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Welcome to the Michigan Public School Employees Retirement System
health care plan

Blue Cross Blue Shield of Michigan and the Michigan Public School Employees Retirement System are pleased to provide you and your family with this booklet that explains your health care benefits, effective January 2016. Please take time to carefully read your benefit booklet and keep it handy for reference. This booklet replaces all previously distributed benefit documents.

In this booklet, the words “you” and “your” refer to the public school retiree and covered dependents.

Every effort has been made to ensure the accuracy of this information. However, if statements in the description differ from the applicable coverage documents, then the terms and conditions of applicable coverage documents will prevail. New benefits and benefit changes will be announced in the Best of Health health plan newsletter. If you have questions that are not answered in this book, please call Blue Cross Blue Shield of Michigan's customer service center at 1-800-422-9146 or visit a Blue Cross walk-in center near you.

Blue Cross Blue Shield of Michigan administers the health plan for the Michigan Public School Employees Retirement System. Benefits and future modifications in benefit coverage and coinsurance, copay and deductible requirements are jointly vested by law in the Michigan Department of Technology, Management and Budget (DTMB) and the Michigan Public School Employees Retirement Board (Retirement Board). The DTMB and the Retirement Board reserve the right to change these benefits at any time in accordance with existing law.

Only you and your eligible dependents may use the benefits provided under the retirement system health plan. Allowing anyone not eligible to use these benefits is illegal and subject to possible fraud investigation and termination of coverage.
Eligibility and Enrollment

The Michigan Public School Employees Retirement System offers all pension recipients and their eligible dependents coverage in the health plan. You are eligible to enroll at the time of your retirement or any time after that provided you do not have a Personal Healthcare Fund.

If you have the Premium Subsidy benefit and you are enrolling yourself, your spouse, or a dependent in insurance after retirement, your coverage will begin on the first day of the sixth month after ORS receives your completed application and proofs. For example, if Office of Retirement Services (ORS) receives your Insurance Enrollment/Change Request and/or HMO enrollment form with proofs on February 10, your coverage would begin August 1.

The waiting period does not apply if you or a dependent has a qualifying event and ORS gets the request and proofs within 30 days of a qualifying event. Qualifying events include adoption, birth, death, divorce, marriage, or involuntary loss of coverage in a group plan (e.g. you lose your job or your employer stops offering health care benefits).

For retirees who do not have Medicare, coverage can begin the first of the month after the month ORS receives:

1. A completed application, and
2. Acceptable proofs: a letter on letterhead from the carrier including name of the previously insured member, their coverage end date, and the reason coverage ended.

When you become eligible for Medicare coverage

Medicare has rules that determine when you can enroll in Medicare. If you do not enroll in Medicare when you are first able to, you may have to wait close to a year before your Medicare coverage becomes effective. Do not delay your enrollment in Medicare. As soon as you or anyone else covered by your retirement system’s health plan becomes eligible for Medicare, that person must enroll in both Part A (hospital) and Part B (medical) in order to remain eligible for coverage in the retirement system’s health plan.

If you’re eligible for Medicare and fail to enroll in Part A and Part B, your retirement system coverage will be cancelled retroactive to the date you were first eligible for Medicare coverage and you will be liable for any claims paid during that time period. Your coverage can be restored on the first day of the next month if you enroll in Part A and Part B within one month after your coverage is cancelled and notify the retirement system within that month.

If your retirement system coverage is cancelled because you did not enroll in Part A and Part B when you were eligible for Medicare, and you do not enroll in Part A and Part B within one month after your coverage is cancelled and notify the retirement system, re-enrollment will begin on the first day of the sixth month after ORS receives your completed application and proofs.

Coverage for your dependents

The health plan provides coverage to eligible dependents. An eligible dependent is:

- Your spouse. If he or she is an eligible public school retiree, you will be covered together on one contract.
- Your unmarried child by birth or legal adoption until December 31 of the year in which he or she turns age 19.
- Your unmarried child by legal guardianship until age 18.
- Your unmarried child, by birth or legal adoption until December 31 of the year in which he or she reaches age 25 if a full-time student and eligible to be claimed as a dependent under Section 152 of the Internal Revenue Code.
• Your unmarried child by birth or legal adoption who is totally and permanently disabled, dependent on you for support, and unable to self-sustain employment.

• Either your parent(s) or parent(s)-in-law residing in your household - one set of parents or the other, but not both.

Coverage for your non-Medicare eligible dependents is the same as yours.

In the fall of each year, Blue Cross will contact you to verify that your dependent children continue to meet the criteria for coverage. When you receive the letter, please read it carefully, complete the requested information, sign the form and return it with all appropriate documentation. If you don’t return the form, coverage for your 19 to 25-year-old dependent will be cancelled automatically effective January 1st of the following year. To enroll again, your coverage will begin on the first day of the sixth month after ORS receives your completed application and proofs.

Dependent children older than age 25 are not eligible for coverage on your contract unless they qualify as a disabled dependent, as described in the next section. At the end of the year in which your covered dependent student reaches age 25, he or she will be removed automatically from your health plan coverage.

Enrolling children who do not meet the enrollment criteria, maintaining ineligible dependents on your coverage or providing false information on your enrollment application are considered health care fraud and are punishable by law. Further, when fraud is detected, you will be required to repay the retirement system for all health care services paid by Blue Cross Blue Shield of Michigan for the ineligible dependent.

**Coverage for your disabled dependent child**

The health plan will provide dependent coverage beyond the age of 19 if your child is physically or mentally disabled. The child must meet all of the requirements below:

• Unmarried,

• Eligible to be claimed as a dependent under Section 152 of the Internal Revenue Code, and

• Incapable of self-sustaining employment as a result of the disability.

Your child may be eligible for Medicare health benefits under Social Security disability coverage. If your child is eligible, you must enroll him or her in Medicare in order to maintain coverage under the retirement system health plan. Contact the Social Security Administration about enrollment. Once eligible for Medicare, your child will have coverage under the retirement system’s plan for Medicare members as long as you (or your survivor, if you chose a survivor option) have coverage in the health plan.

If your child is not enrolled in Medicare, Blue Cross’ clinical staff will evaluate whether your child’s condition meets the criteria for continued coverage under the retirement system. Blue Cross will ask you to submit documentation from your physician that describes the nature of your child’s condition and verifies the disability. Blue Cross may also contact your child’s attending physician to discuss the disability and review pertinent medical records.

**Continuing health coverage for your survivor**

A designated beneficiary may continue in the health plan after your death only if you chose a survivor option when you retired (50%, 75% or 100% Survivor Option) that provides an ongoing monthly benefit under the pension plan.

If you chose no survivor option when you retired, coverage for your dependents stops at your death.

**Continuing health coverage for your dependents**

When your dependents lose eligibility for coverage under the health plan, there are options that enable them to purchase their own health benefits: COBRA coverage or a Blue Cross Blue Shield of Michigan individual plan:
COBRA coverage
The Consolidated Omnibus Budget Reconciliation Act (COBRA) enables dependents who lose their group health plan coverage (due to certain reasons) to purchase that coverage for up to 36 months. To qualify, a dependent must be enrolled in the Michigan Public School Employees Retirement System health plan at the time of a qualifying event, which is the death of the retiree, divorce or legal separation, or loss of dependent eligibility under the requirements of the health plan.

Qualified applicants have 60 days from the date of the qualifying event to apply to ORS for COBRA continuation of coverage. They'll receive an application and information on eligibility, monthly rates for coverage and payment information. Dependents can purchase COBRA coverage for up to 36 months.

For a COBRA application and information, go to www.michigan.gov/orsmiaccount, and use the miAccount Message Board to request a COBRA application.

Blue Cross Blue Shield Individual Coverage
Your enrolled dependents may purchase individual coverage through Blue Cross Blue Shield of Michigan when they no longer qualify for coverage under the retirement system. Individual Coverage is an alternative to COBRA.

Your dependent can choose from various benefit levels. There will be no interruption of health coverage if the initial bill and all subsequent bills are paid when due. Your dependent must reside in Michigan.

To ensure continuous coverage under Blue Cross Blue Shield, your dependents must apply within 30 days from the date they are no longer eligible for coverage through the retirement system. For an application form, rates and benefit information call Blue Cross customer service at 1-855-237-3501. Information is also available at www.bcbsm.com.

Coordination of Benefits
Your health plan contains a Coordination of Benefits (COB) provision that applies when you or your dependents are covered under more than one group health plan. If you or your dependents are covered by another Blue Cross Blue Shield health plan or group health plan, your covered health benefits will be coordinated. This means that when a service is covered by both plans the combined payments of all group health plans will not exceed the allowable amount for that service, after you pay any applicable deductible and copay.

When you enrolled in the health plan, the application asked for information about other group health coverage. It’s important to tell the retirement system about any other health coverage you may have because this allows us to work with the other health plan to coordinate your benefits.

Coordination of Benefits does not apply if you and your spouse are both Michigan public school retirees with the same group number. Insurance plans you purchase on your own, such as the AARP Plan, are not considered group health plans.

Determining the primary payer
Here’s how to determine the primary payer:

- If the patient is the Michigan public school retiree and he or she also has coverage as an active employee of an employer with 20 or more employees, the active coverage has the first obligation to pay for health care expenses. The retiree health plan will pay benefits second.

- If the patient is the Michigan public school retiree or the retiree’s spouse and the other group plan does not contain a coordination of benefits provision, that plan will pay claims before the health plan. The retiree health plan benefit payment will be reduced only to ensure all payable benefits by both plans do not exceed the total of the allowable expenses.

- If the patient is the Michigan public school retiree and is covered as a dependent on the other group plan that contains a coordination of benefits provision, the retiree health plan will be primary. If your spouse is the patient, his or her group health care plan will be primary.
• If the patient is a dependent child, the primary plan is the health plan of the parent whose birthday is earlier in the year. If the birth dates are identical, the health plan that has covered the dependent the longest is the primary plan and will pay health benefits first.

• Benefits for children of divorced or separated spouses are determined in the following order unless a court decree places financial responsibility on one parent:
  1. Plan of the custodial parent
  2. Plan of the noncustodial parent

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

Coordinating your health plan coverage with automobile coverage
If you or an eligible dependent are involved in an automobile accident, payment for medical services will be coordinated between Blue Cross and your automobile insurance carrier. Your retirement system health plan has the first obligation to pay for health care expenses. Then the auto coverage will pay benefits second.

Updating your COB information
You'll make the most of your combined group health benefits if you keep ORS notified when you have other health plan coverage. Therefore, always notify ORS when you have other health plan coverage.

If the retirement system health plan is your only health coverage, you must still let the retirement system know that you have no other group health coverage.

Each year you will receive a Verification of Coverage (VOC) form to obtain current information about other health care coverage for you and your covered dependents in addition to your retirement system coverage. It’s important that you respond to the VOC promptly. When you do, Blue Cross will update your records to ensure all health plans share in the cost of your health care expenses. You must adhere to Verification of Coverage rules and processes. If you do not adhere to the rules and processes, your Blue Preferred SM PPO coverage will be cancelled. Re-enrollment will begin on the first day of the sixth month after ORS receives your completed application and proofs.

Discontinuing your coverage
You may voluntarily cancel your health plan coverage or your dependent’s coverage at any time by going to www.michigan.gov/orsmiaccount or by completing ORS’ Insurance Enrollment/Change Request (R0452C) form. The cancellation date will be the last day of the month in which a premium is paid.

If you choose to re-enroll after you cancel your coverage, enrollment will begin on the first day of the sixth month after ORS receives your completed application and proofs.

Updating your information

When to contact ORS
You must contact ORS to notify the retirement system of the following changes:

• Address change
• Adoption
• Birth
• Death
• Divorce
• Involuntary loss of coverage in another group plan
• Marriage
• Medicare eligibility or enrollment
• Name change
• New phone number
• Other health insurance coverage you have (such as from an employer, your spouse’s employer, workers’ compensation, or Medicaid)
• Power of Attorney (if someone else has the legal authority to act for you)

miAccount is the fastest way to access and make changes to your account. When you log in, you have secure access to change your insurance information, update your address, and much more. Log in to miAccount for more information at www.michigan.gov/ors.

You can also report membership and address changes by contacting ORS or completing and submitting the Insurance Enrollment/Change Request (R0452C) form to ORS.

ORS Customer Contact Center office hours are 8:30 a.m. to 5:00 p.m., Monday through Friday.

Lansing area telephone number: (517) 322-5103
From outside the Lansing area: (800) 381-5111
Fax: (517) 322-1116

miAccount Message Board

Any changes or updates you make to your miAccount or with an ORS Customer Service Representative are automatically forwarded to Blue Cross Blue Shield of Michigan. Blue Cross Blue Shield of Michigan cannot change your records without notification from the retirement system.

To avoid delays in payments, misdirected communications or potential coverage problems, it is important that you contact ORS to report membership and address changes. This is especially important when adding or removing a dependent from your contract because you can be liable for claims paid in error.

Example: If you fail to give timely notice of divorce, you will be responsible for payments made by BCBSM on behalf of your ex-spouse for services provided subsequent to your divorce date.

**When to contact BCBSM**

You must contact a Blue Cross customer service representative at 1-800-422-9146 to notify Blue Cross Blue Shield of the following:

• If you have any liability claims, such as claims from an automobile accident
• If you have been admitted to a nursing home
• If you receive care in an out-of-area or out-of-network hospital or emergency room
• If your designated responsible party (such as a caregiver) changes
• If you are participating in a clinical research study
How the health care plan works

Before you become eligible for Medicare

If you or your covered dependents are not yet eligible for Medicare, you’ll receive health benefits through Blue Preferred®, a preferred provider organization (PPO) that offers high-level hospital, physician and other medical benefits through a network. You may choose any provider or specialist, regardless of whether they participate in the PPO network, but if you use a provider that’s not part of the PPO network, you’ll pay more.

When you become eligible for Medicare

Your health coverage continues when you or your covered dependents become eligible for Medicare. You will enjoy the same covered services as non-Medicare members plus the additional benefits provided by Medicare.

