 73) and for covered dental services (see Page 47).

Audiologist Services

See Section 2 beginning on Page 9 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 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 9 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**

- Applied 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, behavior 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)

- 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 licensed behavior analyst including, but not limited to, treatment of traumatic brain injuries.
-  **NOTE** 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 of practice.
- **Psychological care** – It includes a psychologist's direct or consulting services. The psychologist must be licensed in the state of 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

 **NOTE** 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 spectrum disorder 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.

Behavioral Health Services (Mental Health and Substance Use Disorder)

See Section 2 on Page 18 for what you may be required to pay for these services.

For autism spectrum disorders, please see Page 28.

For emergency services to treat behavioral health conditions, please see Page 57.

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 healthcare 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.

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 also pay for mental health services when:

- Online
- Virtual

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

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

- **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

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

Behavioral Health Services (Mental Health and Substance Use Disorder) (continued)**Mental Health (continued)****Psychiatric residential treatment (continued)****We do not pay for: (continued)**

- Therapeutic boarding schools
- Milieu therapies, such as wilderness program, supportive houses or group homes
- Domiciliary foster care
- Custodial care
- Treatment or programs for sex offenders or perpetrators of sexual or physical violence
- Services to hold or confine a member under chemical influence when the member does not require medical treatment
- A private room or an apartment
- Service provided by a nonparticipating psychiatric residential treatment facility
- 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

- **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

Behavioral Health Services (Mental Health and Substance Use Disorder) (continued)**Mental Health (continued)****Intensive Outpatient Program (IOP) (continued)**

We do not pay for:

- Prescribed drugs given by the hospital or facility during the member's treatment
- Psychological testing
- Outpatient Psychiatric Care Facility, Office Setting, Online and Virtual

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, online and virtual for mental health services. (See Page 28 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.

Behavioral Health Services (Mental Health and Substance Use Disorder) (continued)**Substance Use Disorder (continued)****Residential and Outpatient Substance Abuse Treatment Facility (continued)**

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

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

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

- 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

- 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 9 for what you may be required to pay for these services.

For pulmonary rehabilitation, see Page 117.

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 and pulmonary rehabilitation services.

Cellular and Gene Therapy

See Section 2 beginning on Page 9 for what you may be required to pay for these services.

Cellular and gene therapies are products that involve the use of human cells and/or genetic modification to treat disease. The products that BCBSM considers to be cellular and gene therapies are listed at [bcbsm.com/cellgenetherapy](https://www.bcbsm.com/cellgenetherapy).

We pay for:

- Cellular and gene therapies for cancer indications.



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.

- Cellular and gene therapies for non-cancer indications that have been proven to be effective, as determined by BCBSM.
 - BCBSM considers cellular and gene therapies to be proven effective to treat a condition if the following are true:
 - The drug has full FDA approval that was not obtained under the FDA's accelerated approval pathway; and
 - The drug met all of its primary endpoint(s) in its pivotal trials; or
 - If confirmatory trials were required, the drug met its primary endpoint(s) in its confirmatory trial(s).



Accelerated Approval Pathway: An FDA process that allows for earlier approval of certain drugs, including cellular and gene therapies, that have not yet demonstrated actual clinical benefit(s).

Primary Endpoint: The main outcome(s) the trial is designated to evaluate.

We do not pay for:

- Cellular and gene therapies for non-cancer indications that have not been proven effective as determined by BCBSM.

Chemotherapy

See Section 2 beginning on Page 9 for what you may be required to pay for these services.

For high dose chemotherapy used in bone marrow transplants, see Pages 130 – 132.

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 107.

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 56.

We pay for the outpatient treatment of breast cancer.

Chiropractic Services and Osteopathic Manipulative Therapy

See Section 2 beginning on Page 9 for what you may be required to pay for these services.

When received with physical therapy see Page 86.

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

- An office
- A participation 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).

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 mechanical traction and spinal manipulation are provided on the same day, the services are counted as one visit.

Chiropractic Services and Osteopathic Manipulative Therapy(continued)

We Pay For (continued)

- 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 9 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 9 for what you may be required to pay for these services.

For oncology clinical trial services, see Page 79.

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.

NOTE

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

NOTE

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 (e.g., monthly CT scans for a condition usually requiring only a single scan)
- Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial, or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

NOTE

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 healthcare 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 9 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 108 for more details.

Dental Services

See Section 2 beginning on Page 9 for what you may be required to pay for these services.

For dental surgery, see Page 126.

Locations: We pay for emergency dental care given in:

- A participating 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.
- 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.



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.



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:

- Alveoloplasty
- 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 or (see Page 86 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
- Services covered under any other health plan
- 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 9 for what you may be required to pay for these services.

For allergy testing services, see Page 23.

For diagnostic radiology services, see Page 118.

For mental health diagnostic services, such as psychological testing, see Page 73.

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
 - Nuclear cardiac 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 Services (continued)**We pay for:** (continued)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
- In an office for standard office laboratory tests approved by BCBSM and in connection with medical care. (We do not pay for nonstandard tests performed in a physician's office). Tests must be provided by the member's attending physician or by another physician, if prescribed by the attending physician, or
- By a laboratory when prescribed by a physician



When you receive services from a laboratory that is not a member of the PLUS PPO, the laboratory services will be considered out-of-network. Please see the definition of "PLUS Laboratory" in Section 7.

- By a participating substance abuse facility in connection with treatment of substance use disorder, or
- By your physician, or
- By another physician, if your in-network physician refers you to one, or
- By a lab at your in-network physician's direction.
 - We pay for standard office lab tests in your physician's office. Other lab tests must be sent to a 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 9 for what you may be required to pay for these services.

For End Stage Renal Disease (ESRD) also see Page 192

Locations: We pay for dialysis services in:

- A participating hospital
- A participating freestanding 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 212 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

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

Dialysis Services (continued)**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 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

We do not pay for:

- Services provided by persons under contract with the hospital, agencies or organizations assisting in the dialysis or acting as "backup" 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 members home
- Physician services not paid by the hospital

Durable Medical Equipment

See Section 2 beginning on Page 9 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 must include a description and quantity of the items, diagnosis related to the services or items provided and information to substantiate the need for the items or services.
- The prescriber 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.
- Purchased, we will pay to have the equipment repaired and restored to use, but not for routine periodic maintenance.

Durable Medical Equipment (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 9 for what you may be required to pay for these services.

For urgent care services, please see Page 136.

Locations: We pay for services to treat medical emergencies and accidental injuries (See Section 7 for the definitions) 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.

Enhanced Condition Management Program (ECMP)

Your coverage includes the programs listed below. The services must be received from an approved BCBSM vendor. To see the available programs(s), go to the [Health and Well-Being | My online account | bcbsm.com](#) website or you may also contact BCBSM Customer Service. You may have one or all of the following conditions to qualify for these programs:

- Pre-diabetes
- Diabetes
- Hypertension

We pay for:

- Diabetes Prevention Program
 - Select services, equipment, and tools to reduce the risk of a Type 2 diabetes diagnosis
- Enhanced Diabetes Management Program
 - Select services, equipment, tools to manage Type 2 diabetes
- Cardiovascular Management Program
 - Select services, equipment, and tools to manage hypertension

Limitations:

You are not eligible for this program if:

- You received services from a nonapproved BCBSM vendor
- You do not meet the program eligibility guidelines
- Medicare is your primary payer

Fertility Preservation

See Section 2 beginning on Page 9 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 two years
- Thawing of embryos, mature eggs and sperm within two years of procurement
- Culture of eggs
- Ovarian transposition
- Embryo transfer to member within two years from cryopreservation

We do not pay for:

- Storage of sperm, eggs or embryos for longer than two years
- 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 9 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
- Prescription drugs including hormone therapy (see Prescription Drugs)

We do not pay for:

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

Home Healthcare Services

See Section 2 beginning on Page 9 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 healthcare provides an alternative to long-term hospital care by offering coverage and care services in the member's home. Home healthcare must be:

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

The following criteria for home healthcare 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 healthcare 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 healthcare services and submits a detailed treatment plan to the home healthcare agency.
- The agency accepts the member into its program.

We pay for:

Services provided by healthcare professionals employed by the home healthcare 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 healthcare 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 74
 - Physical therapy, Page 86
 - Speech language therapy, Page 121

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

Home Healthcare 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 described on pages 74, 86 and 121.

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

- If services in a member's home are billed by a home healthcare agency, they will **not** count toward the visit maximums.
- Part-time health aide services, **if all of the following criteria is met:**
 - The member is receiving skilled nursing care or physical therapy or speech language therapy, **and**
 - The member's family cannot provide the services **and** the home healthcare agency has, **and** 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

NOTE

An order from a physician for a home health aide does not guarantee coverage.

We pay the following covered services when the home healthcare 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 (when billed by the home healthcare agency unless the agency is an approved DME provider)
- Physician services (when billed by the home healthcare agency)
- Custodial or nonskilled care
- Services performed by a nonparticipating home healthcare provider

Hospice Care Services

See Section 2 beginning on Page 9 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:

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.

Hospice Care Services (continued)**We pay for:** (continued)Facility Services

- Inpatient care provided by:
 - A participating hospice inpatient unit
 - A participating hospital contracting with the hospice program or
 - A skilled participating 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

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.

Hospice Care Services (continued)**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 care service. When the services are canceled, regular Blue Cross coverage will be reinstated.

How to Reinstatement 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 9 for what you may be required to pay for these services.

For services in a long-term acute care hospital (LTACH), see Page 69.

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 125).

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.)

Infertility Treatment

See Section 2 beginning on Page 9 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 infertility 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.

Services 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 9 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 Drug* 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 (See Section 7 for a definition)
- 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 107.
- 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 9 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

NOTE

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 if the member's primary diagnosis is a mental health or substance use disorder condition

Maternity Care

See Section 2 beginning on Page 9 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
- A member's home

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 pre-natal visit



Prenatal visits conducted by an in-network provider are not subject to deductible, coinsurances or copayments. Diagnostic and laboratory tests performed in the physician's office are subject to the cost-share requirements in Section 2. See Section 2 for what you may be required to pay for prenatal visits conducted by an out-of-network provider.

- Medically necessary genetic testing

Maternity Services (continued)**We pay for:** (continued)

- Vaginal delivery or cesarean section when provided in:
 - 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
 - A member's home
- Postnatal care, including a Papanicolaou (Pap) smear during the six-week visit



Postnatal visits conducted by an in-network provider are not subject to deductible, coinsurances or copayments. Diagnostic and laboratory tests performed in the physician's office are subject to the cost share requirements in Section 2. See Section 2 for what you may be required to pay for postnatal visits conducted by an out-of-network provider.

- Lactation education and alternative fertility awareness counseling
- Newborn services provided **during the first 48 or 96 hours** if the newborn has not been added to the BCBSM contract of the birth parent. These services include:
 - Newborn examination given by a physician other than the anesthesiologist or the birth parent's attending physician
 - 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 healthcare 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 9 for what you may be required to pay for these services.

For medical supplies for outpatient diabetes treatment, see Page 84.

For medical supplies for infusion therapy, see Page 68.

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 9 for what you may be required to pay for these services.

For maternity care, see Page 64.



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

Locations: We pay for facility and professional 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 9 for what you may be required to pay for these services.

For physical therapy services, see Page 86.

For speech language therapy services, see Page 121.

Special rules apply when occupational therapy services are provided to treat autism spectrum disorders (see Page 28).

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 nursing home, if it's the member's primary residence
- A member's home

We pay for:

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

Occupational Therapy (continued)

Important: See Note below about treatment dates and initial evaluations. The combined 30-visit habilitative and combined 30-visit rehabilitative maximum renews each calendar year. It includes 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 healthcare agency, they will not count toward the combined visit maximum (See page 69 for Home Healthcare Services).