You become eligible for Medicare coverage at age 65. If you are disabled or if you have end stage renal disease (ESRD), you are eligible for Medicare at an earlier age.

As soon as you or anyone else covered by your health insurance becomes eligible for Medicare, that person must enroll in both Part A (hospital) and Part B (medical). You must have Medicare Parts A and B to enroll in retiree insurance and prescription drug programs. If you, your spouse, or your dependents don’t enroll in Medicare Part B when first eligible, the insurance for that person will be cancelled and re-enrollment will begin on the first day of the sixth month after ORS receives your completed application and proofs.

If you’re eligible for Medicare and fail to enroll in Part A and Part B, your retirement system coverage will be cancelled retroactive to the date you were first eligible for Medicare coverage and you will be liable for any claims paid during that time period. Your coverage can be restored on the first day of the next month if you enroll in Part A and Part B within one month after your coverage is cancelled and notify the retirement system within that month.

Example: If you were eligible for Medicare but did not enroll in Part A and Part B, and your retirement system coverage was cancelled on July 1, you will have 30 days to re-enroll through the retirement system. Submit a completed application and required proofs to ORS. If you re-enroll before July 15 your coverage begins August 1. If you re-enroll on or after July 15 your coverage begins September 1.

If your retirement system coverage is cancelled because you did not enroll in Part A and Part B when you were eligible for Medicare, and you do not enroll in Part A and Part B within one month after your coverage is cancelled and notify the retirement system, re-enrollment will begin on the first day of the sixth month after ORS receives your completed application and proofs.

Example: If you were eligible for Medicare but did not enroll in Part A and Part B, and your retirement system coverage was cancelled on July 1, and you enroll in Part A and Part B in August and notify the retirement system, your coverage will be restored on February 1.

Medicare also has rules that determine when you can enroll in Medicare. If you do not enroll in Medicare when you are first able, you may have to wait close to a year before your Medicare coverage becomes effective. For more information, contact Medicare through your local Social Security office. You can also visit www.medicare.gov.
Membership card

As a member of the health plan, you receive a Blue Cross Blue Shield of Michigan membership card. Always present this and other health plan membership cards every time you seek health care services that are covered by the health plan. Your health care providers may not know you’re enrolled in another group health plan. That’s why you should always present all your health membership cards whenever you receive services. That way, you’ll be sure to get the most of your combined benefits and your health provider will know with which plan to file the claim.

Lost or stolen membership card

If your membership card is lost or stolen, immediately call a Blue Cross Blue Shield customer service representative at 1-800-422-9146 to report the loss. There’s no charge for a replacement card, and you can still receive services until your new card arrives.

Things to be aware of throughout the year

LivingWell program

LivingWell is a program that helps you track your health, identify areas for improvement and work on an action plan with your doctor.

You have an opportunity to reduce your annual deductible by up to $200 by participating in the LivingWell program.

Each year you will receive a LivingWell questionnaire from Blue Cross Blue Shield of Michigan. Complete the questionnaire, identify your primary care physician and visit that doctor for a physical exam by March 31, 2016 to reduce your annual deductible by $150. The physical exam is covered by the health plan at no cost to you.

NOTE: Members who enroll in the medical plan after April 1, 2016 will have the opportunity to participate in the 2017 LivingWell program.

If the doctor you select as your primary care physician is a Patient-Centered Medical Home (PCMH) doctor, your deductible will be reduced by an additional $50.

A PCMH is a care team led by a primary care physician that focuses on your health goals and needs and works with you to help you manage your care. Here are three reasons to consider choosing a PCMH:
1. **Your PCMH health care team revolves around you.** When you choose a PCMH doctor, your doctor leads a team of health care professionals committed to improving your health. Your team may consist of your regular doctor, specialists, or a nutritionist depending on your health needs. Do you need support to quit smoking or manage a condition such as diabetes? Your PCMH doctor will put the right team together for you.

2. **Your care team works together to help you manage your health.** Your PCMH doctor tracks your care and coordinates with the other health care providers. If you need to see a specialist, your PCMH doctor will help you find the right one and coordinate your visit. Your test results and treatments by other doctors are sent to your PCMH, so you won’t have to re-explain each test or symptom. Your doctor also uses e-prescribing to alert your pharmacist of any possible drug interactions and eliminate errors.

3. **You’ll have more access to your medical team.** PCMH practices offer extended office hours, making it easier to get same-day appointments when you have a health issue. Your PCMH also provides 24-hour access to your care team. If you have a medical question in the middle of the night or on a weekend, you can call your PCMH and possibly avoid a trip to the emergency room.

All of these features add up to you receiving the care you need, when you need it, and experiencing improved health. PCMH doctors are located in many, but not all, areas in Michigan.

**Find a PCMH.** To find a patient centered medical home doctor, use the Find a Doctor tool at www.bcbsm.com.

**New members that join the health plan will have an opportunity to participate in LivingWell and will receive information from Blue Cross.**

### Verification of Coverage

Your retirement system requires collecting information from you about any other medical or drug insurance that you have. Each year you will receive a Verification of Coverage (VOC) form to obtain current information about other health care coverage for you and your covered dependents in addition to your retirement system coverage. It's important that you respond to the VOC promptly. When you do, Blue Cross will update your records to ensure all health plans share in the cost of your health care expenses.

You must adhere to ORS’ Verification of Coverage rules and processes. If you do not adhere to the rules and processes, your Blue Preferred® PPO coverage will be cancelled. Re-enrollment will begin on the first day of the sixth month after ORS receives your completed application and proofs.

### Best of Health newsletter

The Best of Health, aims to help you understand your health coverage, improve nutrition and fitness, manage chronic conditions, and more. Go to www.bcbsm.com/mpsers for recent and previous issues of Best of Health.

### Plan updates

Plan updates are announced in the Best of Health newsletter and annual member benefit seminars. Go to www.bcbsm.com/mpsers for recent and previous issues of Best of Health and recorded versions of the most recent presentation at member benefit seminars.
Taking care of your health

Blue Cross® Health & Wellness

Whether you are looking for ways to improve your lifestyle or manage a chronic illness such as asthma or high blood pressure, Blue Cross® Health & Wellness has the support system you need. You can get to Blue Cross® Health & Wellness by logging into your account at bcbsm.com/mpsers. Once you’re logged in, you can:

- Research topics specific to men, women, and mature adults.
- Use calculators to determine healthy weight, calorie burn rate, target heart rate and much more.
- Take quizzes on a number of health topics.
- Watch videos, listen to podcasts and use other online tools to learn about various health topics.

Blue Cross® Health & Wellness also provides:

24 Hour NurseLine

Supported by board-certified physicians, BCBSM nurses assist individuals who may be uncertain about whether to seek medical care.

To speak to a registered nurse or order health education brochures, call Blue Cross® Health & Wellness, toll free 24 hours a day, seven days a week at: 800-775-2583. TTY users should call 711.

Health assessment

An online questionnaire helps you pinpoint specific health issues and risks, and guides you to healthy behaviors.

Online health programs

A team of online experts outlines a personal plan for you and helpful tips on how to live a healthier lifestyle.

Chronic condition management

Experienced, licensed registered nurses help you learn how to manage your chronic condition with a number of support resources and services.

Case management

Experience, licensed registered case managers help coordinate your care and provide information to help you deal with your chronic condition.

If you have questions and want more information on Blue Cross® Health & Wellness, visit www.bcbsm.com and log in to Member Secured Services.

HealthyBlueXtras

Take advantage of HealthyBlueXtras. This program offers savings and special discounts. HealthyBlueXtras makes it easier and less expensive to get the balanced lifestyle you deserve in these categories:

- **Food and nutrition** - great savings on home meal delivery service and fresh produce at stores
- **Health and fitness** - enjoy a massage at 20 percent off and save on fitness club memberships, classes and consultations
- **Home and garden** - get discounts on plants, flowers and other products for your home, such as a home security system
• **Travel and recreation** - pay less at Michigan’s top resorts and destinations for budget-friendly vacations and getaways, and save on family activities and outings like golf and kayaking

• **Safety** - looking for a security system? HealthyBlueXtras has savings for you

Visit [bcbsm.com/xtras](http://bcbsm.com/xtras) to check out your latest member discounts.

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**Blue365SM**

You have access to the content, tools and discounted offers available through Blue 365SM. This program helps you find health and wellness information, support and services you need every day, all year. The program includes:

• **Health care resources**: Get information and tips about health care providers, prescriptions and supplies; hearing and vision; Medicare: insurance and more. You can also AskBlue.

• **Healthy choices**: Test your health knowledge with a quiz and learn about fitness, food and nutrition, weight control, wellness, children and seniors.

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**Visit the BCBSM Website**

Information is available online 24 hours a day, seven days a week at: [bcbsm.com](http://bcbsm.com). From [bcbsm.com](http://bcbsm.com) you can log in to Member Secured Services from your computer or via the mobile version from your smartphone for the following:

• **Claim information** - view claim information and out-of-pocket costs

• **Provider search** - search for providers by doctor’s name, specialty, network; view side by side comparisons of doctors, including patient reviews

Visit [www.bcbsm.com/mpsers](http://www.bcbsm.com/mpsers) to view plan documents, such as the Summary of Benefits and *Best of Health* newsletters.

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**BCBSM Webcasts and Webinars**

Informative webcasts and webinars can be found under For Members at [www.bcbsm.com/mpsers](http://www.bcbsm.com/mpsers), including:

- The Basics of Medicare
- MPSERS 2016 Health Plan Seminar
- Patient-Centered Medical Home Program

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**Out-of-Pocket Costs**

The health plan is designed to cover most costs associated with your health care. You pay a minimal portion of the cost of covered benefits in addition to any monthly premium deducted from your pension payment. The health plan features cost-sharing that applies to all members:

• Coinsurance (up to the coinsurance maximum)

• Copay

• Annual deductible

• Additional costs for using out-of-network providers

• Additional costs for using providers that do not participate with Blue Cross
You have a benefit dollar maximum that extends over your lifetime and dollar limits on certain transplants and transplant-related services.

**Coinsurance**
A coinsurance requires you to pay a portion of the cost of certain health care services. Your coinsurance is different from your deductible and is applied before and in addition to the deductible amount. The amount of your coinsurance is based on the Blue Cross-approved amount for covered services. If the provider’s charge is less than the Blue Cross-approved amount, then your coinsurance is based on the provider’s charge. For most covered services, the health plan pays 90% of the approved amount, and your coinsurance is 10%.

**Copay**
A copay is a flat dollar amount that you pay when you receive certain health care services.

**Annual deductible**
Each calendar year, you are required to meet a deductible before the health plan will pay benefits. Your current deductible is $900 per non-Medicare member. Your health plan deductible renews on January 1 of each year, regardless of whether you paid your full deductible for the prior year.

You can lower your annual deductible by up to $200 if you participate in the LivingWell program. Refer to the LivingWell program section of this booklet for more information.

Deductible amounts paid under a different health plan do not carry over to this health plan. In cases where an enrolled dependent loses eligibility and obtains individual coverage, deductible amounts paid for that dependent under this health plan do not carry over to the new coverage. If you chose a survivor option at retirement, amounts paid toward your deductible at the time of your death will not be counted toward your surviving spouse and any other dependents’ deductible. Your survivors will be credited only for deductible amounts paid for their own covered services.

The amount applied to your deductible is based on the Blue Cross-approved amount, not the provider’s charge.

**Additional costs for using out-of-network providers**
With a few exceptions you pay an additional 20% of the Blue Cross-approved amount if you use providers outside the Blue Preferred® network. This means that you will pay 30% of the Blue Cross-approved amount for most services received outside the PPO Network: 10% coinsurance plus the additional 20% for using a provider not part of the Blue Preferred® network. If your network provider refers you to a provider not part of the Blue Preferred® network — such as a specialist — the additional 20% is waived and you pay the regular coinsurance for the service.

IMPORTANT: You can save money when you use in-network providers because your 10% coinsurance is based on the Blue Cross-approved amount. In-network providers agree to accept a lower approved amount for the services they provide, which means you pay less out-of-pocket.

**Additional costs for using providers that do not participate with Blue Cross**
Providers that do not participate with Blue Cross Blue Shield do not have an agreement with Blue Cross Blue Shield plans to accept the Blue Cross-approved amounts. When you use providers that do not participate with Blue Cross Blue Shield, in addition to your coinsurance, copay and deductible you are responsible for paying the difference between the Blue Cross-approved amount and the provider’s charge.
**Annual coinsurance maximum**

The health plan limits the amount you will pay each year in coinsurance for medical services. Once coinsurance payments total $850 per member, all covered services that were paid at 90% will be paid at 100% of the approved amount for the rest of the calendar year.

You may not use the following charges to meet your coinsurance maximum:

- Copay
- Deductible amounts
- Additional costs for using out-of-network providers
- Additional costs for using providers that do not participate with Blue Cross
- Charges for non-covered services

**Example: How your coinsurance and annual deductible are applied**

An in-network provider charges $2,000 for services rendered to a retiree who fully participates in the LivingWell program. Blue Cross approves $1,500 for the services. Here’s how the claim would be paid:

<table>
<thead>
<tr>
<th>The retiree has...</th>
<th>The health plan...</th>
<th>The retiree’s out-of-pocket cost...</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>not met</strong> the annual deductible</td>
<td>reduces the approved amount $1,500 by the 10% coinsurance - 150 and the deductible* - 700 and pays $650</td>
<td>10% coinsurance $150 and the deductible $850</td>
</tr>
<tr>
<td><strong>met</strong> the annual deductible</td>
<td>reduces the approved amount $1,500 by the 10% coinsurance - 150 and pays $1,350</td>
<td>10% coinsurance $150</td>
</tr>
</tbody>
</table>

*Note: Retirees that do not fully participate in the LivingWell program have a higher annual deductible.

**Benefit dollar maximums**

The health plan will pay up to the maximum amount for the following:

- **Outpatient services** — payable up to a lifetime maximum of $1 million per member. When you reach the $1 million maximum, an additional $1,000 per calendar year will be restored as long as uninterrupted coverage is in effect. The additional $1,000 allowance is renewed on January 1 of the following calendar year.