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 toward the maximum benefit limit (described above).

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:
 - A physician (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 members' 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

Occupational Therapy (continued)**We do not pay for:**

- More than the combined 30 habilitative and the combined 30 rehabilitative outpatient visits for physical and occupational therapy per member per calendar year, (see above about combined benefit) 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, or residential substance abuse treatment facility
- Services received from a nonparticipating hospital or nonparticipating facility
- Services received from an independent sports medicine clinic
- 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



NOTE 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 Page 9 in Section 2 for what you may be required to pay for these services.

For chiropractic or osteopathic office visits for spinal manipulation, please see Page 42.

Locations: We pay for office visits when provided by a physician or eligible professional provider when medically necessary:

- Medical and behavioral health office visits

They include:

- Urgent care visits (in a physician's office)
- Office consultations
- Presurgical consultations
- Online visits
- Virtual visits
- Retail health clinic visits
- Virtual primary care visits through the Blue Cross selected vendor app
- 24/7 virtual visit through the Blue Cross selected vendor app
- Provider-Delivered Care Management office visits
- Specialist office visits

- Outpatient visits
- Home medical care visits

Online Visits and 24/7 Virtual Visits

We pay for online visits by a professional provider and 24/7 virtual visits through the Blue Cross selected vendor app.



24/7 virtual visits through a 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 a professional provider in real time. The 24/7 virtual visit must allow the member to interact with the BCBSM selected vendor in real time. Treatment and consultation recommendations made online or virtually, including issuing a prescription, are to be held to the same standards of appropriate practice as those in traditional settings.

Online visits and 24/7 virtual visits must meet BCBSM's standards for an Evaluation and Management visit.



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 or 24/7 virtual visit provider must be licensed in the state where the member is located during the online visit.

Office, Outpatient and Home Medical Care Visits (continued)**Online visits and 24/7 virtual visits do not include:**

- Treatment of substance use disorders
- 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.

 NOTE

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 healthcare 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 9 for what you may be required to pay for these services.

For general surgery services, see Page 125.

For transplant services, see Page 129.

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

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 chemotherapeutic 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.

The services covered under this certificate are payable when directly related to a covered transplant. **These transplants must be performed at a designated cancer center or its affiliate to be a covered benefit under this certificate.**

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 0505C
600 Lafayette East
Detroit, MI 48226

Fax: (866) 752-5769

Preapproval will be granted to eligible BCBSM members if:

- The member has BCBSM health 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 if it 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:

- Chemotherapeutic 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 ACIP (Advisory Committee on Immunization Practices).

- **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”)
- Transplants or related services rendered at a nondesignated cancer center or its affiliate
- 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 healthcare 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-healthcare related services and/or research management (such as administrative costs)
- 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)
- 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 9 for what you may be required to pay for these services.

We pay for:

Medically necessary optometrist services performed both inside and outside Michigan.

When covered services are provided in Michigan the optometrist must:

- Be licensed in the state of Michigan, and
- Be certified by the Michigan Board of Optometry to administer and prescribe therapeutic pharmaceutical agents

When outside the state of Michigan, the optometrist must be legally qualified to perform services in the state where services are performed.

We do not pay for:

- Routine eye exams or services.

Outpatient Diabetes Management Program (ODMP)

See Section 2 beginning on Page 9 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



Continuous glucose monitors (CGM) and related supplies are covered only when obtained from the BCBSM designated exclusive vendor. CGMs and related supplies are not covered when supplied through any in-network pharmacy or durable medical equipment (DME) supplier that is not the BCBSM designated exclusive vendor. If your CGM and related supplies are not received from the BCBSM designated exclusive vendor, you may be responsible for the total cost.

- 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 podiatric physician, 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
- Diabetic specialty shoes
- 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

You pay no cost-sharing for training from an in-network provider.

Pain Management

See Section 2 beginning on Page 9 for what you may be required to pay for these services.

For infusion therapy services, see Page 68.

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 9 for what you may be required to pay for these services.

Special rules apply when physical therapy, occupational therapy or speech language therapy services are provided to treat autism spectrum disorders.

For autism spectrum disorders services, see on Page 28.

For occupational therapy services, see Page 74.

For speech language therapy services, see Page 121.

For chiropractic services and osteopathic manipulative therapy, see Page 28.

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 nursing home, if it's the member's primary residence
- A member's home

We pay for:

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

Physical Therapy (continued)**We pay for:** (continued)

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 healthcare agency, they will not count toward the combined visit maximum (See page 69 for Home Healthcare Services).



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 toward the maximum benefit limit (described above).

- Physical therapy must be:
 - Prescribed by a professional provider licensed to prescribe physical therapy services, unless it is performed by a chiropractor (See Page 42).
 - 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 professional provider (M.D., D.O. or podiatric physician)
 - A dentist or optometrist
 - A chiropractor
 - A physical therapist or physical therapist assistant
 - Athletic trainer



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.

Physical Therapy (continued)**We do not pay for:**

- More than the combined 30 habilitative and the combined 30 rehabilitative outpatient visits for physical and occupational therapy per member per calendar year (see above about combined benefit), whether obtained from an in-network or out-of-network provider.
- Services received from a nonparticipating hospital or nonparticipating facility
- Services provided by a freestanding facility in a home, hospital, skilled nursing 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
- Tests to measure physical capacities such as strength, dexterity, coordination or stamina, unless part of a complete physical therapy treatment program
- 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 helps to 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 111.

Certain covered drugs are subject to the annual deductible requirement described in Section 2. After the annual deductible requirement has been met, we will pay for each covered drug and each refill of a covered drug as described in this certificate or riders.

Your coinsurances and copayments for prescription drugs are in the charts in this section. Deductibles, coinsurances and copayments count toward your annual out-of-pocket maximum.



The coinsurance and copayments listed in this section only apply to prescription drugs received from a pharmacy.

To determine what tier is associated with your covered drug see your Prescription Drug List <https://www.bcbsm.com/2027-essential-select-druglist>

Your annual out-of-pocket maximum for covered services is described in the “What You Must Pay” section of this certificate. Once you reach the maximum, you have no out-of-pocket cost for covered drugs.

Locations: We pay for prescribed drugs you get from:

- A pharmacy
- A participating hospital
- Other approved locations

Prescription Drugs Received from a Pharmacy

- Prescription Drug Quantities
We pay up to a 30-day supply of a covered drug.
 - Non-Specialty Drugs
Non-specialty drugs are typically available in a 90-day supply when a 90-day supply is prescribed, and the drug is filled at a 90-day retail network pharmacy or mail order pharmacy. Blue Cross retains the right to limit the supply to a shorter time frame, regardless of the above, for any number of reasons including, but not limited to, packaging size, clinical appropriateness, and manufacturer recommendations, or for new drugs that have not yet been shown to be tolerated by the member.
 - Specialty Drugs
BCBSM has contracted with our exclusive pharmacy network for specialty drugs to provide your specialty drugs. Contact Customer Service for the location nearest you.

Specialty drugs are limited to a 30-day supply.



We only cover specialty drugs when obtained from our exclusive specialty pharmacy network. Specialty drugs are not covered when dispensed through a 90-day retail network pharmacy, in-network mail order or any in-network pharmacy (not part of the 90-day retail network). Covered drugs will be subject to your cost-share requirements. If you obtain your specialty drugs from any other provider, you may be responsible for the total cost.

Prescription Drugs (continued)**Prescription Drug Quantities (continued)**

- Select Specialty Drugs
We reserve the right to:

- Limit the quantity of select specialty drugs to no more than a 15-day supply for each fill.



Applicable cost share applies. Any applicable prescription drug copayments required in your certificate and/or riders will be reduced by one-half (1/2) for each medication limited to a 15-day fill.

- Select Controlled Substances
We reserve the right to:

- Limit the quantity and day supply of select* controlled substances.



The initial fill is limited to a 5-day supply. Additional fills for these medications will be limited to no more than a 30-day supply.

Select controlled substances include, but are not limited to:

- Hydromorphone
- Oxycodone
- Tapentadol

The initial fill limitation for select controlled substances will not apply to members with a cancer diagnosis or who are terminally ill.

**Select specialty drugs, select controlled substances and other covered drugs as determined by BCBSM are subject to change. Please see BCBSM's list of drugs that may have these limits at <https://www.bcbsm.com/2027-essential-select-druglist>*

- **Covered Drugs Obtained from an In-Network Pharmacy**

We will pay an in-network pharmacy for your covered prescription drugs after the integrated deductible has been met and deduction of your copayment. This includes a covered drug that contains bulk chemical powders approved by BCBSM.

We will cover at least the greater of:

- One drug in every United States Pharmacopeia (USP) category and class, or
- The same number of prescription drugs in each category and class as Michigan's benchmark plan. Some drugs covered under the medical benefit are used to meet this standard.

We will also cover:

- Medication Assisted Treatment for Opioid Use Disorder and Opioid Reversal Agents
 - We cover certain medications used to treat opioid use disorder without prior authorization, including buprenorphine.
 - We also cover select medications used for opioid overdose reversal, including intranasal naloxone.



Some medications may have quantity limitations based on FDA approved dosing.

Prescription Drugs (continued)90-Day Retail Network Pharmacy

Drugs obtained from an in-network 90-Day Retail Network Pharmacy are covered.

In-Network Mail Order Prescription Drugs

Drugs obtained from in-network mail-order pharmacies are covered.



Specialty drugs are not covered when dispensed through in-network mail order pharmacies. See specialty drugs within your certificate for more information.

In-Network Pharmacy (not part of the 90-Day Retail Network)

Drugs obtained from in-network pharmacy are covered.

Exclusive Specialty Pharmacy

Specialty Drugs obtained from the exclusive specialty pharmacy are covered

- **Diabetic Supplies and Devices**

We pay for:

- Select diabetic supplies and devices when prescribed by a physician or other professional provider licensed to prescribe it. Select diabetic supplies and devices include:

- Glucometers
- Continuous Glucose Monitors



Continuous glucose monitors (CGM) and related supplies are covered only when obtained from the BCBSM designated exclusive vendor. CGMs and related supplies are not covered when supplied through any in-network pharmacy or durable medical equipment (DME) supplier that is not the BCBSM designated exclusive vendor. If your CGM and related supplies are not received from the BCBSM designated exclusive vendor, you may be responsible for the total cost.

- Insulin Delivery Monitors
- Test strips for glucose monitors
- Test strips and lancets
- Insulin delivery reservoirs



A complete list of eligible pharmacy prescription diabetic supplies and devices can be found in your BCBSM drug list. To access your drug list visit at <https://www.bcbsm.com/2027-essential-select-druglist> and select “Drug lists” under *Find out if your drug is covered*. Please check the Outpatient Diabetes Management Program subsection of this certificate for additional information. Select supplies and devices may require prior authorization, please contact Customer Service.

- Diabetic supplies will be subject to your applicable cost-share requirement
- “Preferred” devices will be covered at 100% of our approved amount. “Nonpreferred” devices will be subject to your Tier 3 cost-share requirement.

- **Covered Drugs Obtained from an Out-of-Network Pharmacy**

Out-of-Network Pharmacies

Except for specialty drugs, covered drugs obtained from out-of-network pharmacies continue to be subject to any additional cost-sharing requirements described in the following charts.

Prescription Drugs (continued)**Contraceptive Drugs**

We pay for FDA-approved contraceptives as required by the Patient Protection and Affordable Care Act (PPACA) and identified by BCBSM. As described below, we will cover generic and select brand-name contraceptive drugs.

You do not have to pay a cost share for non-select brand-name contraceptive drugs if your prescriber receives prior authorization from BCBSM. (See Section 7 for a definition of the pharmacies in the chart below).

90-Day Retail In-Network Pharmacy	1 to 30-day supply You pay \$0 for each prescription	31 to 60-day supply Not covered	61 to 83-day supply Not covered	84 to 90-day supply You pay \$0 for each prescription
In-Network Mail Order Pharmacy	1 to 30-day supply You pay \$0 for each prescription	31 to 60-day supply You pay \$0 for each prescription	61 to 83-day supply You pay \$0 for each prescription.	84 to 90-day supply You pay \$0 for each prescription.
In-Network Pharmacy (not part of the 90-Day Retail Network)	1 to 30-day supply You pay \$0 for each prescription	31 to 60-day supply Not covered.	61 to 83-day supply Not covered	84 to 90-day supply Not covered.
Out-of-Network Pharmacy	1 to 30-day supply You pay: A penalty of 20% of the approved amount and the difference between the approved amount and what the pharmacy charges.			31 to 90-day supply Not covered



Generic and select brand-name contraceptive drugs are not subject to the integrated deductible; you pay member cost sharing as described further down in this section for other brand-name drugs

We do not pay for more than a 30-day supply of covered drugs within 60 days of the end of the plan year.

When a BCBSM in-network pharmacy fills a prescription for most other brand-name contraceptives, you have no out-of-pocket cost if your prescriber receives prior authorization from BCBSM. Prior authorization will depend on medical necessity, the member's current medical information, and criteria approved by BCBSM. For example, previous treatment with one or more preferred drugs may be required.

Prescription Drugs (continued)**Preventive Drugs, Immunization Vaccines, Supplements and Vitamins**

We pay for the following as required by the Patient Protection and Affordable Care Act:

- Preventive drugs
- Select immunization vaccines

NOTE

We will only pay for your immunization vaccine once. For example, if you receive an immunization vaccine that is paid by your BCBSM medical plan, your BCBSM prescription drug plan will not pay for the same immunization vaccine.

- Supplements
- Vitamins

NOTE

We reserve the right to cover only over-the-counter versions of the items listed above. This includes any other drug required to be covered under this Act.

A prescription is required for most preventive drugs, supplements and vitamins to be covered and they must be (See Section 7 for a definition of the pharmacies in the chart below):

- Dispensed by an in-network pharmacy **and**
- Approved by the FDA, when FDA approval is available **and**
- Meet coverage criteria required under the Patient Protection and Affordable Care Act.

90-Day Retail In-Network Pharmacy	1 to 30-day supply You pay \$0 for each prescription.	31 to 60-day supply Not covered	61 to 83-day supply Not covered	84 to 90-day supply You pay \$0 for each prescription.
In-Network Mail Order Pharmacy	1 to 30-day supply You pay \$0 for each prescription.	31 to 60-day supply You pay \$0 for each prescription	61 to 83-day supply You pay \$0 for each prescription.	84 to 90-day supply You pay \$0 for each prescription
In-Network Pharmacy (not part of the 90-Day Retail Network)	1 to 30-day supply You pay \$0 for each prescription	31 to 60-day supply Not covered.	61 to 83-day supply Not covered	84 to 90-day supply Not covered.
Out-of-Network Pharmacy	1 to 30-day supply You pay: • A penalty of 20% of the approved amount and the difference between the approved amount and what the pharmacy charges.			31 to 90-day supply Not covered

NOTE

Generic and select brand-name preventive drugs are not subject to the integrated deductible; you pay member cost sharing as described further down in this section for other brand-name drugs

We do not pay for more than a 30-day supply of covered drugs within 60 days of the end of the plan year.

Prescription Drugs (continued)**Tier 1 Drugs**

The chart below shows your coverage for each covered Tier 1 drug. This tier includes mostly non-specialty generic drugs and select non-specialty brand-name drugs and select specialty generic drugs.

NOTE

We only cover specialty drugs when obtained from our exclusive specialty pharmacy network.

90-Day Retail Network Pharmacy	1 to 30-day supply You pay \$0 for each prescription.	31 to 60-day supply Not covered	61 to 83-day supply Not covered	84 to 90-day supply you pay \$0 for each prescription.
In-Network Mail Order Pharmacy	1 to 30-day supply You pay \$0 for each prescription.	31 to 60-day supply You pay \$0 for each prescription.	61 to 83-day supply You pay \$0 for each prescription.	84 to 90-day supply You pay \$0 for each prescription.
In-Network Retail Pharmacy (not a part of the 90-Day Retail Network)	1 to 30-day supply You pay \$0 for each prescription.	31 to 60-day supply Not covered	61 to 83-day supply Not covered	84 to 90-day supply Not covered
Exclusive Pharmacy Network for Specialty Drugs	1 to 30-day supply* You pay \$0 for each prescription.	31 to 60-day supply Not covered	61 to 83-day supply Not covered	84 to 90-day supply Not covered

NOTE

We do not pay for more than a 30-day supply of covered drugs within 60 days of the end of the plan year.

Payments for the following do not apply toward your integrated deductible or 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
- Amounts that exceed our approved amount for covered drugs or out-of-network retail penalty amounts.
- Drugs obtained from an out-of-network mail order pharmacy

Prescription Drugs (continued)**Tier 2 Drugs**

The chart below shows your copayment for each covered Tier 2 drug. This tier includes mostly non-specialty brand-name drugs and select specialty brand-name drugs.

NOTE

We only cover specialty drugs when obtained from our exclusive specialty pharmacy network.

90-Day Retail Network Pharmacy	1 to 30-day supply After deductible, you pay \$100 for each prescription.	31 to 60-day supply Not covered	61 to 83-day supply Not covered	84 to 90-day supply After deductible, you pay \$300 for each prescription.
In-Network Mail Order Pharmacy	1 to 30-day supply After deductible, you \$100 for each prescription.	31 to 60-day supply After deductible, you pay \$200 for each prescription.	61 to 83-day supply After deductible, you pay \$300 for each prescription.	84 to 90-day supply After deductible, you pay \$300 for each prescription.
In-Network Pharmacy (not part of the 90-Day Retail Network)	1 to 30-day supply After deductible, you \$100 for each prescription.	31 to 60-day supply Not covered	61 to 83-day supply Not covered	84 to 90-day supply Not covered
Exclusive Pharmacy Network for Specialty Drugs	1 to 30-day supply* After deductible, you pay \$100 for each prescription	31 to 60-day supply Not covered	61 to 83-day supply Not covered	84 to 90-day supply Not covered

*Your prescription drug copayment will be reduced by one-half (1/2) for each medication limited to a 15-day fill.

NOTE

We do not pay for more than a 30-day supply of covered drugs within 60 days of the end of the plan year.

After your deductible is met, if the approved amount of the drug is less than your copayment, you pay only the approved amount of the drug.

Payments for the following do not apply toward your integrated deductible or annual out-of-pocket maximum:

- Payment for non-covered drugs or services.
- Any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand-name drug.
- Amounts that exceed our approved amount for covered drugs or out-of-network retail penalty amounts.
- Drugs obtained from an out-of-network mail order pharmacy.

Prescription Drugs (continued)**Tier 3 Drugs**

The chart below shows your copayment for each covered Tier 3 drug. This tier includes mostly non-specialty brand-name drugs and select high cost nonpreferred generic drugs for which there's more cost-effective, generic alternatives or preferred brand-name drugs available.



We only cover specialty drugs when obtained from our exclusive specialty pharmacy network.

90-Day Retail Network Pharmacy	1 to 30-day supply After deductible, you pay \$150 for each prescription.	31 to 60-day supply Not covered	61 to 83-day supply Not covered	84 to 90-day supply After deductible, you pay \$450 for each prescription.
In-Network Mail Order Pharmacy	1 to 30-day supply After deductible, you pay \$150 for each prescription.	31 to 60-day supply After deductible, you pay \$300 for each prescription.	61 to 83-day supply After deductible, you pay \$450 for each prescription.	84 to 90-day supply After deductible, you pay \$450 for each prescription.
In-Network Pharmacy (not part of the 90-Day Retail Network)	1 to 30-day supply After deductible, you pay \$150 for each prescription.	31 to 60-day supply Not covered	61 to 83-day supply Not covered	84 to 90-day supply Not covered
Exclusive Pharmacy Network for Specialty Drugs	1 to 30-day supply* After deductible, you pay \$150 for each prescription.	31 to 60-day supply Not covered	61 to 83-day supply Not covered	84 to 90-day supply Not covered

*Your prescription drug copayment will be reduced by one-half (1/2) for each medication limited to a 15-day fill.



We do not pay for more than a 30-day supply of covered drugs within 60 days of the end of the plan year.

After your deductible is met If the approved amount of the drug is less than your copayment, you pay only the approved amount of the drug.

Payment for the following do not apply toward your integrated deductible or annual out-of-pocket maximum:

- Payment for non-covered drugs or services.
- Any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand-name drug.
- Amounts that exceed our approved amount for covered drugs or out-of-network retail penalty amounts.
- Drugs obtained from an out-of-network mail order pharmacy

Prescription Drugs (continued)**Tier 4 Drugs**

The chart below shows your coinsurance for each covered Tier 4 drug. This tier includes mostly specialty drugs that are used to treat difficult health conditions. It also includes select high cost non-specialty generic and brand-name drugs. Tier 4 drugs are limited to 30-day supply per fill.



We only cover specialty drugs when obtained from our exclusive specialty pharmacy network

90-Day Retail Network Pharmacy	1 to 30-day supply	31 to 60-day supply	61 to 83-day supply	84 to 90-day supply
	After deductible, you pay 45% of the approved amount for each prescription	Not covered	Not covered	Not covered
In-Network Mail Order Pharmacy	1 to 30-day supply	31 to 60-day supply	61 to 83-day supply	84 to 90-day supply
	After deductible, you pay 45% of the approved amount for each prescription	Not covered	Not covered	Not covered
In-Network Pharmacy (not part of the 90-Day Retail Network)	1 to 30-day supply	31 to 60-day supply	61 to 83-day supply	84 to 90-day supply
	After deductible, you pay 45% of the approved amount for each prescription	Not covered	Not covered	Not covered
Exclusive Pharmacy Network for Specialty Drugs	1 to 30-day supply	31 to 60-day supply	61 to 83-day supply	84 to 90-day supply
	After deductible, you pay 45% of the approved amount for each prescription	Not covered	Not covered	Not covered

Payments for the following do not apply toward your integrated deductible or annual out-of-pocket maximum:

- Payment for non-covered drugs or services.
- Any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand-name drug.
- Amounts that exceed our approved amount for covered drugs or out-of-network retail penalty amounts.
- Specialty drugs obtained from any provider other than our exclusive pharmacy network for specialty drugs.
- Drugs obtained from an out-of-network mail order pharmacy.

Prescription Drugs (continued)**Tier 5 Drugs**

The chart below shows your coinsurance for each covered Tier 5 drug. This tier includes mostly high cost specialty brand-name drugs that are used to treat difficult health conditions. It also includes very high cost non-specialty generic and brand-name drugs. Tier 5 drugs are limited to 30-day supply per fill.