- **Residential and outpatient substance abuse treatment** — payable up to the annual minimum dollar amount for substance abuse treatment designated by state law, subject to the health plan’s overall $1 million lifetime maximum. This dollar amount is adjusted annually. For the current benefit amount, call Blue Cross customer service at 1-800-422-9146.

- **Specified organ transplants** — Each of the following transplants have a $1 million lifetime maximum, which is separate from and in addition to the health plan $1 million per member outpatient services lifetime maximum. A transplant benefit period begins five days prior to the actual transplant procedure and ends one year after the surgery. During the transplant benefit period, transplant-related services are applied toward the transplant $1 million lifetime maximum.
  - Heart
  - Heart-lung(s)
  - Liver
Certain transplant-related services have dollar limits:

- Immunosuppressive and other transplant-related prescription drugs are covered as needed during and after the transplant benefit period up to a maximum of $10,000 per year.
- Cost of acquiring the donor organ is covered, including surgery, storage, transportation and payment of covered services if the donor does not have transplant services under any health care plan, up to $10,000 per organ, subject to the transplant $1 million lifetime maximum. (If the organ is obtained from a non-living donor, expenses incurred by the donor before death are not covered.)
- Travel and lodging to and from the designated facility for the transplant surgery is covered, up to a $10,000 maximum. Reasonable and necessary expenses are covered for the patient and one companion (two companions if the patient is under age 18 or the transplant involves a living donor related to the patient).

Selecting your providers and using the Blue Preferred® PPO network

Select a physician that's right for you

If you don’t already have a personal physician, consider choosing one to help you manage and coordinate all your health care needs. This physician will get to know your medical history and lifestyle so that he or she will be in the best position to perform your regular checkups, refer you to specialists or coordinate any necessary hospital care.

Having a good relationship with your doctor is important. The doctor-patient relationship and the advantages that go along with it are at the core of the Patient-Centered Medical Home (PCMH) concept. Refer to the LivingWell program section in this booklet for more information about PCMH and how you can lower your annual deductible by using a PCMH doctor.

Your health plan offers the maximum benefit with the lowest out-of-pocket expense when you use Blue Preferred® network providers in Michigan and BlueCard® PPO providers outside Michigan. Many providers that are not part of the PPO network may participate with Blue Cross Blue Shield plans and you may still lower your out-of-pocket costs by using these providers.

Using a network provider

The health plan offers these provider networks for retirees and their dependents:

- **Blue Preferred® is a preferred provider organization (PPO) network** of doctors, hospitals and other health care specialists in Michigan. Elsewhere in the United States, the BlueCard® PPO network. To find a Patient Centered Medical Home (PCMH) doctor in the Blue Preferred® network, use the Find a Doctor tool at bcbsm.com. Refer to the LivingWell section for more information on PCMH and how selecting a PCMH doctor as your primary care physician can lower your out-of-pocket cost.

- **Quest Diagnostics network** of independent laboratories in Michigan (independent laboratories are not affiliated with a hospital).
Referrals to providers

For some conditions, you may need to see a specialist or another physician. Your network physician can help you find an appropriate provider. You also may select a specialist or other physician on your own.

In some situations, your Blue Preferred® physician may refer you to a provider that is not in the network. Your physician will complete a referral form for you to bring to your out-of-network provider. When this happens, you will not have to pay the additional 20% of the Blue Cross-approved amount normally charged for using out-of-network providers.

If the out-of-network provider you’ve been referred to participates with Blue Cross, you’re only responsible for your deductible and a 10% coinsurance. If the out-of-network provider does not participate with Blue Cross, you’re responsible for the difference between the provider’s charge and the Blue Cross-approved amount in addition to your deductible and the 10% coinsurance.

<table>
<thead>
<tr>
<th>In-network provider</th>
<th>Out-of-network provider that participates with Blue Cross</th>
<th>Provider that does not participate with Blue Cross</th>
</tr>
</thead>
<tbody>
<tr>
<td>your provider</td>
<td>• Member of the Blue Preferred® PPO network</td>
<td>• Not a member of the Blue Preferred® network but participates in other Blue plans</td>
</tr>
<tr>
<td></td>
<td>• Blue Cross selects for quality of care, ability to provide cost-effective services and meet Blue Preferred® standards</td>
<td>• Blue Cross selects for quality of care, ability to provide cost-effective services</td>
</tr>
<tr>
<td>your cost</td>
<td>• Lowest out-of-pocket cost</td>
<td>• Low out-of-pocket cost</td>
</tr>
<tr>
<td></td>
<td>• Coinsurance or copay on most services</td>
<td>• Coinsurance or copay on most services</td>
</tr>
<tr>
<td></td>
<td>• Deductible</td>
<td>• Deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Additional cost for using provider outside the Blue Preferred® PPO network</td>
</tr>
<tr>
<td>claim filing</td>
<td>• Provider submits claim for you</td>
<td>• Provider submits claim for you</td>
</tr>
<tr>
<td></td>
<td>• Blue Cross pays provider directly</td>
<td>• Blue Cross pays provider directly</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• You file claims for covered services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Payment is made to you; you pay provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• No affiliation with Blue Cross Blue Shield</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• No quality screening by Blue Cross Blue Shield</td>
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<tr>
<td></td>
<td></td>
<td>• Higher out-of-pocket cost</td>
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<tr>
<td></td>
<td></td>
<td>• Coinsurance or copay on most services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Additional cost for using provider outside the Blue Preferred® PPO network</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• You pay cost difference between provider charge and Blue Cross approved amount</td>
</tr>
</tbody>
</table>

Locating network providers in Michigan

There are three ways to locate a Blue Preferred® provider, including those that are part of a Patient-Centered Medical Home:

- If you already have a physician, call and ask if he or she is a Blue Preferred® PPO physician.
- Visit the Blue Cross Blue Shield of Michigan Website at [www.bcbsm.com](http://www.bcbsm.com). The online directory is easy to use and is frequently updated.
Call Blue Cross customer service at 1-800-422-9146 for help in locating a network provider in your area.

If you select a network physician and later wish to change physicians, there is no waiting period or paperwork. Just select another physician in the Blue Preferred® network and make your appointment. You don’t have to notify Blue Cross.

You save when you use network providers
The Blue Preferred® PPO plan offers choice when it comes to selecting providers, but you pay more when you use out-of-network providers. Blue Cross carefully selects providers for the quality of care they provide and ability to provide cost-effective care and negotiates discounts for health care services. That means you save when you use Blue Preferred® providers.

Laboratory network in Michigan
Quest Diagnostics provides laboratory services in Michigan. Most of the time, you will not need to do anything special to use your laboratory network. That’s because whenever you receive lab tests in a PPO network doctor’s office, your doctor is responsible for sending them to Quest Diagnostics for processing.

If you need to go directly to a laboratory for tests, make sure you select one of the Quest Diagnostics laboratories to avoid out-of-pocket costs.

To locate the nearest Quest lab, call Quest Diagnostics customer service at 1-866-697-8378 or visit their Website at www.questdiagnostics.com.

Locating network providers outside Michigan
If you live or travel outside Michigan, the health plan offers the BlueCard® PPO network. Just visit www.bcbs.com or call 1-888-630-BLUE (2583) and representatives will give you names, addresses and phone numbers of quality BlueCard® PPO providers in your area. If you're experiencing a medical emergency, just go to the nearest provider.

Laboratory services outside Michigan
The Quest Diagnostics network is located only in Michigan. If you are living or traveling outside Michigan and need laboratory services, you’ll save money by using a lab that participates with the local Blue Cross Blue Shield plan.

Locating network providers outside the United States
For non–emergency inpatient medical care outside of the United States, you must call the BlueCard® Worldwide Service Center to arrange access to a BlueCard® Worldwide hospital. Call 1-800-810-BLUE (2583) and select international option or call collect at 1-804-673-1177 if you are calling outside the United States. If your hospitalization is arranged through the BlueCard® Worldwide Service Center, the hospital will file the claim for you. You will need to pay the hospital the coinsurance and deductible. For a current list of these hospitals, visit the BlueCard® Worldwide website: www.bluecardworldwide.com.

For outpatient and doctor care or inpatient care not arranged through the BlueCard® Worldwide Service Center, you will need to pay the provider and submit a claim form with original bills to Blue Cross Blue Shield of Michigan.

Your covered hospital and medical benefits and cost share is the same when you travel to a foreign country as if the services were rendered in the United States. For covered services performed abroad, the health plan will pay the approved amount at the rate of exchange in effect on the date of service. You are responsible for costs that exceed Blue Cross’s approved amount plus your coinsurance, copay and deductible.

Note: If you receive care out of the country, try to get all receipts itemized in English. Cash register receipts, cancelled checks or money stubs may accompany your itemized receipts, but may not substitute for an itemized statement.
Blue Distinction Centers®

Blue Distinction Centers® are hospitals that meet high quality standards for specialty care. Blue Distinction Centers+® are hospitals that meet the program’s high quality and cost-efficiency standards for specialty care. Expert doctors and medical organizations help develop the standards for this program for Blue Cross Blue Shield of Michigan. Members can find hospitals that deliver high quality, cost-efficient care for:

- Bariatric surgery
- Cardiac care
- Complex and rare cancers
- Knee and hip replacement
- Spine surgery
- Transplants

If you ever need the services described above, Blue Cross Blue Shield of Michigan strongly recommends taking advantage of these centers because they’ve achieved better results: low readmission rates and, most critical, fewer medical complications and deaths. For information about the Blue Distinction Centers® and a current list of hospitals, visit [www.bcbsm.com](http://www.bcbsm.com) or call Blue Cross customer service at 1-800-422-9146.

Health providers not included in the Blue Preferred® PPO network

Prior to obtaining services from the providers below, you must confirm that the facility or provider is Blue Cross-approved. If not, you may be responsible for all or a portion of the charges. For assistance, call Blue Cross customer service at 1-800-422-9146.

Types of facilities and providers that are not part of the Blue Preferred® network include:

- Ambulance
- Ambulatory surgical center
- Hearing Aid providers
- Home Health Agencies
- Home dialysis providers
- Hospice
- Independent medical supplier
- Outpatient psychiatric and substance abuse facilities
- Private duty nurses
- Religious non-medical health care institution
- Skilled nursing facilities

Your health care benefits

This chapter describes the health benefits provided under the health plan. If your only health coverage is through the health plan – that is, if you’re not yet eligible for Medicare or covered by another group health plan – then your benefits will be paid as outlined here. If you have other health coverage, please also see the Coordination of Benefits chapter in this booklet.

You can log in to the secured Member Portal at [www.bcbsm.com/mpsers](http://www.bcbsm.com/mpsers) to view claim information and track out-of-pocket costs.
Your health plan is designed to pay for health care when you need it. **Unless otherwise specified, a service must be medically necessary to be covered by the health plan.** If the service is not medically necessary, you'll be responsible for all of the cost. For a full explanation of medical necessity for hospital and physician services, see “Medical necessity” in the Glossary of Health Care Terms.

Federal and state laws protect the privacy of your medical records and personal health information. Your personal health information is protected as required by these laws.

**Your hospital benefits**

**Inpatient hospital care**

<table>
<thead>
<tr>
<th>What you pay</th>
<th>Outside PPO network</th>
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</thead>
<tbody>
<tr>
<td>In PPO network</td>
<td>10% coinsurance and the annual deductible</td>
</tr>
<tr>
<td></td>
<td>10% coinsurance plus an additional 20% of the Blue Cross-approved amount and the annual deductible. (If provider does not participate with Blue Cross Blue Shield, you also pay difference between the provider's charge and Blue Cross's approved amount.)</td>
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</tbody>
</table>

Refer to the Exclusions and Limitations section of this booklet for additional information.

The health plan provides unlimited days for inpatient hospital care for the diagnosis and treatment of medical and mental health conditions. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.

Hospital care includes the care you get in acute care hospitals, inpatient rehabilitation facilities, and long-term care hospitals.

Covered services include:

- Semiprivate room
- Meals including special diets
- Regular nursing services
- Cost of special care units (such as intensive care or coronary care units)
- Operating and recovery room costs 25
- Drugs and medications
- Lab tests
- X-rays, CAT scans, MRIs, PET scans and other radiology services*
- Anesthesia, including administration, cost of equipment, supplies and the services of a hospital anesthesiologist when billed as a hospital service*
- Blood used for each condition or diagnosis, including storage for blood before surgery
- Diagnostic tests, such as EEGs, EKGs, ECGs and EMGs*
- Chemotherapy and radiation therapy
- Customary, standard and medically-accepted artificial prosthetic devices when permanently implanted internally, such as heart valves and hip joints
• Oxygen and other gas therapy
• Necessary surgical and medical supplies
• Use of appliances and equipment, such as wheelchairs
• Physical, occupational, and speech language therapy for the treatment of the condition for which you are hospitalized
• Routine nursery care of a newborn during the mother’s eligible stay
• Substance abuse services
• Mental health/behavioral health services

*The additional 20% of the Blue Cross-approved amount does not apply to physicians outside the PPO network if the hospital is in the PPO network.

Bariatric surgery and certain transplants are only covered if certain medical criteria are met and the service is performed in a Blue Distinction Center®. For a current list of hospitals, visit www.bcbsm.com or call Blue Cross customer service at 1-800-422-9146. Refer to the Transplants section for more information about transplants that must be performed in a Blue Distinction Center®.

Are you an inpatient?
Staying overnight in a hospital doesn’t always mean you’re an inpatient. You only become an inpatient when a hospital formally admits you as an inpatient, after a doctor orders it. You’re still an outpatient if you haven’t been formally admitted as an inpatient, even if you’re getting emergency department services, observation services, outpatient surgery, lab tests, or X-rays.

Inpatient physician care

<table>
<thead>
<tr>
<th>What you pay</th>
<th>In PPO network</th>
<th>Outside PPO network</th>
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</thead>
<tbody>
<tr>
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</tbody>
</table>

Refer to the Exclusions and Limitations section of this booklet for additional information.