We only cover specialty drugs when obtained from our exclusive specialty pharmacy network

90-Day Retail Network Pharmacy	1 to 30-day supply After deductible, you pay 50% of the approved amount for each prescription	31 to 60-day supply Not covered	61 to 83-day supply Not covered	84 to 90-day supply Not covered
In-Network Mail Order Pharmacy	1 to 30-day supply After deductible, you pay 50% of the approved amount for each prescription	31 to 60-day supply Not covered	61 to 83-day supply Not covered	84 to 90-day supply Not covered
In-Network Pharmacy (not part of the 90-Day Retail Network)	1 to 30-day supply After deductible, you pay 50% of the approved amount for each prescription	31 to 60-day supply Not covered	61 to 83-day supply Not covered	84 to 90-day supply Not covered
Exclusive Pharmacy Network for Specialty Drugs	1 to 30-day supply After deductible, you pay 50% of the approved amount for each prescription	31 to 60-day supply Not covered	61 to 83-day supply Not covered	84 to 90-day supply Not covered

Payments for the following do not apply toward your integrated deductible or annual out-of-pocket maximum:

- Payment for non-covered drugs or services.
- Any difference between the Maximum Allowable Cost and BCBSM's approved amount for a covered brand-name drug.
- Amounts that exceed our approved amount for covered drugs or out-of-network retail penalty amounts.
- Specialty drugs obtained from any provider other than exclusive pharmacy network for specialty drug.
- Drugs obtained from an out-of-network mail order pharmacy.

Prescription Drugs (continued)**Mandatory Prior Authorization**

Some drugs require prior authorization from BCBSM before we will pay for them. If prior authorization is not requested or received from us, we will not pay for the drug. You will be responsible for 100% of the cost of the drug. For some drugs, certain clinical criteria must be met before coverage is provided. In the case of drugs requiring step therapy, for example, previous treatment with one or more preferred drugs may be required. A list of drugs that may require prior authorization or step therapy is available at the BCBSM website at <https://www.bcbsm.com/2027-essential-select-druglist>.

Once we receive the prescriber's request for prior authorization, we will notify the prescriber whether a drug is authorized not authorized, or if the request requires additional information within:

- 7 days
- 72 hours, if your request is urgent



If we approve the request, we will pay the approved amount minus your deductible, coinsurance or copayment for the drugs as noted in your coverage.

Your cost share will not be more than BCBSM's approved amount for covered drugs.

Medication Synchronization

If you take more than one maintenance prescription drug, you can arrange to have your prescriptions filled at the same time.

In order to qualify for this service, you must meet the following criteria:

- You, your prescriber, **and** a pharmacist agree that synchronizing your medications for treatment of your chronic long-term care condition is in your best interest
- The prescription drugs that will be synchronized meet the following requirements:
 - Are covered under your certificate
 - Are used for the management and treatment of chronic long-term care conditions and have authorized refills available
 - If prior authorization is required, that authorization has been obtained
 - Can be split over a short fill period so that they can be synchronized

If you qualify for this service, we will allow for a supply from 1 to 29 days to be dispensed in order to synchronize your maintenance drugs.

Prescription Drugs (continued)**Medication Synchronization** (continued)Exclusions

- Mail order drugs
- Select products that are subject to special fill limits
- Prescription drugs that:
 - Do not meet prior authorization requirements
 - Cannot be split into short fill periods
 - Do not meet quantity limits
- Schedule 2-5 controlled substances
 - The exception is for anti-epileptic drugs

NOTE

You must pay your in-network cost share for these drugs. You are also responsible for any prorated daily cost share that would apply in order to synchronize your medications. Because your medication costs may vary, please see the specific chart that explains your cost share for each drug.

Chemotherapy Specialty Pharmaceuticals

There are certain chemotherapy specialty drugs that need our prior authorization for us to pay for them. We only pay for these drugs when you get them from our exclusive pharmacy network for specialty drugs.

This prior authorization rule applies to all chemotherapy specialty drug claims, whether in Michigan or out of the state. Your prescriber must contact BCBSM Customer Service and follow our process to get approval for these chemotherapy specialty drugs. Once we have all of the information we need to make a decision, we will notify the prescriber. In order to be approved, the drugs must:

- Be FDA-approved
- Meet BCBSM's clinical criteria for treatment of the member's condition.

If prior authorization is requested, but is not approved by BCBSM, you have a right to appeal under applicable law. If the appeal fails, you will be responsible for 100% of the pharmacy's charge.

If prior authorization is required and is not requested we will not pay for the drug. You will be responsible for 100% of the pharmacy's charge.

NOTE

The State of Michigan applies a copayment or coinsurance maximum per 30-day supply that is annually adjusted by the Michigan Department of Insurance and Financial Services. If your plan includes a deductible, you are required to meet the deductible before the State maximum is applied. Once any deductible has been exhausted, your out-of-pocket cost for a 30-day supply of each oral chemotherapy drug will be less than or equal to the Michigan maximum

Prescription Drugs (continued)**Gender Affirming Treatment**

We pay for:

- Any prescribed drugs that are medically necessary for the treatment of gender dysphoria and gender affirming services.

We do not pay for:

- Prescription drugs that we consider to be cosmetic
- Prescription drugs that are experimental or investigational.



See Section 7 for the definition of “gender dysphoria,” “medically necessary,” and “experimental treatment.”

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 **Tier 5 Drug** 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).

Prescription Drugs (continued)

Maximum Allowable Cost (MAC) Drugs

When you receive a generic MAC drug from an in-network pharmacy, you pay your cost share as noted in your coverage.

If the prescriber requests and receives prior authorization and writes “Dispense as Written” or “DAW” on the prescription, then you must pay:

- The difference between the maximum allowable cost and the BCBSM approved amount for the brand name drug, plus
- Your cost share

However, if you request a brand-name drug and the prescriber did not receive prior authorization and write “Dispense as Written” or “DAW” on the prescription you will be responsible for the full cost of the prescription.

How to File a Claim

If an in-network pharmacy required you to pay for a prescription, or if you disagree with the amount you had to pay for a prescription, you may submit a claim form and proof of payment, including the National Drug Code (NDC) of the drug dispensed. To obtain a claim form, go to www.bcbsm.com, or contact Customer Service.

Covered Drugs Obtained from an Out-of-Network Pharmacy

When an out-of-network pharmacy fills a prescription for a covered drug, you must pay the pharmacist the full cost of the drug and submit a claim form and proof of payment, including the National Drug Code (NDC) of the drug dispensed. To obtain a claim form, go to www.bcbsm.com, or contact Customer Service.

For covered drugs obtained in the United States, we will reimburse you 80% of the BCBSM approved amount for the drug minus your copayment. If the drug is to treat an emergency, we will reimburse you 100% of our approved amount.



The remaining 20% is the member's responsibility and will not be applied toward your plan's integrated in-network deductible or out-of-pocket maximum. **If the cost of the drug exceeds our approved amount, you must also pay the difference between the total cost and our approved amount.**

For covered drugs obtained outside of the United States, we will reimburse you 100% of the approved amount after your integrated deductible.

Prescription Drugs (continued)**Prescription Drugs Not Covered**

- We do not pay for the following:
 - Contraceptive medications and devices not required to be covered under the Patient Protection and Affordable Care Act.
 - Brand-name drugs when a generic equivalent is available (multi-source brand)
 - Therapeutic devices or appliances, including, but not limited to hypodermic or disposable needles and syringes when not dispensed with the following:
 - A covered injectable drug
 - Insulin
 - Self-administered chemotherapeutic drugs
 - Drugs prescribed for cosmetic purposes
 - The charge for:
 - Any prescription refill that is more than the number specified by the prescriber or
 - Any refill dispensed one year after prescription was written
 - Any vaccine given solely to resist infectious diseases (except for select immunization vaccines)
 - More than a 30-day supply of covered drugs within 60 days of the end of the plan year
 - More than a 30-day supply of a covered drug unless dispensed by an In-Network Retail 90 pharmacy or In-Network Mail Order pharmacy. We may make exceptions for drugs whose minimal package size prevents a 30-day supply from being dispensed (e.g., inhalers)

NOTE

A 30-day supply limitation applies to Tier 4 and Tier 5 prescription drugs, including drugs that BCBSM defines as “specialty pharmaceuticals.” We will not pay for more than a 30-day supply of a covered specialty pharmaceutical. We may make exceptions if a member requires more than a 30-day supply.

- Non-specialty drugs obtained from out-of-network mail-order pharmacies, including Internet providers.
- Specialty drugs dispensed by an in-network mail order pharmacy. Specialty drugs may only be obtained from the exclusive pharmacy network for specialty drugs. See specialty drugs within your certificate for more information.
- Specialty drugs obtained from a provider other than our exclusive pharmacy network for specialty drugs
- Prescriptions for quantities of 84 through 90 days that are not provided by a 90-Day Retail Network pharmacy or an in-network BCBSM mail order pharmacy.
- More than the quantities allowed per prescription of select drugs by BCBSM, unless the prescriber obtains prior authorization from BCBSM. A list of drugs that may have quantity limits is available at the BCBSM website at <https://www.bcbsm.com/2027-essential-select-druglist>
- Any drug we consider experimental or investigational.

NOTE

However, if Michigan law requires us to pay for the cost of chemotherapy drugs or the reasonable cost to administer the drug, we will pay for these costs.

- State-controlled drugs

Prescription Drugs (continued)**Prescription Drugs Not Covered** (continued)

- Any covered drug entirely consumed at the time and place of the prescription
- Administration of covered drugs except for select immunization vaccines
- Anything other than covered drugs and services
- Diagnostic agents
- Drugs that are not labeled “FDA approved,” except for insulin, or such drugs that BCBSM designates as covered
- Any drug or device prescribed for clinical indications other than those stated in the labeling 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, when certain criteria is met. For additional coverage information, see Coverage for Drugs and Devices under General Conditions. Some chemotherapeutic drugs may be subject to prior authorization review.
- Covered drugs or services that are covered under a medical benefit in a BCBSM certificate you have.
- Drugs or services obtained before the effective date of this contract, or after the contract ends
- Claims for covered drugs or services submitted after the applicable time limit for filing claims (see Page 180)
- Support garments or other nonmedical items
- Compounded drugs that contain any bulk chemical powders or ingredients that are not approved by BCBSM
- Over the counter drugs unless coverage is required under the Patient Protection and Affordable Care Act or not considered a covered service
- Prescription drugs with comparable products available over-the-counter, including but not limited to, cough/cold products
- Lifestyle drugs, such as but not limited to drugs used for weight loss or erectile dysfunction
- Drugs to treat infertility
- Compounded hormones
- Select high abuse drugs
- Dietary supplements
- Drugs newly approved by the FDA until review and coverage determination by BCBSM
- Non-self-administered injectable drugs (except for select immunization vaccines)
- Marijuana (cannabis); medical or otherwise
- Certain drugs that may not be covered based on recommendations from BCBSM

NOTE

If a decision is made by BCBSM to approve a non-covered drug, you will be required to pay the Tier 5 copayment as required by your plan.

- 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.
- Prescription drug services for the treatment of gender dysphoria that are considered by BCBSM to be cosmetic, or prescription drug treatment that is experimental or investigational.

Prescription Drugs (continued)**Drugs Provided by a Medical Provider**

See Section 2 beginning on Page 9 for what you may be required to pay for these services.

BCBSM pays for select prescription drugs that are provided by hospitals, facilities, and professional providers.

We pay for:

- **Drugs Received in a Hospital**

Prescription drugs, biologicals and solutions (such as irrigation and IV solutions) administered as part of the treatment for the disease, condition or injury that are:

- Labeled FDA-approved as defined under the amended Food, Drug and Cosmetic Act and
- 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 127)
- In a participating freestanding ESRD facility in conjunction with dialysis services (see Page 53)
- In a participating skilled nursing facility (see Page 119)
- As part of home health services when services are provided by a participating hospital (see Page 61)
- When required for infusion therapy (see Page 68)
- In a participating hospice for the comfort of the member (see Page 63)
- In a participating residential or outpatient substance abuse treatment facility (see Page 73)

- **Drugs Administered by a Physician**

NOTE

Self-injected drugs are not covered unless approved by BCBSM

- Injectable/Infused Drugs

We pay for injectable/infused drugs or biologicals and their administration. The injectable/infused drugs and biologicals must be:

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

- Specialty Pharmaceuticals

We pay for approved specialty drugs when:

- Administered and billed by a physician.
- Billed by a contracted specialty pharmacy provider and administered by a physician.

Prescription Drugs (continued)**Drugs Provided by a Medical Provider** (continued)**Drugs Administered by a Physician** (continued)**Prior Authorization for Specialty Pharmaceuticals**

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

- Office
- Participating ambulatory infusion center
- Home
- Participating outpatient facilities

BCBSM requires prior authorization for specialty drugs for in-state and out-of-state services (See Section 6 for Prior Authorization). Your prescriber should contact us and follow our utilization management processes to get prior authorization for your specialty drug. Only FDA-approved drugs are eligible for prior authorization. Of those drugs, we will authorize only the specialty drugs that meet our medical policy standards for the treatment of your condition.

Preventive Care Services

See Section 2 beginning on Page 9 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 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.

Preventive care services are covered at 100% of the BCBSM approved amount only when performed by an in-network provider. Out of network cost-sharing applies when preventive services are performed by 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
- An office

We pay for:

- Health Maintenance Examination
 - One exam per member, per calendar year
- Related reading and interpretation of your test results
 - If an in-network provider does a covered preventive test, and a Michigan out-of-network provider reads and interprets the test results, we will pay the claim from the Michigan out-of-network provider as if it were an in-network claim. You will not have to pay your out-of-network cost share for this claim. You will pay out-of-network cost share if an out-of-state out-of-network provider read and the interprets the test results.
- Routine Flexible Sigmoidoscopy Examination
 - One per member, per calendar year
- Routine Gynecological Examination
 - Two visits per member, per calendar year

Preventive Care Services (continued)**We pay for:** (continued)

- Routine Pap Smear
 - One per member, per calendar year, when prescribed by a physician



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

- Screening Mammography
 - One per member per calendar year to screen for breast cancer



We will pay for a Michigan out-of-network provider to read and interpret your mammogram, but only when the mammogram itself was done by an in-network provider.

- 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
 - Subsequent medically necessary mammographies performed during the same calendar year by an in-network or out-of-network provider are subject to your deductible and coinsurance requirements
- Fecal Occult Blood Screening
 - One per member, per calendar year to detect blood in the feces or stool
- Well-Baby and Well-Child Visits

Visits through age 18 as follows:

- 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

Preventive Care Services (continued)**We pay for:** (continued)

- 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 required by PPACA at the time the services are performed.

- Routine Laboratory Services

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

- Chemical profile
- Cholesterol testing

- Colonoscopy

Hospital and physician benefits for colonoscopy services are payable at 100% of the BCBSM approved amount as follows:

- One screening colonoscopy once per member per calendar year, when performed by an in-network provider. This service is not subject to any deductible, coinsurance or copayment requirements.
- If you need another colonoscopy in the same calendar year, you will have to pay your deductible and coinsurance. It can be done by an in-network or out-of-network provider.

- 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 prescription drugs to help you stop smoking

Preventive Care Services (continued)**We pay for:** (continued)

- Contraceptive Services

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



For contraceptive medications other than injectable drugs, see Page 86.

- 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

Including but not limited to:

- Depo-Provera and Intrauterine Devices (IUD)
- Diaphragms (when performed in the physician's office)

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 Drugs
See Page 86, "Contraceptive Drugs," for contraceptive medications that are payable as required by PPACA.
- Contraceptive Mobile App

One per member per 12 consecutive months



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

- 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

Preventive Care Services (continued)

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 9 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 professional provider who has the skills or knowledge needed for the case.

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 9 for what you may be required to pay for these services.

For durable medical equipment services, see Page 542.

- Locations: We pay for prosthetic and orthotic devices in :
 - A participating hospital
 - A participating skilled nursing facility (see Page 119)
 - An office
 - A member's home
 - Stand-alone retail prosthetic and orthotic providers

We pay for:

- The cost of purchasing or replacing the 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 the 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 (continued)**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

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-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 contact 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 an M.D., D.O., or podiatric physician. Please call your local Customer Service center 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 prosthesis 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 and corsets
- Hearing aids

Pulmonary Rehabilitation

See Section 2 beginning on Page 11 for what you may be required to pay for these services.

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 a year for combined outpatient cardiac or pulmonary rehabilitation services

Radiology Services

See Section 2 beginning on Page 9 for what you may be required to pay for these services.

For radiology services in an ambulatory surgical facility, see Page 127.

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
- Nuclear cardiac studies



Mammography services (other than for routine screening – see *Preventive Services*) are payable **only** when your physician prescribes them because of suspected or actual presence of a disease, or when performed as a postoperative procedure.

- 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 9 for what you may be required to pay for these services.

Locations: We will pay for the 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 45 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 purchased from the skilled nursing facility
- Physician services (up to two visits per week)
- Physical therapy (Page 86), speech language therapy (Page 121) or occupational therapy (Page 74) when medically necessary



The physical and occupational therapy or speech language therapy services that are done in a skilled nursing facility are inpatient benefits. The combined 30-visit benefit maximum for occupational therapy and physical therapy and the 30-visit maximum for speech language therapy applies 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 for substance use disorder
- Care for mental illness
- Care provided by a nonparticipating skilled nursing facility

Special Medical Foods for Inborn Errors of Metabolism

See Section 2 beginning on Page 9 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 a 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 0100
 Detroit, MI 48226-2998

You can get the above-mentioned form by visiting our website at <https://www.bcbsm.com/>. Click 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 9 for what you may be required to pay for these services.

For occupational therapy services, see Page 74.

For physical therapy services, see Page 86.

Special rules apply when speech language therapy services are provided to treat autism spectrum disorders (see Page 28).

Locations: We pay for facility and professional speech language therapy

- 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 is the member's primary residence

We pay for:

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

Speech Language Therapy (continued)**We pay for:** (continued)

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 benefit maximum.

If services performed in a member's home are billed by a home healthcare agency, they will not count toward the benefit maximum. (See page 69 for Home Healthcare Services.)



These visit maximums are separate from the maximums that apply to physical or occupational. 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 toward the benefit maximum described above.

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-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.

Speech Language Therapy (continued)**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
- 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
- Member education and home programs
- Treatment of chronic, developmental or congenital conditions, learning disabilities or inherited speech abnormalities



A BCBSM medical consultant may decide that speech language therapy and language 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 pathology assistants or therapy aides
- Services received from a nonparticipating freestanding outpatient physical therapy facility or a nonparticipating skilled nursing facility
- More than 30 habilitative and 30 rehabilitative outpatient visits per member per calendar year, whether obtained from an in-network or out-of-network provider
- Services provided by a freestanding facility in a home, hospital, skilled nursing facility, or residential substance abuse treatment facility

Surgery

See Section 2 beginning on Page 9 for what you may need to pay for these services.

For transplant services, see Page 132.

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

- A participating hospital, inpatient or outpatient
- 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 an MD, DO, podiatric physician or an oral surgeon. The physician must also be an in-network provider.
- The consultation will be paid for 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
- Bariatric surgery



Bariatric surgery is limited to one per member per lifetime

- Sleep studies and surgeries to diagnose and treat sleep apnea



Sleep studies and surgeries must be preapproved by BCBSM.

Surgery (continued)

- Sterilization of female reproductive organs and male reproductive organs (whether or not medically necessary)

NOTE

Reversal of voluntary sterilization of male reproductive organs is not covered.

- Administration of blood
- Cosmetic surgery is only payable 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, and
 - Traumatic scars
 - Blepharoplasty of upper lids
 - Breast reduction
 - Surgical treatment of male gynecomastia
 - Panniculectomy
 - Sleep apnea treatments
- Rhinoplasty
- Septorhinoplasty

NOTE

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 (see Page 47 for examples)
 - Surgery and treatment related to the treatment of temporomandibular joint (jaw joint) dysfunction (TMJ), see Page 50.

Surgery (continued)

- **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:

- Hospital (inpatient or outpatient)
- Ambulatory surgery facility

Contact Customer Service for a list of covered TSA surgeries.

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

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

We pay for:

- 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

Surgery (continued)

We do not pay for:

- Services by a nonparticipating ambulatory surgery facility

Transplant Services

See Section 2 beginning on Page 9 for what you may be required to pay for these services.

For general surgery services, see Page 125.

For oncology clinical trials, see Page 79.

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 (complete list on Page 132) **only** if they are done in a “designated facility” and only when you obtain BCBSM preapproval. (See the definition of a designated facility on Page 191.)

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
 - 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)**We pay for:** (continued)**Bone Marrow Transplants** (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 the definition of “Tandem Transplant” in Section 7.

Allogeneic and autologous transplants are 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 chemotherapeutic 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 “Definitions” on Page 191), **we pay for** transplant of the following organs:

- Combined small intestine-liver
- Heart
- Heart-kidney(s)
- Heart-liver
- Heart-lung(s)
- Kidney(s)
- Liver
- Liver-lung(s)
- Lobar lung
- Lung(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.

During the benefit period, any deductibles, copayments or coinsurances required under your coverage will apply to the organ transplant and related procedures.

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

NOTE

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

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)

NOTE

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 healthcare plan

NOTE

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

Transplant Services (continued)**Specified 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 non-designated facility



You have to pay for the transplant surgery and related services if you receive them in a non-designated 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, 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 the “General Conditions of Your Contract” section for guidelines related to experimental treatment

Urgent Care Services

See Page 9 in Section 2 for what you may be required to pay for these services.

We pay for physician urgent care services provided in a physician's office. We also pay for physician urgent care services at an urgent care facility. (See the definition of "urgent care" in Section 7.)

Value Based Programs

See Section 2 beginning on Page 9 for what you may need to pay for these services.

See Section 7 for the definition of Provider-Delivered Care Management (PDCM).

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 setting
- 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)**PDCM services may include:** (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.

Section 4: How Providers Are Paid

This section explains how BCBSM pays the professional providers and healthcare facilities that provide services or supplies related to your medical care. They include, but are not limited to, hospitals, facilities, physicians, clinics, labs, and healthcare professionals.

Facilities include providers such as outpatient physical therapy facilities, clinics, ambulatory surgical centers and residential or outpatient substance abuse treatment facilities. Healthcare professionals include providers that are not physicians, such as certified nurse midwives, physical therapists, audiologists, labs, home healthcare and home infusion care providers.

Our PPO payment policy is shown in the chart below.

BCBSM 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 minus your cost share as payment in full for the covered services they provide. BCBSM sends payment directly to in-network PPO providers.
BCBSM PPO 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 process claims for those services as out-of-network. Not all out-of-network services are covered. 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. <u>Here's why:</u> • Providers that participate with BCBSM – BCBSM pays its approved amount directly to participating providers. They accept this payment minus your cost share as payment in full. You must pay your out-of-network cost share. • Providers that participate with BCBSM – When there is no PPO network BCBSM pays its approved amount directly to participating providers. They accept this payment minus your cost share as payment in full. You must pay your in-network cost share. • Physicians and other healthcare professionals that do not participate with BCBSM – BCBSM pays its approved amount directly to you and you may need to pay the provider. (See Surprise Billing in General Conditions of Your Contract section for more information) You must pay your out-of-network cost share. You may be responsible for the difference between what we pay and what the provider charges. • Hospitals that do not participate with BCBSM – BCBSM does not pay for services from nonparticipating hospitals except for urgent care, treatment of an accidental injury or medical emergency. You must pay your in-network cost share. You may also be responsible for the difference between what we pay and what the provider charges. BCBSM pays its approved amount directly to you. • Facilities that do not participate with BCBSM – BCBSM does not pay for services from nonparticipating facilities. You will need to pay the provider's charges.