Your hospital benefit covers:

• **Inpatient physician visits** — You’re covered for inpatient medical care from a physician, including care for general medical conditions and mental health conditions.

• **Inpatient care from a specialist** — You’re covered when you’re being treated by more than one physician only if the doctors have different specialties and you’re being treated for more than one medical condition.

• **Inpatient physician consultations** — In complicated situations, the physician in charge of your case may consult another physician for assistance or advice in making a diagnosis or providing treatment. Patient consultations are covered when medically necessary and requested by your attending physician.
Outpatient hospital care

<table>
<thead>
<tr>
<th>What you pay</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>In PPO network</td>
<td>Outside PPO network</td>
</tr>
<tr>
<td>10% coinsurance and the annual deductible</td>
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</tr>
</tbody>
</table>

Refer to the Exclusions and Limitations section of this booklet for additional information.

The services listed under inpatient hospital benefits are also covered when performed in the outpatient department of a hospital. Refer to Emergency Services for information on cost share for emergency room care.

Partial hospitalization is covered for active psychiatric treatment provided in a hospital outpatient setting or by a community mental health center. Partial hospitalization is a structured program that is more intense than the care received in a doctor’s or therapist’s office and is an alternative to inpatient hospitalization.

Dialysis

<table>
<thead>
<tr>
<th>What you pay</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>In PPO network</td>
<td>Outside PPO network</td>
</tr>
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</table>

Refer to the Exclusions and Limitations section of this booklet for additional information.

The health plan covers treatment for chronic, irreversible kidney disease in the outpatient department of a hospital and renal dialysis facility when arranged by your doctor and billed through a network provider or participating hospital. Dialysis is also covered if you are admitted as an inpatient to a hospital for special care.

The PPO network does not include home dialysis providers, but the health plan will cover this service in your home if the provider is Blue Cross-approved. Home dialysis services include the acquisition and installation of a dialysis machine, training in the operation of the machine, necessary laboratory tests, visits by trained dialysis workers, support services, drugs required during the dialysis, and consumable supplies. Refer to the Medical equipment and supplies section in this booklet for cost-share on home dialysis equipment and supplies.
Emergency services

Emergency room care

<table>
<thead>
<tr>
<th>What you pay</th>
<th>In PPO network</th>
<th>Outside PPO network</th>
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<tbody>
<tr>
<td></td>
<td>10% coinsurance and the annual deductible</td>
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<tr>
<td></td>
<td>$75 copay per visit once the annual coinsurance maximum is met.</td>
<td>$75 copay per visit once the annual coinsurance maximum is met.</td>
</tr>
<tr>
<td></td>
<td>The $75 copay is waived if you are admitted to the hospital within 72 hours</td>
<td>The $75 copay is waived if you are admitted to the hospital within 72 hours. (If provider does not participate with Blue Cross Blue Shield, you also pay difference between the provider’s charge and Blue Cross’s approved amount.)</td>
</tr>
</tbody>
</table>

Refer to the Exclusions and Limitations section of this booklet for additional information.

A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Examples of covered emergency services include:

- Severe chest pain
- Loss of consciousness
- Convulsions
- Broken bones
- Cuts requiring prompt medical treatment
- Frostbite

Other services that may be provided in treating the emergency (for example, physician services, laboratory, X-ray, etc.), are discussed elsewhere in this booklet.

Urgently needed care

<table>
<thead>
<tr>
<th>What you pay</th>
<th>In PPO network</th>
<th>Outside PPO network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

Refer to the Exclusions and Limitations section of this booklet for additional information.
Urgently needed care is nonemergency, unforeseen medical illness, injury, or a condition that requires immediate medical care. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.

**What type of treatment should you get?**

Is it a minor illness, or something more serious? Should you go to the emergency room or wait for an appointment with your doctor? Or can you take care of yourself at home? The Blue Cross® Health & Wellness 24-Hour Nurse Line may help you. This 24-hour, seven day a week nurse hotline is available free to all enrolled members. You can speak directly with a registered nurse by calling the Blue Cross® Health & Wellness 24-Hour Nurse Line at 1-800-775-BLUE (2583) (TTY users can call 711). Refer to the Blue Cross® Health & Wellness section for more information.

**Ambulance services**

<table>
<thead>
<tr>
<th>What you pay</th>
<th>Non-approved provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Cross approved provider</td>
<td>10% coinsurance and the annual deductible plus the difference between the provider’s charge and Blue Cross’s approved amount.</td>
</tr>
<tr>
<td></td>
<td>10% coinsurance and the annual deductible</td>
</tr>
</tbody>
</table>

Refer to the Exclusions and Limitations section of this booklet for additional information.

The health plan covers ground ambulance transportation when you need to be transported to a hospital or skilled nursing facility for medically necessary services, and transportation in any other vehicle could endanger your health. The health plan may pay for emergency ambulance transportation in an airplane or helicopter to a hospital if you need immediate and rapid ambulance transportation that ground transportation can’t provide. In some cases, the health plan may pay for limited, medically necessary, non-emergency ambulance transportation if you have a written order from your doctor stating that ambulance transportation is necessary due to your medical condition. The health plan will only cover ambulance services to the nearest appropriate medical facility that’s able to give you the care you need.

The Blue Preferred® PPO network does not include ambulance providers, but the health plan will cover this service if the provider is Blue Cross-approved.

**Surgical services**

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<thead>
<tr>
<th>What you pay</th>
<th>Outside PPO network</th>
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<tbody>
<tr>
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</tbody>
</table>

Refer to the Exclusions and Limitations section of this booklet for additional information.

Surgical procedures are covered when required for the diagnosis and treatment of a disease or injury and performed in an approved location, such as a hospital, physician’s office or ambulatory surgical center.

Services received in an ambulatory surgical center are payable only when performed in a center approved by Blue Cross Blue Shield. This care generally includes elective surgery that does not require the use of hospital facilities and support systems, but is not routinely performed in an office setting.
In addition to general surgery, the following surgeries and surgical services are covered:

- **Dental surgery** to remove impacted teeth or to perform multiple extractions is covered only when you’re hospitalized for the surgery because of a concurrent medical condition, such as a heart condition. The inpatient admission for the dental surgery must be considered medically necessary to safeguard your life.

- **Cosmetic surgery** is limited to the correction of deformities present at birth, conditions caused by accidental injuries and deformities resulting from cancer surgery, such as breast reconstruction following a mastectomy. Your doctor must pre-authorize the procedure and your benefits are subject to specific medical criteria. Surgery primarily for improving your appearance is not covered.

- **Anesthesia** — Covered services include drugs or gases and their administration when medically necessary for a covered service and when given by a physician other than the operating surgeon or an assistant. Anesthesia provided by a Certified Registered Nurse Anesthetist under the direction of an anesthesiologist is also covered.

- **Technical surgical assistance** — Surgical assistance provided by another physician when requested by the operating surgeon is covered. However, it is payable only when an intern or hospital physician is not available for assistance. The surgery requiring the assistance must be an approved major-surgical procedure.

- **Multiple surgeries** — Two or more surgical procedures performed during the same operative session are subject to payment limitations.

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**Doctor visits and other medical services**

<table>
<thead>
<tr>
<th>What you pay</th>
<th>In PPO network</th>
<th>Outside PPO network</th>
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Refer to the Exclusions and Limitations section of this booklet for additional information.

Your health plan covers visits to a physician for the examination, diagnosis and treatment of general medical conditions. Services such as medical care, including urgent medical care, consultations, injections and medications are payable in the physician’s office, clinic or in your home.

In addition to physicians, the health plan also covers medically appropriate services provided by other qualified health care providers, like physician assistants, nurse practitioners, social workers, physical therapists, and psychologists.

The health plan does not cover routine office visits.

**Save money on your doctor visits**

You can limit your out-of-pocket expenses for doctor visits by using Blue Preferred® network providers. Your coinsurance will be less and you won’t have to pay additional charges for covered services. Another bonus: in most cases, you won’t have to bother with paperwork. Network providers will file your claim for you.
Allergy treatment
Covered services include tests to help arrive at a diagnosis.

Cardiac rehabilitation
The health plan covers comprehensive programs that include exercise, education, and counseling for patients who meet these conditions:

- A heart attack in the last 12 months
- Coronary artery bypass surgery
- Current stable angina pectoris (chest pain)
- A heart valve repair or replacement
- A coronary angioplasty (a medical procedure used to open a blocked artery) or coronary stenting (a procedure used to keep an artery open)
- A heart or heart-lung transplant

The health plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than regular cardiac rehabilitation programs. Services are covered in a doctor’s office or hospital outpatient setting.

Chemotherapy services
The health plan covers chemotherapy, including administration of therapy, doctor services and the cost of drugs, except when the treatment or drugs are considered experimental or investigative. Drugs covered under the retirement system’s Prescription Drug Plan are not covered under the Blue Preferred® PPO Plan.

Chiropractic services
Chiropractic benefits are limited to spinal X-rays and spinal manipulations for diagnoses related to the spine (subluxation of the spine). The health plan covers up to 26 spinal manipulations per calendar year.

Dental services
The plan doesn’t cover most dental care, dental procedures, or supplies, like cleanings, fillings, tooth extractions, dentures, dental plates, or other dental devices. You have coverage for certain dental services that you get when you’re in a hospital. You also have coverage for services required for the initial treatment of an injury to the jaws, sound natural teeth, mouth or face. The injury must have occurred after the effective date of your coverage. Services must be performed by a physician or dentist. The health plan does not cover injuries resulting from biting or chewing, or preventive or maintenance services.

Infusion therapy
Infusion therapy is 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. The health plan covers infusion therapy in a doctor’s office, outpatient Ambulatory Infusion Center and in the patient’s home.

The drugs used in infusion therapy must be approved by Blue Cross.

Home infusion therapy is covered when it is:

- Prescribed by a physician within his or her scope of practice to:
  - Manage an incurable or chronic condition
  - Treat a condition that requires acute care if it can be managed safely at home
- Certified by the physician as medically necessary for the treatment of the condition
- Appropriate for use in the patient’s home
• Medical IV therapy, injectable therapy or total parenteral nutrition therapy

Home infusion therapy coverage includes:

• Nursing visits needed to:
  — Administer home infusion therapy or parenteral nutrition
  — Instruct patient or caregivers on infusion administration techniques
  — Provide IV access care (catheter care)

• Durable medical equipment, medical supplies and solutions needed for home infusion therapy or parenteral nutrition

**Medication**

The health plan covers a limited number of prescription drugs like injections you get in a doctor’s office, certain oral anti-cancer drugs, drugs used with some types of durable medical equipment (like a nebulizer or external infusion pump) and immunosuppressant drugs. Self-administered drugs (drugs you would normally take on your own) are not covered. Refer to the Specified Organ and Tissue Transplants section of this booklet for more information on coverage for immunosuppressive drugs.

**Pain management**

Pain management is an integral part of a complete disease treatment plan. You have coverage for the comprehensive evaluation and treatment of diseases, including the management of symptoms such as intractable pain that may be associated with these diseases.

**Physical and occupational therapy, and speech therapy**

The health plan covers evaluation and treatment for injuries and diseases that change your ability to function when your doctor or other health care provider certifies your need for it. These services are covered only when the services are specific, safe and an effective treatment for your condition. The amount, frequency and time period of the services needs to be reasonable, and they need to be complex or only qualified therapists can do them safely and effectively. To be eligible your condition must be expected to improve in a reasonable and generally-predictable period of time.

Physical or occupational therapy and speech therapy services can be performed in a freestanding physical therapy facility or the offices of a doctor of medicine (MD) or osteopathy (DO) or independent physical therapist (IPT). Before receiving physical therapy treatment call Blue Cross Blue Shield customer service at 1-800-422-9146 for information on approved facilities, procedures and diagnoses.

**Pulmonary rehabilitation**

The health plan covers a comprehensive pulmonary rehabilitation program if you have moderate to very severe chronic obstructive pulmonary disease (COPD) and have a referral from the doctor treating this chronic respiratory disease.

**Radiation therapy**

The health plan covers radiation therapy including X-rays, radium, external radiation or radioactive isotopes, except when the treatment is considered experimental or investigative.

**Second opinion on surgery**

The health plan covers second surgical opinions in some cases for surgery that isn’t an emergency. In some cases the health plan covers third surgical opinions.
Telehealth (telemedicine)
The health plan covers limited medical or other health services like office visits and consultation provided using an interactive, two-way telecommunications system (like real-time audio and video) by an eligible provider who isn’t at your location. These services are available in some rural areas, under certain conditions, and only if you’re located at: a doctor’s office, hospital, hospital-based dialysis facility, skilled nursing facility, or community mental health center.

Temporomandibular (TMJ) or Jaw-Joint Disorder
The health plan will cover reversible treatment for jaw-joint disorders. Reversible treatment is treatment of the mouth, teeth or jaw that is not intended to effect a permanent alteration of the bite (occlusion) and is directed at managing symptoms. It can include, but is not limited to, physical medicine, medications or reversible appliance therapy.

The health plan does not cover irreversible medical, surgical and/or dental treatment of the mouth, jaw and associated structures. Irreversible treatment is treatment of the mouth, teeth or jaw that is intended to effect a permanent change in the positioning of the jaws or permanent alteration of the vertical bite dimension. It includes, but is not limited to, crowns, inlays, caps, restorations, grinding, orthodontics and the installation of removable or fixed appliances such as dentures, partial dentures or bridges.

Exceptions: The health plan does cover irreversible surgery directly to the temporomandibular joint, X-rays (including MRIs) and arthrocenteses (injections), regardless of the cause of the jaw-joint disorder. Jaw-joint disorders include, but are not limited to, muscle tension and spasms of musculature related to the temporomandibular joint, skeletal defects and occlusal defects (problem of the bite), that cause pain, loss of function, neurological and personality dysfunctions. This also includes temporomandibular joint syndrome, craniomandibular disorders and myofacial pain dysfunction syndrome.

Vision services
The health plan covers the examination and fitting of one pair of corrective lenses prescribed by a physician following cataract surgery in one or both eyes. The health plan does not cover routine eye examinations, preparation, fitting or procurement of eyeglasses or other corrective visual appliances except as described above.