How Providers Are Paid (continued)

Out-of-State Providers that do not participate with BCBSM	Out-of-state providers may or may not be in local BCBS PPO network. Providers who are in their local BCBS PPO network have agreed to accept their PPO's approved amount minus the cost-share requirement as payment in full. Those providers who are not in the PPO network may or may not accept the approved amount for their area's PPO as payment in full. What you pay will depend on whether your provider is a part of the area's PPO network. If they are, you are only responsible for your out-of-network cost share. If they are not, you may also be responsible for the difference between what we pay and what the provider charges. • In-Network (PPO) – Providers accept their local BCBS PPO approved amount as payment in full. You pay your out-of-network cost share. Providers are paid directly. See BlueCard Services for more information. • Out-of-Network (Non-PPO) – Providers may or may not accept their local BCBS PPO approved amount as payment in full. You pay your out-of-network cost share. Providers are paid directly. See BlueCard Services for more information. Out-of-state providers may or may not participate in their local plan. • Participating providers participate in their local plan and may or may not be a part of their local PPO network. They have agreed to accept their plan's approved amount minus your out-of-network cost share as payment in full. Providers are paid directly. See BlueCard Services for more information. • Nonparticipating Providers do not participate in their local plan and are not a part of their local PPO network. They have not agreed to accept their plan's approved amount as payment in full. This means that you must pay your out-of-network cost share <u>and</u> you may be responsible for the difference between what we pay and what the provider charges. BCBSM pays you directly and you will need to pay the provider.
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You must pay your out-of-network cost share for **all** services performed outside the state of Michigan, unless your provider is in BCBSM's PPO network.

Exception: Urgent care, treatment of an accidental injury or medical emergency services are subject to your in-network cost share.

BCBSM has agreements with different types of providers. BCBSM has separate payment practices for each type of provider. In this section, we describe the payment practices that we have with the following types of providers:

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

BCBSM PPO In-Network Providers****(Hospitals, Facilities, Physicians and Healthcare Professionals)***

* Participates with BCBS and is in BCBSM's PPO network

How They Are Paid

Step 1 	Step 2 	Step 3 
Services	Approved amount	Provider Payment
You receive covered services from a Michigan 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 deductible, 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 claims.	- 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

BCBSM Out-of-Network, Participating Providers* (Hospitals, Facilities, Physicians and Healthcare Professionals)

*Participates with BCBS and is not in BCBSM 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 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 deductible, coinsurances and copayments - Services not covered by your contract - Services that we determine are not medically necessary or 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 claims.	- 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-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.

BCBSM Out-of-Network, Participating Providers (Hospitals, Facilities, Physicians and Healthcare Professionals Not in BCBSM's 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 an out-of-network provider in:
 - An in-network hospital
 - A participating freestanding ambulatory surgery facility or
 - Any other location identified by BCBSM
- The reading and interpretation of select routine or screening services where an in-network provider preforms the service, but a Michigan out-of-network provider does the analysis and interprets the results



Even though you do not have to pay out-of-network cost-sharing for these services, you *will* have 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, call us at one of the numbers listed in Section 9: “How to Reach Us”.

BCBSM Out-of-Network, Nonparticipating Providers* ***(Physicians and Healthcare Professionals Not in the PPO Network)***

* Does not participate with BCBS and is not in BCBSM PPO network

If the out-of-network provider is nonparticipating, you will 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 a Michigan 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. Unless otherwise noted in Surprise Billing, you pay the provider.

What We Pay and What You Pay

We pay:	You pay:	You do not pay for:
The approved amount minus what you must pay	- Out-of-network deductible, 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 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.

BCBSM Out-of-Network Nonparticipating Providers (Physicians and Healthcare 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 approved amount, after your deductible, copayments and coinsurances have been met, as payment in full for a service they have provided. The provider will 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 Providers* ***(Hospitals and Facilities)***

Non-Emergency Services**

* Does not participate with BCBS and is not in BCBSM PPO network

How They Are Paid

Step 1 	Step 2 	Step 3 
Services	Approved Amount	Provider Payment
You receive covered services from a nonparticipating hospital or other facility for treatment that is not for an urgent care, treatment of an 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.

** Non-emergency services are all services, except urgent care, treatment of accidental injuries, or medical emergency services (see chart below to see how these services are paid).

BCBSM does not pay for services at nonparticipating hospitals and facilities:

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

If you need to know if a provider participates, ask your provider, the provider's admitting staff, or call us. (Use the numbers listed in Section 9: "How to Reach Us".)

Out-of-Network Nonparticipating Providers* (Hospitals and Facilities)

Emergency Services**

* Does not participate with BCBS and is not in BCBSM PPO network

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:	You pay:	You Do Not Pay
- The approved amount minus your in-network cost share for urgent care, treatment of an accidental injury or medical emergency. - The approved amount is a rate based on the requirements of state or federal law	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.

Out-of-Network, Nonparticipating Providers*(Physicians Healthcare Professionals) Non-Emergency Services*

* Does not participate with BCBS and is not in BCBSM PPO network

Step 1 	Step 2 	Step 3 
Services You receive services from an out-of-network and nonparticipating provider for non-emergency services. *	Approved Amount The provider may or may not accept BCBSM's approved amount as payment in full. You are responsible for out-of-network cost share for these services and you may also be balance billed for these services.	Provider Payment BCBSM does not send payment to out-of-network, nonparticipating providers. You pay for these services and send a claim to BCBSM. We will send you our approved amount for the service if it is covered, minus your out-of-network cost share.

*Non-emergency services are all services, except urgent care, treatment of accidental injuries, or medical emergency services (see chart below to see how these services are paid).

Out-of-Network, Nonparticipating Providers*(Physicians and Healthcare Professionals) Emergency Services

* Does not participate with BCBS and is not in BCBSM PPO network

Step 1 	Step 2 	Step 3 
Services You receive services for urgent care, treatment of an accidental injury or medical emergency.	Approved Amount BCBSM pays for treatment. These services are subject to in-network cost-share requirements.	Provider Payment BCBSM sends its approved amount to you. You pay your in-network cost share for these services.

Continuity of Care

When a contract terminates between BCBSM and a participating professional provider or facility, that is actively treating you for conditions under the circumstances listed below and as required by law, the provider or facility may continue treating you.

BCBSM will notify you of the provider's termination. If you meet the requirements for Continuity of Care, you may continue treatment with the provider for up to **90 days**. During that Continuity of Care timeframe, your plan cost share will apply.

Provider Requirements

The Continuity of Care provisions apply only when your provider:

- Agrees you qualify as a continuing care member
 - If the provider agrees you are a continuing care member, the provider must, to the extent required by applicable law, accept the BCBSM approved amount as payment in full for the services provided as if the provider's contract had not changed
- Continues to meet BCBSM's quality standards
- Continues to adhere to BCBSM medical and quality management policies and procedures
- Provides care for 90 days of continued coverage or until you are no longer a continuing care member whichever occurs first. The 90 days may be extended if agreed by BCBSM and the provider



Emergency room services will continue to be covered as required by law; see Surprise Billing section for additional information.

Member Requirements

You qualify to continue treatment for up to **90 days** if one of the following is true. You are:

- Undergoing a continued and regular course of treatment for a "serious and complex condition", defined as one of the following:
 - An acute illness – a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm
 - A chronic illness or condition - a condition that is life-threatening, degenerative, potentially disabling, or congenital; and that requires specialized medical care over a prolonged period of time
- Undergoing a course of inpatient care
- Scheduled to undergo nonelective surgery, including receiving postoperative care related to a surgery
- Pregnant and undergoing a course of treatment for the pregnancy

Determined to be terminally ill and receiving treatment for such illness from the provider.

Continuity of Care (continued)

Additionally, for Continuity of Care to apply, the following conditions must also be true:

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

Payment for Continuity of Care Services

If coverage requirements are met, 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.

If the coverage requirements are not met, covered services will be paid at the out-of-network benefit level for physician services. Services provided by nonparticipating facilities may not be covered.

These inter-plan programs allow our members to receive covered services from out-of-state Host Plan providers processed at the Host Plan's in-network rates for urgent care, emergencies or accidental injuries. If you receive other covered services from out-of-state and out-of-network providers, those services are processed by the Host Plan and are subject to your out-of-network cost share. You may also be responsible for paying the difference between what the out-of-state provider charges and what the Host Plan pays, depending on whether the provider participates with the Host Plan's PPO network.

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.

Your cost share will vary depending on where you get your services. Outside the state of Michigan, BCBSM covers urgent care, emergencies or accidental injuries, which will be processed as in-network benefits with in-network cost share. Any other covered services are subject to your out-of-network cost share.

The Blue Cross and/or Blue Shield Plan located outside of Michigan is the Host Plan. BCBSM pays the Host Plan for covered services you receive outside Michigan. The Host Plan then pays its contracted amounts to its network providers.

You are responsible for your in-network or out-of-network cost share, as well as any other charges, depending on the type of covered service you receive. If your service is not considered urgent, an emergency or an accidental injury, you will have to pay your out-of-network cost share.

The BlueCard PPO Program does not process claims for prescription drugs, vision care, or dental care that are not part of your medical claims or benefits which may be administered by a third party for BCBSM.

BlueCard PPO Network Providers

If you receive urgent care, emergency services or accidental injury 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.
- Your deductible, copayment and coinsurance and will be based on the lower of:
- 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 “negotiate” 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 considers special arrangements with your provider or provider group that may include settlements, incentive payments, and/or other credits or charges; or

BlueCard PPO Program (continued)

The price the Host Plan will apply the actual, average or estimated price method consistent with its specific provider contracts. 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.

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.

Any other covered services you receive from an out-of-network provider are subject to your out-of-network cost share. You may also be responsible for the difference between what the Host Plan pays and the provider's charge.

Outside the state of Michigan, this certificate does not cover medical benefits at the Host Plan's in-network rate except for urgent care, emergencies or accidental injuries no matter the provider's status.

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 Host Plan's participating provider. The Host Plan will notify BCBSM, and BCBSM will verify the provider's status.

An out-of-area provider that does not participate with the Host Plan may require you to pay for urgent care, emergency services or accidental injury services at the time they are provided. If they do:

- Call Customer Service 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. If the out-of-network provider is not a participating provider with the Host Plan, you also may be responsible for the difference between what the provider charges and what the Host Plan pays.

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 <https://www.bcbs.com/> to see a list of participating providers.

BlueCard PPO Program (continued)**Member Liability Calculation**

When you receive covered services outside the state of Michigan 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 what 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 charges for covered services
- 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 what the nonparticipating provider bills and the amount the Host Plan will pay. This is true even for urgent care, emergency services or accidental injury services you receive from professional providers and facilities.

Specialty Providers in the BlueCard Program

The Host Plan can pay for you to get urgent, emergency or accidental injury 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 processed as in-network under the Host Plan.

Out-of-State Services

If you see an out-of-state provider for a service that is not urgent, an emergency, or an accidental injury, the service may not be covered. If it is a covered service, your out-of-network cost share will apply. If the provider is not a participating Host Plan BlueCard PPO network provider, you will also have to pay the difference between what the Host Plan pays and the provider's charge.

Blue Cross Blue Shield Global® Core Program

The Blue Cross Blue Shield Global Core Program does not expand your coverage to include providers from other countries except for urgent care, emergency services or accidental injuries. Claims for covered services outside the country will be processed by BCBSM through the Blue Cross Blue Shield Global Core Program. Any other services will not be covered by BCBSM.

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 healthcare 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 healthcare 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), if you are calling from inside the United States or
- 1-804-673-1177, 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 and file a claim for reimbursement for covered services.

Blue Cross Blue Shield Global Core Program (continued)**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 for emergency services or accidental injury services, 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) coinsurance(s) and copayment(s) for emergency services or accidental injury services when you are admitted to the hospital. When cashless access is arranged, 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 and filing a claim for reimbursement for covered services.
- 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 Customer Service and get preapproval for the services you will receive.

Outpatient Hospital Services

You are responsible for:

- Paying for all of the outpatient emergency services or accidental injury 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.

Blue Cross Blue Shield Global Core Program (continued)**Coverage for Blue Cross Blue Shield Global 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) coinsurance(s) and copayment(s) for all covered services you receive when you are admitted to the hospital. When cashless access is arranged, the hospital will file the claim with the service center for you.

You are responsible for:

- Out-of-network deductible(s), coinsurance(s) and copayment(s)
- The payment of noncovered services
- If you set up cashless access, you will be responsible for the out-of-network deductible(s) coinsurance(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 the total cost for all of the services that you receive and filing a claim for reimbursement for covered services.
- Submitting the international claim form(s), if you did not get cashless access
 - Forms are available from BCBSM, the service center or online at <https://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 Customer Service and get preauthorization for the services you will receive.

Outpatient Hospital Services

You are responsible for:

- Paying for all outpatient emergency services or accidental injury services at the time they are provided
- Submitting the international claim form(s)
 - Forms are available from BCBSM, the service center or online at <https://www.bcbsglobalcore.com>.
- Providing copies of the medical record, itemized bill, and proof of payment with the claim form. BCBSM will only pay for emergency services or accidental injury services.

Blue Cross Blue Shield Global Core Program (continued)**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 emergency services or accidental injury 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 <https://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 emergency services or accidental injury services.

Blue Cross Blue Shield Global Core Professional Services

You are responsible for payment of all professional services at the time the emergency services or accidental injury services are provided.

- You are also responsible for submitting the international claim form(s).
 - Forms are available from BCBSM, the service center or online at <https://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 emergency services or accidental injury 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.
- 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
- Services performed in Michigan from participating or nonparticipating providers who are not registered with BCBSM.
- Gender affirming services, including prescription drug treatments, that BCBSM considers to be cosmetic, or treatment that is experimental or investigational.
- 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 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.

- 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
- 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
- Psychoanalysis
- Routine eye exams or hearing tests (unless they are related to illness, injury, or pregnancy)
- Treatment programs that have predetermined or fixed lengths of care
- Self-injectable drugs unless approved by BCBSM

We do not pay for: (continued)

- Refills of prescriptions for covered drugs that exceed BCBSM's limits:
 - BCBSM does not cover refills that are dispensed before an allowable portion of the previous prescription has been used, as determined by the plan.
 - BCBSM does not cover more refills than your prescription allows.
-  Your prescription can be refilled six times. If you get a seventh refill, it will not be covered.
- BCBSM does not cover more than a 30-day supply of covered drugs within 60 days of the end of the plan year.
-  Your plan year ends in December. You may only receive a 30-day supply of your prescription drug in the months of November and December.
- 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.

We do not pay for: (continued)

- 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
- Alternative 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 healthcare providers other than the nursing home staff.

- 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 126
 - 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
 - Weight loss programs (unless covered elsewhere in this certificate or otherwise required by law)

We do not pay for (continued)**Professional provider services that we do not pay for:** (continued)

- Services provided by persons who are not eligible for payment or not appropriately credentialed or privileged or 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
- Benefits for eye surgeries such as, but not limited to, LASIK, and 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
- Prescription drug compounding kits or services provided to you related to the kits



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 healthcare providers other than the nursing home staff.

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

You 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

You 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.

If you purchased your coverage **on** the Health Insurance Marketplace (Marketplace), you must notify the Marketplace within 60 days of the change. Once you provide this notice, the Marketplace will notify BCBSM of the date the change will take effect. The date of this change is set by federal law.

If you purchased your coverage **off** the Marketplace, we must receive notice from you within 60 days of when a dependent or spouse is removed from coverage, and within 60 days of when a dependent or spouse is added. Contract changes take effect as of 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.

NOTE

It is your responsibility to provide complete and accurate information when requested by us to coordinate benefits. Failure to provide 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.

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 1395III, 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.

Coordination of Benefits (continued)**Order of Benefit Payments** (continued)

- (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.
 - (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 healthcare expenses or healthcare 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 healthcare coverage for the dependent child's healthcare 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 healthcare expenses or healthcare 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 healthcare expenses or healthcare 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 healthcare expenses or healthcare 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)**Order of Benefit Payments** (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 healthcare 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 healthcare 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, if you elect to keep your coverage under this certificate without enrolling in Medicare:

- You will no longer be eligible for a federal premium tax credit, and
- You may incur a late enrollment penalty if you later elect to enroll in Medicare.

The member should apply for Medicare to keep costs down, otherwise they will be responsible for paying the cost of ESRD treatment (see “Services That are Not Payable” in Section 6, “General Conditions of Your Contract”).

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](#).

Members with ESRD have the option to either:

- Remain covered under this certificate
- Enroll in Medicare and remain covered under this certificate, or
- Transition fully to Medicare coverage.

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.

If you are enrolled in Medicare because have ESRD, your BCBSM coverage is your primary plan for all covered services only during the three-month (maximum) waiting period for Medicare coverage.

Once you are enrolled in Medicare, you should apply for BCBSM supplemental coverage. We will pay coinsurances and we may pay deductibles, if applicable, for Medicare-covered services, depending on the type of supplemental coverage you select.

Coverage for Drugs and Devices

We do not pay for a drug or device prescribed for clinical indications other than those stated in the labeling 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 all three of the below criteria are met:

- i. The drug is approved by the Food and Drug Administration;
- ii. The drug is prescribed for treatment of either;
 - a. A life-threatening condition if the drug is medically necessary to treat the condition and: 1) is included within the plan's drug list, or 2) BCBSM otherwise approves the drug;
 - b. A chronic and seriously debilitating condition if the drug is medically necessary to treat the condition and: 1) is included within the plan's drug list, or 2) BCBSM otherwise approves the drug;
- iii. The drug is recognized for treatment of the condition for which it is prescribed by one of the following sources, and the prescribing provider supplies BCBSM with supporting documentation of the same
 - The American Medical Association drug evaluations
 - The American Hospital Formulary Service Drug Information
 - The United States Pharmacopoeia Dispensing Information, Volume 1, "Drug Information for the Healthcare 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.

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, drugs, devices and administrative costs related to experimental treatment
- Costs of research management



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 determines whether a treatment 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 based 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

If you are not receiving a tax subsidy, 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. If you are receiving a tax subsidy, the grace period is three months.

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
- Terminate or cancel your coverage
- Begin legal action against you
- Refuse to cover your healthcare services at a later date

Notification

When we need to notify you, we mail it to you 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.

Pediatric Dental Essential Health Benefit

The Affordable Care Act (ACA) requires that Qualified Health Plans (QHPs) like this one offer 10 Essential Health Benefits (EHBs). One benefit is pediatric dental coverage. This requirement applies to anyone who obtains medical coverage, regardless of their age.

Members over 18 years of age without dependents are still required to have the pediatric dental benefit EHB as part of their plans. This certificate satisfies the ACA requirement for pediatric dental coverage as part of a Qualified Health Plan. This certificate **does not** provide dental benefits to members over 18 years of age. There is **no rate** added to your premium to satisfy the ACA-mandated pediatric dental coverage.

To satisfy the ACA pediatric dental coverage mandate for members under 18 years of age, a stand-alone pediatric dental plan (SADP) is available. This SADP may be purchased by a subscriber who is 18 years of age on the plan's effective date, or by a subscriber with dependents under 18 years of age. Contact Customer Service for more information on how and when you may purchase a stand-alone pediatric dental plan.

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

Personalized Care Protocol Program

A program that supports members who need enhanced coordination of care for controlled substances. Members enrolled in the program are identified by BCBSM. BCBSM will send the member a letter 30-days before the program takes effect that explains the program's requirements and its effective date.

For controlled substances to be covered, they **must be**:

- Prescribed by a BCBSM approved prescriber **and**
- Dispensed by a BCBSM approved pharmacy

There may be times when members enrolled in the Personalized Care Protocol Program cannot meet these requirements, such as when they are travelling. Should this occur, a controlled substance will be covered **only** if BCBSM approves the prescriber and the pharmacy **before** a controlled substance is dispensed.

Only controlled substances fall under this program. For all other medications (i.e., non-controlled substances), members can go to a prescriber or pharmacy of their choice.

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 prescriptions 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 a Michigan 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 their services.
- Out-of-state or nonparticipating providers may require you to pay for the cost of their 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 Customer Service (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.

Refund of Premiums

If we determine that we must refund a premium, we will refund up to a maximum of two years of payments.

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 healthcare 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, we will pay for services 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 or compliance 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 are not eligible to enroll in the program, you will pay the applicable cost-share for the service as defined in the certificate and associated riders. If you are eligible and do not enroll when the special program is required, you must pay the applicable coupon amount for your medical services and medications and this amount will not apply towards your annual out-of-pocket maximum. This amount will also not apply towards your deductible, if applicable.



When you have enrolled in the program, 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.

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.

Whether you are represented by an attorney or not, this provision applies to:

- You
- Your covered dependents

Subrogation: When Others Are Responsible for Illness or Injury (continued)**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 Customer Service 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 the 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 are 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 requires 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 non-participating 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 notify us if you want to terminate your coverage under this certificate. Once you provide us with this notice, your coverage will end on one of the following dates:



If you purchased this coverage on the Marketplace, you may terminate it only if you provide the Marketplace with proper notice.

- If you notify us at least 14 days before the date you want your coverage to end, your coverage will end on your requested date, or
- If you notify us in less than 14 days before the date you want your coverage to end, we will end it on your requested date only if it is feasible for us to do so, or
- In all other cases, we will end your coverage 14 days after you request that your coverage be terminated.

If we decide to terminate your coverage under this certificate, we may notify you of our decision at least 30 days before your last day of coverage. The notification will include the reason for the termination and the date your coverage 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 Filing Prescription Drug Claims

We will not pay claims for drugs that are filed after the following time limits from the date of service:

- 60 days for pay-provider claims
- One year for pay-subscriber claims

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 pay for 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.

24/7 Virtual Visit

A structured real-time virtual health consultation using secure audio-visual technology to connect with a BCBSM selected vendor. The visit is for the purpose of diagnosing and providing medical treatment for urgent non-life-threatening conditions. Contact is initiated by the member you and must be within the provider's scope of practice.

90-Day Retail Network Pharmacy

A pharmacy selected by BCBSM to provide covered drugs through the 90-Day Retail Pharmacy Network. Participating and in-network providers have agreed to accept our payment as payment in full for the covered drugs provided to members.

Accelerated Approval Pathway

An FDA process that allows for earlier approval of certain drugs, including cellular and gene therapies, that have not yet demonstrated actual clinical benefit(s).

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 Healthcare 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 or cancel coverage.

Affiliate Cancer Center

A healthcare 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.

Ambulance Services

Medically necessary ground and air ambulance transportation provided for the sudden onset of a medical emergency or accidental injury if it manifests itself by signs and symptoms of sufficient severity, including:

- Severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the member's health or pregnancy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

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 deductibles, which may be required of you, are subtracted from the approved amount before we make our payment.

For prescription drugs: The lower of (1) the cash price or (2) the sum of the drug cost plus dispensing fee as established by BCBSM for a covered drug prior to cost share. Copayment or coinsurance that 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 FDA
- 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 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 healthcare 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 healthcare 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.

BlueCard® PPO Program

A program that allows Blue Cross Blue Shield PPO members to receive healthcare 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 healthcare plan for its members

Case Management

A program that is designed to help manage the healthcare 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.