Preventive services

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<th>What you pay</th>
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Refer to the Exclusions and Limitations section of this booklet for additional information.

If you are treated or monitored for an existing medical condition when you receive a preventive service, cost-sharing applies for the care received for the existing medical condition.

Breast cancer screening
The health plan covers one routine, screening mammogram (breast X-ray) for women every calendar year.
Cervical and vaginal cancer screening
Pap tests and pelvic exams to check for cervical and vaginal cancers are covered once every calendar year.

Pap tests are covered at no cost to you at a Quest Lab in Michigan. Refer to the Laboratory services section in this booklet for more information.

Colorectal cancer screening
Screening colonoscopy is generally covered once every 120 months (high risk every 24 months). There’s no minimum age and no cost to you. If a polyp or other tissue is found and removed during the colonoscopy, you pay a 10% coinsurance and the annual deductible In-network and Out-of-network.

Diabetes self-management training
The health plan covers diabetes outpatient self-management training to teach you to cope with and manage your diabetes. The program may include tips for eating healthy, being active, monitoring blood sugar, taking medication, and reducing risks. You must have diabetes and a written order from your doctor or other qualified health care provider.

Flu shot
You have coverage for one flu shot per flu season (fall or winter) at no cost to you.

Physical exam
The health plan covers a routine physical exam once per calendar year at no cost to you in the PPO network. Outside the network you pay 20% of the Blue Cross-approved amount. If provider does not participate with Blue Cross Blue Shield, you also pay difference between the provider’s charge and Blue Cross’s approved amount.

Prostate cancer screening
The health plan covers a routine screening Prostate Specific Antigen (PSA) test once every calendar year. You pay nothing for the PSA test at a Quest Lab in Michigan. Refer to the Laboratory services section in this booklet for more information.

Laboratory services
Laboratory services are tests of body fluid or tissue that help your doctor diagnose a disease or an injury. Covered services include:

- Pap tests and Prostate Specific Antigen (PSA) tests if requested by your physician because of a suspected or actual presence of disease*
- Blood tests
- Urine tests
- Pathology services (laboratory examination of tissue)

* Refer to the Preventive services section in this booklet for more information.

Most often your doctor will collect a specimen from you and send it to a laboratory for processing. In Michigan, Blue Preferred® PPO doctors are responsible for sending your specimens to Quest Diagnostics for processing. If you need to go directly to a lab for tests in Michigan, you have no out-of-pocket cost when you use Quest laboratories. If your Michigan doctor is not in the Blue Preferred® PPO network, ask him or her to send the specimen to a Quest lab.
### Tests at an independent laboratory

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<tr>
<th>What you pay</th>
<th>In Michigan - At a Quest Lab</th>
<th>In Michigan - At a lab that does not participate with Blue Cross</th>
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<tr>
<td>Nothing</td>
<td>You pay the difference between the provider's charge and Blue Cross’ approved amount</td>
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### Tests in your doctor’s office

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<th>What you pay</th>
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### Other diagnostic services

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*Refer to the Exclusions and Limitations section of this booklet for additional information.*
When medically necessary and performed in an approved location, the health plan covers diagnostic services, including:

- X-rays, CAT scans, MRIs, PET scans and other radiology services
- EEGs, EKGs, ECGs and EMGs
- Mammograms if requested by the physician because of a suspected or actual presence of disease or when required as a post-operative procedure
- Nerve conduction studies
- Ultrasounds

The health plan requires that network providers preauthorize specific high technology diagnostic radiology services. Your provider will arrange for this authorization. Preauthorization does not apply to emergency room care.

**Outpatient mental health treatment**

The health plan covers mental health care services to help with conditions like depression or anxiety. Coverage includes services generally provided in an outpatient setting (like a doctor’s or other health care provider’s office or hospital outpatient department), including visits with a psychiatrist or other doctor, clinical psychologist, licensed master social worker, nurse practitioner, physician assistant, or clinical nurse specialist. Laboratory tests are also covered. Certain limits and conditions apply.

**Services in an outpatient mental health facility**

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<tr>
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Refer to the Exclusions and Limitations section of this booklet for additional information.

Mental health treatment in an approved outpatient mental health facility includes:

- All services of professional and other trained staff, and related services necessary for your care
- Prescribed drugs and medications related to your treatment administered in the facility
- Electroshock therapy and anesthesia administered by a physician
- Psychological testing once every 12 months when administered by a fully licensed psychologist employed by or having privileges at the facility
- Counseling for your family members
Services in a physician's office

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Refer to the Exclusions and Limitations section of this booklet for additional information.

Mental health treatment is also payable for services rendered in a physician’s office, including counseling for you and your family members and psychological testing prescribed, rendered and billed by a fully licensed psychologist once every 12 months.

Substance abuse treatment

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Refer to the Exclusions and Limitations section of this booklet for additional information.

Treatment for substance abuse is payable for services rendered in an approved residential or outpatient substance abuse treatment facility. A residential substance abuse treatment facility may be a freestanding facility exclusively treating substance abuse, or a hospital-based treatment center. Services include:

- Services of professional and trained staff, and services necessary for your care and treatment, including diagnostic tests
- Individual and group therapy or counseling
- Psychological testing once every 12 months
- Laboratory examinations related to your treatment in the program
- Drugs, biologicals and solutions related to your treatment in the program
- Supplies and use of equipment required for detoxification or rehabilitation
- Counseling for your family members

If you are admitted to a residential substance abuse treatment program, the health plan also covers bed, board and general nursing care during your admission, in addition to the services listed above. Inpatient care for up to five days of detoxification is payable under the inpatient hospital benefit.

Make sure your treatment facility is Blue Cross-approved
Before you enter a treatment program, make sure it’s approved by Blue Cross Blue Shield. Treatment at non-approved facilities is not covered under the health plan. You can find out by calling a Blue Cross customer service representative at 1-800-422-9146 before you begin treatment.
Nursing care

Private duty nursing

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Refer to the Exclusions and Limitations section of this booklet for additional information.

When your condition requires continuous skilled care by a professional nurse on a one-to-one basis, the health plan will pay for services prescribed and arranged by a physician and rendered by a registered nurse (RN), a licensed practical nurse (LPN) or a licensed vocational nurse (LVN). The benefit is payable only if you meet clinical criteria, as determined by BCBSM, establishing your need for private nursing care. Payment for private duty nursing services is generally made directly to you.

Private duty nursing requires more skilled care than can be provided by a skilled nursing visit as described in the Home Health Care benefit. Private duty nursing does not cover services provided by, or within the scope of practice of, medical assistants, nurse’s aides, home health aides or other non-nurse level caregivers.

Private duty nursing tasks are required so frequently that the need for care is continuous whether delivered by a skilled professional or a trained family member. The benefit is not intended to supplement the caregiving responsibility of the family, guardian or other responsible parties. The services are temporary, with the goal of training caregivers to provide the necessary services as competently, independently and completely as possible.

8 hours per day of skilled care must be required to meet your needs. Generally, more than 16 hours per day will not be approved. However, up to 16 hours per day may be approved up to 30 days while you are being transitioned from an inpatient setting to your home.

Your attending physician must certify every three months that you require continuous private duty nursing to restore or maintain your maximal level of function and health. Examples of continuous skilled care include:

- Respirator or ventilator care
- 24-hour intravenous (in the vein) or intramuscular (in the muscle) medications
- Nasopharyngeal and tracheotomy aspiration (removal of fluid or gases by suction from the nose/throat and the windpipe) 40

The private duty nursing benefit does not cover:

- Preparing and serving food or feeding you
- Forcing liquids, or measuring your intake and output
- Your personal or oral hygiene, including bathing or changing linen and clothing, laundry and housekeeping
- Helping you walk or get in and out of bed or a wheelchair
- Giving you oral or topical medications
- Routine checking of your vital signs
- Giving insulin injections or checking your blood sugar
- Inpatient private duty nursing services requested by you and your family, and care provided by a hospital employee
• Respite care
• Care provided by a nurse who ordinarily resides in your home or is a member of your immediate family
• Care that is non-medical in nature
• Care that can be provided by a non-skilled professional — even though it may be performed by a RN, LPN or LVN
• Travel expenses

**Not all nursing care is covered**

*Although your doctor may prescribe private duty nursing, the fact that your doctor prescribes such care does not guarantee payment.* How do you know when nursing care will be covered? Call a Blue Cross customer service representative at **1-800-422-9146** before care begins.

### Skilled nursing facility care

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Refer to the *Exclusions and Limitations section of this booklet for additional information.*

The health plan will cover 100 days of medically-necessary care in a Blue Cross-approved skilled nursing facility. After you’ve been discharged from the skilled nursing facility for at least 60 consecutive days, you become eligible for another 100 days of care. To qualify for care in a skilled nursing facility, your doctor must certify that you need daily skilled care, like intravenous injections or physical therapy.

Your skilled nursing benefits include:

• Semiprivate room and board (or a private room if medically necessary)
• Meals, including special diets
• General and skilled nursing care
• Physician/practitioner services
• Physical and occupational therapy, and speech therapy
• Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors)
• Blood, including storage and administration
• Medical and surgical supplies ordinarily provided by the facility
• Laboratory tests ordinarily provided by the facility
• X-rays and other radiology services ordinarily provided by the facility
• Use of appliances, such as wheelchairs, ordinarily provided by the facility

The health plan does not cover custodial or domiciliary care, or care for intellectual disability or senile deterioration.
### Home health agency care

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<td>Annual deductible</td>
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Refer to the Exclusions and Limitations section of this booklet for additional information.

Home health care is covered for patients confined to home if medically necessary and provided by a Blue Cross-approved home health care agency. Your physician must prescribe the care and prepare a treatment plan.

Confined to home means both of these are true:

- You have trouble leaving your home without help (like using a cane, wheelchair, walker, or crutches; special transportation; or help from another person) because of an illness or injury
- Leaving your home isn’t recommended because of your condition, and you’re normally unable to leave your home because it’s a major effort

A doctor, or certain qualified health care professionals who work with a doctor, must see you face-to-face before a doctor can certify that you need home health services.

At each visit, the health plan will cover:

- Part-time or intermittent skilled nursing care by an employee of the home health care agency
- Part-time or intermittent home health aide services such as meal preparation, bathing and feeding
- Nutritional guidance and medical social services
- Medical and surgical supplies such as catheters and colostomy supplies, oxygen, laboratory services and medications for use at home (refer to the medical equipment and supplies section for information on your costs)
- Physical, occupational and speech therapy (may be covered outside the home when equipment cannot be brought into the home). These services are covered only when the services are specific, safe and an effective treatment for your condition. The amount, frequency and time period of the services needs to be reasonable, and they need to be complex or only qualified therapists can do them safely and effectively. To be eligible your condition must be expected to improve in a reasonable and generally-predictable period of time.

Note: To be covered under the home health care benefit, your skilled nursing and home health aid services combined must total fewer than eight hours per day and 35 hours per week.

### Hospice care

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Refer to the Exclusions and Limitations section of this booklet for additional information.
The health plan will pay for care provided in an approved hospice care program up to the specified number of days described below. **Your decision to receive hospice care is entirely voluntary and can be cancelled by you at any time.**

**ELECTING HOSPICE BENEFITS**

To qualify for hospice benefits you must be terminally ill, as certified by a physician, and have a medical prognosis that indicates a life expectancy of twelve months or less.

You may elect to receive hospice benefits by filing an election statement with an approved hospice program. An election statement is a document that you sign to declare that you elect to receive hospice benefits and waive your rights to receive Blue Cross benefits (both inpatient and outpatient) for conditions related to your terminal illness. Each hospice program designs its own election statement.

**Note:** If you elect hospice benefits, you’re still eligible to receive health plan benefits, but not for those conditions related to your terminal illness.

Hospice benefits are divided into three election periods:

- One period of 90 consecutive days
- A second period of 90 consecutive days
- A third period of 30 consecutive days

You may continue to use your hospice benefit periods until you exhaust all three periods or cancel your hospice benefits. Before electing the 30-day period, you must first exhaust the two 90-day periods.

**LEVELS OF HOSPICE CARE**

You’re entitled to the following levels of hospice care:

- **Home care services** in periods of one- to eight-hours per day, or continuous home care up to 24-hours per day during crisis periods
- **Facility services** provided by a participating hospice inpatient unit, or by a participating hospital or skilled nursing facility that has a contract with Blue Cross Blue Shield of Michigan to provide hospice care. These facilities can provide:
  - **Occasional respite care** to relieve family members or other persons caring for you at home. When necessary, up to five days of respite care is covered within a 30-day calendar period
  - **Short-term general inpatient care** for pain control or symptom management, to the extent such care is consistent with the plan of care established by the hospice program

**HOSPICE CARE BENEFITS**

When admitted to an approved hospice program, you’re entitled to the following services:

- Physician services by a member of the hospice care program
- Nursing care by, or under the supervision of, a registered nurse
- Medical social services by a qualified social worker and under the direction of a physician
- Coverage for evaluation, consultation, and supportive services for the patient and family
- Counseling services provided to you and your family members (or other persons caring for you at home)
- Medical appliances and supplies, including drugs and biologicals, furnished to relieve pain or lessen the effects of the terminal illness
• Durable medical equipment furnished by the hospice program for use in your home while you are under hospice care
• Home health aide services provided by qualified aides, and homemaker services rendered under the general supervision of a registered nurse
• Physical and occupational therapy, and speech language pathology services provided for purposes of symptom control or to enable you to maintain activities of daily living and basic functional skills
• Bereavement counseling for your family after your death

**Canceling hospice benefits**
You may discontinue hospice care at any time by submitting a cancellation statement to the hospice program administrator. You or the hospice program can develop the cancellation statement, which must include:

- Your acknowledgment that you are canceling hospice benefits for the remainder of the current election period
- The effective date of the cancellation of hospice benefits
- Your Blue Cross Blue Shield contract number and group number
- Your signature

When you cancel hospice benefits, your regular health plan benefits will be reinstated without any lapse of coverage.