Cellular and Gene Therapies

Products that involve the use of human cells and/or genetic modification to treat disease.

Certificate

This book, which describes your benefit plan, and any riders that amend it.

Certified Nurse Midwife

A nurse who provides some maternity 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 and Seriously Debilitating

A disease or condition that requires ongoing treatment to maintain remission or prevent deterioration and that causes significant long-term morbidity.

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 members to determine the effect of a treatment. For purposes of this certificate, coverage for clinical trials is in accordance with recommendations in the Patient Protection and Affordable Care Act (PPACA) law and includes but is not limited to:

- Phase II - a study conducted on a number of members 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 members 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

The 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 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 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.

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 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.

Controlled Substances

These medications are regulated by state and/or federal laws that aim to control the danger of addiction, overuse, physical and mental harm, death, trafficking by illegal means, and other harms. Select controlled substances identified by BCBSM require limits on the quantity dispensed or the day supply.

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.



A separate copayment is not required for covered disposable needles and syringes when dispensed at the same time as insulin or chemotherapeutic drugs.

Your copayment will be reduced by one-half (1/2) for the initial fill (15 days) of select specialty drugs once applicable deductible(s) have been met.

Cosmetic Drugs

Prescription drugs that are used primarily for improving appearance rather than for treating a disease.

Cost Sharing

Copayments, coinsurances, and deductibles you must pay under this certificate.

Covered Drugs

Drugs on the BCBSM covered drug list, including injectable insulin, when the following conditions are met:

- A prescription must be issued by a prescriber who is legally authorized to prescribe drugs for human use
- The cost of the drug must not be included in the charge for other services or supplies provided to you
- The drug is not entirely consumed at the time and place where the prescription is written

The drug must also be approved by the Food and Drug Administration for treatment of the condition for which it is prescribed or recognized for treatment of the condition for which it is prescribed by one of the following sources:

- The American Medical Association drug evaluations
- The American Hospital Formulary Service Drug Information
- The United States Pharmacopoeia Dispensing Information, Volume 1, "Drug Information for the Healthcare 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



Any compounded drugs are covered if they meet all the above requirements, subject to the provisions and exclusions of this certificate.

Covered Services

A healthcare 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.

For prescription drugs: drugs or supplies used to treat medical conditions, such as disposable needles and syringes when dispensed with insulin, or chemotherapeutic drugs.

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.

“DAW” (Dispense as Written)

An instruction on a drug prescription by a prescriber that requires the pharmacist to dispense only the drug named on the prescription.

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 a claim is processed or 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 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 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.

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.

Dispensing Fee

The amount we pay to a provider for filling a prescription.

Diversional Therapy

Planned recreational activities, such as hobbies, arts and crafts, etc., not directly related to functional therapy for a medical condition.

Drug List

A list of approved drugs, as determined by a group of physicians, pharmacists and other experts that review drugs for coverage determination.

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 6 of this certificate under **Coordination of Coverage for 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 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 Pharmacy Services

Pharmacy services needed immediately because an injury or illness occurred suddenly and unexpectedly.

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 department, services rendered after the member is stabilized will continue to be emergency service 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 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 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.

Essential Health Benefits

A set of healthcare service categories that must be covered by health plans under the Affordable Care Act.

Essential Health Benefits Benchmark Plan

The health plan chosen by the state, which defines the standard set of benefits that must be covered by plans in that state under the Affordable Care Act.

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.

Exclusive Pharmacy Network for Specialty Drugs

A provider selected by BCBSM to provide covered specialty drugs to our members. The provider agrees to accept our payment as payment in full for covered specialty drugs.

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 or drug 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, rehabilitation 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.

Generic Equivalent

A prescription drug that contains the same active ingredients, is identical in strength and dosage form and is administered in the same way as a brand-name drug.

Gynecological Examination

A history and physical examination of the female genital tract.

Habilitative/Habilitation Services

Healthcare 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 Abuse Drugs

Drugs that affect the central nervous system and cause sedation, euphoria or mood change.

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 Healthcare 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. Sometimes referred to as Host Blue.

In-Network Mail Order Pharmacy

A pharmacy who has agreed to accept the Blue Cross allowed amount as payment in full for covered drugs provided to members through our PPO mail order program. (This does not include mail order pharmacies in your exclusive specialty network)

In-Network Pharmacy

A provider selected by BCBSM to provide covered drugs through our PPO program. In-network pharmacies have agreed to accept our payment as payment in full for covered provided to members.

In-Network Providers

Hospitals, physicians and other licensed facilities or healthcare professionals who provide services through this PPO program. In-network providers have agreed to accept BCBSM's payment as payment in full for covered services provided under this PPO program.

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.

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.

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

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 or that has a potentially fatal outcome and as to which the end point of clinical intervention is survival.

Lifestyle Drugs

Drugs such as but not limited to those that treat erectile dysfunction or help a person lose weight.

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.

Maintenance Prescription Drugs

Drugs which are used to treat chronic, long-term conditions.

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

Mandatory Prior Authorization

A process that requires a physician to obtain approval from BCBSM before prescribing select prescription drugs.

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 Allowable Cost

The most BCBSM will pay for generically equivalent drugs covered by BCBSM.

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 healthcare 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 healthcare provider.
- The treatment is not generally regarded as experimental by BCBSM.

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.

Medical necessity (continued)

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 Drugs

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.

Medication Synchronization

A coordination process which allows you, your physician, and your pharmacist to synchronize your multiple maintenance prescription drugs. You, and the drugs you take, must meet specific requirements in order to synchronize your medication.

Member

Any person eligible for healthcare 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 drugs or services.

Multiple Source Brand (MSB) Drug

A brand-name drug that has a generic equivalent available.

Network Providers

Also called “in-network providers” See the definition of “In-network Providers” on Page 197.

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 birth parent’s attending physician 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.

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 healthcare 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.

Nonpreferred Brand-Name Drug

A nonpreferred brand-name drug that is on BCBSM’s drug list.

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, orthoses (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/Virtual 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 Services

Services available to members living or traveling outside a health plan's service area.

Out-of-Network Mail Order Pharmacy

A pharmacy who does not have an agreement with Blue Cross to provide drug coverage through the Mail Order Prescription Drug Program for drugs through our PPO mail order program. These providers have not agreed to accept our allowed amount as payment in full for covered drugs.

Out-of-Network Pharmacy

A provider that has not been selected for participation and has not signed an agreement to provide covered drugs through our PPO program. Out-of-network pharmacies have not agreed to accept our payment as payment in full for covered drugs or services provided to members.

Out-of-Network Providers

Hospitals, physicians and other licensed facilities or healthcare professionals who have not signed an agreement to provide services under this PPO program.

Out-of-Network Specialty Pharmacy

Any specialty drug provider that is not a BCBSM exclusive specialty network drug provider.

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 healthcare 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.

Over-the-Counter (OTC) Drug

A drug that does not require a prescription under federal law. However, a prescription is required for select over-the-counter drugs that may be covered under the pharmacy benefit.

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 healthcare 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, treatment or covered drugs.

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.

Pharmacy

A licensed establishment where a licensed pharmacist dispenses prescription drugs under the laws of the state or country where the pharmacist practices

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.

PLUS Laboratory

A participating independent laboratory that also has a signed agreement with BCBSM under the PLUS program.

PLUS Program

A preferred provider organization of independent laboratories. These laboratories have agreed to provide laboratory and pathology services to BCBSM members enrolled in the PLUS (Prudent Laboratory Use) program. They also accept the BCBSM-approved amount as payment in full.

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, podiatrist, chiropractor, fully licensed psychologist, clinical licensed master's social worker, licensed professional counselor, genetic counselor, athletic trainer, or oral surgeon) or another 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 Brand-Name Drug

A preferred brand-name drug that is on BCBSM's drug list.

Preferred Provider Organization (PPO)

A limited group of healthcare providers or pharmacies who have agreed to provide covered drugs or services to BCBSM members enrolled in the PPO program. These providers or pharmacies accept our payment as payment in full for covered drugs or services.

Prescriber

A healthcare professional authorized by law to prescribe FDA-approved or state-controlled drugs for the treatment of human conditions.

Prescription

An order for medication or supplies written by a prescriber, as defined in this section.

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 like 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 Endpoint

The main outcome(s) the trial is designated to evaluate.

Primary Payer

The healthcare coverage plan that pays first when you are provided benefits by more than one carrier. (For example, you may have BCBSM coverage and Medicare.)

Primary Plan

The healthcare plan obligated to pay for services before any other healthcare plan that covers the member or member.

Prior Authorization

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

A professional provider is an individual who is 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 or a pharmacy legally licensed to dispense drugs.

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 healthcare and treatment, seven days a week. The facility must participate with BCBSM (if located in Michigan).

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 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 healthcare coverage or change your current coverage:

- Start or end of military service. Members must perform military duty for more than 30 days.
- Death of the subscriber
- Divorce
- Loss of dependent status due to age, marriage, change in student status, etc.
- The member 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, nuclear cardiac studies, 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 that is an in-network or out-of-network PPO provider that has the qualifications to meet BCBSM's provider enrollment and credentialing standards.

Rehabilitative/Rehabilitation Services

Healthcare 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 86 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 trial participant (e.g., monthly CT scans for a condition usually requiring only a single scan)

- Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial
- 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 members 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 healthcare plan obligated to pay for services after the primary plan has paid for services.

Select Controlled Substances

These medications are regulated by state and/or federal laws that aim to control the danger of addiction, overuse, physical and mental harm, death, trafficking by illegal means, and other harms. Select controlled substances identified by BCBSM require limits on the quantity dispensed or the day supply.

Select Radiology Procedures

Specialized radiology procedures, including certain diagnostic imaging services such as CAT scans and MRIs.

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 healthcare provider to diagnose or treat a disease, injury, condition or pregnancy.

Short Fill Period

A shorter prescription drug fill time period. For example, a normal fill for your prescription could be 30 days. A short fill period would be to fill your prescription for 15 days. This short fill period is used to synchronize medications, or to avoid waste when trying new medications.

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 healthcare 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 exclude 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 healthcare 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 healthcare 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 healthcare 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

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.

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 woman who is having contractions, to deliver the child (including the placenta)).

State-Controlled Drugs

Drugs that are usually sold over-the-counter, but require a prescription under state law when certain quantities are dispensed

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.

Step Therapy

Previous treatment with one or more preferred drugs may be required.

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 healthcare 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 the 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.

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 healthcare. 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 Payments (EOB) 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 an entire 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 or cancel your coverage.

Grievance and Appeals 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 (DIFS).



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 sends 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 E. 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 Appeals 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 and 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 Appeals 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

- If 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 ask for an expedited review. Your physician should also call this number to confirm 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 Appeals 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 expedited external review 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 preapproval 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 physician 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 card 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 enrollee ID 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 yours, and
- 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.

Need More Information?

At your request and without charge, we will send you details from your healthcare 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

You can 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 to 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 877-469-2583 TTY: 711 أو تحدث إلى مزود الخدمة الخاص بك.

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

ৱেবসাইট: আপনি বাংলায় কথা বললে আমাদের 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।

LU'U 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. Ndiham 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 Sprachassistentendienste 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 or write our BCBSM Customer Service center.

To Call

Most of our Customer Service lines are open for calls 8 a.m. to 8 p.m., Monday through Friday. Please have your ID card ready when you call.

The number to reach us is 1-888-288-2738

When you are out-of-state, call BlueCard 1-800-810-2583

When you are out of the country, call Blue Cross Blue Shield Global Core 1-804-673-1177 (call collect)

To Write

Blue Cross Blue Shield of Michigan
Mail Code X410
600 East Lafayette Boulevard
Detroit, Michigan 48226

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