You may cancel hospice benefits a maximum of three times: once per election period. You can cancel at any time within an election period, and Blue Cross Blue Shield will reinstate benefits for your care. However, if you cancel hospice benefits, you forfeit any unused days in the 90- or 30-day election period in effect when you cancelled hospice care.

**Hospice benefit limitations and exclusions**
Hospice care is subject to the following limitations and exclusions:

- Benefits include only those services provided primarily in connection with the terminal illness by the hospice program
- Benefits are limited to services of an approved hospice program you designate, unless your designated hospice program makes arrangements with another approved hospice program to provide services
- Benefits include only those services that are part of the plan of care established by the hospice program

**Medical equipment, prosthetics, orthotics and supplies**

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<th>Blue Cross participating independent medical supplier</th>
<th>Non-participating independent medical supplier</th>
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Refer to the Exclusions and Limitations section of this booklet for additional information.
Refer to the chapters in this booklet about hospital benefits and doctor’s office benefits for information about obtaining items from those locations. This section does not apply to items you use during a hospital stay or purchase from your doctor.

Items that you purchase or rent from an independent medical supplier must be prescribed by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) for use at home.

If you need medical supplies the quantity you receive will be based on your prescription and the medical necessity guidelines used by Blue Cross Blue Shield of Michigan.

Types of equipment, supplies and services include:

- Durable medical equipment used in your home, such as hospital beds, wheelchairs, walkers, canes and oxygen equipment
- Respiratory equipment such as oxygen concentrators and apnea monitors
- Home dialysis equipment and supplies
- Prosthetic devices such as artificial limbs and mastectomy supplies
- Orthotic devices such as leg braces, back braces and ankle or wrist supports
- Medical supplies such as colostomy supplies, surgical dressings, adult disposable diapers, surgical stockings (up to eight per year) and home infusion needles
- Equipment setup and training when medically necessary, such as assistance by an RN or respiratory therapist

**Diabetic supplies and medications**

Some diabetic supplies are covered under your medical plan while others are covered under your prescription drug benefit plan.

The medical plan covers blood sugar testing monitors, blood sugar test strips, lancet devices and lancets, blood sugar control solutions at no cost to you when you use in-network and out-of-network providers.

People who have diabetes and severe diabetic foot disease have coverage for the furnishing and fitting of either one pair of custom-molded shoes or inserts or one pair of extra-depth shoes each calendar year, prescribed by a podiatrist or other qualified doctor and provided by a podiatrist, orthotist, prosthetist, pedorthist, or other qualified individual. The health plan covers 2 additional pairs of inserts each calendar year for custom-molded shoes and 3 pairs of inserts each calendar year for extra-depth shoes. The health plan will cover shoe modifications instead of inserts.

Injectable insulin and needles and syringes for injectable insulin are covered under your Prescription Drug Plan when prescribed by your physician.

### Transplants

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<th>What you pay</th>
<th>In PPO network</th>
<th>Outside PPO network</th>
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<tr>
<td>10% coinsurance and the annual deductible, unless otherwise noted</td>
<td>10% coinsurance and the annual deductible, unless otherwise noted</td>
<td>10% coinsurance plus an additional 20% of the Blue Cross-approved amount and the annual deductible, unless otherwise noted. (If provider does not participate with Blue Cross Blue Shield, you also pay difference between the provider’s charge and Blue Cross’s approved amount.)</td>
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Refer to the Exclusions and Limitations section of this booklet for additional information.
The health plan will pay for organ and tissue transplants, bone marrow transplants and specified organ transplants approved by Blue Cross Blue Shield of Michigan and performed at a participating hospital or a designated transplant facility approved by Blue Cross Blue Shield of Michigan.

Transplant coverage includes:

- hospital and medical expenses
- transplant-related services, such as tests, labs, and exams before surgery
- services needed to treat a condition arising out of the organ transplant surgery
- immunosuppressive drugs (under certain conditions)
- travel and lodging (under certain conditions)
- evaluation and surgical removal of the donated part from a living or nonliving donor and surgically transplanting the part to you
- procurement of organs
- follow up care

**Obtaining authorization for transplant surgery**

Prior to surgery, your physician must request authorization from Blue Cross Blue Shield of Michigan for certain transplants. This authorization is necessary to ensure that your surgery is covered by the health plan and performed in a designated transplant center meeting established standards. Authorization for the transplant will be sent to the transplant center or the physician (whomever requests the authorization) and to you.

**Immunosuppressive drugs**

Blue Preferred® covers a limited number of outpatient prescription drugs. Prescription drugs not covered under Blue Preferred® may be covered under your prescription drug plan.

Immunosuppressive and other transplant-related prescription drugs covered under your prescription drug plan are not covered under Blue Preferred®.

If you receive a heart, heart-lung, liver, lung, pancreas or intestine transplant, you have coverage for immunosuppressive and other transplant-related prescription drugs up to a maximum of $10,000 per year.

**Organ and tissue transplants**

Covered services include the evaluation and surgical removal of the donated part (including skin, corneas and kidneys) from a living or nonliving donor and surgically transplanting the part to you.

**Bone marrow and stem cell transplants**

Bone marrow transplants involve replacing the bone marrow of a patient with bone marrow of another person (called allogeneic transplants) or using the patient’s own bone marrow or peripheral blood stem cells (called autologous transplants) for transplantation back into the patient. This procedure is used to treat certain types of cancer.

Bone marrow transplants are payable only for approved diagnoses. Your physician must obtain preauthorization from Blue Cross Blue Shield of Michigan prior to your surgery. **This authorization is necessary to ensure that your diagnosis is covered under the bone marrow transplant benefit and that your surgery will be performed in a Blue Cross-approved location by an approved provider.**

Additional covered services for autologous and allogeneic bone marrow and/or peripheral stem cell transplants include:

- Blood tests on first-degree relatives to evaluate them as donors (if these services are not already covered by their health insurance)
• A search of a bone marrow donor registry for a donor (A search will begin only when the need for a donor is established. The registry’s name and charges must be submitted for approval to Blue Cross Blue Shield of Michigan by the bone marrow transplant center)

• Infusion of colony-stimulating growth factors

• Harvesting of bone marrow and/or stem cells and associated storage costs if transplant is intended within one year

• ECP (Extracorporeal Photopheresis for Graft vs. Host Disease) for treatment of transplanted cells/tissues that attack and destroy the tissues/organs of the transplant receipt

• Hospitalization in an intensive care or special care unit

• Infusion of bone marrow and/or stem cells into the patient

• Services received when you donate bone marrow and/or peripheral blood stem cells

**Specified organ transplants**

You have coverage for travel and lodging to and from the designated facility for the following organ transplants if the facility is farther away than the normal community patterns of care and you choose to have the transplant at this distant location:

- Heart
- Heart-lung
- Liver
- Lung
- Pancreas
- Intestine

Travel and lodging to and from the designated facility for the transplant surgery is covered without cost share, up to a $10,000 maximum. Reasonable and necessary expenses are covered for you and one companion (two companions if the patient is under age 18 or the transplant involves a living donor related to the patient).

Travel and lodging is not covered for other types of transplants.

Each specified organ transplant listed above has a $1 million lifetime maximum, which is separate from and in addition to the health plan $1 million outpatient services lifetime maximum. Transplant-related services beginning five days prior to specified organ transplant procedure are applied toward the transplant $1 million maximum and continue for one year after the surgery.

Cost of acquiring the donor organ is covered, including surgery, storage, transportation and payment of covered services if the donor does not have transplant services under any health care plan, up to $10,000 per organ, subject to the transplant $1 million lifetime maximum. (If the organ is obtained from a non-living donor, expenses incurred by the donor before death are not covered.)

For additional information about transplants and designated transplant facilities, call the Blue Cross Human Organ Transplant Program, Monday through Friday from 8 a.m. to 5 p.m. at 1-800-242-3504.

**Religious non-medical health care institution**

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<th>What you pay</th>
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<td>Blue Cross approved provider</td>
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<td>10% coinsurance and the annual deductible</td>
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Refer to the Exclusions and Limitations section of this booklet for additional information.
In these facilities, religious beliefs prohibit conventional and unconventional medical care. If you qualify for hospital or skilled nursing facility care, the health plan will only cover the inpatient, non-religious, non-medical items and services. An example is room and board, or any items and services that don’t require a doctor’s order or prescription, like unmedicated wound dressings or use of a simple walker.

### Hearing care

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<td><strong>Blue Cross approved provider</strong></td>
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<td>10% coinsurance and the annual deductible</td>
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<tr>
<td><strong>Non approved provider</strong></td>
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<tr>
<td>You pay all costs</td>
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Refer to the Exclusions and Limitations section of this booklet for additional information.

Your hearing benefits include the following services:

- **Audiometric examination** — Measures hearing ability, including tests for air and bone conduction, speech reception and speech discrimination.

- **Hearing aid evaluation test** — Determines what type of hearing aid should be prescribed to compensate for loss of hearing.

- **Hearing aid** — Includes standard monaural (one ear) and binaural (involving both ears) in-the-ear, behind-the-ear and basic hearing aids worn on the body – with ear molds, if necessary. Not all models of hearing aids are covered under your hearing benefits.

- **Conformity test** — Evaluates the performance of a hearing aid and its conformity to the original prescription after it is fitted.

### Frequency limitation

Covered hearing program benefits are payable once every 36 consecutive months.

**Note:** Binaural hearing aids, or two hearing aids to correct hearing loss in both ears, are covered only when they’re purchased on the same date. Two hearing aids provided to you on different dates are not considered binaural hearing aids and only one will be paid during a 36-month period.

### Payment provisions

1. Hearing program services are payable only when all of the following provisions are met: You receive all hearing services from a participating provider. In Michigan, this means the provider participates with Blue Cross Blue Shield of Michigan. Outside Michigan, the provider must participate with either the Blue Cross Blue Shield plan in that state or any other health insurer or carrier. Hearing services and supplies provided by a nonparticipating provider are not payable.

2. Before any hearing benefits will be approved, you must receive a medical examination of the ear, sometimes called a medical clearance exam. This only applies the first time you purchase hearing aids. The exam must be performed by a participating board-certified or board-eligible otologist, otolaryngologist or otorhinolaryngologist.

   The medical examination of the ear is covered under the health plan benefit for doctor visits and is subject to the health plan coinsurance and deductible.

3. If a hearing aid is prescribed, you must receive an audiometric exam and a hearing aid evaluation test. This can be performed by an audiologist or approved hearing aid dealer. You must obtain your hearing aid and undergo a conformity test within six (6) months of your medical examination of the ear.
Exclusions and limitations

The following exclusions and limitations apply to your health plan benefits. These conditions are in addition to other applicable exclusions and limitations listed elsewhere in this booklet.

- Services provided before the effective date of coverage or after the coverage termination date
- Any charges for care, treatment, service or supplies to the extent such charges exceed Blue Cross Blue Shield’s determination of the amount of reasonable charges
- Services and supplies considered not reasonable and necessary, according to the standards of Blue Cross Blue Shield of Michigan, for the diagnosis or treatment of the illness or injury, unless these services are listed as covered elsewhere in this benefit booklet
- Routine health screenings and preventive services except as otherwise specified in this booklet. Exclusions include but are not limited to: abdominal aortic aneurysm screening, alcohol misuse screening and counseling, bone mass measurement (bone density), cardiovascular disease screenings, screening barium enema, screening fecal occult blood tests, screening flexible sigmoidoscopy, depression screening, diabetes screenings, EKG or ECG screening, routine foot exams and care, screening digital rectal exams, glaucoma tests, HIV screening, obesity screening and counseling, and sexually transmitted infections screening and counseling.
- Services for premarital and pre-employment examinations
- Tobacco-use cessation counseling (Quit the Nic is a free smoking cessation program provided to members as part of Blue Cross® Health & Wellness)
- Kidney disease education services
- Medical nutrition therapy services, except as described elsewhere in this benefit booklet
- Vaccinations, including but not limited to: hepatitis B shot, pneumococcal shot and shingles shot
- Services for cosmetic or beautifying purposes unless required for the correction of a defect incurred through an injury or for the correction of a congenital anomaly or breast reconstruction
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary
- Voluntary sterilization, reversal of sterilization, sex change operations, contraceptive supplies
- Surgical treatment for morbid obesity, except when it is considered medically necessary
- Services for detoxification for drug addiction or alcoholism except for treatment of the underlying causes and for services leading to rehabilitation
- Mental health services extending beyond the period necessary for evaluation and diagnosis for intellectual disability
- Services and supplies not medically necessary. For a definition of medical necessity, refer to the Glossary of Health Care Terms
- Private room in a hospital
- Custodial or domiciliary care
- Rest therapy and care in nursing or rest home facilities
- Care for intellectual disability or senile deterioration
- Personal care items
• Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television

• Hospital admissions principally for observation or diagnostic evaluation, physical therapy, X-ray or laboratory tests, weight reduction (with or without medication), basal metabolism tests, electrocardiography, ultrasound studies or nuclear medicine studies

• Treatment for conditions that do not require substantially continuous bed care under the constant care of licensed physicians and registered nurses

• Hospital care for dental services except for services rendered when you are a hospital bed patient for either multiple extractions or the removal of unerupted teeth, performed under a general anesthesia when a concurrent hazardous medical condition exists

• Treatment of temporomandibular joint (TMJ) syndrome and related jaw-joint problems by any method other than direct surgery on the jaw joint, X-rays or arthrocenteses (injections)

• Routine dental care, such as cleanings, fillings or dentures

• Chiropractic care, other than manual manipulation of the spine and spinal x-rays

• Routine foot care

• Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a person with diabetic foot disease

• Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease

• Items such as air purifiers, air conditioners and exercise equipment

• Adjustment or replacement of eligible appliances unless required because of wear or a change in your condition

• Eyeglasses, routine eye examinations, radial keratotomy, LASIK surgery, vision therapy and other low vision aids, except for corrective lenses covered following cataract surgery as described elsewhere in this booklet

• Prescription drugs except as otherwise specified in this booklet

• Separate charges for infiltration of a local anesthetic during a surgical procedure

• Physical, occupational and speech language pathology (speech therapy) to treat long-standing, chronic conditions

• Massage therapy

• Physical therapy solely for pain management

• Tests to measure physical capacities, such as strength, dexterity, coordination or stamina unless part of a complete physical therapy treatment program

• Recreational services

• Services and items primarily for your comfort and convenience

• Cost of transportation and travel, except for ambulance service and specified organ transplant benefits specified in this booklet

• Ambulance transportation not medically necessary

• Transportation in a vehicle not state-certified as an ambulance

• Services rendered by fire departments, rescue squads or other carriers whose fee is paid as a voluntary donation
• Cadaver transport
• Transportation in connection with outpatient care for a non-accidental illness
• Transportation for your and your family’s convenience or doctor and hospital preference
• Homemaker services and household assistance, including light housekeeping or light meal preparation
• Fees charged by your immediate relatives or members of your household
• Meals delivered to your home
• Charges for the completion of claim forms
• Charges for missed appointments
• Services, care, supplies or devices considered experimental or investigative, including clinical research studies and all services associated with clinical research studies. For a definition of experimental/investigative, refer to the Glossary of Health Care Terms
• Acupuncture
• Naturopath services (use of natural or alternative treatments)
• Treatment of an illness or injury caused by military action or war, declared or undeclared
• Care and services you receive at no cost to you when provided in a veteran’s, marine or other federal hospital or any hospital maintained by any state or governmental agency, unless required by law
• Services provided to veterans in Veterans Affairs (VA) facilities except for the difference in cost-share if emergency services are received and the VA cost-share is more than the cost-share under this health plan
• Care and services payable by a government-sponsored health care program, such as Medicare or TRICARE, for which a member is eligible. These services are not payable even if you have not signed up to receive the benefits provided by such programs
• Cost of care and services covered by another insurance plan that has primary responsible for first payment
• Injury or sickness covered by Workers Compensation
• Care of an occupational injury or disease for which the employer is obligated to provide reimbursement for services
• Cost of installation of water, electrical or waste systems in a residence where such systems are not present
• Cost of water or electricity used in the operation of a dialysis machine
• Expenses incurred in the installation of a dialysis machine which are not essential to its operation
• Installation cost incurred in moving a dialysis machine to another location within the patient’s residence
• An examination performed by an audiologist or hearing aid dealer but not prescribed by an otologist or otolaryngologist
• A hearing aid ordered while you are a member, but delivered more than 60 days after your coverage terminates
• Replacement of lost or broken hearing aids within the frequency limitation
• Repairs of hearing aids or replacement parts for hearing aids
• A hearing aid that does not meet Food and Drug Administration and Federal Trade Commission requirements
• The cost difference between digital-controlled programmable hearing devices and analog hearing devices
• The cost difference between an eyeglass-type hearing aid and a behind-the-ear hearing aid
• All hearing program services and supplies provided by a nonparticipating provider

Subrogation

In certain cases, another person, insurance company or organization may be legally obligated to pay for health services that Blue Cross has paid. Subrogation is the legal process by which Blue Cross recovers these payments. If you are awarded compensation for health services already paid by Blue Cross:

• Your right to recover payment from the other person, insurance company or organization is automatically transferred to Blue Cross.
• You're required to fully cooperate with Blue Cross to help enforce its right to recovery.
• If you receive money through a lawsuit, settlement or other means for services paid under your health coverage, you must reimburse Blue Cross.

Filing claims

Ask your provider to bill Blue Cross Blue Shield for covered services. Some nonparticipating providers will file a claim or assist you with claim filing. Do not file a claim if your provider is billing Blue Cross Blue Shield for the services. If the provider gives you a receipt, just keep it for your records.

If you receive services from a provider that does not participate with Blue Cross Blue Shield, and the provider will not file your claim, you will need to file it. Unless otherwise noted, you must file your claim to Blue Cross within 24 months of the date of service. Remember: payment from Blue Cross Blue Shield of Michigan is made to you; it's your responsibility to pay the provider. Charges for filing claims are not covered.

Filing claims for COB

In most instances, when you go to a participating provider your provider will bill the primary and secondary plans directly. However, if you receive services from a nonparticipating provider and the provider will not file your claim, you will need to do so.

How to file a claim

1. Ask for an itemized statement of services at the time of service. Your itemized receipt must contain the following:
   • Name, address and telephone number of the provider (physician, hospital, etc.)
   • Provider’s identification number (outside Michigan, you need the tax ID)
   • The retiree’s nine-digit identification number from his/her Blue Cross membership card
   • Patient’s full name and date of birth
   • Exact date (month, day, year) the service was performed or supplied
• Diagnosis
• Type of service performed or item supplied
• Amount charged for each service performed or item supplied

• For services received from a physician in a clinic, make sure the name and license number of the physician who provided the service is indicated on the receipt plus the name of the clinic.

• For ambulance services, ask for an itemization of the provider’s base rate, total miles traveled, location of patient pickup and delivery, and reason for ambulance service. Include the names of hospitals if you are moved from one hospital to another; the accident scene or home address if you are moved to, or from a hospital.

• For private duty nursing, ask for an itemized statement that includes the name and contract number of retiree (cardholder), the patient’s name, the location of service (such as your home), exact number of hours the nurse worked, doctor’s statement of medical necessity, including diagnosis and care requirements, nurse’s name, degree and license (registration) number and copy of photo ID, the nurse’s duties and hour-by-hour nursing notes.

• For Coordination of Benefits claims, always submit your claim to your primary payer first. Once the primary payer has approved or rejected your claim, then file a claim to Blue Cross Blue Shield and include the explanation of benefits statement from your primary carrier.

2. File your claims immediately after receiving covered services. It’s easier to obtain information needed to process your claim when dates of service are recent.

3. Use one Member Application for Payment Consideration claim form per member on your contract. You can use one claim form for multiple services for the same patient.

   • You can download a copy of the form from www.bcbsm.com or call 1-800-422-9146 and ask for one to be mailed to you. You don’t have to use the form, but it will help Blue Cross process the claim faster.

4. Review claim forms to ensure the information is accurate and complete and be sure to sign the form.

5. Make copies of all statements and forms for your files before sending the originals.

6. Mail your request for payment together with any bills or receipts to Blue Cross Blue Shield of Michigan at this address:

   Member Claims, MC 0010
   Blue Cross Blue Shield of Michigan

   600 E. Lafayette Blvd.
   Detroit, MI 48226-2998

**Why you should always file claims as soon as possible**
You have at least a year to file your claims, but why wait? If Blue Cross has questions about the claim, your memory – and certainly your provider’s– won’t be as clear on the details of the diagnosis and services rendered. But most important, if you’ve paid for services, why not get your reimbursement now…instead of a year from now?
Explanation of Benefit Payment Statement

Once your claim is processed, Blue Cross Blue Shield of Michigan will send you an Explanation of Benefit Payments (EOBP) statement. The EOBP is not a bill. It is provided to help you understand how your benefits were paid and shows:

- Date of service
- Name of the hospital, physician or other health care professional that provided each service. If services are performed outside of Michigan, “out-of-state provider” will be indicated.
- Amount billed by your provider
- Blue Cross Blue Shield-approved amount for each service
- Any amount you may owe your provider for coinsurance, copays, deductibles and non-covered services
- Any amount applied toward your annual deductible and annual maximum
- An explanation when payment is denied

The EOBP is also provided to make sure the information received was correct. Therefore, it’s important that you carefully review your EOBP statements to make sure that payments agree with services you actually received and that names and dates agree with your records. If you do find an error, immediately tell your provider and request a corrected statement. If you have questions about your EOBP, call Blue Cross Blue Shield customer service at 1-800-422-9146.

Keep a copy for your records
When you submit claims, always make a photocopy of the claim form, receipts and any other supporting documentation that you send to Blue Cross. That way, you’ll have a reference in case you have to call us with a question, as well as a permanent record for your files.

Grievance Process

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What to do if you have a problem or concern

Blue Cross Blue Shield of Michigan wants to make sure you’re satisfied with the services you receive as a member of the Blue Preferred® PPO plan. If you have a question or concern about how your claim or request for benefits was handled, call Blue Cross customer service.

Most questions or concerns can be resolved through a phone call to a Blue Cross customer service. However, Michigan Public Act 350, as amended by Public Act 516 of 1996 and Public Act 250 of 2000, protects you by providing an internal grievance procedure, which includes a managerial-level conference, if you believe BCBSM has violated Section 402 or 403 of Public Act 350. You will find the specific provisions of those two parts of the act at the end of this section.

You can select someone to act on your behalf at any step of the grievance process, including your physician. Just download and fill out a Authorized Representative Form (PDF) or call Blue Cross customer service and ask to have a form mailed to you. This form gives your representative the permission to communicate with Blue Cross Blue Shield of Michigan on a one-time basis about your concern.

**Standard internal grievance procedure**

1. You or your authorized representative must send Blue Cross a written statement (grievance) explaining why you disagree with the determination on your request for benefits or payment.

2. Once Blue Cross receives your written grievance, a representative will contact you to conduct or schedule the managerial-level conference. That will be your opportunity to provide Blue Cross with any additional information or testimony you want Blue Cross to consider in reviewing your grievance. You can ask that the conference be conducted in person or over the telephone. If in person, the conference can be held at Blue Cross headquarters in Detroit or at a Michigan Blue Cross customer service center. Blue Cross' written resolution will be the final determination regarding your grievance. You may obtain copies of all information relating to Blue Cross' response free of charge.

3. Blue Cross must provide you with its final written determination within 30 calendar days of its receipt of your written grievance. However, that timeframe may be extended if you need more time to provide information, or for a period of up to 10 days if Blue Cross has not received information requested from a health care provider, for example, your doctor or hospital.

**Expeditied internal grievance procedure**

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

An expedited internal grievance can only be requested when you think Blue Cross wrongfully denied, terminated, or reduced coverage for a health care service prior to your having received that health care service or if you believe Blue Cross failed to respond timely to a request for benefits or payment. The procedure is as follows:

1. Call [313] 225-6800. The required physician’s substantiation that your condition qualifies for an expedited grievance can also be submitted by telephone.

2. Blue Cross must provide you with its decision within 72 hours of receiving both your grievance and the physician's substantiation. If the decision is communicated to you orally, Blue Cross must provide you with written confirmation within 2 business days.

**Section 402 of Public Act 350**

The sections below provide the exact language in the law. Section 402 (1) provides that Blue Cross may not do any of the following:

- Misrepresent pertinent facts or certificate provisions relating to coverage.
• Fail to acknowledge promptly or to act reasonably and promptly upon communications with respect to a claim arising under a certificate.

• Fail to adopt and implement reasonable standards for the prompt investigation of a claim arising under a certificate.

• Refuse to pay claims without conducting a reasonable investigation based upon the available information.

• Fail to affirm or deny coverage of a claim within a reasonable time after a claim has been received.

• Fail to attempt in good faith to make a prompt, fair and equitable settlement of a claim for which liability has become reasonably clear.

• Compel members to institute litigation to recover amounts due under a certificate by offering substantially less than the amounts due.

• Attempt to settle a claim for less than the amount which a reasonable person would believe was due under a certificate by making reference to written or printed advertising material accompanying or made part of an application for coverage.

• Make known to the member a policy of appealing from administrative hearing decisions in favor of members for the purpose of compelling a member to accept a settlement or compromise in a claim.

• Attempt to settle a claim on the basis of an application which was altered without notice to, knowledge or consent of, the subscriber under whose certificate the claim is being made.

• Delay the investigation or payment of a claim by requiring a member, or the provider of health care services to the member, to submit a preliminary claim and then requiring subsequent submission of a formal claim, seeking solely the duplication of a verification.

• Fail to promptly provide a reasonable explanation of the basis for a denial of a claim or for the offer of a compromise settlement.

• Fail to promptly settle a claim where liability has become reasonably clear under one portion of the certificate in order to influence a settlement under another portion of the certificate.

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

The things Blue Cross cannot do under this section are:

• Issue or deliver to a person money or other valuable consideration.

• Offer to make or make an agreement relating to a certificate other than as plainly expressed in the certificate.

• Offer to give or pay, directly or indirectly, a rebate or part of a premium, or an advantage with respect to the furnishing of health care benefits or administrative or other services offered by the corporation except as reflected in the rate and expressly provided in the certificate.

• Make, issue or circulate, or cause to be made, issued or circulated, any estimate, illustration, circular or statement misrepresenting the terms of a certificate or contract for administrative or other services, the benefits thereunder, or the true nature thereof.

• Make a misrepresentation or incomplete comparison, whether oral or written, between certificates of the corporation or between certificates or contracts of the corporation and another health care corporation, health maintenance organization or other person.
Section 403 of Public Act 350

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

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

Disclosure required by the Patient Protection Act

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

The following information is available to you by calling or writing Blue Cross Blue Shield of Michigan customer service at the number or address listed in the How to reach Blue Cross Blue Shield of Michigan section of this book. You can request:

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

Blue Cross requires that your request for information be submitted in writing.
### How to reach
**Blue Cross Blue Shield of Michigan**

When calling or visiting, please be prepared to provide the retiree's nine digit identification number from your Blue Cross Blue Preferred® PPO membership card.

| Blue Cross Blue Shield of Michigan Customer Service Contact Information |
| --- | --- |
| **Call** | 1-800-422-9146  
Monday through Friday, 8:30 a.m. to 5:00 p.m., Eastern Standard Time  
Toll free from the United States or Canada  
Call 1-313-225-800 outside the United States or Canada and ask to be transferred to the customer area that services Michigan public school retirees.  
Customer Service also has free language interpreter services available for non-English speakers |
| **TTY** | 711  
Monday through Friday, 8:30 a.m. to 5:00 p.m., Eastern Standard Time  
Toll free  
This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking |
| **Fax** | 1-866-458-9342 |
| **Visit a Walk-in Center** | Visit [www.bcbsm.com](http://www.bcbsm.com) for locations and business hours  
Service centers are open weekdays.  
Some offices close for lunch |
| **Write** | Blue Cross Blue Shield of Michigan  
Michigan Public School Employees Retirement System  
Customer Service Inquiry Department - Mail Code X521  
600 Lafayette East  
Detroit, MI 48226-2998 |
| **Website** | [www.bcbsm.com/mpers](http://www.bcbsm.com/mpers) |
Glossary of health care terms

**Acute**
A condition that occurs suddenly and rapidly with severe symptoms and short course. This condition is not chronic.

**Ambulatory Infusion Center**
An outpatient center, not part of a hospital, where patients can receive medication administered intravenously.

**Ambulatory surgical center**
An outpatient facility, not part of a hospital, where surgery is performed and care related to the surgery is given. Procedures performed in this facility can be performed safely without overnight inpatient hospital care.

**Approved amount**
The maximum payment level approved by Blue Cross Blue Shield of Michigan or the provider’s charge for the covered service, whichever is lower. Applicable coinsurance, copay and deductible amounts are deducted from the approved amount. All reference to approved amount in this booklet refers to the approved amount as determined by Blue Cross Blue Shield of Michigan.

**Benefit**
Coverage for health care services available in accordance with the terms of your health care coverage.

**Benefit period**
The health plan benefit period is a period of 12 consecutive months based on the calendar year, January 1 through December 31. Certain benefits are payable only once during the benefit period and renew each year.

**Blue Distinction Centers®**
Hospitals recognized for their expertise in delivering specialty care.

**Blue Preferred® PPO network provider**
A select group of Michigan preferred provider organization (PPO) health care providers that meet stringent quality requirements and agree to provide services at a lower cost in return for a greater, predictable volume of patients.

**Chronic condition**
A disease or other health condition of long duration or frequent recurrence. Chronic conditions usually show little change or are of slow progression.

**Coordination of Benefits (COB)**
A program that coordinates your health benefits when you or your covered dependents have coverage under more than one group health plan.

**COBRA coverage**
A federal requirement that allows departing members to continue group health coverage at their own expense for a fixed period of time.

**Coinsurance, copay**
The designated portion of the approved amount you are required to pay for services covered under the health plan. A coinsurance is a percentage of the approved amount and it applied before the deductible. A copay is a flat dollar amount.
Cosmetic treatment
Treatment primarily for improving appearance rather than medically treating a disease or other health condition.

Cost-sharing
Amounts that you have to pay when services are received.

Covered service
A service, procedure, treatment, device or supply identified as payable under the health plan.

Custodial care
Care that is primarily for the purpose of meeting an individual’s personal needs or the convenience of the family and can be provided by a person without skills or training. The term also includes care that does not require medical supervision that is administered to help a person with activities of daily living such as walking, getting in and out of bed, bathing, dressing, eating and taking medicine, etc. This care may be given with or without routine nursing care, training in personal hygiene and other forms of self-care, or care supervised by a physician.

Deductible
A specific dollar amount you must pay during each calendar year before the health plan will begin to pay for covered services and supplies. The deductible is applied after the coinsurance.

Dialysis
Treatment of kidney disease using equipment to remove harmful substances from the blood. Dialysis is one of the primary treatments for end stage renal disease.

Durable medical equipment
Equipment that is able to withstand repeated use, is primarily and customarily used to serve a medical purpose and is not generally useful to a person in the absence of illness or injury. This equipment must be prescribed by a physician and includes items such as wheelchairs, canes, and access railings for the bath.

Emergency, medical emergency
A condition that occurs suddenly and unexpectedly and that could result in serious bodily harm or threaten life unless immediately treated. Examples of medical emergencies include loss of consciousness, severe chest pain, convulsions, etc. Symptoms or conditions such as the common cold, slight fever, headaches, etc., are not considered life-threatening and do not qualify as a medical emergency.

ESRD (end stage renal disease)
Permanent kidney failure which requires a regular course of dialysis or a kidney transplant to maintain life.

Experimental/investigative
A service or treatment that has not been scientifically demonstrated to be as safe and effective for treatment of a condition as a conventional or standard treatment. Experimental/investigative services are not covered under the health plan. This includes facility services and physician services, including diagnostic tests, which are related to experimental/investigative procedures. The Blue Cross Blue Shield of Michigan medical director is responsible for determining whether the use of any service is experimental or investigational. The service may be determined to be experimental or investigational when there is:

- A written experimental or investigational plan by the attending provider or another provider studying the same service; or
- A written informed consent used by the treating provider in which the service is referred to as experimental, investigational or other than conventional or standard therapy.
The Blue Cross Blue Shield of Michigan medical director uses the following information in the evaluation process:

- Scientific data such as 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 local and national medical societies, other appropriate professional societies, organizations, committees or government agencies.
- Approval, when applicable, by the Food and Drug Administration (FDA), the Office of Health Technology Association (OHTA) and other governmental agencies.
- Accepted national standards of practice in the medical profession.
- Approval by the Institutional Review Board of the hospital or medical center.

**Facility, approved facility**
A hospital or clinic that offers acute care or specialized treatment, such as substance abuse, rehabilitation treatment, skilled nursing care or physical therapy. An approved facility must meet all applicable local and state licensing and certification requirements and be accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association. The facility must be approved as a provider by Blue Cross Blue Shield of Michigan or an affiliate of Blue Cross Blue Shield of Michigan.

**Grievance**
A type of complaint you make about Blue Cross' decision on a claim or benefit determination.

**Home health care agency, approved home health care agency**
A centrally administered agency that provides physician-directed nursing and other paramedical services to patients at home. An approved home health care agency is required to be affiliated with a participating hospital, must meet all local and state licensure and certification requirements and must be approved as a provider by Blue Cross Blue Shield of Michigan or an affiliate of Blue Cross Blue Shield of Michigan.

**Hospice, approved hospice**
A public agency or private program that primarily provides medical, psychological, social and spiritual services to terminally ill individuals and their families. Hospice care may take place in the patient's home, or in an approved facility. An approved hospice program must meet the State of Michigan licensure requirements, must be certified by Medicare and hold membership in the National Hospice Organization or the Michigan Hospice Organization. The hospice provider must also participate in an agreement with Blue Cross Blue Shield of Michigan to accept the approved amount as payment in full.

**Hospital, approved hospital**
A facility that, in return for compensation from its patients, provides diagnostic and therapeutic services on a continuous inpatient or outpatient basis for the surgical, medical or psychiatric diagnosis, treatment and care of injuries or acutely sick persons. These services are provided by or under the supervision of a professional staff of licensed physicians and surgeons. A hospital continuously provides 24 hour-a-day nursing services by registered nurses. A hospital is not, other than incidentally, a place for custodial, convalescent, pulmonary tuberculosis, rest or domiciliary care; an institution for exceptional children; an institution for the treatment of the aged or substance abusers; or a skilled nursing facility or other nursing care facility. An approved hospital meets all applicable local and state licensure and certification requirements, is accredited as a hospital by state or national medical or hospital authorities or associations, and has been approved as a provider by Blue Cross Blue Shield of Michigan or an affiliate of Blue Cross Blue Shield of Michigan.

**Injury**
Physical damage caused by an action, object or substance outside the body. Examples include injuries from automobile accidents, sprains or cuts requiring prompt medical treatment, broken bones and frostbite.
**Investigative services**
See experimental/investigative.

**Laboratory services**
Tests of body fluid or tissue that help your doctor diagnose a disease or an injury. Examples are blood tests, urine tests and Pap smears.

**Mammogram**
A low-dose radiograph of the breast, featuring two views per breast. The radiation machine must be state authorized and specifically designed and used to perform mammography.

**Medicaid**
A joint federal and state government program that helps with medical costs for certain people with limited incomes and resources.

**Medicare**
The federal-funded program that pays for medical services for U.S. citizens age 65 or older, persons of any age who are permanently disabled, or persons with End-Stage Renal Disease.

**Medical necessity**
Services and treatments that are necessary to treat an illness or injury. Unless otherwise specified, only medically necessary services are covered under the health plan.

**Medical necessity for payment of professional provider services:**
Health care services that a professional provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the member’s illness, injury or disease and not primarily for the convenience of the member, professional provider, or other health care provider, and 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.

NOTE: “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.

**Medical necessity for payment of hospital and LTACH services:**
Determination by BCBSM that allows for the payment of covered hospital services when all of the following conditions are met:

- The covered service is for the treatment, diagnosis or symptoms of an injury, condition or disease.
- The service, treatment, or supply is appropriate for the symptoms and is consistent with the diagnosis. Appropriate means that the type, level and length of care, treatment or supply and setting is needed to provide safe and adequate care and treatment.
- For inpatient hospital stays, acute care as an inpatient must be necessitated by the patient’s condition because safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.
- The services are not mainly for the convenience of the member or health care provider.
• The treatment is not generally regarded as experimental by BCBSM.

• The treatment is not determined to be medically inappropriate by the Utilization Quality and Health Management Programs (applies only to hospitals, not to LTACHs).

Medical necessity for payment of services of other providers:
Determination by physicians acting for BCBSM, based on criteria and guidelines developed by physicians for BCBSM who are acting for their respective provider type or medical specialty, that:

• The covered service is accepted as necessary and appropriate for the patient’s condition.

• It is not mainly for the convenience of the member or physician.

• In the case of diagnostic testing, the results are essential to and are used in the diagnosis or management of the patient’s condition.

NOTE: In the absence of established criteria, medical necessity will be determined by physicians according to accepted standards and practices.

Medicare
The federally-funded program that pays for medical services to U.S. citizens age 65 or older, persons of any age who are permanently disabled, or persons with End-Stage Renal Disease.

Network provider
A health care provider selected by Blue Cross Blue Shield of Michigan to provide medical services through the Blue Preferred® plan. These providers have signed participating agreements with Blue Cross Blue Shield of Michigan agreeing to accept the approved amount as payment in full for covered services.

Networks in Michigan:
• The Blue Preferred® network comprising physicians, hospitals and certain other qualified health care providers.

• Quest Diagnostics network of independent laboratories.

Networks outside Michigan:
• BlueCard® program comprising physicians, hospitals and certain other health care.

Out-of-pocket
A member's cost-sharing requirement to pay for a portion of services received.

Outpatient psychiatric facility, approved outpatient psychiatric facility
A legally constituted, centrally administered facility providing comprehensive mental health services to the community. An approved facility is an administratively distinct governmental, public, private or independent unit or part of such unit that provides outpatient mental health services and has been approved as a provider by Blue Cross Blue Shield of Michigan or an affiliate of Blue Cross Blue Shield of Michigan. These include centers for the care of adults or children, such as hospitals, clinics, day treatment centers and Community Mental Health Centers as defined in the Federal Community Mental Health Act of 1963, as amended.

Outpatient substance abuse treatment program, approved substance abuse treatment program
An outpatient program that provides medical and other services specifically for persons who are physiologically or psychologically dependent upon or abusing alcohol or drugs. An approved program meets all state licensure requirements and has been approved as a provider by Blue Cross Blue Shield of Michigan or an affiliate of Blue Cross Blue Shield of Michigan.
Participating provider
A health care provider who has signed participating agreements with Blue Cross Blue Shield of Michigan agreeing to accept its approved amount as payment in full for covered services. Participating providers may or may not be part of the Blue Preferred® PPO network. Participating providers include doctors, hospitals and specialty care facilities, pharmacies and certain other health care professionals.

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

Physician
A doctor of medicine or osteopathy legally qualified and licensed to practice medicine and perform surgery at the time and place services are performed. For the purpose of this booklet, a dentist, a podiatrist or a doctor of chiropractic who is legally qualified and licensed to practice dentistry, podiatry or chiropractic at the time and place services are performed is deemed to be a physician to the extent that the doctor renders covered services which the doctor is legally qualified to prescribe or perform.

Prosthetic device
An artificial device that replaces all or part of a body part, or replaces all or part of the functions of a permanently-inoperative malfunctioning body part.

Psychologist
A mental health practitioner who is certified or licensed, whichever is applicable, as a psychologist at the time and place services are performed. Where there are no certification or licensure requirements, a psychologist is one who is recognized as such by the appropriate professional society at the time and place services are performed.

Residential substance abuse treatment program, approved substance abuse treatment program
A program that provides medical and other services specifically for people who are physiologically or psychologically dependent upon or abusing alcohol or drugs. Residential substance abuse programs must be administered in a licensed facility that operates 24 hours a day, seven days a week. An approved residential program meets all state licensure requirements and has been approved as a provider by Blue Cross Blue Shield of Michigan or an affiliate of Blue Cross Blue Shield of Michigan.

Routine service
A procedure or test ordered for you without direct relationship to the diagnosis or treatment of a specific disease or injury.

Semiprivate room
A hospital room with two beds.

Services
Surgery, care, treatment, supplies, devices, drugs and equipment given by a health provider to diagnose or treat disease, injury, condition or pregnancy, and which are based on valid medical need according to accepted standards of medical practice.
Skilled nursing facility, approved skilled nursing facility
A facility that provides convalescent and short- or long-term care for illness with continuous nursing and other health care services by or under the supervision of a physician and a registered nurse. The facility may be operated independently or as part of an accredited acute care hospital. An approved facility is accredited by the Joint Commission on Accreditation of Hospitals and is recognized as an extended-care facility by the Secretary of Health and Human Services of the U.S., has entered into a written agreement as a provider by Blue Cross Blue Shield of Michigan and has been approved as a provider by Blue Cross Blue Shield of Michigan or an affiliate of Blue Cross Blue Shield of Michigan.

Special care unit
A designated care unit within a hospital such as a cardiac care, burn care or intensive care unit that contains all necessary types of equipment, together with skilled nursing and support services needed for care of critically ill patients and is recognized as such by Blue Cross Blue Shield of Michigan.

Substance abuse
Taking alcohol or other drugs in amounts that can:

- Harm a person’s physical, mental, social and economic well-being.
- Cause the person to lose self-control.
- Endanger the safety or welfare of others because of the substance’s habitual influence on the person.

TRICARE
A health care program of the United States Department of Defense Military Health System.

Urgently Needed Care
Care provided to treat a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care.